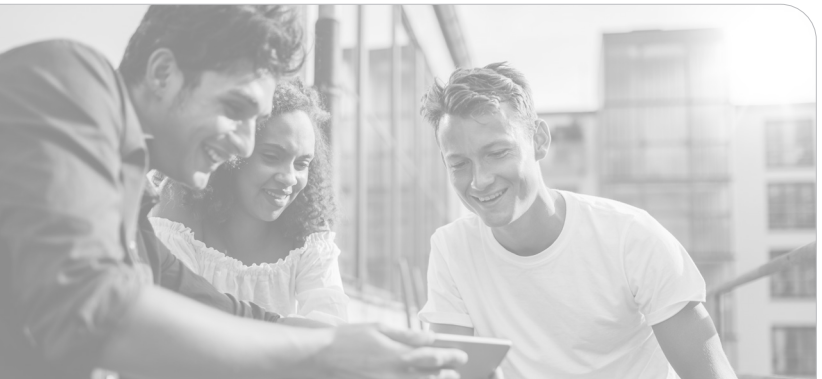
Short Term Medical

Health care coverage for you and your family from National General.

PPO Network[1] provided by: Cigna.

1. The Cigna PPO Network refers to the health care providers (doctors, hospitals, specialists) contracted as part of the Cigna PPO Network for Shared Administration.



National General Accident and Health markets products underwritten by National Health Insurance Company, Integon National Insurance Company, and Integon Indemnity Corporation.

NGAH-STMPPO-C-INDIVIDUALBRO-UT

National General Accident & Health

For use in Utah

Brochure Overview

Our Short Term Medical Plan

Short Term Medical gives you the flexibility to get the coverage you want, for the time that best suits you.

Get access to benefits and options that provide protection for the costs associated with everyday health care and the unexpected, such as:

- Doctor visits and preventive care.
- Emergency room and hospital stays.
- Pharmacy benefits and discount options.

Together with network providers like Cigna® our Short Term Medical plans can save you more on your health care; and help you keep your wallet, coverage, and wellness going strong.

THIS PLAN PROVIDES LIMITED BENEFITS.

Short Term Medical plans are medically underwritten and do not cover pre-existing conditions. They are not Minimum Essential Coverage under the Affordable Care Act.

Short Term Medical Highlights

A quick breakdown on some key features and benefits of our Short Term Medical plan.

Office visits for everyone

Office visit benefits come with all our plans and copay options are available.

Next day effective dates

Get the benefits you need for injuries, preventive care, and sickness right away.

Deductible waived on Urgent Care visits

You pay a $50 access fee and the rest applies to coinsurance.

Prescription drug options

Keep your costs low with a pharmacy discount card on all plans, or a $10 copay on generics with our Copay Enhanced PPO plan.

Flexible coverage periods and solutions

Choose the coverage duration that best suits your needs, whether it's 30 days or up to 12 months.[1]

Coverage for the time you need it!

Access to Cigna

Choose your doctor from more than 1,000,000[2] doctors and specialists across 6,300[2] hospitals in the Cigna PPO Network[3]

Once enrolled, find an in-network provider at:
MyNatGen.com/CignaPPO

1. Maximum allowable policy period in UT is 12 months minus 1 day. | 2. Cigna analysis of actual number of doctors in the PPO Network as of September 1, 2018. Data is subject to change.
3. The Cigna PPO Network refers to the health care providers (doctors, hospitals, specialists) contracted as part of the Cigna PPO Network for Shared Administration.

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Plan Options & Benefits

	Enhanced PPO						Copay Enhanced PPO	
[1] Individual Plan Deductible	$2.5k	$2.5k	$5k	$5k	$7.5k	$10k	$6k	$8k
Coinsurance (% Paid by you)	20%	0%	20%	0%	20%	0%	0%	0%
Coinsurance Out-of-Pocket Per member	$5k	$0	$5k	$0	$5k	$0	$0	$0
Coverage Period Maximum	$1,000,000						$5,000,000	
Office Visits including preventive visits	– Applies to deductible & coinsurance						Copay:[2] $40 PCP; $60 Specialist **Up to 6 months:** Single: 1 total, Family: 3 total **Over 6 months:** Single: 2 total, Family: 4 total	
[3] Pharmacy	Not Applicable						– $10 Copay on generic drugs – Maximum benefit of $3,000	
[4] Outpatient Services	– Applies to deductible & coinsurance – Some limit restrictions apply, see footnote for details [5]						– Applies to deductible & coinsurance – Some limit restrictions apply, see footnote for details [5]	
Adult Screenings	– Applies to deductible & coinsurance						– Includes Immunizations – Applies to deductible & coinsurance	

GENERAL BENEFITS

These benefits apply to all plan options. Please refer to your Benefits Schedule for a complete list.

Inpatient Services	Emergency Room Visit	Diagnostic, X-Ray & Lab	Urgent Care	Child Immunizations
Includes Hospital Stays *Applies to deductible and coinsurance*	$250 access fee; waived if admitted *Applies to deductible and coinsurance*	*Applies to deductible and coinsurance*	$50 access fee. Deductible waived. Remaining cost subject to coinsurance	First Dollar Benefit

Out-of-network deductibles and coinsurances are double their in-network amounts. Coinsurance percentages are the same for out-of-network services.

1. The family deductible is capped at 3x the individual deductible. For families with more than 3 members, all covered expenses accumulate towards the family deductible, but no individual member will pay more than their individual deductible. | 2. Additional applies to deductible and coinsurance. Copay not applicable to out-of-network services. | 3. No waiting period applies. | 4. Includes services such as Surgeon, Anesthesia, Office Visits, Preventive Services, Urgent Care, Diagnostics and Lab. | 5. A $5,000 benefit limit applies to outpatient treatment of a joint, neck, spine, or connective tissue including tendons, ligaments, and cartilage (exclusions may apply, see exclusion list). There is also a 30 visit limit for PT, OT, ST Cardiac and Pulmonary rehabilitation.

Short Term Medical Coverage Solutions

Extend your coverage

Gain flexibility and save yourself time by purchasing multiple plans with one application or set up a renewable plan option. These solutions[1] can let you extend your coverage for up to 3 full years!

Renewable Plan Option

- Eligible expenses for pre-existing conditions are covered after the first 12 months of coverage.
- Deductible/coinsurance reset with each new policy term.
- Coverage Period Maximum does not reset.
- Guaranteed rate option available, letting you plan ahead knowing your rates won't change.
- Get up to 3 full years of coverage!

Consecutive Plans

- Eligible expenses for pre-existing conditions are covered after the first 12 months of coverage.
- Deductible/coinsurance reset with each new policy term.
- Coverage Period Maximum resets with each new policy term.
- Rates are determined at the time of purchase and may vary between policies.
- Purchase multiple plans with just one application and get up to 2 years of coverage![2]

1. All plan options must be selected at the time of purchase. | 2. Maximum allowable policy period in UT is 12 months minus 1 day.

What about out-of-pocket costs?

We have smart solutions for those, too

Short Term Medical coverage helps you get the health care coverage you need, when you need it. But, like other insurance plans, there are always out-of-pocket costs. Out-of-pocket costs include expenses you are responsible for like deductibles and coinsurance.

Add one of our Supplemental Coverage plans to get out-of-pocket protection from costs not covered by your Short Term Medical plan. They're affordable options that help you keep more money in your pocket.

Get supplemental coverage for:

- Accidental Injuries
- Cancer and Heart/Stroke
- Critical Illnesses
- Hospital Stays

How does Supplemental coverage work?

The average cost of a fractured hip is $12,923.[1] Now, let's assume you chose to pair our Plan Enhancer supplemental coverage with a $5,000 benefit level with our $5,000 deductible Short Term Medical plan.

Treatment Cost	**$12,923**[1]
Short Term Medical Deductible	**$5,000**
Plan Enhancer Paid	**$4,750**
Plan Enhancer Deductible	**$250**

In this example, Plan Enhancer pays 98% of your medical plan's deductible.

1. Average cost of a fractured hip according to the National Center for Biotechnology Information. Retrieved April 17, 2015, from www.ncbi.nlm.nih.gov/pubmed/23035626

Limitations & Exclusions

Pre-Existing Condition Exclusion

» The Pre-Existing Condition exclusion will not be applicable for those Covered Persons after the Initial Benefit Period Termination Date as shown in the Benefit Schedule if you purchased a Renewability Rider or the Consecutive Plan options that provide more than 12 months of consecutive coverage.

» This Plan does not cover any charges related to Certificate benefits resulting directly or indirectly from a Pre-Existing Condition or a complication resulting therefrom.

Pre-Existing Condition means:

» A Sickness, Injury, or condition, including any related or resulting complications:

- For which medical advice, consultation, diagnosis, care, or treatment (includes receipt of services, supplies, or diagnostic tests) was received or recommended from a provider or prescription drugs were prescribed during the 1 year period immediately prior to the Covered Person's Effective Date, regardless of whether the condition was diagnosed, misdiagnosed or not diagnosed; or
- That produced signs or symptoms during the 1 year period immediately prior to the Covered Person's Effective Date.

» The signs or symptoms were significant enough to establish manifestation or onset by one of the following:

- The signs or symptoms reasonably should have allowed or would have allowed a medical provider to diagnose the condition; or
- The signs or symptoms reasonably should have caused or would have caused an ordinarily prudent person to seek medical advice, consultation, diagnosis, care, or treatment.

» A pregnancy that exists on the day before the Covered Person's Effective Date will be considered a Pre-Existing Condition.

Organ Transplant or Marrow Reconstitution

Both Organ Transplant and Marrow Reconstitution services are covered under the plan pursuant to applicable terms and limitations. Benefits are subject to deductible and coinsurance.

» Maximum benefit of $100,000 per Certificate.

» Utah Only: Donor expenses will be covered to the extent the Organ Transplant or Marrow Reconstitution Benefits maximum benefit has not been exhausted after all benefits for the recipient's expenses have been paid.

Additional Charges Not Covered By This Certificate

Unless set forth as a benefit in the Benefits section, this Certificate does not cover charges for:

Treatment, services or supplies that are: 1) received before the Effective Date or after the termination date; 2) provided at no cost to the Covered Person; 3) not specifically listed in the Benefits section; 4) are in excess of the Maximum Allowable Amount or Maximum benefit stated.

» Complications resulting or related to treatment, services or supplies that are not covered.

» Treatment, services or supplies that are: 1) Experimental or Investigational Services; 2) preventive; 3) prophylactic; 4) not Medically Necessary; 5) received in a clinical trial; 6) for the personal comfort or convenience of the Covered Person, the Covered Person's family, a Health Care Practitioner or a provider; 7) incurred outside of the United States or its possessions or Canada.

» Suicide or attempted suicide, Health Care Practitioner assisted suicide, and intentionally self-inflicted injury; war or any act of war or participation in the military service of any country.

» Treatment, services or supplies paid by Medicare or any other government law or program except Medicaid (Medi-Cal in California), motor vehicle insurance, no fault insurance or worker's compensation insurance.

» Treatment, services or supplies incurred while a Covered Person is committing or participating in a felony.

» An Injury resulting from or related to a Covered Person being under the influence of illegal narcotics, non-prescribed controlled substances, or alcohol (such that the Covered Person is intoxicated per state law).

» Eyeglasses, contact lenses, eye exams, eye refraction, eye surgery, vision therapy.

» Artificial hearing devices, batteries, cochlear implants, auditory prostheses or other mechanical or surgical means of enhancing, creating or restoring auditory comprehension.

» Smoking cessation; snoring; sleep disorders; treatment of hair loss; change in skin pigmentation; cognitive enhancement.

» Gastric bypass surgery.

» Weight reduction or weight control programs or treatment, surgery for weight control, obesity or morbid obesity, suction lipectomy, physical fitness programs, exercise equipment, exercise therapy, health club or gym membership fees, nutritional and dietary counseling.

Limitations & Exclusions

- Family and/or marriage counseling; hypnotherapy; Custodial Care, respite care; rest care; supportive care; homemaker services; private duty nursing services rendered during Hospital confinement; standby Health Care Practitioners; hospice care.
- Adjustments; manipulations; acupuncture; rolfing; cupping therapy; massage; biofeedback; neurotherapy; electrical stimulation; aversion therapy; non-medical items; self-care or self-help programs; stress management; aromatherapy; meditation or relaxation therapy; naturopathic medicine; homeopathic medicine; acne.
- Cosmetic Services, capsular contraction, augmentation or reduction mammoplasty, except Reconstructive Surgery.
- Sales tax or gross receipt tax; provider administrative expenses; missed appointments; non-medical items.
- Learning disorders or disabilities or developmental delays; educational services; wilderness therapy programs; or, education-based residential treatment programs.
- In Nebraska, treatment, services or supplies resulting from or related to Mental Illness, except as covered in the Autism Spectrum Disorder benefit.
- In Utah, treatment, services or supplies resulting from or related to Mental Illness, Substance Abuse, Schizophrenia, Paranoia, Psychotic Disorders, Bipolar Disorders, Major Depressive Disorders, Mood Disorders, or Obsessive-Compulsive Disorder; applied behavior therapy or applied behavior analysis, except as covered in the Autism Spectrum Disorder benefit.
- Any hazardous activity, whether or not compensation is received including, but not limited to: parachute jumping, hang-gliding, bungee jumping, rodeo activities, racing any motorized or non-motorized vehicle or conveyance, rock or mountain climbing, skydiving or parkour.
- Any hazardous occupation or other activity for which compensation is received including, but not limited to: skiing, horse riding, or racing any non-motorized vehicle or conveyance.
- Chronic pain disorders.
- Surgery for: ear tubes, tonsils, adenoids, hernia, sinuses, or deviated septum.
- Joint replacement, unless related to an Injury.
- Foot conditions.
- Cranial orthotic devices.
- Genetic testing, genetic counseling or reproductive treatment; growth hormone therapy; allergies and allergy testing.
- Pregnancy, except for Complications of Pregnancy; including but not limited to: childbirth; fetal reduction surgery; routine well babycare, including Hospital nursery charges at birth; abortion; infertility diagnosis and treatment; cryopreservation of sperm or eggs; surrogate pregnancy; umbilical cord stem cell or other blood component harvest; sterilization, drugs or devices used directly or indirectly to promote or prevent conception except as otherwise covered in the Preventive Health Care Services benefit; and sexual treatment regardless of underlying causes.
- Treatment, services or supplies resulting from or related to any congenital condition, except when provided to a newborn or adopted child added who is a Covered Dependent.
- Dental treatment, orthodontic treatment, or care for supporting structures of the teeth.
- Sclerotherapy, varicose veins or spider veins.
- Herbal or homeopathic medicines or products; minerals; vitamins; appetite suppressants; dietary or nutritional substances or dietary supplements; Nutraceuticals; tube feeding formulas and infant formulas; medical foods.
- Over-the-counter products or drugs; Inpatient Drugs prescribed for treatment of a Sickness or an Injury that is not covered; outpatient prescription drugs, except as otherwise covered.
- Treatment, services or supplies 1) provided by or through any employer of a Covered Person or the employer of a Covered Person's Immediate Family member; or 2) provided by the Covered Person's Immediate Family member or any entity in which a Covered Person or their Immediate Family member receives, or is entitled to receive, any direct or indirect financial benefit, including but not limited to an ownership interest in any such entity.

Prescription Drug Exclusions and Limitations

If you purchase the Copay Enhanced PPO plan with prescription drug coverage, then in addition to the exclusions and limitations listed in the Certificate, we will not pay outpatient prescription drug benefits for:

- Drugs that are:
  - Not on Our Drug List, received at a Non-Participating Pharmacy, or covered under the Plan.
  - Prescribed for treatment of a Sickness or Injury that is not covered under the Plan.
  - Dispensed in excess of the Supply Limits provision.
  - Taken to prevent the transmission of disease during activities such as intercourse, sharing of needles, or direct or indirect exchange of bodily fluids.
  - Obtained from Pharmacy provider sources online outside the United States.

Limitations & Exclusions

- Designed or used to diagnose, treat, alter, impact, or differentiate genetic make-up or genetic predisposition.

» Diagnostic kits and products, blood or blood products.

» Duplicate prescriptions; replacement of lost, stolen, destroyed, spilled or damaged prescriptions; prescriptions refilled more frequently than the prescribed dosage indicates, except for the early refill of prescription eye drops as dispensed in the Supply Limits provision.

» Bulk powder/chemical drugs and drugs containing, or made of, bulk powder/chemicals.

» Compounded medications made up of two or more active parts or ingredients.

» Combination drugs or drug products manufactured and/or packaged together and containing one or more active ingredients.

» Amounts above the Contracted Rate for a Participating Pharmacy.

» DDAVP (desmopressin acetate) or other drugs used in the treatment of nocturnal enuresis (bedwetting) for a Covered Person under the age of 8.

» Postage, handling and shipping charges for any drugs.

» Injectable Outpatient Prescription Drugs.

» Any administrative charge for drugs.

Short Term Medical is nonrenewable

This Short Term Medical plan is nonrenewable unless you purchased a Renewability Rider at the time you initially enrolled in your Short Term Medical plan. If you purchased the Renewability Rider, your plan will be renewable up to 36 months so long as you maintain compliance with the plan provisions. Availability of Renewability Riders varies by state. Termination of this plan is not considered a qualifying life event for the purposes of enrolling in an ACA-compliant major medical plan.

If you choose to purchase a new subsequent Short Term Medical plan, you must submit a new application. Any sickness or condition developed during a previous plan will be considered a pre-existing condition, regardless of whether the sickness or condition was covered under your previous plan, and will not be covered by subsequent Short Term Medical plans. Re-application may not be available in all states.

This coverage is not required to comply with federal market requirements for health insurance, principally those contained in the Affordable Care Act. Be sure to check your policy carefully to make sure you are aware of any exclusions or limitations regarding coverage of pre-existing conditions or health benefits (such as hospitalization, emergency services, maternity care, preventive care, prescription drugs, and mental health and substance use disorder services). If this coverage expires or you lose eligibility for this coverage, you might have to wait until an open enrollment period to get other health insurance coverage.

This policy does not meet the definition of qualifying previous coverage or qualifying existing coverage. As a result, if purchased in lieu of a conversion policy or other group coverage, you may have to meet a pre-existing condition requirement when renewing or purchasing other coverage.

This document provides summary information. For a complete listing of benefits, exclusions and limitations, please refer to the Insurance policy. In the event there are discrepancies with the information in this document, the terms and conditions of the coverage documents will govern.

For a full list of limitations and exclusions go to:

NatGenHealth.com/claims-help.php

Who we are

National General Holdings Corp. (NGHC), headquartered in New York City, is a specialty personal lines insurance holding company. National General traces its roots to 1939, has a financial strength rating of A+ (Superior) from A.M. Best, and provides personal and commercial automobile, homeowners, umbrella, recreational vehicle, motorcycle, lender-placed, supplemental health, and other niche insurance products.

National General Accident & Health, a division of NGHC, is focused on providing supplemental and short-term coverage options to individuals, associations and groups. Products are underwritten by National Health Insurance Company (incorporated in 1965), Integon National Insurance Company (incorporated in 1987), and Integon Indemnity Corporation (incorporated in 1946). These three companies, together, are authorized to provide health insurance in all 50 states and the District of Columbia. National Health Insurance Company, Integon National Insurance Company, and Integon Indemnity Corporation have been rated as A+ (Superior) by A.M. Best. Each underwriting company is financially responsible for its respective products.

Brochure for use in: UT

Visit us on the web at:
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National General
Accident & Health

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