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PAN AMERICAN
ACCIDENT & HEALTH

SureCare Short-Term Medical Insurance

This short-term medical insurance policy (Certificate Form No. STM-CRT-19) is marketed by Pivot Health by Healthcare.com, and underwritten by Pan-American Life Insurance Company.

Why Choose a SureCare Short-Term Medical Insurance Plan?

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Short-term medical (STM) insurance plans provide coverage for a limited period of time to help pay for medical expenses. This flexible medical expense plan is designed to help address gaps in medical coverage created by temporary situations. If you're in a time of transition or looking for next-day coverage, consider a short-term medical plan.

SureCare Plans Key Features

- Unlimited doctor office visits, $40 primary care/ Specialist
- Child immunizations paid at 100%
- Prostate, mammograms and annual cervical screening
- No narrow provider network
- No emergency room copays
- No hospital copays
- Adult preventive annual exam $50 copay, deductible waived
- Deductible is waived for routine prostate, annual OB-GYN and mammograms and benefit pays 80% until the coinsurance max. Plan then pays at 100%.
- Physical, speech, and occupational therapy and mental/nervous pay up to $100 per day after deductible
- Plan durations up to 180 days
- Next day effective dates available for injury[1]

Quick Guide to SureCare Plan

This coverage is not required to comply with certain federal market requirements for medical insurance, principally those contained in the Affordable Care Act. Be sure to check your Policy/Certificate carefully to make sure you are aware of any exclusions or limitations regarding coverage of preexisting conditions or health benefits (such as hospitalization, emergency services, maternity care, preventative care, prescription drugs, and mental health and substance use disorder services.) Your Policy/Certificate might also have lifetime and/or annual dollar limits on health benefits. If this coverage expires or you lose eligibility for this coverage, you might have to wait until an open enrollment period to get other medical insurance coverage. Also, this coverage is not "minimum essential coverage."

[1] See waiting period provisions on page 11 for more details.

SureCare Plan Details

	SureCare STM
No Network Requirements	All Provider Access
	COVERED EXPENSE HIGHLIGHTS
Deductibles	$2,500, $5,000, $10,000
Family Deductible Maximum	3x individual deductible
Coinsurance (Percentage you pay)	20%
Coinsurance Maximum (The amount the insured is required to pay out of pocket for covered medical expenses before the insurance company starts covering benefits at 100%.)[2]	$10,000
	MEDICAL EXPENSE HIGHLIGHTS
Total Coverage Maximum	$250,000 or $1,000,000
Primary Doctor Visit[3]	$40 copay
Specialist Doctor and Urgent Care Visit[4]	$40 copay
Preventive Examination	For adults, $50 copay, once per year, and then covered 100%. For children, subject to the deductible and then 20% coinsurance.
Children's Preventive Immunizations	Covered 100%, not subject to deductible.

[2]This does not include Deductibles, Copayments, Pre-Authorization penalties, amounts in excess of the Maximum Allowable Expense charge and any amounts in excess of the maximum benefit amounts do not apply towards the Coinsurance Maximum.

[3],[4]After copay the company pays coinsurance 100% for covered expenses and deductible does not apply. Expenses for any other services or test performed as part of the visit will be subject to the deductible and coinsurance.

SureCare Plan Details (continued)

	SureCare STM
Emergency Room	Subject to deductible and coinsurance.
Hospital Inpatient[5]	Subject to deductible and coinsurance.
Ambulance Services (Ground or Air)	Subject to deductible, and coinsurance, up to $1,000.
Outpatient Surgical Facility	Subject to deductible and coinsurance.
Surgeon Services	Subject to deductible and coinsurance for surgeon, assistant surgeon, surgeon's assistant and anesthesia.
Therapy Services	Subject to deductible and coinsurance. Maximum benefit up to $100 per day for maximum of 20 days per coverage period.
Mental Illness and Substance Use Disorder	Subject to deductible and coinsurance. Inpatient cannot exceed $100 a day for maximum of 30 days. Outpatient cannot exceed $100 a day for maximum of 10 days.

[5]Not to exceed the standard room rate. Benefits, exclusions, limitations and conditions may vary by state.

Reference Based Pricing

Reference Based Pricing

Reference based pricing occurs when a provider submits a claim to the Claim Administration. The administrator then pays the provider based on Medicare allowable amounts. Pivot Health reimburses medical providers based on a percentage above payment maximums which are higher than Medicare allowable amounts, paying up to 150% of Medicare allowable amount for medical facilities and up to 125% of Medicare allowable amount for medical professional services and supplies.

All Provider Access

With All Provider Access plans, members choose providers that best fit their needs without network restrictions. There is simply one benefit level for all providers, differing from a PPO plan where there are separate in-network and out-of-network benefits.

No Balance Bill

If a member is presented with unexpected charges on covered benefits for which the member is not liable, due to cost share or limitations, the Plan's Claim Administrator is authorized to resolve the balance bill on their behalf. The member is required to notify Plan's Claim Administrator if an unexpected charge is incurred.

point health

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The healthcare provider system can be challenging to navigate. That's why Pivot Health short-term medical plans provide advantages beyond your standard coverage. These plans are designed to give members access to helpful resources through our patient advocacy partner, Point Health. Support is available to help locate healthcare facilities, choose a provider, and find the lowest-cost treatment plan.

Point Health offers a variety of services:

- Find the best provider to match needs and schedule appointments
- Handle the transfer of medical records to the provider
- Help negotiate medical bills and lower out-of-pocket costs

Patient Advocates are available to help identify the best source of care and help members save.

Simply call 855-540-9507 for assistance.

Fast Facts About Point Health

- 61% average cost savings on medical bills through its healthcare recommendations.
- $384+ million in medical bill savings for its members on their negotiated bills.

Expense Highlights

The following Medical Expenses are subject to the selected Benefit Plan, the applicable Deductible, Coinsurance and Copays, and all Plan provisions, exclusions, and limitations (unless otherwise stated). You will find complete Coverage details in the Certificate of Coverage. The Expenses must be incurred for a Covered Illness or Injury while insured under the Benefit Plan.

Injuries incurred during school and intramural sports are included, but injuries incurred participating in hazardous or professional sports are not covered. Please refer to the Exclusions and Limitations for details.

Preventive Health

Preventive examination
One preventive examination occurs during a doctor office visit which is performed appropriate for age and risk.

Annual Cervical Screening (PAP Smear)
One annual female cytological screening, not subject to deductible.

Children's preventive health care visits and immunizations
Immunizations are exempt from any deductible. Children's preventive healthcare refers to doctor services for eligible dependents from birth through 16 years of age, including collection of medical history, physical examination, developmental assessment, immunizations and laboratory tests; routine tests and procedures for the purpose of detection of abnormalities according to accepted medical practice.

Mammography
For women 50 and older, periodic screening mammography and breast ultrasound for the diagnosis of breast disease such as cancer and the evaluation of dense breast. No deductibles will apply to screening or breast ultrasound.

Prostate cancer screening
Screening for the early detection of prostate cancer in a male 50 years of age and older according to the National Comprehensive Cancer Network guidelines. Prostate cancer screening is not subject to the deductible.

Facility and Associated Services

Hospitalizations, surgeries, services, and supplies
Includes daily room and board and nursing services; intensive care units; use of operating, treatment, and recovery rooms; doctor visits while hospitalized; surgeons and anesthesia expenses; blood, oxygen, drugs, services and supplies routinely administered while hospitalized.

Emergency room services
Emergency services provided in a hospital emergency room (not an Urgent Care Facility) to treat an emergency medical condition, even if hospital confinement is not required.

Ambulance services
Local ground or air ambulance transportation in connection with an emergency medical condition (limited benefit).

Ambulatory Surgical Center or Outpatient Hospital Facility
Charges for treatment or services in a Hospital Outpatient Surgery Facility or state-approved freestanding Ambulatory Surgical Center that is not part of a Hospital.

Extended care facility
Facility fees and professional care for $150 per day, up to 30 days maximum, by a RN or LPN who is not a member of the covered person's immediate family and authorized by a doctor. Not for custodial or convalescence care.

Home health care
Up to 30 visits, $50 maximum, 1 per day, from a home health care agency with up to four (4) consecutive hours in a 24-hour period are considered as one visit. Specific services are detailed in the Certificate.

Organ or tissue transplants
Charges are applied toward the $50,000 maximum transplant benefit.

Hospice
Hospice care for a terminally ill person with a life expectancy of 6 months or less, not to exceed $5,000 per coverage period.

Expense Highlights (continued)

Professional Services and Supplies

Doctor's office visits
Treatment provided for a $40 copay by a doctor in a doctor's office, a specialist's office, and an urgent care center. Preventive care exam listed above.

Diagnostic testing
Diagnostic testing using radiology, ultrasonographic or laboratory services (psychometric, intelligence, behavioral and educational testing are not included). Diagnostic testing includes advanced studies such as MRI, CT, and PET.

Durable medical equipment
Durable medical equipment for wheelchair, hospital type bed or similar, for temporary or permanent use. We reserve the right to pay rental costs rather than the purchase price. Benefits do not include the cost of customization, repair, replacement, or maintenance (limited benefit).

Radiation therapy and chemotherapy
Therapeutic treatment of benign and malignant conditions, including charges for x-rays, radium, radioactive isotopes, chemotherapy drugs, and supplies used in treatment.

Physical therapy, occupational therapy and speech therapy
Up to 20 total visits, 1 visit at $100 per day, for physical, occupational and speech therapy for diagnosis and rehabilitation prescribed by a doctor.

Dental care for injuries
Dental treatment and dental surgery necessary to restore or replace sound natural teeth lost or damaged because of an injury.

Benefit highlights are subject to plan provisions, exclusions, limitations, deductibles, copays and coinsurance apply. Benefits may vary by state. For complete details please see the certificate of insurance.

Exclusions & Limitations

PRE-EXISTING CONDITIONS LIMITATION: We will not provide benefits for any loss caused by, or resulting from, a Pre-existing Condition. "Preexisting Conditions" means any medical condition or Sickness for which:

1. Medical advice, care, diagnosis, treatment, Consultation, or medication was recommended by or received from a Doctor within the 24 months immediately prior to a Covered Person's Effective Date of coverage; or
2. Symptoms existed within the 24 months immediately prior to the Covered Persons Effective Date of coverage which would cause a reasonable person to seek diagnosis, care or treatment.

"Consultation" means evaluation, diagnosis, or medical advice was given with or without the necessity of a personal examination or visit. This limitation does not apply to a newborn child or newborn adopted child who is added to coverage in accordance with Eligibility provision.

This limitation does not apply to any Covered Expense payable for Pre-Existing Conditions until the Pre-Existing Allowance Maximum benefit shown in the Schedule of Benefits has been reached.

In addition, the company will not pay for loss or expense caused by or resulting from any of the following:

1. Expenses for the treatment of Preexisting Conditions, as defined in the Preexisting Conditions Limitation provision (above).
2. Expenses incurred prior to the Effective Date of a Covered Person's coverage or incurred after the Expiration Date, regardless of when the condition originated, except in accordance with the Extension of Benefits provision.
3. Expenses to treat complications resulting from treatment, drugs, supplies, devices, procedures or conditions which are not covered under the Group Policy.
4. Expenses incurred for Experimental or Investigational services or treatment or unproven services or treatment.
5. Amounts in excess of the Maximum Allowable Expense for covered services or supplies.
6. Expenses You or Your Covered Dependent are not required to pay, or which would not have been billed, if no insurance existed.
7. Expenses that do not meet the definition of or are not specifically identified under the Group Policy as Covered Expenses.
8. Expenses for purposes determined by Us to be educational.
9. Expenses to the extent that they are paid or payable under another group insurance or medical prepayment plan.
10. Charges that are eligible for payment by Medicare or any other government program except Medicaid.

Exclusions & Limitations (continued)

11. Expenses for care in government institutions unless You or Your Covered Dependent are obligated to pay for such care.
12. Expenses 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 has been made.
13. Medical expenses which are payable under any automobile insurance policy without regard to fault (does not apply in any state where prohibited).
14. Expenses 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 You on a pro-rated basis.
15. Expenses resulting from a declared or undeclared war, or from voluntary participation in a riot or insurrection.
16. Expenses incurred while engaging in an illegal act or occupation or during the commission, or the attempted commission, of a felony or assault.
17. Expenses for the treatment of normal pregnancy or childbirth, except for Complications of Pregnancy.
18. Expenses for voluntary termination of normal pregnancy or elective cesarean section.
19. Expenses incurred for any drug, including birth control pills, implants, injections, supply, treatment device or procedure that prevents conception or childbirth.
20. Expenses for the diagnosis and treatment of infertility, including but not limited to any attempt to induce fertilization by any method, in vitro fertilization, artificial insemination or similar procedures, whether the Covered Person is a donor, recipient or surrogate.
21. Expenses for sterilization or reversal of sterilization.
22. 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, and except as state mandates.
23. Expenses for sex transformation or penile implants or sex dysfunction or inadequacies.
24. Expenses for physical exams or other services not needed for medical treatment, except as specifically covered.
25. Expenses for prophylactic treatment, including surgery or diagnostic testing, except as specifically covered.
26. Expenses for the treatment of mental illness or nervous disorders, including, but not limited to, neurosis, psychoneurosis, psychopathy, psychosis, attention deficit disorder, autism, hyperactivity, or mental or emotional disease or disorder of any kind; unless it is specifically covered.
27. Expenses for the treatment of alcoholism or alcohol abuse, chemical dependency, substance abuse or drug addiction; unless it is specifically covered.
28. Expenses incurred for loss sustained or contracted in consequence of the Covered Person being intoxicated or under the influence of any narcotic unless administered on the advice of a Doctor. Intoxication shall be established conclusively by a blood alcohol level of .10 or the legal limit in the state where the incident occurred, whichever is less.
29. Expenses incurred in connection with programs, treatment, or procedures for tobacco use cessation.
30. Expenses resulting from suicide or attempted suicide or intentionally self-inflicted Injury, while sane or insane.
31. Expenses for dental treatment or care or orthodontia or other treatment involving the teeth or supporting structures, except as specifically covered.
32. 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 it is specifically covered.
33. Expenses of radial keratotomy or correction of refractive error, eye refractions, vision therapy, routine vision exams to assess the initial need for, or changes to prescription eyeglasses or contact lenses, the purchase, fitting or adjustment of eyeglasses or contact lenses, or treatment of cataracts.
34. Expenses for routine hearing exams to assess the need for or change to hearing aids, or the purchase, fittings or adjustments of hearing aids.

Exclusions & Limitations (continued)

35. Expenses for cosmetic or reconstructive procedures, services or supplies; except as specifically covered.
36. Expenses for breast reduction or augmentation or complications arising from these procedures; except as specifically covered.
37. Outpatient Prescription or Legend Drugs, medications, vitamins, and mineral or food supplements, including pre-natal vitamins, or any over-the-counter medicines, whether or not ordered by a Doctor, unless it is specifically included as a Covered Expense. This does not include Prescription or Legend Drugs administered by a Doctor in an inpatient or outpatient setting in conjunction with a Covered Expense, unless they are drugs that can be self-administered.
38. Expenses incurred in connection with any drug or other item used to treat hair loss.
39. Expenses incurred in the treatment of weak, strained, flat, unstable, or unbalanced feet, metatarsalgia, bunions, spurs, or the removal of corms, calluses or toenails, unless specifically for the treatment of a metabolic or peripheral vascular disease or for the prompt repair of an Injury sustained while coverage is in force for the Covered Person.
40. Expenses incurred in the treatment of acne, or varicose veins.
41. Expenses of weight loss programs or diets.
42. Transportation Expenses, except as specifically covered.
43. Expenses for rest or recuperation cures or care in an extended care facility, convalescent nursing home, a facility providing rehabilitative treatment, Extended Care Facility, or home for the aged, whether or not part of a Hospital, unless it is specifically covered.
44. All charges incurred while confined primarily to receive custodial or convalescent care, unless it is specifically covered.
45. Expenses for services or supplies for personal comfort or convenience, including homemaker services or supportive services focusing on activities of daily life that do not require the skills of qualified technical or professional personnel, including but not limited to bathing, dressing, feeding, routine skin care, bladder care and administration of oral medications or eye drops.
46. Expenses for services or supplies furnished or provided by a member of Your Immediate Family.
47. Expenses for diagnosis or treatment of a sleeping disorder.
48. Expenses incurred in the treatment of Injury or Sickness resulting from participation, instructing, demonstrating, guiding or accompanying others in the following: operation of a flight in an aircraft other than a regularly scheduled flight by an airline; extreme sports: hot-air ballooning; skydiving, scuba diving, hang or ultra-light gliding, base jumping, rock or mountain climbing, bungee jumping, sail gliding, parasailing, para kiting, cave exploration, parkour; riding an all-terrain vehicle such as a dirt bike, snowmobile or go-cart; racing with a motorcycle, boat or any form of aircraft; racing including stunt show or speed test of any motorized or non-motorized vehicle; any participation in sports for pay or profit; participation in rodeo contests; or similar hazardous activities.
49. Expenses for the purchase of a noninvasive osteogenesis stimulator (bone stimulator).
50. Expenses for services or supplies of a common household use, such as exercise cycles, air or water purifiers, air conditioners, allergenic mattresses, and blood pressure kits.
51. Expenses during the first 6-months after the Effective Date of coverage for a Covered Person for: (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; or (g) herniorrhaphy; (subject to all other coverage provisions, including but not limited to, the Pre-existing Conditions exclusion).
52. Medical care, treatment, service or supplies received outside of the United States, Canada or its possessions, unless specifically covered.
53. Expenses for private duty nursing services.
54. Expenses for the repair or maintenance of a wheelchair, hospital-type bed or similar durable mechanical equipment.
55. Expenses for orthotics, special shoes, spine and arch supports, heel wedges, sneakers or similar devices unless they are a permanent part of an orthopedic leg brace.
56. Expenses incurred in connection with the voluntary taking of a poison or inhaling gas.
57. Expenses incurred in connection with obesity treatment or weight reduction including all forms of intestinal

Exclusions & Limitations (continued)

and gastric bypass surgery, including the reversal of such surgery even if the Covered Person has other health conditions that might be helped by a reduction of obesity or weight.

58. Expenses for marital counseling or social counseling.
59. Expenses for acupuncture.
60. Expenses for a service or supply whose primary purpose is to provide a Covered Person with (1) training in the requirements of daily living; (2) instruction in scholastic skills such as reading and writing; (3) preparation for an occupation; (4) treatment of learning disabilities, developmental delays or dyslexia; or (5) development beyond a point where function has been demonstrably restored.
61. Expenses for replacement of artificial limbs or eyes.
62. Expenses for removal of breast implants.
63. Chronic fatigue or pain disorders.
64. Kidney or end stage renal disease.
65. Treatment or diagnosis of allergies, except for emergency treatment of allergic reactions.
66. Biofeedback, acupuncture, recreational, sleep or mist therapy, holistic care of any nature, massage and kinesitherapy, excepted as provided for under Home Health Care.
67. Hypnotherapy when used to treat conditions that are not recognized as Mental Disorders by the American Psychiatric Association, and biofeedback and non-medical self-care or self-help programs.
68. Failure to keep a scheduled appointment.
69. 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.
70. Treatment incurred as a result of exposure to non-medical nuclear radiation and/or radioactive material(s).

Exclusions & Limitations (continued)

Waiting Period Limitation[6]

Expenses incurred during the 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 Effective Date of coverage under the Certificate.

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 Effective Date of coverage under the Certificate.

Pre-Notification on SureCare plans

Emergency hospital admissions should be reported within 48 hours or by the next regular working day following admission (72 hours in some states).

Pre-Authorization is required for the following on SureCare plans:

In-Patient Hospitalizations and other In-Patient care. In-Patient surgeries and surgical procedures.

This is a very brief description of the short-term medical plan issued by Pan-American Life Insurance Company. For full details, limitations, exclusions, and terms of coverage, review the Policy, Certificate of Insurance and/or Riders in your state. Coverage and benefits may vary or may not be available in all states. Definitions of each Covered Expense is provided in the Certificate of Insurance. Please review for full details. All benefits are limited to Usual, Reasonable and Customary Fees. Coverage is not limited to the benefits listed and eligible expenses are subject to plan limitations.

[6] Waiting periods are not applicable in Kansas and North Dakota.

Policy Provisions

Free Look Period

If you are not satisfied with your plan from Pan-American Life Insurance Company, provide a written request for cancellation within 10 days of receipt. Certificate of coverage will be cancelled as of the effective date and your premium and application fee will be returned.

Eligibility

Pan-American Life Insurance Company plans are made available to members of Communicating for America, and their spouses, and dependent children who are at least 1 year in age, up to age 65 who can answer "No" to all of the questions in the application for insurance. Association membership is not required in all states. You may become a member of Communicating for America without purchasing insurance.

Termination of Coverage

Pan-American Life Insurance Company will automatically terminate primary and dependent coverage on the earliest of the following dates: The date the Group Policy terminates; The first day of the month in which the Insured or spouse reaches the age of 65 or becomes eligible for Medicare; The last day for which the Insured's or dependent's premium has been paid, subject to the grace period; The date the Insured asks Us to end his or her coverage in writing; The date the Insured dies; The end of the Coverage Period; The date the Insured or a dependent reaches the Overall Maximum Benefit shown on the Schedule of Benefits; The date the Insured or the dependent enters the armed forces of any country, state or international organization, other than for reserve duty of less than 30 days; The date a Dependent attains the limiting age of 26 or a dependent's marriage; The first date following a Spouse's divorce. (See Certificate for extension of limiting age and for details).

Company Information

About Pan-American Life Insurance Company

Pan-American Accident & Health is the division for accident and health plans that Pan-American Life Insurance Company (PALIC) provides in the U.S. Pan-American Life is rated "A" (Excellent) by AM Best, a large third-party independent reporting and rating company that rates an insurance company based on the company's financial strength, operating performance and ability to meet its ongoing obligation to policyholders, and "A" (Strong) Insurer Financial Strength with Outlook Stable from Fitch, whose Insurer Financial Strength (IFS) Rating provides an assessment of the financial strength of an insurance organization.

For States except States of Kansas, Missouri, North Carolina, North Dakota, Oklahoma, and South Dakota

This plan is available to those who become members of Communicating for America, Inc. (CA), an association that promotes the betterment of general health and welfare for all Americans, particularly those who are self-employed in rural areas or own a small business. Membership in CA also provides access to non-insurance Telemedicine and other important benefits described below. Non-Insurance Benefits and Services are not provided by or affiliated with Pan-American Life Insurance Company.

States of Kansas, Missouri, North Carolina, North Dakota, Oklahoma, and South Dakota

For people selecting an individual plan underwritten by Pan-American Life Insurance Company, non-insurance Telemedicine and other important benefits described below are provided by Pivot Health. Non-Insurance Benefits and Services are not provided by or affiliated with Pan-American Life Insurance Company.

Non-Insurance Benefits (Not affiliated with Pan-American Life Insurance Company)

- ✓ Free and unlimited telemedicine doctor consultations 24/7 - Including dermatology consultations
- ✓ Discounts on hearing and audiology
- ✓ Discounts on durable medical equipment
- ✓ Access to health liaisons who advocate for members

THIS PLAN IS A GROUP SHORT TERM MEDICAL INSURANCE POLICY.
BENEFITS PROVIDED ARE LIMITED AND ARE NOT INTENDED TO COVER ALL MEDICAL EXPENSES.

This is a brief description of coverage provided under the Certificate of Insurance and is subject to the terms, conditions, limitations and exclusions of the Certificate of Insurance. Please see the Certificate of Insurance for complete details. Coverage may vary or may not be available in all states. Plans are underwritten by Pan-American Life Insurance Company. The insurance described in this document provides limited benefits.

The insurance coverage is not an alternative to comprehensive coverage. It does not provide major medical or comprehensive medical coverage and is not designed to replace major medical insurance. Further, the insurance coverage is not minimum essential benefits as set forth under the Patient Protection and Affordable Care Act.