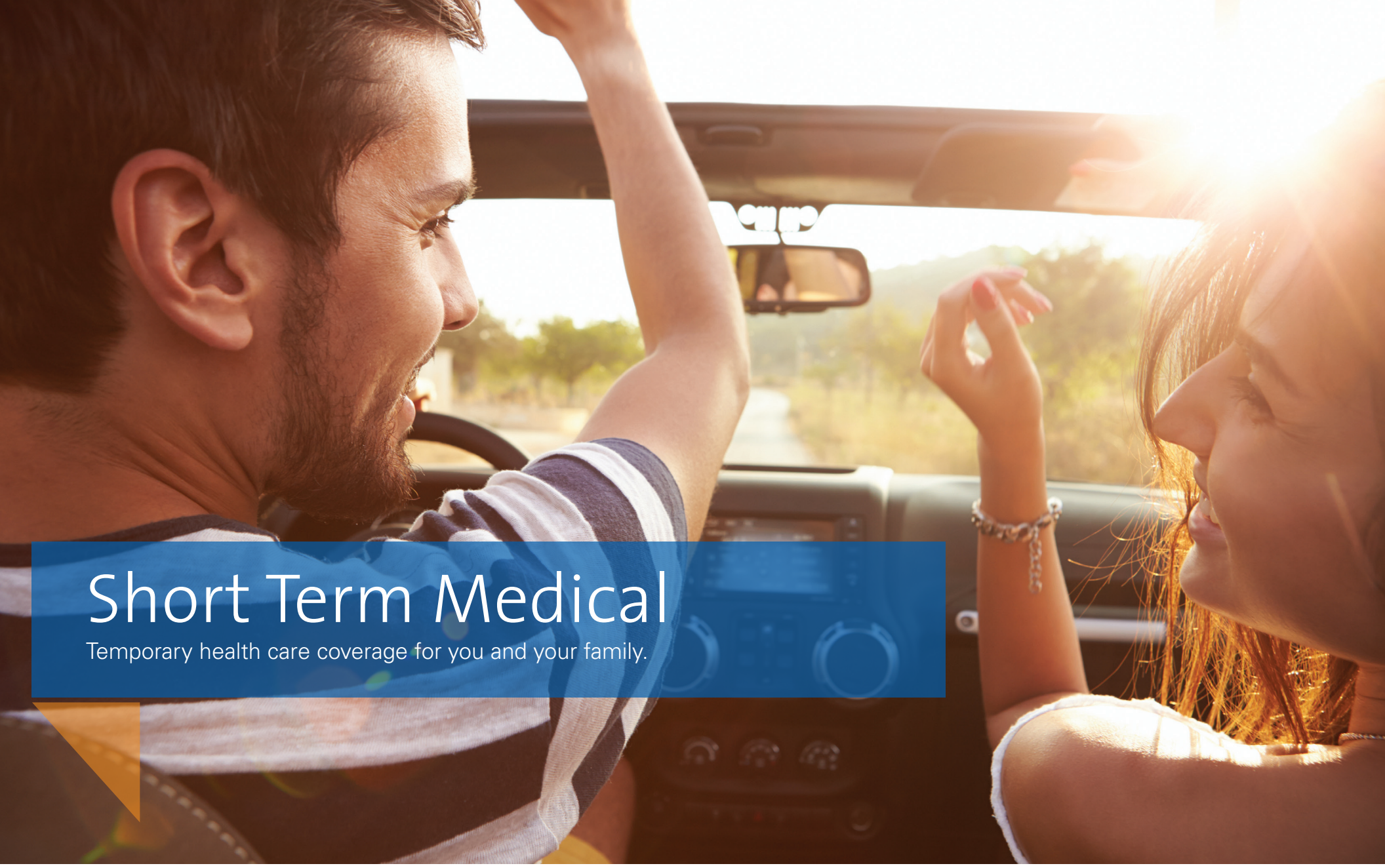

Short Term Medical

Temporary health care coverage for you and your family.

Healthcare Solutions Team
A Plan for Everyone™

National General Accident & Health

NGAH-STMINDIVIDUALBRO-HST

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

Why choose Short Term Medical?

Because life is unpredictable.

Our Short Term Medical insurance gives you a plan to face those unpredictable moments in life with confidence. It provides the financial protection you need from unexpected medical bills and other health care expenses, including:

- Doctor visits and some preventive care
- Emergency room and ambulance coverage
- Urgent care benefits, and more

Short Term Medical helps you save more on health care when you visit network providers.

Any amount of time without health insurance is too long. Our Short Term Medical insurance includes flexible plan designs and options to help you find the plan that fits your needs, budget, and in this case, your time frame.

- Access to the large, national Aetna Open Choice® PPO Network helps you get the care you need for less
- Choose the coverage period that fits your needs from 30 days to 3 months
- Choose from a variety of deductible and coinsurance options designed to help you find the plan that fits your budget

$250,000 to $1,000,000 in health care coverage benefits available per coverage term

THIS PLAN PROVIDES LIMITED BENEFITS.

Short Term Medical plans offer affordable medical coverage but are medically underwritten. They do not provide Minimum Essential Coverage as mandated by the Affordable Care Act.

Plan highlights

Our Short Term Medical coverage provides protection from a variety of medical expenses

URGENT CARE *A medical facility providing immediate, non-routine urgent care for an injury or sickness treated on a walk-in basis.*	• Unlimited visits • You pay $50 per visit; your medical deductible is waived and remaining expenses apply to coinsurance
EMERGENCY ROOM CARE	• Unlimited visits • Subject to an additional $250 access fee unless admitted to a hospital; costs apply to deductible and coinsurance
AMBULANCE SERVICE	• Unlimited trips • Maximum benefit of $250 per trip
DOCTOR VISITS	• Doctor visits are subject to deductible and coinsurance[1]

Get coverage as soon as the next day

1 In Colorado, Florida, Ohio, Maryland, New Mexico, Oregon and Utah, this plan pays one $50 benefit for one doctor visit. Subsequent visits apply to deductible and coinsurance.
2 Provider count source: https://www.aetna.com/about-us/aetna-facts-and-subsidiaries/aetna-facts.html

aetna®

Choose your doctor from more than 664,000 participating providers in the Aetna Open Choice® PPO Network[2]

Find a provider at
www.aetna.com/docfind/custom/mymeritain

Standard Issue plans

Plans requiring a health questionnaire

Building a Standard Issue Short Term Medical plan is easy

All you have to do is choose a deductible, select a coinsurance option, and designate your coverage term. Then, complete a health questionnaire, and you're all set.[3]

DEDUCTIBLE*	COINSURANCE	OUT-OF-POCKET MAXIMUM *(after deductible is met)*	COVERAGE PERIOD MAXIMUM
$1,000	50% / 50%	$2,500	$250,000
	80% / 20%	$1,500	$1,000,000
$2,500	50% / 50%	$2,500	$250,000
	80% / 20%	$1,500	$1,000,000
	100%	$0	$1,000,000
$5,000	50% / 50%	$3,750	$250,000
	80% / 20%	$2,000	$1,000,000
	100%	$0	$1,000,000
$10,000	80% / 20%	$2,000	$1,000,000
$25,000	80% / 20%	$2,000	$1,000,000

You choose your own coverage term — from 30 days to 3 months

* Per-person deductible and out-of-pocket amounts are capped at 3x the individual amounts for a family greater than three. This means that when three insured family members satisfy their individual deductibles and out-of-pocket amounts, the remaining individual deductibles and out-of-pocket amounts will be deemed as satisfied for the remainder of the coverage term.

3 Short Term Medical plans do not cover costs associated with pre-existing conditions.

Guaranteed Issue plans

Choosing a Guaranteed Issue Short Term Medical plan is even easier

Our Guaranteed Issue plans help you get coverage without the possibility of getting denied.[4] First, fill out a health questionnaire. Then, choose your plan design.

Basic

DEDUCTIBLE*	$5,000
COINSURANCE	90% / 10%
OUT-OF-POCKET MAXIMUM	$10,000
COVERAGE TERM	Choose your own coverage term — from 30 days to 3 months
COVERAGE PERIOD MAXIMUM	$100,000

Enhanced

DEDUCTIBLE*	$3,500
COINSURANCE	80% / 20%
OUT-OF-POCKET MAXIMUM	$10,000
COVERAGE TERM	Choose your own coverage term — from 30 days to 3 months
COVERAGE PERIOD MAXIMUM	$100,000

Plan availability varies by state.

* Per-person deductible and out-of-pocket amounts are capped at 3x the individual amounts for a family greater than three. This means that when three insured family members satisfy their individual deductibles and out-of-pocket amounts, the remaining individual deductibles and out-of-pocket amounts will be deemed as satisfied for the remainder of the coverage term.

4 Short Term Medical plans do not cover costs associated with pre-existing conditions.

Is Short Term Medical right for you?

Short Term Medical insurance isn't for everyone. Find out what it covers and what it doesn't.

Short Term Medical insurance, as its name implies, isn't meant to be a long-term solution. While it covers some medical expenses, it doesn't cover everything. Make sure you take a look at what you need your health insurance to do for you and compare it to the benefits provided through Short Term Medical.

The examples provided are from larger lists of covered and non-covered services. For the complete listing of non-covered services, please refer to the Limitations and Exclusions pages in the back of this brochure.

COVERED

All apply to deductible and coinsurance

- Doctor visits, urgent care,* ambulance service and emergency room care
- Diagnostic testing, mammograms, radiation therapy and Chemotherapy
- Surgery, inpatient and outpatient hospital benefits, and hospital confinement benefits
- Physical therapy, skilled nursing facility benefits and home health care
- Transplant benefits and more

NOT COVERED

- Outpatient prescription medications, eyeglass prescriptions and vision therapy
- Normal pregnancy, or diagnosis and treatment of infertility
- Any medical expenses resulting from pre-existing conditions[5]

* For urgent care visits, this plan requires you to pay a $50 copay per visit. The deductible is waived, and the remaining expenses apply to coinsurance. Please refer to page 3 for more details

5 Please refer to page 10 for a full definition of a pre-existing condition

What about out-of-pocket costs?

We have smart solutions for those, too.

Short Term Medical coverage helps you get the temporary 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 the out-of-pocket protection you need from costs not covered by your Short Term Medical plan. They're affordable options that help you broaden your financial protection and keep more money in your pocket.

Ask your agent for more information.

SUPPLEMENTAL COVERAGE PROVIDES BENEFITS FOR COSTS ASSOCIATED WITH:

- Accidents
- Critical Illnesses
- Accidental death and dismemberment
- Hospital stays

Save more with your L.I.F.E. Membership

Your optional L.I.F.E. Membership can get you convenient services and discounts on:

Telemedicine services

Connect with a physician in real-time regardless of the time or your location. There are no limits to the number of consultations and no extra cost to you.

WellCard savings

Access to pre-negotiated savings on prescriptions, vitamins, diabetic supplies and more through a network for more than 59,000 pharmacies

Discounts on everyday items and services

You'll also enjoy discounts on everyday needs with your L.I.F.E. Association Membership. Now, you don't have to wait for a sale or dig through clearance racks to find savings. Just show your L.I.F.E. card, and let the discounts appear.

Your L.I.F.E. Membership will also get you discounts on:

- ID-theft programs
- Fitness programs
- Automobile services
- Member travel advantages, entertainment and more

L.I.F.E. Association is a non-profit, members-only organization which provides you with lifestyle-related benefits and discounts.

L.I.F.E. Association Membership benefits may vary by state.

Lifestyle and wellness benefits and discounts are not insurance. Your agent and National General Accident & Health may receive financial compensation in connection with membership fees.

Limitations and Exclusions

Limitations and exclusions may vary by state. Please check your policy certificate for a full list of limitations and exclusions.

This plan will not pay benefits for sicknesses or injuries that are caused by or expenses incurred for:

- Conditions for which claims were submitted under a prior Short Term Medical policy or Policy issued by Us that provided coverage that ended within 90 days before the Effective Date of this Policy.
- Intentionally self-inflicted Sickness or Injury, whether sane or insane.
- Sickness or Injury to the extent that benefits are paid by Medicare or any other government law or program, except Medicaid (Medi-Cal in California); or medical coverage under any automobile or no fault insurance.
- Sickness or Injury eligible for benefits under worker's compensation, employers' liability or similar laws even when You do not file a claim for benefits.
- Treatment of Sickness or Injury caused by or contributed to by war or any act of war; or participation in the military service of any country. Any premium paid for a time not covered will be returned pro-rata.
- Dental treatment unless a Hospital stay is required due to Injury from an accidental blow to the mouth causing trauma to sound, natural teeth, the gums or supporting structures of the teeth. A sound, natural tooth has no decay and has never had a filling, root canal therapy or crown. Inpatient Hospital care must be the least expensive setting needed to produce a professionally adequate result and the Hospital charges only are Covered Expense. The treatment must be received while the Policy is in force.
- Eyeglasses, contact lenses, eye exams, eye refraction or eye surgery for correction of refraction error; vision therapy; or artificial hearing devices.
- Normal pregnancy or childbirth; routine well baby care including Hospital nursery charges at birth; or abortion, except as provided in the complications arising from pregnancy provision in the Benefits section.
- Infertility diagnosis and treatment for males and females including, but not limited to, drugs and medications, artificial insemination, in-vitro fertilization and reversal of sterilization.
- Genetic testing or counseling including, but not limited to, amniocentesis and chorionic villi testing.
- Sex transformation; treatment of sexual function, dysfunction or inadequacy; or treatment to enhance sexual performance or desire.
- Treatment and medication to stimulate growth and growth hormones for any purpose.
- Treatment, services or supplies to address quality of life or lifestyle concerns including, but not limited to: smoking cessation; snoring or sleep disorders; the treatment or prevention of hair loss; change in skin pigmentation; or cognitive enhancement.
- Sterilization and drugs or devices used directly or indirectly to promote or prevent conception.
- Weight reduction or weight control programs or treatment; or surgery for weight control, obesity or morbid obesity.
- All treatments for varicose veins.
- Therapy or treatment for learning disorders or disabilities or developmental delays.
- Sales tax or gross receipt tax; provider administrative expenses including, but not limited to, charges for claim filing, contacting utilization review organizations, or case management fees.
- Cosmetic treatment or reconstructive or plastic surgery that is primarily a cosmetic procedure, including medical or surgical complications arising therefrom, except as provided in the Benefits section.
- Treatment of Mental Health Conditions or substance abuse.
- Treatment or services rendered by, or supplies purchased from, a member of Your Immediate Family or an employer.
- Treatment or services required due to accidental Injury sustained in operating a motor vehicle while the Covered Person's blood alcohol level, as defined by law, exceeds that level permitted by law or otherwise violates legal standards for a person operating a motor vehicle in the state where the Injury occurred. This exclusion applies whether or not the Injury occurred in connection with an incident involving the operation of a motor vehicle, and whether or not the Covered Person is charged with any violation in connection with the accident.
- Treatment or services required due to Injury received while engaging in any hazardous occupation or other activity, including the following: Participating, instructing, demonstrating, guiding or accompanying others in parachute jumping, hang-gliding, bungee jumping, flight in an aircraft other than a regularly scheduled flight by an airline, racing any motorized or non-motorized vehicle, rock or mountain climbing, professional or semi-professional contact sports of any kind. Also excluded are treatment and services required due to Injury received while practicing, exercising, undergoing conditioning or physical preparation for any such activity.
- Treatment or services required due to Injury received while engaging in any hazardous occupation or other activity for which compensation is received, including the following: Participating, instructing, demonstrating, guiding or accompanying others in skiing and horse riding. Also excluded are treatment and services required due to Injury received while practicing, exercising, undergoing conditioning or physical preparation for any such compensated activity.
- Treatment or services required due to Injury sustained while participating in any inter-collegiate sport, contest or competition or while practicing, exercising, undergoing conditioning or physical preparation for any such sport, contest or competition.
- Treatment or services required for Sickness or Injury resulting from being intoxicated (where the blood alcohol content meets the legal presumption of intoxication under the law of the state where the Sickness or Injury took place.
- Expense incurred due to Sickness or Injury of which a contributing cause was the Covered Person's voluntary attempt to commit, participation in or commission of a felony, whether or not charged, or as a consequence of the Covered Person's being under the influence of illegal narcotics or non-prescribed controlled substances.
- Custodial Care; respite care; rest care; or supportive care.
- Expenses incurred outside of the United States or its possessions or Canada.
- Expenses incurred for Experimental or Investigational Treatment.
- Private duty nursing services rendered during Hospital confinement and charges for standby Health Care Practitioners.
- Dental braces, dental appliances, corrective shoes, repairs to or replacement of prosthetic devices, or orthotics, except as provided in the Benefits section.
- Reduction mammoplasty; revision of breast surgery for capsular contraction or replacement of prosthesis, except as provided in the Benefits section.
- Services or supplies for foot care, including care of corns, bunions or calluses, except capsular or bone surgery.
- Treatment, services or supplies rendered or received when coverage under the Policy is not in effect, except as provided under the Extension of Benefits provision.
- Any amount in excess of the Usual, Reasonable and Customary Amount, as determined by Us under this Policy.
- Prophylactic treatment or services. Prophylactic means any surgery or other procedure performed to prevent a disease process from becoming evident in the organ or tissue at a later date.
- Treatment, services or supplies that are not Medically Necessary as determined by Us under this Policy.
- Treatment, services or supplies that are prescribed, provided or furnished in a manner primarily for the convenience of the Covered Person or Physician.
- Treatment, services or supplies not described in the Benefits section.
- Expenses for marital counseling or social counseling.
- Outpatient Prescription 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.
- Treatment, services or supplies provided at no cost to the Covered Person.

Limitations and Exclusions, cont.

- Telephone consultations or failure to keep a scheduled appointment.
- Abortions, except in connection with covered Complications of Pregnancy or if the life of the expectant mother would be at risk.
- Eye surgery, such as radial keratotomy, when the primary purpose is to correct nearsightedness, farsightedness or astigmatism.
- Treatment for cataracts.
- Treatment of the temporomandibular joint unless Medically Necessary and caused by a congenital or developmental deformity, Sickness or Injury.
- Speech, vocational, occupational, biofeedback, acupuncture, recreational, sleep or music therapy, holistic care of any nature, massage and kinestherapy.
- Orthoptics and visual eye training.
- Hypnotherapy when used to treat conditions that are not recognized as Mental or Nervous Disorders by the American Psychiatric Association, and biofeedback, and nonmedical self-care or self-help programs.
- Any services or supplies in connection with cigarette smoking cessation.
- Treatment incurred as a result of exposure to non-medical nuclear radiation and/or radioactive material(s).
- Treatment for or related to any congenital condition, except as it relates to a newborn or adopted child added as a Covered Person to this Policy.
- Spinal manipulation or adjustment.
- Sclerotherapy for veins of the extremities.
- Chronic fatigue or pain disorders; or immunodeficiency disorders.
- Treatment or diagnosis of allergies, except for emergency treatment of allergic reactions.
- Kidney or end stage renal disease.
- Joint replacement or other treatment of joints, spine, bones or connective tissue including tendons, ligaments and cartilage, unless related to a covered Injury.
- Expenses or losses related to or in connection with the treatment of Acquired Immunodeficiency Syndrome and its related effects.
- Hospice care.
- Costs of 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, except as specifically covered.
- Expenses for surgery 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 or carcinoma (subject to all other coverage provisions, including but not limited to, the Pre-Existing Conditions exclusion); tonsillectomy, adenoidectomy, repair of deviated nasal septum or any type of surgery involving the sinus, myringotomy, tympanotomy, herniorraphy, or cholecystectomies.

Pre-existing condition exclusion

Charges resulting directly from a pre-existing condition are excluded from coverage. A pre-existing condition is defined as a condition:

- For which medical advice, diagnosis, care, or treatment (includes receiving services and supplies, consultations, diagnostic tests or prescription medicines) was recommended or received within the 12 months immediately preceding the Effective Date; or
- That had manifested itself in such a manner that would have caused an ordinarily prudent person to seek medical advice, diagnosis, care, or treatment (includes receiving services and supplies, consultations, diagnostic tests or prescription medicines) within the 12 months immediately preceding such person's Effective Date.

This exclusion does not apply to a newborn or newly adopted child who is added in accordance with the coverage eligibility and effective date sections within the certificate of coverage.

This exclusion also does not apply to routine follow-up care for breast cancer to determine whether a breast cancer has recurred in a covered person who has been previously diagnosed with breast cancer, unless evidence of breast cancer is found during or as a result of follow-up care.

Short Term Medical is nonrenewable

This Short Term Medical policy is nonrenewable, and plan termination is not considered a qualifying life event for purposes of enrolling in a major medical plan. Therefore, depending on the length of your coverage term, you may have a gap in insurance coverage until you can begin coverage with a new Short Term Medical or other health plan.

If you choose to purchase a new Short Term Medical plan, you must submit a new application. Any illness or condition that developed and was covered under your previous plan is considered a pre-existing condition and will not be covered by subsequent Short Term Medical plans. Reapplication may not be available in all states.

Short Term Medical does not meet Minimum Essential Coverage as mandated by the Affordable Care Act

Short-term, limited duration plans are not subject to certain provisions of federal health care reform, including the provisions related to Essential Health Benefits, lifetime limits, preventive care, guaranteed renewability, and pre-existing conditions. The pre-existing condition exclusion for Short Term Medical plans will apply for all insureds, including those under the age of 19. Know your plan. Short Term Medical plans offer affordable medical coverage, but are medically underwritten (so you can be declined) and do not provide Minimum Essential Coverage.

What does this mean for the applicant? They may have to pay a tax penalty, depending on their income level and the cost of plans available. Examples of the claims Short Term Medical plans do not cover are for most preventive care, maternity, mental health and treatment related to medical conditions they had prior to the plan's effective date. Because these plans are not guaranteed renewable, the applicant may not be eligible for another short-term plan after the plan's termination date; and the pre-existing condition exclusion will apply to any conditions that arose during any prior short-term plans.

THIS IS NOT QUALIFYING HEALTH COVERAGE ("MINIMUM ESSENTIAL COVERAGE") THAT SATISFIES THE HEALTH COVERAGE REQUIREMENT OF THE AFFORDABLE CARE ACT. IF YOU DON'T HAVE MINIMUM ESSENTIAL COVERAGE, YOU MAY OWE AN ADDITIONAL PAYMENT WITH YOUR TAXES.

National General Accident & Health

National General Holdings Corp. (NGHC) is a publicly traded company with approximately $2.5 billion in annual revenue. The companies held by NGHC provide personal and commercial automobile insurance, recreational vehicle and motorcycle insurance, homeowner and flood insurance, self-funded business products, life, supplemental health insurance products, Short Term Medical, 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 Time Insurance Company (est. in 1892), National Health Insurance Company (incorporated in 1965), Integon National Insurance Company (incorporated in 1987) and Integon Indemnity Corporation (incorporated in 1946). These four 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- (Excellent) by A.M. Best. Each underwriting company is financially responsible for its respective products.

Brochure not for use in MI, PA and VA.
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