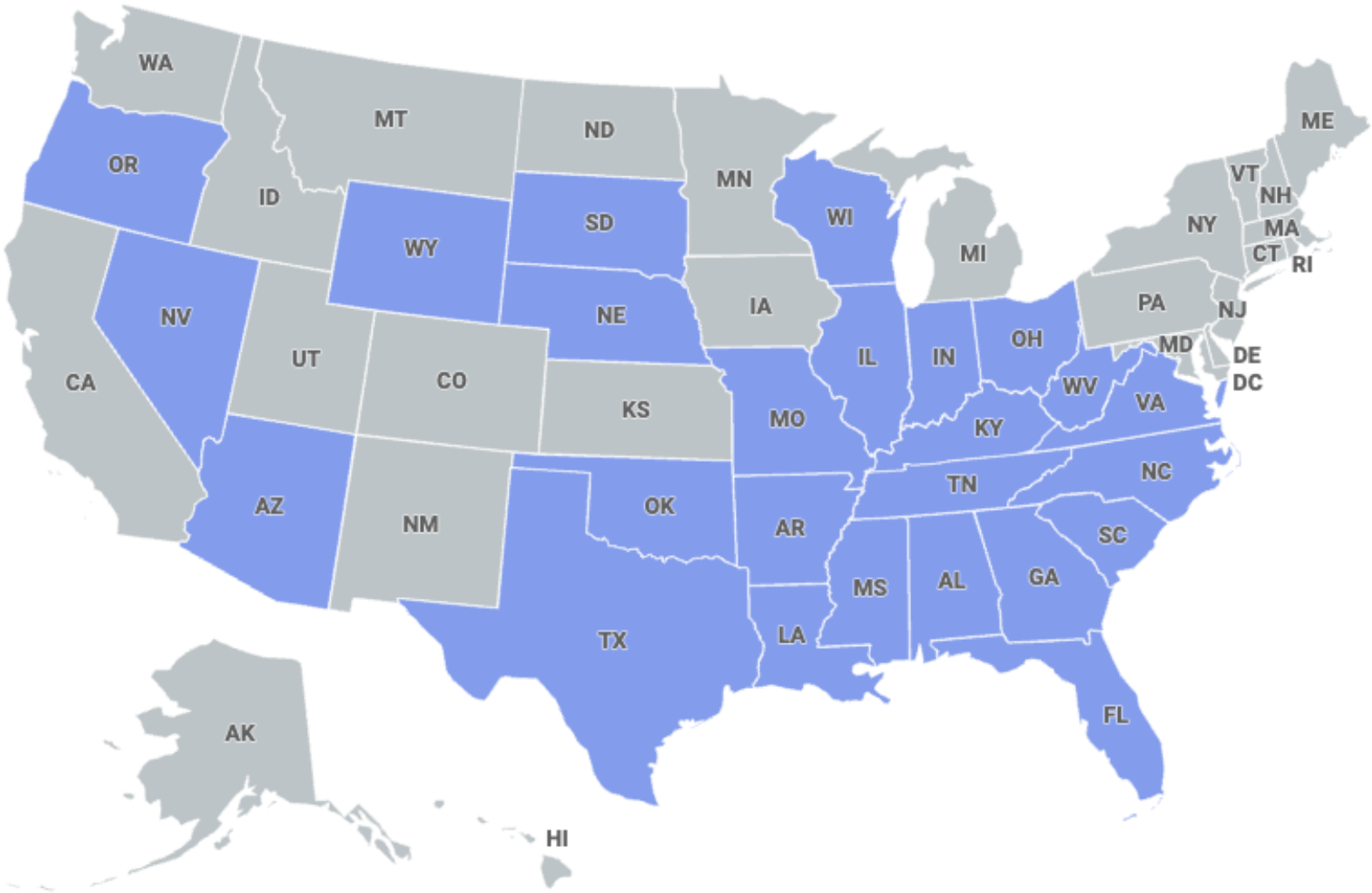
PINNACLE SHORT TERM MEDICAL

An Everest™ Product

TABLE OF CONTENTS

STATE AVAILABILITY



State	Reapply Rules
IL	60 day wait before applying for another plan
NV	Cannot exceed 185 days in any 365 day period
OH	Not Allowed
WI	Must have 63 day break after 18 months coverage

PLAN HIGHLIGHTS

Length of Coverage

Members may enroll for 6-month or 364-day policy terms, subject to state regulations. Refer to the information below on consecutive policy terms.

PPO Access and Cost Savings

- Pinnacle STM is NOT a network plan. However, covered persons have access to physicians participating in the PHCS Practitioner & Ancillary network, which provides members with in-network negotiated rates.*
- PHCS contracted pricing does not apply to "facility" charges, which are covered up to 150% of Medicare allowable charges. * *Exception: In the State of Nebraska, all applicable provider, facility and ancillary charges are covered up to 150% of Medicare allowable charges.

Coverage Effective Date

Next day coverage; later effective date available, but not to exceed 60 days from date of transmission

Waiting Period

- 5 days for sickness
- 30 days for cancer
- No waiting period for injuries

How will consecutive policy terms work?

At the end of their policy term, members may re-apply for another policy term, up to a maximum of 36 months of coverage, as allowed by the specific regulations set in their state.

Will the plan benefits carry-over between terms?

Deductible and coinsurance and all benefit limits will reset with each policy block (may be up to 12 month blocks).

After your plan expires

This Short Term Medical insurance is nonrenewable, and policy termination is not considered a qualifying life event for purposes of enrolling in a plan. Therefore, depending on your policy's termination date and state laws about reapplying for a new plan, when your Pinnacle STM Health Insurance expires, you may have a gap in insurance coverage until you can begin coverage with new Short Term Medical Insurance or an ACA or other comprehensive insurance plan. You must re-apply for a new STM policy if you want to remain covered after expiration of your existing policy. Your new plan is not an extension of your current plan. As a result, your deductibles, waiting periods, maximum benefit limits and maximum out-of-pocket obligations will reset under your new policy and any illness or condition you develop under your current policy will be considered a pre-existing condition under your new plan.

IS PINNACLE RIGHT FOR YOU?

Unexpected illnesses and accidents happen every day, and the resulting medical bills can be disastrous.

Pinnacle STM Health Insurance helps to protect you from the medical bills that can result from unexpected Injuries and Sickness. Safeguard your financial future with Pinnacle STM Health Insurance. It provides the peace of mind and health care access you need at a price you can afford.

- Plans available up to 12 months*
- Simple application process
- Flexibility to choose your own physician and hospital
- Next Day Coverage

Valuable Health Insurance Coverage for times of transition

Between Jobs

If you're between jobs, consider Short Term Medical. For about half the cost of COBRA 2, Short Term Medical offers next-day coverage to help you bridge the insurance gap.

Waiting for Employer Benefits

Often new employers impose a waiting period before you're eligible for health benefits. With Short Term Medical, you stay insured and can choose your own plan duration.

Temporary Employees

When your employment schedule is unpredictable, it's hard to maintain health coverage. Short Term Medical offers you flexible coverage options to suit your situation.

New Graduates

When your employment schedule is unpredictable, it's hard to maintain health coverage. Short Term Medical offers you flexible coverage options to suit your situation.

This Pinnacle STM Health Insurance Plan does not qualify as the minimum essential coverage required by the Affordable Care Act (ACA). Unless you purchase a plan that provides minimum essential coverage in accordance with the ACA, you may be subject to a federal tax penalty.
Underwritten by Everest Reinsurance Company, rated A+ Superior by the A.M. Best Company (5/7/21). A.M. Best is an independent global rating organization that examines insurance companies and publishes its opinion on their financial strength.
Everest Reinsurance Company, 100 Everest Way, Warren, NJ 07059. Benefits not available in all states at this time. Members can be enrolled only once. Duplicate or multiple memberships are not allowed. Coverage is not provided for members age 65 or over, coverage will terminate at the end of the month insured turns age 65. If coverage is canceled, persons may not re-enroll in coverage with Everest Reinsurance Company until six months after their termination date.

* States may vary
** Short Term Medical insurance is often a lower-cost alternative to COBRA. However, if you purchase Short Term Medical rather than maintaining COBRA coverage, you may give up your rights to coverage for pre-existing conditions or guaranteed health insurance in the future. Short Term Medical benefits may be limited compared to COBRA coverage.

ABOUT EVEREST REINSURANCE

A solid foundation to rely on

Everest is a leading global reinsurance and insurance organization with extensive product and distribution capabilities, a strong balance sheet and an innovative culture. Throughout our history, Everest has maintained its discipline and focus on creating long term value through underwriting excellence and strong risk and capital management.

A global leader in reinsurance and insurance

For over 40 years, Everest has been a global leader in reinsurance with a broad footprint, deep client relationships, underwriting excellence, responsive service and customized solutions. Our insurance arm draws upon impressive global resources and financial strength to tailor each policy to meet the individual needs of our customers.

Ascend with experienced leaders

Our diverse leaders rely on deep knowledge and decades of industry experience to deliver long-term value for our shareholders. We aim to provide strength and stability through a smart, nimble, and disciplined approach.

Recognized throughout the industry

Everest Reinsurance Company is rated A+ Superior by the A.M. Best Company (5/7/21). A.M. Best is an independent global rating organization that examines insurance companies and publishes its opinion on their financial strength.

Recognized throughout the industry

Everest Re is a longstanding U.S. property and casualty reinsurer offering a diverse range of products. We rely on proven financial strength, underwriting excellence, and industry proficiency to customize smart solutions for our clients.

We rank among the top reinsurers with locations around the world. Our approach is client-centered, and unique in each region. We have a broad distribution network and can underwrite all types of property, casualty, and reinsurance products throughout the world.

SHORT TERM MEDICAL BENEFITS

Traditional Plan	
PPO Network	PHCS Practitioner & Ancillary Network
Coinsurance	50/50 or 80/20
Deductible	$500, $1,000, $2,500, $5,000, $7,500, $10,000
Out-Of-Pocket Maximum	$5,000
Coverage Period Maximum	$1,000,000
Unless specified otherwise, the following benefits are for the Insured and each Covered Dependent subject to the plan Deductible, Coinsurance Percentage, Out-Of-Pocket Maximum and Policy Maximum chosen. Coinsurance does not include Deductibles, Copayments, penalty coinsurance for failure to pre-certify required services or any charges in excess of the Maximum Allowable Expense. Benefits are limited to the Maximum Allowable Expense for each Covered Expense, in addition to any specific limits stated in the policy. All Inpatient Hospitalizations and procedures done at an Outpatient Surgery Facility must be pre-certified.	
Doctor Office Consultation	
Copay	$50 Copay
Wellness Benefit Copay	$50 Copay
Inpatient Hospital Services	
Average Standard Room Rate	Average Standard Room Rate
Hospital ICU	Average Standard Room Rate
Doctor Visits	Subject to Deductible and Coinsurance
Outpatient Services	
Outpatient Surgery Deductible	$500 per surgery, maximum 3
Emergency Room - Deductible	$500 per visit, maximum 3
Advanced Diagnostic Studies Deductible	$500 per occurrence
Ambulance Benefit	Injury and Sickness: $250 per transport
Extended Care Facility Benefit	$150 per day, maximum 30 days
Home Health Care Benefit	$50 per visit, maximum 30 days (1 per day)
Physical, Occupational and Speech Therapy Benefit	$50 per day, maximum 20 visits
Mental Disorders	
Inpatient	$100 per day, maximum 31 days
Outpatient	$50 per day, maximum 10 visits
Substance Abuse	
Inpatient	$100 per day, maximum 31 days
Outpatient	$50 per day, maximum 10 visits

This is a summary of what is not covered. Complete details are included in your policy.

- Treatment of a Pre-Existing condition, including those not inquired about on the enrollment form
- Charges for services or supplies in excess of the Maximum Allowable Expense (MAE). MAE means the maximum charge that will be considered as an Eligible Expense; will be the lesser of billed charges, the Usual and Customary Fee, the negotiated or contracted discount, the maximum benefit under this Policy, or a percent of the Medicare allowable charge
- Prescription Drugs, except those administered by a Doctor in a covered Inpatient or Outpatient setting
- Spinal manipulations or adjustments
- Illness or injury that is self-inflicted or caused while engaged in a felony, under the influence, in military service, in a hazardous occupation or activity, or while engaged in intercollegiate sports
- Vision or dental treatments, foot care or orthotic
- Expenses incurred outside the United States and its possessions
- Genetics or fertility treatment or testing
- Cosmetic, experimental, investigational, or non-medically necessary treatment
- Hearing examination or hearing aids
- Maternity
- Benefits for Sicknesses that begin 5 days (30 days for cancer) following the Effective Date
- Charges during the first 6 months after the Effective Date for: Total or partial hysterectomy, unless it is Medically Necessary due to a diagnosis of carcinoma; Tonsillectomy; Adenoidectomy; Repair of deviated nasal septum or any type of surgery involving the sinus; Myringotomy; Tympanotomy; Herniorraphy; or Cholecystectomy
- Benefits exceeding the specified amounts in the Schedule of Benefits for: Kidney stones; Appendectomy; Joint or tendon Surgery; Knee Injury or disorder; Acquired Immune Deficiency Syndrome (AIDS)/ Human Immuno-deficiency Virus (HIV); or Gallbladder
- Custodial care or private duty nursing
- Surgery

Note: Plan terms, limitations and exclusions may vary by state.

KEY TERMS & OVERVIEW

- **ACA Major Medical** - Affordable Care Act health insurance plans provided through the government run insurance marketplace www.healthcare.gov.
- **Additional Deductible** - Advanced Diagnostics, ER visit and Outpatient Surgery have additional deductibles that apply. The Additional Deductible applies first, then the Plan Deductible and then Coinsurance applies for eligible services.
- **Benefit Appeals** - If a health insurer refuses to pay a claim or ends your coverage, you have the right to appeal the decision and have it reviewed. You can ask that your insurance company reconsider its decision. Appeals must be sent in writing to the insurer and include all applicable information as to the reason behind contesting the decision made by the insurer.
- **Benefit Eligibility** - Benefits are payable under the Policy after a Covered Person incurs charges for Eligible Expenses in excess of any applicable Additional Deductible, and then the Plan Deductible or Copayment, unless otherwise specified. The Schedule of Benefits defines and limits the type and amount of services which may be paid for by the insurance. Benefits will be paid at the Coinsurance amount shown in the Schedule of Benefits. Once the Out of Pocket Maximum amount is reached, the Coinsurance amount for the remainder of the Coverage Period is 100%. All benefits payable are subject to the Coverage Period Maximum Benefit.
- **Benefit Reductions for certain procedures** - Scheduled benefit for specifically assigned conditions or services rendered. A maximum benefit is assigned and that is the most that the plan will apply to that service(s).
- **COBRA Insuranc**e - The Consolidated Omnibus Budget Reconciliation Act of 1985 allows workers and their qualified dependents the right to continue their employer-sponsored health insurance for a short period of time, if that insurance would stop due termination of employment, reduction in hours or changes within their immediate family.
- **Coinsurance** - the percentage amount the Company will pay of the Eligible Expenses that the Insured and the Company share after the applicable Deductibles and Copayments are met. Coinsurance does not include Deductibles, Copayments, penalty coinsurance for failure to pre-certify required services or any charges in excess of the Maximum Allowable Expense.
- **Copayment** - the designated amount that must be paid by a Covered Person for medical care. Copays do not apply to any Deductible or Out of Pocket Maximum.
- **Exclusion and Limitations** - Loss caused by, contributed to, or resulting from the following is excluded or otherwise limited as specified: See Exclusion and Limitations section of the sample Certificate of Insurance/Policy. These services are either excluded from the policy or the benefit may have a waiting period that will apply depending on the condition and/or cause of the condition.
- **Insurance marketplace** - any website which provides consumers access to quote and/or enroll into insurance products.
- **Maximum Allowable Expense (MAE)** - This is the maximum charge that will be considered as an Eligible Expense. It is the lesser of billed charges, Usual and Customary (U&C), the negotiated discount or 150% of Medicare allowable charge.
- **Out of Pocket Maximum** - the amount of eligible expenses that is the responsibility of each Covered Person to meet before the plan pays expenses at the coinsurance level. This does not include Deductibles or Coinsurance. This includes charges in excess of the MAE.
- **Plan Deductible** - the amount of Eligible Expenses that must be paid by each Covered Person during any Coverage Period before any benefits are payable.

KEY TERMS & OVERVIEW

- **Policy Duration** - the length of time a STM plans will last. Example: if someone buys a STM plan for 3 months, the STM plan terminates after 3 months (does not continue therefore there are no covered events after the 3 months is over).
- **Policy Maximum** - the maximum amount that the insurance company will pay during a policy period.
- **Premium** - the cost of insurance
- **Pre-Existing Conditions** - 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 (timeline may vary by state regulation) period immediately preceding such person's Certificate Effective Date are excluded for the first 12 months (timeline may vary by state regulation) of coverage hereunder. Pre-Existing Conditions includes conditions that produced any symptoms which would have caused a reasonably 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.
- **Pretreatment Review-(Pre-Certification)** - aka Pre-authorization is the process of obtaining approval from the insurance company to receive a particular medical service, and/or treatment. Pre-certification is usually required for planned medical procedures such as, but not limited to, outpatient surgery or inpatient hospitalization Absence of a pre-certification will result in a 50% penalty of eligible charges. Pre-certification DOES NOT add to the type or amount of benefits available in the Schedule of Benefits.
- **Provider Categories:**
  - **Facility (includes, but not limited to):**
    - Accredited Hospital Facility
    - Extended Care Facility
    - Assisted Living Facility
    - Nursing Home
    - Convalescent Care
    - Drug and Alcohol Addiction Facility
    - Mental Disorders Facility
    - Outpatient Surgical Facility
  - **Ancillary:** Diagnostic Lab and X-ray
  - Practitioner: A licensed practitioner who is recognized by the law of the state in which treatment is received as qualified to perform the service for which claim is made and who is not a member of Your immediate family.
- **STM** - is the acronym for Short Term Medical. STM is a short-term medical insurance plan with defined, limited benefits that is not major medical insurance for those who need temporary health insurance for a specific time.
- **Temporary Health Insurance** - Another term describing Short Term Medical plans.
- **Usual & Customary (U&C)** - "Usual and Customary Fee" (or "Fees") means the usual, fair, and reasonable fee for medical treatment provided to a Covered Person (or any other form of medical care, procedure, drug, or supply). U&C applies to out of network providers for services rendered for practitioner or ancillary charges.
- **Waiting Periods** - A period of time that must pass from the effective before services for illness or cancer will be eligible. Covered Persons will not be able to receive benefits for:
  - Sickness: 5 day waiting period from the effective date of coverage
  - Cancer: 30 days waiting period from the effective date of coverage
- **150% of Medicare** - 150% of the Medicare allowable established by the Centers for Medicare & Medicaid Services (CMS). This allowable amount applies to Facility charges only. (See description of "Facility" above) EXCEPT for Nebraska which has a state mandate that 150% of Medicare allowable applies to all services/all locations such as Facility, Practitioner and Ancillary services.

FAQS

Q. What is Short Term Medical

A. Short-term medical (STM) insurance policies are designed to provide temporary coverage during life's transitions until you can secure an Affordable Care Act (ACA) insurance plan. STM insurance policies are not required to comply with the requirements of the ACA and may have exclusions and limitations not permitted in ACA plans. ACA plans are guaranteed issue, must cover certain "essential health benefits" (EHBs), and you cannot be denied coverage based on pre-existing medical conditions. In contrast, STM insurance requires that you answer a series of medical questions to determine your eligibility, may not cover all EHBs, and does not cover pre-existing conditions. The limitations on benefits and exclusions, including the pre-existing conditions exclusion, likely will result in STM policies having lower insurance premiums than ACA plans and make them a viable option for your health insurance needs. If you have had medical conditions in the past or have current or chronic conditions, you should seek an ACA or other comprehensive insurance plan as soon as you are eligible for enrollment.

Q. Why would I want coverage for a short period of time?

A. If you're between jobs, missed Open Enrollment, do not qualify for Special Enrollment, are waiting for a new job or coverage from an ACA plan to start, a recent college graduate, or seasonal employee who needs coverage only for a specific period of time, STM insurance may make sense for you. STM may be the insurance protection you need to transition you to the next period in your life.

Q. How Soon can my policy start?

A. STM insurance does not have specific enrollment periods so you can apply at any time. You can be covered by a policy as soon as next day if you apply online, meet eligibility criteria and pay using a credit card or automatic bank debit.

Q. Can I access my short-term medical benefits right away?

A. Your Pinnacle STM policy covers accidental injuries occurring on or after the effective date of your policy. Benefits are available under your Pinnacle STM policy for sicknesses that begin more than five days after your effective date and for cancer that begins more than 30 days after your effective date. **

† In the State of Nebraska, all practitioner and ancillary charges as well as facility charges are covered at 150% of Medicare allowable charges – as of February 2021. The PHCS Practitioner and Ancillary network repricing can no longer be used in this state. Therefore, covered persons may be subject to excess charges (otherwise referred to as "balance billing"- see description below).

* Pinnacle STM Insurance is underwritten by Everest Reinsurance Company.

** Terms may vary by state. Consult your policy for complete terms and limitations.

*** Balance billing is when the provider is allowed to bill you for the difference between the amount billed by the provider and the amount allowed under your policy. For example, if your doctor bills $100 for your office visit and only $70 is allowed under your policy, your doctor may hold you responsible for the remaining $30. Similarly, if a hospital bills you $2,500 for a hospital visit and $1,800 is equal to the 150% of Medicare allowable expense maximum under your policy, your hospital may hold you responsible for the remaining $700.

FAQS

Q. Can I avoid ACA tax penalties buying a short-term medical policy?

A. STM insurance is not "minimum essential coverage" as defined by the ACA. If you do not have "minimum essential coverage," you may have to pay a tax penalty. Consult your tax advisor for more information.

Q. Can I renew my short-term medical insurance when my policy ends?

A. Your Pinnacle STM policy is issued for a specific period of time (up to 364 days)** and is not renewable. You must re-apply for a new STM policy if you want to remain covered after expiration of your existing Pinnacle STM policy. Your new plan is not an extension of your current plan. As a result, your deductibles, waiting periods, maximum benefit limits and maximum out-of-pocket obligations will reset under your new policy and any illness or condition you develop under your current policy will be considered a pre-existing condition under your new plan.

Q. Do I have to go to doctors or facilities in network?

A.Your Pinnacle STM policy does not confine you to a specific network, but it can be advantageous to see doctors and obtain other ancillary services in the PHCS Practitioner Plus Ancillary Network (PHCS Network). When you see doctors in the PHCS Network, you can avoid balance billing*** for services that are covered by your policy. For care from a hospital or facility, your benefits for eligible expenses under your Pinnacle STM policy are limited to up to 150% of the rates that Medicare would typically pay your hospital or facility.† This information is included on your ID card and you should make sure your hospital or facility provider understands this when seeking services in order to avoid issues later.

Q. Are maternity and newborn care covered?

A. Complications of maternity are covered, but not standard childbirth services.**

Q. Does STM Insurance cover Dental and Vision benefits?

A. No. STM insurance is designed to protect you in the event of an unexpected illness or injury and does not provide dental and vision care coverage. STM policies are for temporary coverage only and therefore do not include some of the benefits that may be offered by ACA plans. In the event you purchase dental, vision or any other insurance or non-insurance coverages from another carrier, such products are not affiliated with your Pinnacle STM policy.

† In the State of Nebraska, all practitioner and ancillary charges as well as facility charges are covered at 150% of Medicare allowable charges – as of February 2021. The PHCS Practitioner and Ancillary network repricing can no longer be used in this state. Therefore, covered persons may be subject to excess charges (otherwise referred to as "balance billing"- see description below).

* Pinnacle STM Insurance is underwritten by Everest Reinsurance Company.

** Terms may vary by state. Consult your policy for complete terms and limitations.

*** Balance billing is when the provider is allowed to bill you for the difference between the amount billed by the provider and the amount allowed under your policy. For example, if your doctor bills $100 for your office visit and only $70 is allowed under your policy, your doctor may hold you responsible for the remaining $30. Similarly, if a hospital bills you $2,500 for a hospital visit and $1,800 is equal to the 150% of Medicare allowable expense maximum under your policy, your hospital may hold you responsible for the remaining $700.

PINNACLE SHORT TERM MEDICAL

Member Services:

(866) 870-7730

M-TH 9:00 AM - 6:00 PM EST

F 9:00 AM - 5:00 PM EST

VALUE ADDED NETWORK

There are no network requirements for Pinnacle STM - members may use the providers and facilities of their choice. The plan benefits do not change regardless of provider or facility. However, members may be able to decrease their out-of-pocket costs by utilizing a participating provider in the PHCS Practitioner & Ancillary Only network.

PHCS
Practitioner &
Ancillary Only

PHCS Practitioner & Ancillary Only Network Provides:

- 915,000 Contracted healthcare providers
- 60 million consumers accessing the network
- 135 million medical bills processed for cost reductions

Provider Lookup

Members can find participating doctors or facilities near them by going to multiplan.com/phcspracanc. The website and phone number will also be available on your member ID card.

American Workers Association

What is AWA?

Enrollment in the Pinnacle Short Term Medical product includes a membership in the American Workers Association. AWA strives to provide a wide range of discounts, services, education and resources that are not normally available to the modern American worker. The benefits and privileges of AWA Membership are specially selected to meet the unique needs of our Members. We continuously seek out new benefits that we believe will improve your everyday life.

- A Reputation For Excellence
- We Build Partnerships
- Guided By Commitment
- A Team Of Professionals

AWA strives to provide a wide range of discounts, services, education and resources that are not normally available to the modern American worker. The benefits and privileges of AWA Membership are specially selected to meet the unique needs of our Members. We continuously seek out new benefits that we believe will improve your everyday life.

Some of your Discount benefits include:

- Marquee Health
- Vitamin Discounts
- Coast to Coast Vision
- Tax Hotline
- Hotel Discounts
- Cura Link Mental Health Benefits
- Prescription Discounts & Advocacy
- Financial Assistance
- Vacation Discounts

Rx Savers

HOW IT WORKS

1. Scan the QR code below to download your app
2. Enter in your information to start your clever story.
3. Select “Clever rx”
4. Add new prescription
5. Select your voucher and save!
    a. If you need any help with any name brand department, our prescription advocate team will help!

Call us:
1-800-393-9545