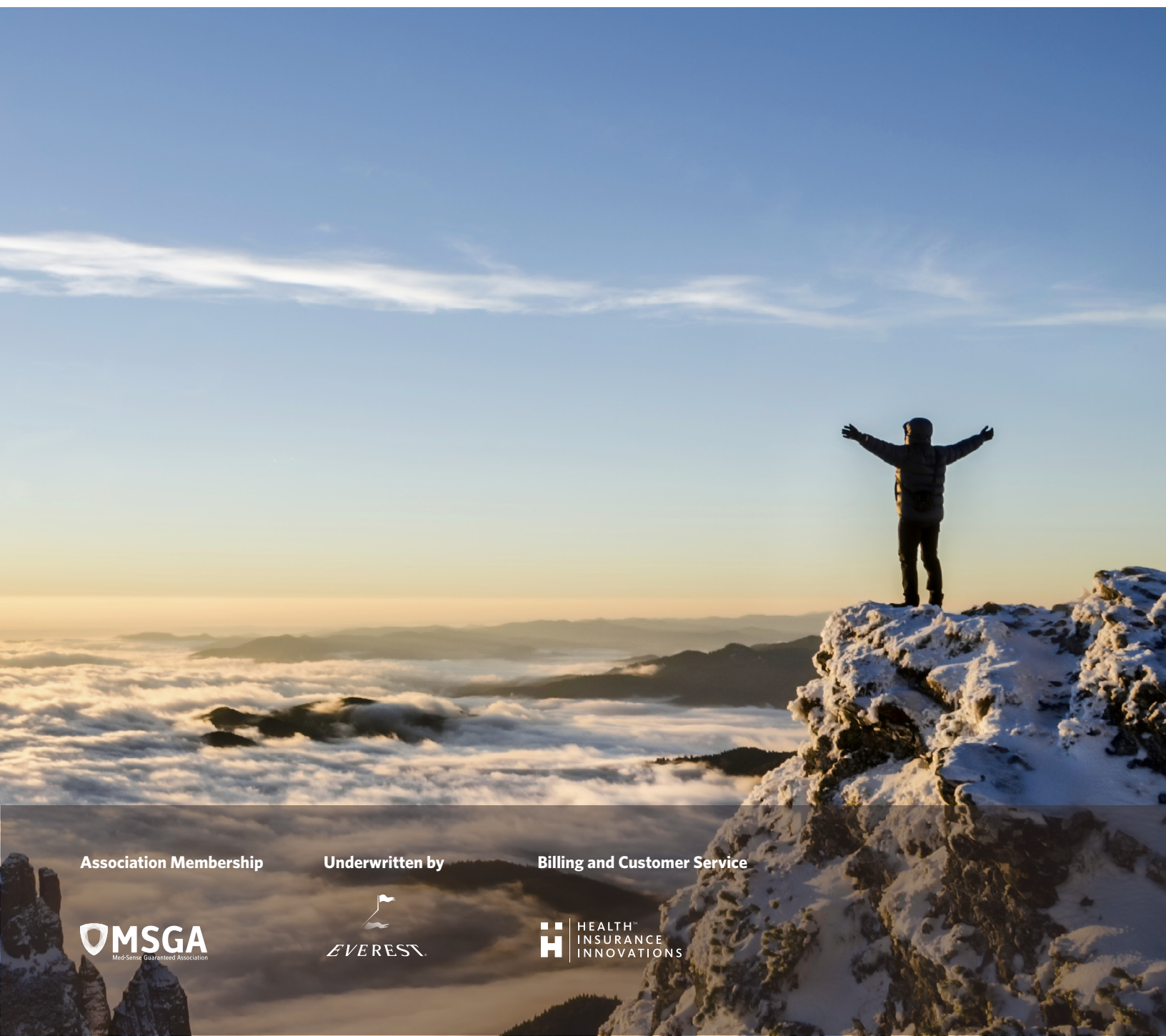


# Everest STM

Everest STM is available directly to policyholders or to members of the Med-Sense Guaranteed Association (depending on state). Everest STM ushers in a more affordable solution with reapply options up to 36 months, transforming the level of coverage available to your customers.



Association Membership



Underwritten by



Billing and Customer Service



## Plan Benefits

<b>Deductible Options</b>	\$1,000, \$2,500, \$5,000, \$7,500, or \$10,000
<b>Coinsurance Options</b>	50/50, 70/30, 80/20, or 100/0
<b>Coverage Period Maximum</b>	\$250,000, \$750,000, \$1,000,000, or \$1,500,000
<b>Length of Coverage</b>	Up to 6 or 12 months
<b>Network</b>	<p>One of the popular aspects of short-term medical insurance plans is they do not confine you to a specific network. In other types of major medical plans if a member seeks services outside of the network they either have a higher percentage of cost shares or they have to pay the full claim themselves. Your Everest Prime STM does not confine you to a specific network. Everest Prime plan pays up to 150%* of Medicare allowable expenses.</p> <p>*Actual amount may be greater in some states. The coverage is subject to the language of the policy as issued.</p>
<b>Coverage Effective Date</b>	Next day coverage; later effective date available, but not to exceed 60 days from date of transmission
<b>Eligibility</b>	<b>18 - 64</b>  Child only coverage available for ages 2-25
<b>Waiting Period</b>	5 days for sickness 30 days for cancer

## Reapply Rules

**Arizona** - 1 reapply of 180 days or less in any 12 month period

**California** - Reapplies not allowed without a 64 day break

**Colorado** - Cannot exceed 2 STM policies (any carrier) in a 12 month period

**Idaho** - Reapplies not allowed without a 64 day break

**Kansas** - 1 allowed

**Maine** - Reapplies not allowed without a 12 month break

**Minnesota** - Cannot exceed 365 days in any 555 day period; must wait 190 days after insured has had 365 days coverage to reapply

**Montana** - 1 reapply after a 1 day break

**Nevada** - Cannot exceed 185 days in any 365 day period; must wait 180 days after insured has had 185 days of coverage

**New Hampshire** - Cannot exceed 540 days in any 24 month period; must wait 190 days after insured has had 540 days of coverage

**Oregon** - Total coverage cannot exceed 364 days without a 60 day break

**West Virginia** - Not allowed

**Wisconsin** - Total coverage cannot exceed 18 months without a 64 day break

# Plan Benefits

	Plan 1	Plan 2	Plan 3
<b>Deductible Options</b>	\$1000, \$2500, \$5000, or \$7500	\$1000, \$2500, \$5000, \$7500, or \$10,000	\$1000, \$2500, \$5000, \$7500, or \$10,000
<b>Coinsurance Options</b>	70/30, 80/20, or 100/0	50/50, 70/30, 80/20, or 100/0	50/50, 70/30, 80/20, or 100/0
<b>Out-Of-Pocket Maximum</b>	\$2,000, \$3,000, or \$4,000	\$2,000, \$3,000, or \$4,000	\$2,000, \$3,000, \$4,000, or 5,000
<b>Coverage Period Maximum</b>	\$250,000, \$750,000, or \$1,000,000	\$250,000, \$750,000, \$1,000,000, or \$1,500,000	\$250,000, \$750,000, \$1,000,000, or \$1,500,000

Unless specified otherwise, the following benefits are for Insured and each Covered Dependent subject to the plan Deductible, Coinsurance Percentage, Out-Of-Pocket Maximum and Policy Maximum chosen. Benefits are limited to the Maximum Allowable Expense for each Covered Expense, in addition to any specific limits stated in the policy.

## Doctor Office Consultation / Urgent Care

Copay	\$30 Copay, maximum 3	\$50, unlimited	\$40, unlimited
Wellness Benefit Copay	\$50 Copay, maximum 1	\$50 Copay, maximum 1	\$50 Copay, maximum 1

## Inpatient Hospital Services

Average Standard Room Rate	\$1,000 per day	Average Standard Room Rate	Average Standard Room Rate
Hospital ICU	\$1,250 per day	Average Standard Room Rate	Average Standard Room Rate
Doctor Visits	\$50 per day, maximum \$500	Subject to Coinsurance and Deductible	Subject to Coinsurance and Deductible

## Outpatient Services

Surgical Facility	\$1,250 per day	Subject to Coinsurance and Deductible	Subject to Coinsurance and Deductible
Outpatient Surgery Deductible	N/A	\$500 Additional deductible applies, maximum 3	\$500 Additional deductible applies, maximum 3
Emergency Room	\$250 per visit	\$500 Additional deductible applies	\$500 Additional deductible applies
Advanced Diagnostic Studies Deductible	N/A	\$500 per occurrence	\$500 per occurrence
Ambulance	\$250 per transport	\$250 per transport	\$250 per transport
Extended Care Facility	\$150 per day, maximum 30 days	\$150 per day, maximum 30 days	\$150 per day, maximum 30 days
Home Health Care	\$50 per visit, maximum 30 days	\$50 per visit, maximum 30 days	\$50 per visit, maximum 30 days
Physical, Occupational and Speech Therapy	\$50 per day, maximum 20 visits	\$50 per day, maximum 20 visits	\$50 per day, maximum 20 visits

## Mental Disorders

Inpatient	\$100 per day, maximum 31 days	\$100 per day, maximum 31 days	\$100 per day, maximum 31 days
Outpatient	\$50 per day, maximum 10 visits	\$50 per day, maximum 10 visits	\$50 per day, maximum 10 visits

## Substance Abuse

Inpatient	\$100 per day, maximum 31 days	\$100 per day, maximum 31 days	\$100 per day, maximum 31 days
Outpatient	\$50 per day, maximum 10 visits	\$50 per day, maximum 10 visits	\$50 per day, maximum 10 visits



# Covered Medical Expenses

**The following benefits are for the Insured and each Covered Dependent subject to the plan Deductible, Coinsurance Percentage, Out Of Pocket Maximum, Additional Deductibles, and Coverage Period Maximum Benefit. Benefits are limited to the Maximum Allowable Expense for each Covered Eligible Expense, in addition to any specific limits stated in the policy.**

- Preventive / Wellness Care
- Doctor’s office consultation / Urgent Care in excess of a \$30, \$40 or \$50 copay; this benefit is not subject to the Plan Deductible or Coinsurance Percentage
- Outpatient and Inpatient Treatment for Mental and Nervous Disorders
- Outpatient and Inpatient Treatment for Substance Abuse
- Organ and Tissue transplants
- Inpatient prescription drugs
- Physical, Occupational, and Speech Therapy \$50 per day and 20 visits combined
- Ambulance Transportation maximum benefit \$250
- Outpatient Hospital or Emergency Room Care
- Inpatient Room & Board, including Intensive Care
- Outpatient Miscellaneous Medical Services, doctors medical care and treatment performed in a hospital
- Home Health Care benefit \$50 per visit for a maximum of 1 visit per day and 30 Home Health Care visits.
- Extended Care Facility up to \$150 per day for a maximum of 30 days
- Outpatient Surgical Facility
- Surgeon services in the hospital or outpatient surgical facility

*Note: This is a brief description of the plan benefits, which may vary by state.*

THIS IS A SHORT-TERM LIMITED DURATION HEALTH INSURANCE POLICY THAT IS NOT INTENDED TO AND DOES NOT QUALIFY AS THE MINIMUM ESSENTIAL COVERAGE REQUIRED BY THE AFFORDABLE CARE ACT (ACA). UNLESS YOU PURCHASE A POLICY THAT PROVIDES MINIMUM ESSENTIAL COVERAGE IN ACCORDANCE WITH THE ACA, YOU MAY BE SUBJECT TO A FEDERAL TAX PENALTY. ALSO, THE TERMINATION OR LOSS OF THIS POLICY DOES NOT ENTITLE YOU TO A SPECIAL ENROLLMENT PERIOD TO PURCHASE A HEALTH INSURANCE POLICY THAT QUALIFIES AS MINIMUM ESSENTIAL COVERAGE OUTSIDE OF AN OPEN ENROLLMENT PERIOD.

THIS IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. LACK OF MAJOR MEDICAL COVERAGE (OR OTHER MINIMUM ESSENTIAL COVERAGE) MAY RESULT IN AN ADDITIONAL PAYMENT WITH YOUR TAXES.



# Medical Expenses Not Covered

## **Loss caused by, contributed to, or resulting from the following is excluded or otherwise limited as specified:**

### 1. Pre-Existing Conditions:

a. Charges resulting directly or indirectly from a condition for which a Covered Person received medical treatment, diagnosis, care or advice, including diagnostic tests or medications, within the 60 month period immediately preceding such person's Certificate Effective Date are excluded for the first 12 months of coverage hereunder.

b. Pre-Existing Conditions includes conditions that produced any symptoms which would have caused a reasonable prudent person to seek diagnosis, care, or treatment within the 60 month period immediately prior to the Covered Person's Certificate Effective Date of coverage under the Policy.

This exclusion does not apply to a newborn child or newborn adopted child who is added to coverage in accordance with PART II – ELIGIBILITY AND EFFECTIVE DATE OF INSURANCE.

### 2. Waiting Period:

- a. Covered Persons will only be entitled to receive benefits for Sicknesses that begin, by occurrence of symptoms and/or receipt of treatment, more than 5 days following the Covered Person's Certificate Effective Date of coverage under the Policy.
- b. Covered Persons will only be entitled to receive benefits for Cancer that begins, by occurrence of symptoms or receipt of treatment more than 30 days following the Covered Person's Certificate Effective Date of coverage under the Policy.

### 3. Charges during the first 6 months after the Certificate Effective Date of coverage for a Covered Person for the following:

- a. Total or partial hysterectomy, unless it is Medically Necessary due to a diagnosis of carcinoma;
- b. Tonsillectomy;
- c. Adenoidectomy;
- d. Repair of deviated nasal septum or any type of surgery involving the sinus;
- e. Myringotomy;
- f. Tympanotomy;
- g. Herniorrhaphy; or
- h. Cholecystectomy.

However, if such condition is a Pre-Existing Condition, any benefit consideration will be in accordance with the Pre-Existing Conditions limitation.

### 4. The benefits payable for the following conditions or procedures are limited to the specified amounts shown in the Schedule of Benefits:

- a. Kidney stones
- b. Appendectomy
- c. Joint or tendon Surgery
- d. Knee Injury or disorder
- e. Acquired Immune Deficiency Syndrome (AIDS)/ Human Immuno-deficiency Virus (HIV)
- f. Gallbladder Surgery

### 5. Charges which are not incurred by a Covered Person during his/her Coverage Period.

### 6. Charges which exceed any limits or limitations specified in this Certificate, including the Schedule of Benefits.

### 7. Charges for services of supplies in excess of the Maximum Allowable Expense.

8. Charges for services or supplies which are not administered by or under the supervision of a Doctor.

9. Mental, emotional or nervous disorders or counseling of any type, except as specifically covered as an Eligible Expense.

10. Marital counseling or social counseling.

11. Treatment for Substance Abuse, unless specifically covered under the Policy as an Eligible Expense.

12. Prescription Drugs, except those administered by a Doctor in an Inpatient or Outpatient setting covered under this Policy as an Eligible Expense.

13. Medications, vitamins, and mineral or food supplements including pre-natal vitamins, or any over-the-counter medicines, whether or not ordered by a Doctor.

14. Any drug, treatment, or procedure that either promotes or prevents conception including but not limited to: artificial insemination, treatment for infertility or impotency, sterilization or reversal of sterilization.

15. Any drug, treatment or procedure that corrects impotency or non-organic sexual dysfunction.

16. Modifications of the physical body in order to improve the psychological, mental or emotional well-being of the Covered Person, such as sex-change surgery.

17. Cosmetic Treatment, except for re-constructive surgery where expressly covered under the Policy.

18. Weight modification or surgical treatment of obesity.

19. Eye surgery, including LASIK, when the primary purpose is to correct nearsightedness, farsightedness or astigmatism.

20. Dental Expenses, except as necessary to restore or replace sound and natural teeth lost or damaged as a result of an Injury. The Injury must be severe enough that the contact with the Doctor occurs within seventy-two (72) hours of the Accident, unless extenuating circumstances exist due to the severity of the Injury that prevent you from contacting the Doctor.

21. Expenses incurred in the treatment by any method for jaw joint problems including temporomandibular joint dysfunction (TMJ), TMJ pain syndromes, craniomandibular disorders, myofascial pain dysfunction or other conditions of the joint linking the jaw bone, and skull and the complex of muscles, nerves, and other tissues related to the joint, unless specifically covered under the Policy as an Eligible Expense.

22. Routine pre-natal care, Pregnancy, child birth, and post natal care. (This exclusion does not apply to "Complications of Pregnancy" as defined.)

23. Charges for a Covered Dependent who is a newborn child not yet discharged from the Hospital, unless the charges are Medically Necessary to treat premature birth, congenital Injury or Sickness, or Sickness or Injury sustained during or after birth.

24. Sclerotherapy for veins of the extremities.

25. Abortions, except in connection with covered Complications of Pregnancy or if the life of the expectant mother would be at risk.

26. Joint replacement or other treatment of joints, spine, bones or connective tissue including tendons, ligaments and cartilage, unless related to a covered Injury.

27. Surgeries, treatments, services or supplies which are deemed to be Experimental Treatment.

28. Chronic fatigue or pain disorders.

29. Kidney or end stage renal disease.

30. Treatment or diagnosis of allergies, except for emergency treatment of allergic reactions.

31. Treatment for cataracts.

32. Treatment of sleep disorders.

33. Treatment required as a result of complications or consequences of a treatment or condition not covered under this Certificate.

34. Treatment incurred as a result of exposure to non-medical nuclear radiation and/or radioactive material(s).

35. Treatment for acne, moles, skin tags, diseases of sebaceous glands, seborrhea, sebaceous cyst, unspecified disease of sebaceous glands, hypertrophic and atrophic conditions of skin, nevus.

36. Treatment for or related to any Congenital Condition, except as it relates to a newborn child or newborn adopted child added as a Covered Person pursuant to the terms of this Certificate.

37. Treatment, medication, or hormones to stimulate growth, or treatment of learning disorders, disabilities, developmental delays or deficiencies, including therapy.

38. Spinal manipulation or adjustment.

39. Biofeedback, acupuncture, recreational, sleep or MIST Therapy®, holistic care of any nature, massage and kinestherapy, excepted as provided for under Home Health Care.

40. Hypnotherapy when used to treat conditions that are not recognized as Mental Disorders by the American Psychiatric Association, and non-medical self-care or self-help programs.

41. Eyeglasses, contact lenses, hearing aids, hearing implants, eye refraction, visual therapy, orthoptics, visual eye training, and any examination or fitting related to these devices, and all vision and hearing tests and examinations.

42. Care, treatment or supplies for the feet, orthopedic shoes, orthopedic prescription devices to be attached to or placed in shoes, treatment of weak, strained, flat, unstable or unbalanced feet, metatarsalgia or bunions and treatment of corns, calluses or toenails.

43. Care and treatment for hair loss including wigs, hair transplants or any drug that promises hair growth, whether or not prescribed by a Doctor.

44. Exercise programs, whether or not prescribed or recommended by a Doctor.

45. Telephone or Internet consultations and/or treatment or failure to keep a scheduled appointment.

46. Charges for travel or accommodations, except as expressly provided for local ambulance.

47. All charges incurred while confined primarily to receive Custodial or Convalescent Care.

48. Services received or supplies purchased outside the United States, its territories or possessions, or Canada unless specifically covered

under the Policy as an Eligible Expense

49. Any services or supplies in connection with cigarette smoking cessation.

50. Any services performed or supplies provided by a member of a Covered Person's Immediate Family.

51. Services received for any condition caused by a Covered Person's commission of or attempt to commit an assault, battery, or felony, whether charged or not, or to which a contributing cause was the Covered Person being engaged in an illegal occupation.

52. Services or supplies which are not included as Eligible Expenses as described herein.

53. Participating in hazardous occupations or other activity including participating, instructing, demonstrating, guiding or accompanying others in the following: operation of a flight in an aircraft other than a regularly scheduled flight by a commercial airline, professional or semi-professional sports, extreme sports, parachute jumping, hot-air ballooning, hang-gliding, base jumping, mountain climbing, bungee jumping, scuba diving, sail gliding, parasailing, parakiting, rock or mountain climbing, cave exploration, parkour, racing including stunt show or speed test of any motorized or non-motorized vehicle, rodeo activities, or similar hazardous activities. Also excluded is Injury received while practicing, exercising, undergoing conditional or physical preparation for such activity.

54. Injuries or Sicknesses resulting from participation in interscholastic, intercollegiate or organized competitive sports. This does not include dependent children participating in local community sports activities.

55. Injury resulting from being under the influence of or due wholly or partly to the effects of alcohol or drugs, other than drugs taken in accordance with treatment prescribed by a Doctor.

56. Intentionally self-inflicted Injury or Sickness (whether the Covered Person is sane or insane).

57. Charges resulting from a declared or undeclared war, or from voluntary participation in a riot or insurrection.

58. Charges incurred by a Covered Person while on active duty in the armed forces. Upon written notice to Us of entry into such active duty, the unused premium will be returned to the Covered Person on a pro-rated basis.

59. Costs for Routine Physical Exams or other services not needed for medical treatment, unless specifically covered under the Policy as an Eligible Expense.

60. Charges You or Your Covered Dependent are not required to pay, or which would not have been billed, if no insurance existed.

61. Charges to the extent that they are paid or payable under other valid or collectible group insurance or medical prepayment plan.

62. Charges that are eligible for payment by Medicare or any other government program except Medicaid. Costs for care in government institutions unless You or Your Covered Dependent are obligated to pay for such care.

63. Charges related to Injury or Sickness arising out of or in the course of any occupation for compensation, wage or profit, if the Covered Person is insured, or is required to be insured, by occupational disease or workers' compensation insurance pursuant to applicable state or federal law, whether or not application for such benefits have been made.

64. Medical expenses which are payable under any automobile insurance policy without regard to fault (does not apply in any state where prohibited).

