Standard Life
Select Short-Term Major Medical (STM)

For Use in Idaho Only
MSGASTM-ID

ASSOCIATION BENEFITS PROVIDED BY:

MSGA
Med-Sense Guaranteed Association

INSURANCE COVERAGE UNDERWRITTEN BY:

Standard Life
and Accident Insurance Company

BILLING, FULFILLMENT, AND CUSTOMER SERVICE PROVIDED BY:

agile
Health Insurance

Being a member of the Med-Sense Guaranteed Association provides great discounts and services for a variety of health, travel, business services and more.

Med-Sense Guaranteed Association is NOT INSURANCE.

We know how important it is to find the right plan and benefits. Your Standard Life Select STM plan offers a deductible, coinsurance and lifetime maximum amount tailored to your needs.

We've got you covered! Your plan offers doctor visit copays, wellness exams and a PPO network accepted at almost 900,000 healthcare providers.

Finding a doctor for the first time? Not a problem! Choosing a doctor in the PHCS Network has never been easier. You can search by location, zip code, doctor's name or just the type of doctor you are looking for.

Understanding your plan is easy:

1. The deductible you choose is an amount that must be paid by each Covered Person before the Coinsurance benefits are payable. If 3 individuals meet their deductible, it is deemed satisfied for any remaining individuals.
2. The insurance pays the coinsurance percentage up to your chosen stop loss amount of $10,000 or $20,000
3. Once you have met the stop loss amount of $10,000 or $20,000, the plan pays 100% up to $250,000 or $1,000,000 based on the plan selected. (Benefits received Out-of Network are subject to Reasonable and Customary Charges. Benefits received In-Network are subject to the PPO Negotiated Rate.)

ACA NOTICE

This coverage is not required to comply with certain 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 preexisting conditions or health benefits (such as hospitalization, emergency services, maternity care, preventive care, prescription drugs, and mental health and substance use disorder services). Your policy 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 health insurance coverage. Also, this coverage is not "minimum essential coverage." If you don't have minimum essential coverage for any month in 2018, you may have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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What is covered?

The following benefits are for the Insured and each Covered Dependent subject to the plan Deductible, Coinsurance Percentage, Stop Loss Amount and Maximum Limit per Coverage Period. Benefits received Out-of Network are limited to the Reasonable and Customary Charge and benefits received In-Network are limited to the PPO Negotiated Rate for each Covered Eligible Expense, in addition to any specific limits stated in the policy. State options and benefits may vary.

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, unless otherwise specified. Benefits will be paid at the Coinsurance Percentage listed in the Schedule of Benefits. All benefits payable are subject to the Coverage Period Maximum Benefit. Your Schedule of Benefits shows Your Plan Deductible, Additional Deductible, Coinsurance Percentage, Stop Loss Amount and Coverage Period Maximum Benefit.

Maximum Benefit	Plan 2	Plan 3
Deductible Options	$500, $1,000 $2,500, $5,000, $7,500, or $10,000	$250, $500, $1,000 $2,500, $5,000, $7,500, or $10,000
In Network Coinsurance Percentage	70%/30%, 80%/20%	70%/30%, 80%/20%, 100%/0%
Out of Network Coinsurance Percentage	50% or 60%	50%, 60%, or 80%
Stop Loss Amount	$10,000 or $20,000	$10,000 or $20,000
Maximum Limit per Coverage Period	$250,000 or $1,000,000	$1,000,000
ER Facility & Prof		
Maximum per day	Unlimited	Unlimited
Deductible (Sickness without admit)	$250	0
Maximum number of deductibles	3	0
Doctor Office Consultation		
Copay	$50	$40
Maximum Excess of Copay	$2,000	$2,000
Wellness (maximum amount)	$75	$75
Inpatient Services		
Hospital Services		
Maximum per day	Unlimited	Unlimited
Deductible	0	0
Maximum number of deductibles	0	0
Hospital ICU	0	0
Doctor Visits (maximum per stay)	Unlimited	Unlimited
Outpatient Services		
Surgical Facility		
Maximum per day	Unlimited	Unlimited
Deductible	0	0
Maximum number of deductibles	0	0
Extended Care Facility	$150	$150
Maximum number of days	30	30
Home Health (Maximum per day)	$40	$40
Maximum number of days	30	30
Ambulance (maximum amount)	$250	$250
Hospital Services (not surgical or advanced studies)		
Maximum per day	Unlimited	Unlimited
Deductible	0	0
Maximum number of deductibles	0	0
Physical Therapy Professional		
Maximum per day	$50	$50
Maximum number of visits	20	20

About My Plan

Does the plan require Pre-Certification?

All Inpatient hospitalizations and procedures done at an Outpatient Surgery Facility must be pre-certified. It is the responsibility of the medical provider of those services to contact Standard Life and Accident's professional review organization as soon as possible before the expense is to be incurred. If an In-Network provider does not comply with the pre-certification requirements or if the expenses are not pre-certified, the Company will not penalize the Covered Person for failure to obtain pre-certification. However, if an Out-Of-Network provider fails to obtain pre-certification, the Covered Person is penalized by a 50% reduction in payment of Eligible Expenses.

How does Reasonable and Customary affect my benefits when I use an Out-of-Network provider?

We may use and subscribe to a standard industry reference source that collects data and makes it available to its member companies in order to determine the amount that should be considered as Reasonable and Customary for services and supplies.

The policy defines Reasonable and Customary charges as:

1. A usual fee is defined as the charge made for a given service by a Doctor to the majority of his or her patients; and
2. A customary fee is one that is charged by the majority of Doctors within a community for the same services.

All benefits received Out-of-Network are limited to Reasonable and Customary charges.

BENEFITS RECEIVED IN-NETWORK (FROM PPO PROVIDERS) ARE NOT SUBJECT TO REASONABLE AND CUSTOMARY CHARGES.

What if I change my mind after I purchase the STM Coverage?

If you are not 100% satisfied with your coverage, and you have not already used any of your insurance benefits, return the certificate within 10 days of receipt. Certificate can be returned and premium will be refunded less any benefits paid. Coverage will be cancelled as of the effective date and your plan cost will be refunded minus any benefits paid. No questions asked!

What is the Pre-Existing Conditions Limitation?

"Preexisting Condition" means:
(a) a condition that would have caused an ordinarily prudent person to seek medical advice, diagnosis, care or treatment during the six (6) months immediately preceding the effective date of coverage;
(b) a condition for which medical advice, diagnosis, care or treatment was recommended or received during the six (6) months immediately preceding the effective date of coverage; or
(c) a pregnancy existing on the Certificate Effective Date.
Preexisting Conditions are excluded for twelve (12) months following the Certificate Effective Date.

Coverage under this plan is provided on a short term basis and is not renewable.

Who is eligible to apply for this insurance?

Standard Life Select STM is available to members and their spouses who are between 18 and 64 years old and their dependent, unmarried children under 26 years old. They must also be able to answer "No" to all of the questions in the application for insurance. Child-only coverage is available for ages 0-25 (adult rates apply to anyone 18 or older).

When does the STM coverage terminate?

Coverage under the Policy will cease at 12:01 a.m. for a Covered Person, based on the time zone in the place where the Insured resides, on the earliest of the following:

3. The date premiums are not paid in accordance with the terms of the Policy, subject to the Grace Period;
4. On the next premium due date after the Company receives a written request from the Insured to terminate coverage, or any later date stated in the request;
5. The date an Insured performs an act or practice that constitutes fraud, or is found to have made an intentional misrepresentation of material fact, relating in any way to the Policy, including claims for benefits under the Policy;
6. The date of the Insured's death or the termination date of the Insured's coverage, if the Insured's spouse is not covered under the Policy;
7. The date the Insured obtains other insurance, excluding Medicare;
8. The Certificate termination date stated on Your Schedule of Benefits.

Limitations and Exclusions

Loss caused by, contributed to or resulting from the follow-ing is excluded or otherwise limited as specified:

a. Preexisting Conditions, except for congenital anomalies of a newborn child continuously covered under the Policy from birth. Preexisting Conditions are excluded from the first 12 months of coverage hereunder.

b. Mental Disorders and Substance Abuse;

c. Pregnancy, except for Complications of Pregnancy;

d. Abortions for any reason other than to preserve the life of the female upon whom the abortion is performed.

e. Illness, treatment or medical condition arising out of:
i. War or act of war (whether declared or undeclared); participation in a felony, riot or insurrections; service in the
armed forces or units auxiliary to it;
ii. Suicide (sane or insane), attempted suicide or intentionally self-inflicted injury;

g. Cosmetic surgery, except that "cosmetic surgery" shall not include reconstructive surgery when the service is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part, and reconstructive surgery because of congenital disease or anomaly of a covered dependent child;

h. Foot care in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain or symptomatic complaints of the feet;

i. Care in connection with the detection and correction by manual or mechanical means of structural imbalance, distortion, or subluxation in the human body for purposes of removing nerve interference and the effects of it, where the interference is the result of or related to distortion, misalignment or subluxation of, or in the vertebral column;

j. Benefits provided under Medicare or other governmental program (except Medicaid), a state or federal worker's compensation law, employers liability or occupational disease law, or motor vehicle no-fault law; services performed by a member of the covered person's immediate family; and services for which no charge is normally made in the absence of insurance;

k. Dental care or treatment;

l. Eye glasses, hearing aids, and examination for the prescription, or fitting of them;

m. Rest cures, custodial care, transportation and routine physical examinations;

n. Services received or supplies purchased outside the United States, its territories or possessions, or Canada, except as expressly described under the Policy.

General Definitions

"Accident" means a sudden, unforeseeable event that causes Injury to one or more Covered Persons.

"Certificate Effective Date" is the date coverage begins for each Covered Person under the Policy. It will be different for a Covered Person added to the Certificate after the original date of issue or when a change in coverage for any Covered Person occurs. Each Covered Person's Effective Date is shown in the Schedule of Benefits.

"Complications of Pregnancy" means either of these two general types of conditions:

1. Conditions, requiring Hospital confinement (when the pregnancy is not terminated), whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy or are caused by pregnancy, such as acute nephritis, nephrosis, cardiac decompensation, missed abortion and similar medical and surgical conditions of comparable severity, but shall not include false labor, occasional spotting, physician prescribed rest during the period of pregnancy, morning sickness, hyperemesis qravidarum, preeclampsia and similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy.

2. Cesarean section delivery, ectopic pregnancy which is terminated, spontaneous termination of pregnancy which occurs during a period of gestation in which a viable birth is not possible, puerperal infection, eclampsia and toxemia.

"Congenital Condition" means a condition existing at or from birth that is a significant deviation from the common form or function of the body, whether caused by a hereditary or developmental defect or disease. A significant deviation is a deviation which impairs the function of the body and includes, but is not limited to, the conditions of cleft lip, cleft palate, webbed fingers or toes, sixth toes or fingers, or defects of metabolism and other conditions that are medically diagnosed to be congenital anomalies.

"Coverage Period" means the length of time which the Insured selected in the Insured's Enrollment Form and approved by Us.

"Covered Person" means You and Your covered Dependents (spouse and/or children), listed as a Covered Person in the Schedule of Benefits and for whom premium has been paid.

"Custodial or Convalescence Care" means any care that is provided to a Covered Person who is disabled and needs help to support the essential activities of daily living when the Covered Person is not under active and specific medical, surgical, or psychiatric treatment that will reduce the disability to the extent necessary for the person to perform the essentials of daily living on his own.

"Dependent" means Your family as follows:
1. The lawful spouse, if not legally separated or divorced;

2. Children (whether natural, adopted or stepchildren) under the limiting age of 26, except as provided under Section III, CONTINUATION OF COVERAGE FOR AN INCAPACITATED CHILD; or

3. Children for whom You are required to provide insurance under a medical support order or an order enforceable by a court.

"Doctor" means any duly 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.

"Eligible Expense" means the Reasonable and Customary Charges (if using an Out-of-Network provider), or the PPO Negotiated Rate (if using an In-Network provider), for Medically Necessary services, supplies, or treatment prescribed or provided by a Doctor for a covered Injury or Sickness while coverage is in force for a Covered Person. The Company reserves the right to interpret and determine coverage for Eligible Expenses. The fact that a Doctor has prescribed, recommended, approved, or provided a treatment, service or supply does not, in itself, make such treatment, service or supply a Medically Necessary covered expense.

"Enrollment Form" means the form(s) that You (and Your spouse, if any) signed to apply for coverage under the Policy. It also includes any other document approved by the Company that You use to change coverage under the Policy.

"Experimental or Investigational Treatment" means in Our discretion a treatment, drug, device, procedure, supply or service and related services (or any portion thereof, including the form, administration or dosage) for a particular diagnosis or condition when any one of the following exists:

1. The treatment, drug, device, procedure, supply or service is in any clinical trial or a Phase I, II or III trial.

2. The treatment, drug, device, procedure, supply or service is not yet fully approved or recognized (for other than experimental, investigational, research or clinical trial purposes) by the National Cancer Institute (NCI), Food & Drug Administration (FDA), or other pertinent governmental agency or professional organization.

3. The results are not proven through controlled clinical trials with results published in peer-reviewed English language medical journals, to be of greater safety and efficacy than conventional treatment, in both the short and long term.

4. The treatment, drug, device, procedure, supply or service is not generally accepted medical practice in the state where the Covered Person resides or as generally accepted throughout the United States as determined in Our discretion, by reference to any one or more of the following: peer-reviewed English-language medical literature, consultation with physicians, authoritative medical compendia, the American Medical Association, or other pertinent professional organization or governmental agency.

5. The treatment, drug, device, procedure, supply or service is described as investigational, experimental, a study, or for research or the like in any consent, release or authorization which the Covered Person, or someone acting on his or her behalf, may be required to sign. The fact that a procedure, service, supply, treatment, drug, or device may be the only hope for survival will not change the fact that it is otherwise experimental in nature.

"Extended Care Facility" means an institution, other than a Hospital, operated and licensed pursuant to law, that provides: (a) permanent and full-time facilities for the continuous skilled nursing care of three (3) or more sick or injured persons on an Inpatient basis during the convalescent stage of their Sicknesses or Injuries; (b) full-time supervision of a Doctor; (c) twenty-four (24) hour a day nursing service of one or more nurses; and (d) is not, other than incidentally, a rest home or a home for custodial care or for the aged. Extended Care Facility does not include an institution that primarily engages in the care and treatment of drug addiction or alcoholism.

"Home Health Care Agency" means an entity licensed by state or local law operated primarily to provide skilled nursing care and therapeutic services in an individual's home and:
a) Which maintains clinical records on each patient;
b) Whose services are under the supervision of a Doctor or a licensed graduate registered nurse (RN); and
c) Which maintains operational policies established by a professional group including at least one Doctor and one licensed graduate registered nurse (RN).

"Home Health Care Plan" means a program for continued care and treatment of an individual established and approved in writing by the individual's attending Doctor. As part of the Plan, an attending Doctor must certify (and re-certify every 30 days) that proper treatment of the Injury or Sickness would require continued confinement in a Hospital in the absence of the services and supplies.

"Hospital" means an institution operated by law for the care and treatment of Injuries or Sicknesses; has organized facilities for diagnosis and surgery or has a contract with another Hospital for these services; and has 24-hour nursing service. Hospital excludes any institution that is primarily a rest home, nursing home, convalescent home, a home for the aged, an alcoholism or drug addiction treatment facility or a facility for treatment of Mental Disorders.

"Immediate Family" means the parents, spouse, children, or siblings of a Covered Person, or any person residing with a Covered Person.

"Injury" means Accidental bodily Injury of a Covered Person:
a) Caused by an Accident; and
b) That results in covered loss directly and independently of all other causes.
All Injuries sustained in one Accident, including all related conditions and recurring symptoms of the Injuries, will be considered one Injury.

"Inpatient" means a Covered Person who incurs medical expenses for at least one day's room and board from a Hospital.

"Insured" means the Applicant named in the attached Enrollment Form and to whom the Certificate is issued.

"Intensive Care Unit" means that part of a Hospital service specifically designed as an intensive care unit permanently equipped and staffed to provide the highest level of care for critically ill or Injured patients, including a Coronary Care Unit and Neonatal Intensive Care Unit. Coverage includes close observation by trained and qualified personnel whose duties are primarily confined to the part of the Hospital for which an additional charge is made.

"Medically Necessary" means that, based on generally accepted current medical practice, a service or supply is necessary and appropriate for the diagnosis or treatment of Injury or Sickness. We do not consider a service or supply as
Medically Necessary if:
1. It is provided only as a convenience to the Covered Person or provider;
2. It is not appropriate treatment for the Covered Person's diagnosis or symptoms;
3. It exceeds (in scope, duration or intensity) that level of care that is needed to provide safe, adequate and appropriate diagnosis or treatment;
4. It is Experimental or Investigational Treatment.

The fact that a Doctor may prescribe, order, recommend or approve a service or supply does not, of itself, make the service or supply Medically Necessary.

"Mental Disorder" means a "biologically-based" mental disorder, including Schizophrenia, Schizoaffective disorder, Major depressive disorder, Bipolar disorder, Paranoia and other psychotic disorders, Obsessive-compulsive disorder, Panic disorder, Delirium and dementia, Affective disorders, and any other "biologically-based" mental disorders appearing in the most recent edition of the Diagnostic and Statistical Manual of the American Psychiatric Association (the "DSM").

"Outpatient" means a Covered Person who incurs medical expenses at Doctor's offices and freestanding clinics, and at Hospitals when not admitted as an Inpatient.

"Outpatient Surgical Facility" means a licensed medical facility or a part of a Hospital:
1. With an organized staff of Doctors;
2. That is permanently equipped and operated primarily for the purpose of performing surgical procedures;
3. That does not provide accommodations for overnight stays; and
4. That provides continuous Doctor services and nursing services whenever a patient is in the facility.
The term "Outpatient Surgical Facility" does not include a:
1. Hospital emergency room;
2. Trauma center; or
3. Doctor's office or clinic.

"PPO Negotiated Rate" means the amount or rate of payment agreed upon by a PPO provider/organization and Standard Life and Accident Insurance Company, that the PPO provider will accept as payment for supplies or services rendered.

"Preexisting Condition" means: (a) a condition that would have caused an ordinarily prudent person to seek medical advice, diagnosis, care or treatment during the six (6) months immediately preceding the effective date of coverage; (b) a condition for which medical advice, diagnosis, care or treatment was recommended or received during the six (6) months immediately preceding the effective date of coverage; or (c) a pregnancy existing on the Certificate Effective Date. Preexisting Conditions are excluded for twelve (12) months following the Certificate Effective Date.

"Preferred Provider" means a Hospital, Outpatient Surgical Facility or Doctor located in the United States that participates in a Preferred Provider Organization (PPO) to which the Company subscribes. Services or supplies that are received from providers that participate in the PPO are considered "In-Network." Services or supplies that are received from providers that do not participate in the PPO, are considered "Out-of-Network."

"Preferred Provider Organization (or PPO)" means a group of Hospitals, other medical care facilities, or Doctors that offer their services at a negotiated rate to certain contracted groups. Your coverage under the Policy is being provided as a PPO Plan. In order to receive the maximum benefit, You should choose Hospitals, Outpatient Surgical Facilities and Doctors who are part of the PPO. Confinement, surgery or services provided as emergency care will be considered In-Network even if they are provided by Out-of-Network providers.

"Prescription Drug" means any medication or medicinal substance which has been approved by the U.S. Food and Drug Administration for general use and which can, under federal or state law, be dispensed only pursuant to a Prescription Order (a legend drug). Insulin and the syringes necessary for its injection are considered Prescription Drugs.

"Regular and Customary Activities" means a Covered Person can carry on a substantial part of the standard and commonly practiced activities of a person in good health of the same sex and age. Activities performed while confined in a Hospital or other medical institution may not be used to meet this requirement.

"Reasonable and Customary Charge" means the lesser of the following: (1) the charge made for a given service by a Doctor to the majority of his or her patients; or (2) a fee that is charged by the majority of Doctors within a specified geographic area for the same service. All benefits received from Out-of-Network providers are limited to the Reasonable and Customary Charge.

"Routine Physical Exam" means examination of the physical body by a Doctor for preventive or informative purposes only, and not for the diagnosis or treatment of any condition.

"Sickness" means a Covered Person's illness, disease or condition that:
a) Is treated by a Doctor while the person is covered under the Policy; and
b) Results directly and independently of all other causes in loss covered by the Policy.

"Substance Abuse" means the overindulgence in and dependence on a psychoactive leading to effects that are detrimental to the individual's physical health or mental health, or the welfare of others.

"Surgery or Surgical Procedure" means an invasive diagnostic procedure; or the treatment of Injury or Sickness by manual or instrumental operations performed by a Doctor while the patient is under general or local anesthesia.

"You" (or "Your" or "Yours") means the Insured

How to file a claim

Claims Status & Verification

1-888-350-1488

All Medical Claims Mail to:

Claimedix, Inc
P.O. Box 140067
Kansas City, MO 64114
Emdeon EDI Payor ID: 74048

All Other Claims Information:

Standard Life and Accident Insurance Company
P.O. Box 10546
Springfield, MO 65808-0546

This is a Short-Term Medical plan that is not intended to 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. Also, the termination or loss of this policy does not entitle you to a special enrollment period to purchase a health benefit plan that qualifies as minimum essential coverage outside of an open enrollment period.

This is a brief summary of Standard Life Select Short-Term Medical Insurance underwritten by Standard Life and Accident Insurance Company. Provided by Idaho Certificate SL-CMS14STMED-ID (Rev.5/2018). Pre-existing conditions are not covered for the first 12 months and benefits are subject to the policy limitations and exclusions. Refer to the policy, certificate and riders for complete details.

IDAHO DEPARTMENT OF INSURANCE CONTACT INFORMATION

You may contact the Idaho Department of Insurance at:
Idaho Department of Insurance
Consumer Affairs
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P.O. Box 83720
Boise, Idaho 83720-0043
1-800-721-3272 or 208-334-4250 or
www.DOI.Idaho.gov