HealthAccess II℠

USHEALTH® ADVISORS

Insurance underwritten by: National Foundation Life Insurance Company

HealthAccess II-IBR-UT-NFL-0222

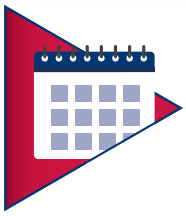
The HealthAccess II℠ Plan Difference

HealthAccess II Fixed Indemnity Plan[1]

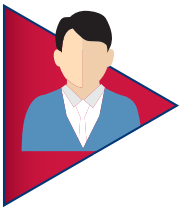
If You and/or Your family are interested in fixed indemnity coverage, You may apply for coverage under National Foundation Life's HealthAccess II Fixed Indemnity Plan without medical underwriting.

- With the HealthAccess II Fixed Indemnity Plan, **You have access to a PPO network** that is available for Your state.
- **You May Choose Any Doctor and Any Hospital!** The HealthAccess II Fixed Indemnity Plan pays the same fixed dollar amount shown on the schedule of benefits regardless of whether services are provided in or out of network. **But You can stretch Your dollars further by choosing an In-Network Provider.**
- **No Calendar Year Deductibles to Satisfy**!
- The HealthAccess II Fixed Indemnity Plan pays *in addition* to any coverage You have in force.
- **Your initial rate is guaranteed for 12 months** at no extra charge![2]
- **24-Hour coverage, on or off the job.**
- **Portable coverage You can take with You** even if You move or change jobs.
- The HealthAccess II Fixed Indemnity Plan is not an essential health benefit plan under the Affordable Care Act ("ACA"). Instead, it will supplement an essential health benefit plan under which You must first satisfy a deductible every year before You are eligible to receive benefit payments.[3]

Any Doctor Any Hospital



12-Month Rate Guarantee



Take your coverage with you

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. CANCELLATION OF THE HEALTHACCESS II PLAN DOES NOT CONSTITUTE A SPECIAL ENROLLMENT EVENT UNDER THE ACA.

[1]The Plan is underwritten by National Foundation Life Insurance Company.
[2]The Premium Rate Guarantee Period does not apply to any rate change due to: change of address; addition of Insureds; change of benefits or options; change of Mode Of Premium Payment; Policy coverage, benefits, limitation or exclusion changes; or any future requirements of any federal or state law.
[3]The HealthAccess II Fixed Indemnity Plan provides benefits for covered medical and surgical services but is not a traditional major medical plan nor a Workers' Compensation plan under state law. The HealthAccess II Fixed Indemnity Plan is considered an "excepted benefit plan" under the ACA and is not a "minimum essential coverage" plan under the ACA. The ACA generally requires individuals to maintain "minimum essential coverage" or be subject to the payment of the annual shared responsibility payment with the payment of their taxes to the federal government from 2014 – 2018. Congress eliminated the shared responsibility payment in 2019 and beyond for individuals who do not maintain ACA "minimum essential coverage" during 2019 or any year thereafter. (See page 23 of this brochure for details.)

HealthAccess II℠ Fixed Indemnity Plan[1]

The Benefits You Need… When You Need Them.

▶ **Some of the more popular Outpatient Benefits include coverage for:**

- Doctor Office Visits
- X-Rays
- Prescription Drugs
- Emergency Room Benefits
- Ambulance Transports
- Radiology
- Outpatient Surgery
- MRIs
- Diabetes

Prescription Drugs

Almost **50%** of the population used prescription drugs in the past 30 days

~National Center for Health Statistics. Health, United States, 2019

Doctor Office Visits

About **85%** of American Adults visited a Doctor in the past year

~Interactive Summary Health Statistics for Adults: National Health Review, 2019

Diabetes

People with diabetes have medical costs **twice as high** as people without diabetes

~CDC - Diabetes Fast Facts 2020

[1]The Plan is underwritten by National Foundation Life Insurance Company and is subject to the Exclusions and Limitations of the Plan (see pages 11-13).

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HealthAccess II℠ Fixed Indemnity Plan

Outpatient Fixed Indemnity Benefits	HealthAccess II
Doctor Office Visit Benefit	
Amount Per Visit	$100
Visits Per Insured Per Policy Year	6
Unused Doctor Office Visits Rollover to the Next Policy Year	Yes
Outpatient Spinal Manipulation Office Visit Benefit	
Amount Per Visit	$100
Visits Per Insured Per Policy Year	6
Outpatient Urgent Care Facility Benefit	
Amount Per Visit	$100
Visits Per Insured Per Policy Year	1
Outpatient X-Ray Benefit	
Amount Per Calendar Day	$50
Calendar Days Per Insured Per Policy Year	4
Outpatient Laboratory Benefit	
Amount Per Calendar Day	$30
Calendar Days Per Insured Per Policy Year	4
Prescription Drug Benefit	
Amount Per Generic Drug	$10
Amount Per Brand Name Drug	$30
Policy Year Maximum for all Prescriptions	$600
Emergency Room Benefit	
Amount Per Calendar Day	$250
Calendar Days Per Insured Per Policy Year	1
Emergency Ambulance Benefit	
Ground - Amount Per Calendar Day	$100
Ground - Transports Per Insured Per Policy Year	1
Air - Amount Per Calendar Day	$2,500
Air - Transports Per Insured Per Policy Year	1
Specialty Radiology Benefit	
Outpatient CAT Scan - Amount Per Calendar Day	$200
Outpatient CAT Scan - Calendar Days Per Insured Per Policy Year	1
Outpatient PET Scan - Amount Per Calendar Day	$300
Outpatient PET Scan - Calendar Days Per Insured Per Policy Year	1
Outpatient MRI - Amount Per Calendar Day	$500
Outpatient MRI - Calendar Days Per Insured Per Policy Year	1
Outpatient Surgery Facility Benefit	
Amount Per Calendar Day	$1,200
Calendar Days Per Insured Per Policy Year	1
Outpatient Surgery Provider Benefit	
Benefit varies by procedure, range is -	$80-$8,000
Surgeries Per Insured Per Policy Year	1

HealthAccess II℠ Fixed Indemnity Plan

Outpatient Fixed Indemnity Benefits	HealthAccess II
Radiation/Chemotherapy Benefit	
Outpatient Oral Chemotherapy - Amount Per Calendar Month	$2,000
Outpatient Oral Chemotherapy - Calendar Months Per Insured Per Policy Year	3
Outpatient Intravenous Chemotherapy - Amount Per Calendar Day	$500
Outpatient Intravenous Chemotherapy - Calendar Days Per Insured Per Policy Year	60
Outpatient Radiation Therapy - Amount Per Calendar Day	$500
Outpatient Radiation Therapy - Calendar Days Per Insured Per Policy Year	60
Outpatient Kidney Dialysis Benefit	
Amount Per Calendar Day	$500
Calendar Days Per Insured Per Policy Year	60
Emergency Room Physician Visit Benefit	
Amount Per Visit	$100
Visits Per Insured Per Policy Year	1
Outpatient Anesthesiology Provider Benefit	
Benefit varies by procedure, range is -	$40-$4,000
Surgeries per Insured per Policy Year	1
Outpatient Pathology Provider Benefit	
Amount Per Calendar Day	$50
Calendar Days Per Insured Per Policy Year	4
Outpatient Radiology Provider Benefit	
Amount Per Calendar Day	$50
Calendar Days Per Insured Per Policy Year	4
Outpatient Diabetes Equipment Benefit	
Amount Per Calendar Day	$15
Calendar Days Per Insured Per Policy Year	1
Outpatient Diabetes Self-Management Training Benefit	
Amount Per Calendar Day	$15
Calendar Days Per Insured Per Policy Year	1
Outpatient Diabetes Supplies Benefit	
Amount Per Calendar Day	$15
Calendar Days Per Insured Per Policy Year	1

HealthAccess II℠ Fixed Indemnity Plan[1]

COVERAGE
You Can Count On

Some of the more popular Inpatient Benefits include coverage for:

- Inpatient Surgery
- Hospital Room & Board
- ICU Room & Board
- Severe Burns
- Heart Attacks
- Life Threatening Cancer
- Strokes
- Coronary Artery By-Pass
- Comas

Heart Disease
Over **121.5 million** Americans have Heart Disease

~American Heart Association
Heart Disease and Stroke Statistics 2019

Cancer
More than **1.8 million** Americans were diagnosed with Cancer in 2020

~American Cancer Society
Cancer Facts & Figures 2020

Stroke
A Stroke occurs **Every 40 seconds** in the US

~American Heart Association
Heart Disease and Stroke Statistics 2019

[1]The Plan is underwritten by National Foundation Life Insurance Company and is subject to the Exclusions and Limitations of the Plan (see pages 11-13).

The HealthAccess II Fixed Indemnity Plan provides benefits for covered medical and surgical services but is not a traditional major medical plan nor a Workers' Compensation plan under state law. The HealthAccess II Fixed Indemnity Plan is considered an "excepted benefit plan" under the ACA and is not a "minimum essential coverage" plan under the ACA. The ACA generally requires individuals to maintain "minimum essential coverage" or be subject to the payment of the annual shared responsibility payment with the payment of their taxes to the federal government from 2014 – 2018. Congress eliminated the shared responsibility payment in 2019 and beyond for individuals who do not maintain ACA "minimum essential coverage" during 2019 or any year thereafter. (See page 23 of this brochure for details.)

HealthAccess II℠ Fixed Indemnity Plan

Inpatient Fixed Indemnity Benefits	HealthAccess II
Inpatient Surgery Provider Benefit	
Benefit varies by procedure, range is -	$80-$8,000
Surgeries Per Insured Per Policy Year	1
Hospital Room & Board Benefit	
Amount Per Calendar Day	$700
Calendar Days Per Insured Per Policy Year	365
Hospital Miscellaneous Expenses Benefit	
Amount Per Calendar Day	$700
Calendar Days Per Insured Per Policy Year	365
Hospital ICU Room & Board Benefit *(in lieu of Hospital Room & Board Benefits)*	
Amount Per Calendar Day	$1,400
Calendar Days Per Insured Per Policy Year	30
Inpatient Assistant Surgery Provider Benefit	
Benefit varies by procedure, range is -	$20-$2,000
Surgeries Per Insured Per Policy Year	1
Inpatient Anesthesiology Provider Benefit	
Benefit varies by procedure, range is -	$40-$4,000
Surgeries per Insured per Policy Year	1
Hospital Provider Visit Benefit	
Amount Per Visit	$100
Visits Per Insured Per Policy Year	4

HealthAccess II℠ Fixed Indemnity Plan

If Confinement is due to one of the Sicknesses or Bodily Injuries below, the following Hospital Miscellaneous Expenses Benefits Apply.

Hospital Miscellaneous Expenses Fixed Indemnity Benefits *(Benefits paid in lieu of Hospital Miscellaneous Expenses Fixed Indemnity Benefit)*	HealthAccess II
Acute Heart Attack Benefit	
Amount Per Calendar Day	$4,200
Calendar Days Per Insured Per Policy Year	30
Life Threatening Cancer Benefit	
Amount Per Calendar Day	$4,200
Calendar Days Per Insured Per Policy Year	30
Stroke Benefit	
Amount Per Calendar Day	$4,200
Calendar Days Per Insured Per Policy Year	30
Coronary Artery By-pass Surgery Benefit	
Amount Per Calendar Day	$4,200
Calendar Days Per Insured Per Policy Year	30
Coma Benefit	
Amount Per Calendar Day	$4,200
Calendar Days Per Insured Per Policy Year	30
Severe Burns Benefit	
Amount Per Calendar Day	$4,200
Calendar Days Per Insured Per Policy Year	30

HealthAccess II℠ Fixed Indemnity Plan[1]

Some of the more popular Wellness & Health Screening Benefits include coverage for:

- Physical Exams
- Diagnostic Labs
- Children Routine Immunizations
- PSA Tests
- Pap Smears
- Mammograms
- Colonoscopies
- Chest X-Rays
- EKGs

Health

860.4 Million Doctor's Office Visits in the United States

~ National Ambulatory Medical Care Survey: 2018 National Summary Tables, table 1

Child Immunizations

Almost **95%** of kindergartners received state-required vaccines for the 2018 school year

~ CDC, 2017-2019

Preventive Care

About **1 in 8** U.S. women will develop invasive breast cancer over the course of their lifetime

~ American Cancer Society 2021

[1]The Plan is underwritten by National Foundation Life Insurance Company and is subject to the Exclusions and Limitations of the Plan (see pages 11-13).

The HealthAccess II Fixed Indemnity Plan provides benefits for covered medical and surgical services but is not a traditional major medical plan nor a Workers' Compensation plan under state law. The HealthAccess II Fixed Indemnity Plan is considered an "excepted benefit plan" under the ACA and is not a "minimum essential coverage" plan under the ACA. The ACA generally requires individuals to maintain "minimum essential coverage" or be subject to the payment of the annual shared responsibility payment with the payment of their taxes to the federal government from 2014 – 2018. Congress eliminated the shared responsibility payment in 2019 and beyond for individuals who do not maintain ACA "minimum essential coverage" during 2019 or any year thereafter. (See page 23 of this brochure for details.)

HealthAccess II℠ Fixed Indemnity Plan

Wellness & Health Screening Fixed Indemnity Benefits	HealthAccess II
Physical Examination Benefit	
Amount Per Calendar Day	$100
Physical Examinations Per Insured Per Policy Year	1
Health Screening Diagnostic Labs Benefit	
Amount Per Calendar Day	$45
Calendar Days Per Insured Per Policy Year	1
Children Routine Immunizations Benefit[1]	
Amount Per Immunization	$50
Immunizations Per Insured Per Policy Year	10
Pap Smear Benefit	
Amount Per Calendar Day	$35
Calendar Days Per female Insured Per Policy Year	1
Mammogram Benefit[1]	
Amount Per Calendar Day	$250
Calendar Days Per female Insured Per Policy Year	1
PSA Test Benefit[1]	
Amount Per Calendar Day	$25
Calendar Days Per male Insured Per Policy Year	1
Colonoscopy Benefit[1]	
Amount Per Calendar Day	$650
Calendar Days Per Insured Per Policy Year	1
Osteoporosis Screening Benefit[1]	
Amount Per Calendar Day	$150
Calendar Days Per High Risk female Insured Per Policy Year	1
Health Screening Chest X-Ray Benefit	
Amount Per Calendar Day	$200
Calendar Days Per Insured Per Policy Year	1
EKG Benefit[1]	
Amount Per Calendar Day	$50
Calendar Days Per Insured Per Policy Year	1
Stress EKG Benefit[1]	
Amount Per Calendar Day	$100
Calendar Days Per Insured Per Policy Year	1

Benefit Maximums	HealthAccess II
Policy Year Maximum Fixed Indemnity Benefit Payments Per Insured	$300,000
Lifetime Policy Maximum Fixed Indemnity Benefit Per Insured	$5,000,000

[1]*Age-related restrictions and other limitations apply. Please see page 11 for more details.*

All HealthAccess II Fixed Indemnity Plan Wellness & Health Screening Benefits are required to be deemed Medically Necessary by a Provider in connection with the Insured's routine physical examination or child's wellness & health evaluation.

HealthAccess II℠ Fixed Indemnity Plan Features

Premium Rate Adjustments

We will not raise Your premium rates on an individual basis due to Your personal claims experience. We may raise Your premium rates on Your Renewal Premium Class for all Policies in Your state.

Renewability

Coverage under the HealthAccess II Fixed Indemnity Plan is guaranteed renewable, subject to the termination provisions.

Termination

Your coverage will end upon the occurrence of one of the following: with respect to Your Spouse who is covered, Your divorce decree, annulment or court approved separation becomes effective; Your covered child(ren) reach the limiting age as defined by Your state; the due date of any unpaid premium (subject to the grace period); You terminate coverage by notifying Us; We are required by an appropriate regulatory authority to non-renew or cancel the Policy; We cease offering and renewing the same form of coverage as the Policy in Your state; the date We receive due proof that fraud or intentional misrepresentation of material fact existed in applying for coverage or filing a claim; the month following attainment of age 65 for You or Your Spouse, or in the event You or Your Spouse are eligible for Medicare; or the total amount of any fixed indemnity benefit payments made by Us are equal to the lifetime maximum.

Limitations

Coverage under the HealthAccess II Fixed Indemnity Plan is limited as provided by the definitions, limitations, exclusions, and terms contained in each and every section of the HealthAccess II Fixed Indemnity Plan, as well as the following limitations:

- any treatment, medical service, surgery, medication, equipment, claim, loss or expense received, purchased, leased or otherwise incurred under the (i) HOSPITAL CONFINEMENT SICKNESS AND BODILY INJURY FIXED INDEMNITY BENEFITS, (ii) OUTPATIENT SURGERY FACILITY FIXED INDEMNITY BENEFIT, (iii) OUTPATIENT SURGERY PROVIDER FIXED INDEMNITY BENEFIT, and (iv) OUTPATIENT ANESTHESIOLOGY PROVIDER FIXED INDEMNITY BENEFIT as a result of an Insured's Pre-existing Condition is not covered under the HealthAccess II Fixed Indemnity Plan unless such treatment, medical service, surgery, medication, equipment, claim, loss or expense constitutes Covered Medical & Surgical Services incurred by such Insured more than 12 months after the Issue Date, and such treatment, medical service, surgery, medication, equipment, claim, loss or expense is not otherwise limited or excluded by the HealthAccess II Fixed Indemnity Plan or any riders, endorsements, or amendments attached to the HealthAccess II Fixed Indemnity Plan; and
- Pre-existing Condition means an Insured's Sickness (physical or mental) or Bodily Injury for which medical advice, diagnosis, care or treatment was recommended or received during the twelve (12) month period immediately preceding the effective date of coverage under the HealthAccess II Fixed Indemnity Plan for such Insured; which Manifested during the twelve (12) month period immediately preceding the effective date of coverage under the HealthAccess II Fixed Indemnity Plan for such Insured; or which resulted from an Accident that occurred before the Issue Date for the Insured incurring the expense.

- **Children Routine Immunizations** - Ten covered immunizations per Insured per Policy Year are available to Insureds under the age of 18 under the Children Routine Immunization Fixed Indemnity Benefit.
- **Mammogram** - One Mammogram Fixed Indemnity Benefit per Policy Year is available to female Insureds who are age 35 or older.
- **PSA Test** - One PSA Test Fixed Indemnity Benefit per Insured per Policy Year is available to male Insureds who are at least 50 years of age and asymptomatic, or at least 40 years of age with either a Family history of prostate cancer or another prostate cancer risk factor.
- **Colonoscopy** - One Colonoscopy Fixed Indemnity Benefit per Insured per Policy Year is available to Insureds at least 50 years of age and asymptomatic, or at least 40 years of age with either a Family history of colon cancer or another colon cancer risk factor.
- **Osteoporosis Screening** - One Osteoporosis Screening Fixed Indemnity Benefit per Insured per Policy Year is available to High Risk Female Insureds who are between the ages of 40 and 65 by undergoing a Bone Density Test.
- **EKG** - One EKG Fixed Indemnity Benefit per Insured per Policy Year is available to Insureds at least 50 years of age and asymptomatic, or at least 40 years of age with either a Family history of cardiovascular disease or another cardiovascular disease risk factor.
- **Stress EKG** - One Stress EKG Fixed Indemnity Benefit per Insured per Policy Year is available to Insureds at least 50 years of age and asymptomatic, or at least 40 years of age with either a Family history of cardiovascular disease or another cardiovascular disease risk factor.

HealthAccess II℠ Fixed Indemnity Plan Non-Covered Items At a Glance

Coverage under the HealthAccess II Fixed Indemnity Plan is limited as provided by the definitions, terms, conditions, limitations, and exclusions contained in each and every section of the HealthAccess II Fixed Indemnity Plan. In addition, the HealthAccess II Fixed Indemnity Plan does not provide coverage for professional fees and medical services Provided to an Insured or any payment obligation for Us for any of the following, all of which are excluded from coverage:

- any cost, item, treatments, care, procedures, services or supplies which do not constitute Covered Medical & Surgical Services;
- treatments, care, procedures, services or supplies received before the HealthAccess II Fixed Indemnity Plan Issue Date;
- Covered Medical & Surgical Services received after the HealthAccess II Fixed Indemnity Plan terminates, regardless of when the Sickness or Bodily Injury occurred;
- fixed indemnity payments under the HealthAccess II Fixed Indemnity Plan for Covered Medical & Surgical Services that in combination exceed the amount of either the Policy Year Maximum Fixed Indemnity Benefit Payments Per Insured or the Lifetime Policy Maximum Fixed Indemnity Benefit Per Insured;
- any treatments, care, procedures, services or supplies which are not specifically enumerated in the COVERED MEDICAL AND SURGICAL SERVICES section of the HealthAccess II Fixed Indemnity Plan and any optional coverage rider attached hereto;
- any medical care, service, treatments, procedures, or supplies received, provided to, or incurred by an Insured for which the Insured and/or any covered family member are not required to pay;
- any medical care, service, treatments, procedures, or supplies received, provided to, or incurred by an Insured for which the Insured and/or any covered family member are not legally liable for payment;
- any medical care, service, treatments, procedures, or supplies received, provided to, or incurred by an Insured for which the Insured and/or any covered family member were once legally liable for payment, but from which liability the Insured and/or family member were released;
- Bodily Injury or Sickness due to any act of war (whether declared or undeclared);
- drugs or medication not used for a Food and Drug Administration ("FDA") approved use or indication;
- administration of experimental drugs or substances or investigational use or experimental use of Prescription Drugs except for any Prescription Drug prescribed to treat a covered chronic, disabling, life-threatening Sickness or Bodily Injury, but only if the investigational or experimental drug in question: a) has been approved by the FDA for at least one indication; b) is recognized for treatment of the indication for which the drug is prescribed in: 1) a standard drug reference compendia; or 2) substantially accepted peer-reviewed medical literature; or c) drugs labeled "Caution - limited by Federal law to investigational use";
- any medical care, service, treatments, procedures, or supplies received, provided to, or incurred by an Insured as a result of experimental procedures or treatment methods not approved by the American Medical Association, or other appropriate medical society;
- eye refractions, eyeglasses, contact lenses, radial keratotomy, lasik surgery, hearing aids, and exams for their prescription or fitting;
- any cochlear implants;
- intentionally self inflicted Bodily Injury;
- suicide or any suicide attempt while sane or insane;
- Sickness or Bodily Injury while serving in one of the branches of the armed forces of the United States of America;
- Sickness or Bodily Injury while in a foreign country and serving on active duty in the United States Army, Navy, Marine Corps, Air Force, Reserves, or the National Guard;
- Sickness or Bodily Injury while serving on active duty in the armed forces of any foreign country or any international authority;
- any voluntary abortions, abortifacients or any other drug or device that terminates a pregnancy;
- any medical condition excluded by name or specific description by either the HealthAccess II Fixed Indemnity Plan or any riders, endorsements, or amendments attached to the HealthAccess II Fixed Indemnity Plan;
- any loss to which a contributing cause was the Insured's being voluntarily engaged in an illegal occupation or illegal activity;
- participation in aviation, except as fare-paying passenger traveling on a regular, scheduled commercial airline flight;
- any cosmetic surgery or reconstructive procedures, except for Medically Necessary cosmetic surgery or reconstructive procedures performed under the following circumstances: (i) where such cosmetic surgery is incidental to or following surgery resulting from bacterial infection or viral infection, (ii) to correct a normal bodily function in connection with the treatment of a covered Sickness or Bodily Injury, or (iii) such cosmetic surgery constitutes Breast Reconstruction that is incident to a Mastectomy, provided any of the above occurred while the Insured was covered under the HealthAccess II Fixed Indemnity Plan;
- any treatments, care, procedures, services or supplies for breast reduction or augmentation or complications arising from these procedures;
- Prescription Drugs or other medicines and products used for cosmetic purposes or indications;
- any treatments, care, procedures, services or supplies for voluntary sterilization, reversal or attempted reversal of a previous elective attempt to induce or facilitate sterilization;
- any treatment, care, procedures, services, or supplies for treatment of infertility, including fertility hormone therapy and/or fertility devices for any type of fertility therapy, artificial insemination or any other direct conception;
- any treatment, care, procedures, services, or supplies for any operation or treatment performed, Prescription or medication prescribed in connection with sex transformations or any type of sexual or erectile dysfunction, including complications arising from any such operation or treatment;
- any treatment, care, procedures, services, or supplies for appetite suppressants, including but not limited to, anorectics or any other drugs used for the purpose of weight control, or services, treatments, or surgical procedures rendered or performed in connection with an overweight condition or a condition of obesity or related conditions;
- any treatment, care, procedures, services, or supplies incurred for the diagnosis, care, or treatment of Mental & Emotional Disorders, Alcoholism, addiction to illegal drugs or substances, and/or abuse of illegal drugs or substances;
- Prescription Drugs that are classified as psychotherapeutic drugs, including antidepressants;
- any treatment, care, procedures, services, or supplies incurred for the diagnosis, care, or treatment of routine maternity or any other expenses related to normal labor and delivery, including routine nursery services and well-baby care, other than Complications of Pregnancy;
- Prescription Drugs produced from blood, blood plasma and blood products, derivatives, Hemofil M, Factor VIII, and synthetic blood products, or immunization agents, biological or allergy sera, hematinics, blood or blood products administered on an Outpatient basis;
- level one controlled substances;
- Prescription Drugs used to treat or cure hair loss or baldness;
- Prescription Drugs that are classified as anabolic steroids or growth hormones;

HealthAccess II℠ Fixed Indemnity Plan Non-Covered Items At a Glance - Continued

- compounded Prescription Drugs;
- any fluoride products;
- allergy kits intended for future emergency treatment of possible future allergic reactions;
- replacement of a prior filled Prescription for Prescription Drugs that was covered and is replaced because the original Prescription was lost, stolen or damaged;
- any intentional misuse or abuse of Prescription Drugs, including Prescription Drugs purchased by an Insured for consumption by someone other than such Insured;
- any programs, treatment or procedures for tobacco use cessation;
- Prescription Drugs that are classified as tobacco cessation products;
- any charges for blood, blood plasma, or derivatives that has been replaced;
- any treatment, care, procedures, services, or supplies for the diagnosis, care, or treatment of Autism Spectrum Disorder;
- any treatment, care, procedures, services or supplies for TMJ Disorder and Craniomandibular Disorder (CMD);
- any treatment received outside of the United States, except as provided for in the EXTRATERRITORIAL MEDICAL EXPENSES provision;
- any treatment, care, procedures, services, or supplies (including Prescription Drugs) incurred for the diagnosis, care, or treatment or services for behavioral or learning disorders, of Attention Deficit Disorder (ADD) or Attention Deficit Hyperactivity Disorder (ADHD);
- any treatment, care, procedures, services, or supplies incurred for the diagnosis, care, or treatment of cirrhosis of the liver due to chronic alcohol abuse; and
- any services or supplies for personal convenience, including Custodial Care or homemaker services, except as provided for in the HealthAccess II Fixed Indemnity Plan.

⋆Optional Critical Illness⋆

If additional coverage for critical illness events is appropriate for You and/or Your family, You may be interested in the MedGuard Plan.

MedGuard[1]

5 YEAR TERM LIFE INSURANCE WITH ACCELERATED DEATH BENEFIT

Filling The Gap Between Health Coverage And Life Insurance[2]

Health coverage provides benefits for medical treatment but doesn't include benefits for non-medical expenses. Traditional life insurance pays benefits to the named beneficiary after death. What if You survive a critical illness? Where will You find the financial resources to cover non-medical costs during Your recovery?

The amount of the Death Benefit is up to $10,000 for You and Your Spouse and up to $5,000 for Your dependent children, without medical underwriting, when purchased with the HealthAccess II Fixed Indemnity Plan. If You are interested in higher levels of MedGuard benefits, they can be purchased with medical underwriting.

Covered Critical Illnesses/Covered Surgeries	Benefit
Life Threatening Cancer	100% of the Death Benefit
Heart Attack	100% of the Death Benefit
Stroke	100% of the Death Benefit
Kidney Failure	100% of the Death Benefit
Major Organ Transplant	100% of the Death Benefit
Permanent Paralysis	100% of the Death Benefit
Terminal Illness	100% of the Death Benefit
Aorta Graft Surgery	25% of the Death Benefit
Coronary Artery Bypass Surgery	25% of the Death Benefit
Heart Valve Surgery	25% of the Death Benefit
Coronary Angioplasty	10% of the Death Benefit
COVID-19 Infection Complications Resulting in Inpatient Hospital Confinement	10% of the Death Benefit
1st through 30th day Death Benefit amount for other than Life Threatening Cancer	$500
1st through 90th day Death Benefit amount for any Life Threatening Cancer	$500

The Death Benefit is reduced by 50% at age 65.
Benefits are reduced by the amount of the Critical Illness Benefit previously paid.
Coverage under the MedGuard Plan ends at age 70.

Cancer
There are **16.9 Million** cancer survivors in the U.S.
~American Cancer Society Cancer Facts & Figures 2020

Heart Attack
805,000 heart attacks occur each year - one every **40 seconds**
~American Heart Association Heart Disease and Stroke Statistics 2019

Stroke
Account for about **1 of every 19 deaths** in America
~American Heart Association Heart Disease and Stroke Statistics 2019

[1]The Plan is underwritten by National Foundation Life Insurance Company.
[2]The MedGuard Plan is a 5-year, renewable term life insurance plan with the plan's stated death benefit paid to the insured's designated beneficiary. The MedGuard plan also contains an accelerated critical illness benefit, which provides the accelerated lump sum payment to the insured, while living, the stated percentage of the death benefit, if the insured is diagnosed with a covered critical illness or covered critical injury or undergoes a covered critical surgical procedure. Life insurance plans are not considered "health insurance" under the ACA. The ACA generally requires individuals to maintain "minimum essential coverage" or be subject to the payment of the annual shared responsibility payment with the payment of their taxes to the federal government from 2014 – 2018. Congress eliminated the shared responsibility payment in 2019 and beyond for individuals who do not maintain ACA "minimum essential coverage" during 2019 or any year thereafter. (See page 23 of this brochure for details.)

MedGuard Plan Benefits

Death Benefit

If the Primary Insured dies while coverage under the Policy is in force, We will pay the Death Benefit to the Beneficiary, subject to the provisions of the Policy. The Death Benefit will be reduced by any amount payable under the Critical Illness Benefit. If a Dependent dies while coverage under the Policy is in force, We will pay the Death Benefit to the Primary Insured, subject to the provisions of the Policy. The Death Benefit will be reduced by any amount payable under the Critical Illness Benefit.

Critical Illness Accelerated Death Benefit Payment

All or a portion of a Primary Insured or Dependent's Life Insurance Benefit may be paid before his or her death. If an Insured has a First Occurrence of a Specified Critical Illness Event or Specified Critical Illness Surgery while covered under the Policy, and satisfies the applicable Accelerated Critical Illness Benefit Payment Requirement, then We will pay the specified percentage of the Death Benefit to You.

When a Specified Critical Illness Event or Specified Critical Illness Surgery First Occurs during the first 30 days following the Issue Date, We will pay a Death Benefit of $500 for the 1st through 30th day for any Specified Critical Illness Event or Specified Critical Illness Surgery shown in the Policy Schedule. When an instance of Life-Threatening Cancer First Occurs within the first 90 days following the Issue Date, We will pay a Death Benefit of $500.

MedGuard Plan Features

Renewal Options

Your insurance coverage under the Policy may be renewed at the end of the first term period (i.e. after the first 5 years), and any later term period until You reach age 70 or the date Your coverage under the Policy ends. To renew, just send Us the applicable Renewal Premium within 31 days after the end of the preceding term period and while the Policy is in force.

Pre-existing Condition Limitation

We will not pay Accelerated Death Benefits for any Specified Critical Illness Event or Specified Critical Illness Surgery which occurs during the first (12) twelve months of any Insured's coverage under the Policy if such Specified Critical Illness Event or Specified Critical Illness Surgery is caused by or results from a Pre-existing Condition.

Premium Adjustments

We may change Premium Rates and apply a new table of Premium Rates based on class. The current table of rates includes scheduled increases based upon age.

Termination of Insurance

An Insured's coverage ends on the earlier of the following: with respect to Your Spouse, the premium due date in the month following the effective date of Your divorce decree, annulment or court approved separation; with respect to Your children who are covered, the premium due date in the month following Your child reaching the limiting age; the date of the Insured's 70th birthday; payment by Us of 100% of the Death Benefit; premium was due and not paid; You terminate coverage by notifying Us of the date You desire coverage to terminate and specify the Insured whose coverage is to terminate; We are required by the order of an appropriate regulatory authority to non-renew or cancel the Policy; We cease offering and renewing coverage of the same form of coverage as the Policy in Your state upon a minimum of 30 days prior written notice mailed to Your last known address; the date We receive due proof that fraud or intentional misrepresentation of material fact existed in applying for Your coverage or the coverage of Your Spouse or Children.

MedGuard Limitations

- For each Insured, Benefits payable under the Policy for all Specified Critical Illness Events or Specified Critical Illness Surgery combined will not exceed the Death Benefit that applies to the Insured. We will reduce what We pay for a claim so that the amount that We pay, when combined with amounts for all claims We have previously paid for the same Insured does not exceed the Death Benefit that was in effect for that Insured on the date of the most recent Specified Critical Illness Event or Specified Critical Illness Surgery.
- We will pay the Benefits for any Specified Critical Illness Event or Specified Critical Illness Surgery that First Occurs after the first 30 days immediately following the Issue Date, or as a result of diagnostic testing performed after the first 30 days immediately following the Issue Date, except for the limited Benefit amount shown in the Policy Schedule for the 1st through 30th day for any Specified Critical Illness Event or Specified Critical Illness Surgery other than Life Threatening Cancer. Life Threatening Cancer will be limited to the amount shown on the Policy Schedule during the first 90 days immediately following the Issue Date.

MedGuard Non-Covered Items

No Benefits shall be payable under the Policy for any loss caused by, in whole or in part, contributed to or resulting from, directly or indirectly, any of the following incidents, events, occurrences or activities involving any Insured for:

- participating in a felony, riot or insurrection;
- intentionally causing a self-inflicted injury;
- committing or attempting to commit suicide while sane or insane, within two (2) years from the Insured's Issue Date;
- engaging in any illegal activity;
- serving in the armed forces or an auxiliary unit of the armed forces of any country;
- war or any act of war, even if war is not declared;
- a diagnosis which is made outside the United States, unless a Definitive Diagnosis of a Specified Critical Illness Event or a Specified Critical Illness Surgery is confirmed in the United States;
- an Insured being intoxicated or under the influence of alcohol or any drug, narcotic or hallucinogens unless administered via a prescription and on the advice of a Doctor and taken in accordance with the limits of such advice. An Insured is conclusively determined to be intoxicated by drug or alcohol if (i) a chemical test administered in the jurisdiction where the loss or cause of loss occurred is at or above the legal limit set by that jurisdiction or (ii) the level of alcohol was such that a person's coordination, ability to reason, was impaired, regardless of the legal limit set by that jurisdiction;
- with respect to Critical Illness-Accelerated Death Benefit Payment section V.B. of the Policy, any Specified Critical Illness Event or Specified Critical Illness Surgery suffered, diagnosed and/or sustained by an Insured prior to the Issue Date; and
- with respect to Critical Illness-Accelerated Death Benefit Payment section V.B. of the Policy, any medical condition that is not a Specified Critical Illness Event or Specified Critical Illness Surgery.

⋆Optional Dental⋆

If additional coverage for dental expenses is appropriate for You and/or Your family, You may be interested in the SecureDental Plans.

SecureDental[1]

DENTAL INSURANCE

EVERYONE DESERVES A HEALTHY SMILE[2]

SecureDental Offers 3 Plans:

Premium Plan

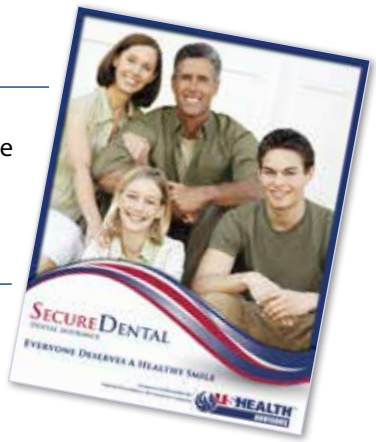
Deductibles: $50 for an Individual; $150 for a Family;
Additional Orthodontic Deductible $150 per Insured
Covers Preventive Care, Basic Care, Major Care & Orthodontic Care
Calendar Year Maximum Per Insured $1,500;
Orthodontic Calendar Year Maximum Per Insured $400

Saver Plus Plan

Deductibles: $50 for an Individual; $150 for a Family
Covers Preventive Care, Basic Care & Major Care, with Orthodontic Care Services discounted at participating providers.
Calendar Year Maximum Per Insured $1,000

Saver Plan

Deductibles: $50 for an Individual; $150 for a Family
Covers Preventive Care & Basic Care, with Major Care & Orthodontic Care Services discounted at participating providers.
Calendar Year Maximum Per Insured $500



Preventive Care

Benefits include:

- Initial & Periodic oral examinations
- Intraoral X-rays, with/without bitewings
- Prophylaxis (cleaning of the teeth) with/without oral examination

... and more

Basic Care

Benefits include:

- Amalgam, silicate cement, acrylic or plastic fillings
- Simple tooth Extractions
- Oral Surgery

... and more

Major Care

(Covered on Premium Plan & Saver Plus Plans. For Saver Plan, Insured(s) receive discounted services at participating providers for Major Care.)

Benefits include:

- Single Crown restorations
- Dentures, including fixed or removable prosthetic devices, complete Dentures, upper & lower
- Root Canal Therapy, including treatment plan & follow-up care

... and more

Orthodontic Care

(Covered on Premium Plan. For Saver Plus Plan & Saver Plans, Insured(s) receive discounted services at participating providers for Orthodontic Care.)

Benefits include:

- Comprehensive Orthodontic Treatment of the adult dentition
- Comprehensive Orthodontic Treatment of the adolescent dentition
- Orthodontic retention (removal of appliances, construction & placement of retainer(s))

... and more

[1]The Plans are underwritten by National Foundation Life Insurance Company.
[2]The SecureDental Plans provide benefits for covered dental services only. The SecureDental Plans are considered "excepted benefit plans" under the ACA and are not "minimum essential coverage" plans under the ACA. The ACA generally requires individuals to maintain "minimum essential coverage" or be subject to the payment of the annual shared responsibility payment with the payment of their taxes to the federal government from 2014 – 2018. Congress eliminated the shared responsibility payment in 2019 and beyond for individuals who do not maintain ACA "minimum essential coverage" during 2019 or any year thereafter. (See page 23 of this brochure for details.)

SecureDental Renewability & Termination

Your Policy is guaranteed renewable to age sixty-five (65) or in the event an Insured otherwise becomes a Medicare enrollee subject to the termination provisions.

An Insured's coverage ends on the earlier of: with respect to Your Spouse who is covered under the Policy, the premium due date in the month following the effective date of Your divorce decree, annulment or court approved separation; the date Your child(ren) who are covered under the Policy reach the limiting age as defined by Your state; the due date of any unpaid Renewal Premium, subject to the grace period; the date You terminate coverage by notifying Us of the date You desire coverage to terminate and specify the Insured whose coverage is to terminate; We are required by the order of an appropriate regulatory authority to non-renew or cancel the Policy; We cease or discontinue offering and renewing coverage of the same form of coverage as the Policy in Your state upon a minimum of thirty-one (31) days prior written notice mailed to Your last known address; the date We receive due proof that fraud or intentional misrepresentation of material fact existed in applying for the Policy or in filing a claim for Benefits under the Policy; Orthodontic Benefits for an Insured if the total amount of any orthodontic payments made by Us are equal to the Lifetime Maximum Orthodontic Benefit for such Insured; or with respect to You and Your Spouse who is covered under the Policy, the premium due date in the month following the attainment of age 65 or You, or in the event Your Spouse, are eligible for Medicare.

SecureDental Insurance With Other Insurers

Benefits under the SecureDental Dental Insurance Plan may be reduced when an Insured has more than one plan, covering the same loss, and it was not disclosed to Us. The SecureDental Dental Insurance Plan contains an Insurance With Other Insurers provision which says that liability under the SecureDental Dental Insurance Plan shall only be for a certain proportion of the total loss amount when taking this coverage and Your other coverage into consideration.

SecureDental Pre-Treatment Estimate of Benefits

An Insured may find the amount payable by the Policy prior to having a Dentist begin any extensive treatment. Your Dentist may submit the treatment plan to Us prior to services being performed. We will notify You and the Dentist, in advance regarding what benefits are considered Covered Dental Expenses or Covered Orthodontic Expenses, how much is payable under the Policy and how much You will be responsible for paying.

The Pre-Treatment Estimate is not a guarantee of payment. Benefits are payable if coverage is in effect on the date Covered Dental Expenses or Covered Orthodontic Expenses are performed, subject to the definitions, exclusions, limitations, and Benefit Waiting Periods.

SecureDental Premium Plan Limitations

In addition to any other provisions of the Policy, Benefits and coverage are limited as follows:

- The amount of the Calendar Year Maximum Dental Benefit Per Insured shall not exceed the sum of $1,500, with an additional $400 Calendar Year Maximum Orthodontic Benefit per Insured and Lifetime Maximum Orthodontic Benefit Per Insured of $1,000.
- No Benefits are payable under the BASIC DENTAL CARE provision unless they are incurred at least six (6) months after the Issue Date.
- No Benefits are payable under the MAJOR DENTAL CARE provision unless they are incurred at least twelve (12) months after the Issue Date.
- No Benefits are payable under the ORTHODONTIC DENTAL EXPENSES provision unless they are incurred at least twelve (12) months after the Issue Date.

SecureDental Premium Plan Non-Covered Items

Coverage under the Policy is limited as provided by the definitions, terms, conditions, limitations, and exclusions contained in each and every section of the Policy. In addition, the Policy does not provide coverage for professional and dental services Provided to an Insured or any payment obligation for Us under the Policy for any of the following, all of which are excluded from coverage:

- any expenses for treatments, care, procedures, services or supplies which are not Covered Dental Expenses or Covered Orthodontic Expenses incurred by a Covered Insured, and which are not specifically enumerated in the COVERED DENTAL EXPENSE or COVERED ORTHODONTIC EXPENSE section of the Policy;
- treatments, care, procedures, services or supplies received before the Policy Issue Date;
- Covered Dental Expense or Covered Orthodontic Expense received after the Policy terminates, regardless of when the condition originated;
- Covered Dental Expenses that exceed the amount of the Calendar Year Maximum Dental Benefit Per Insured;
- Covered Orthodontic Expenses that exceed the amount of the Calendar Year Maximum Orthodontic Benefit Per Insured;
- Prescription Drugs;
- any treatments, care, procedures, services or supplies which are not specifically enumerated in the COVERED DENTAL EXPENSES or COVERED ORTHODONTIC EXPENSE sections of the Policy and any optional coverage rider attached to the Policy;
- any professional services for which the Insured and/or any covered family member are not legally liable for payment;
- any professional services for which the Insured and/or any covered family member were once legally liable for payment, but from which liability the Insured and/or family member were released;
- Dental Injury or Dental Sickness due to any act of war (whether declared or undeclared);
- services provided by any state or federal government agency, including the Veterans Administration unless, by law, an Insured must pay for such services;
- any dental conditions for which the covered Insured has received or is entitled to receive compensation for that particular dental condition under any Worker's Compensation or Occupational Disease Law;
- expenses incurred for oral hygiene instructions, a plaque control program or dietary instructions;
- expenses incurred for dental care which is not customarily performed, which is experimental in nature or which is not considered acceptable by the American Dental Association or Federal Drug Administration;
- any professional and dental services provided an Insured in treatment of a Dental Sickness or Dental Injury caused or contributed to by such Insured's being intoxicated or under the influence of any drug, narcotic or hallucinogens unless administered on the advice of a Provider, and taken in accordance with the limits of such advice;
- intentionally self-inflicted Dental Injury, suicide or any suicide attempt while sane or insane;
- Dental Sickness or Dental Injury while serving in one of the branches of the armed forces of the United States of America;
- Dental Sickness or Dental Injury while in a foreign country and serving on active duty in the United States Army, Navy, Marine Corp or Air Force Reserves or the National Guard;
- Dental Sickness or Dental Injury while serving on active duty in the armed forces of any foreign country or any international authority;
- any services Provided by You or a provider who is a member of an Insured's family;
- any dental condition excluded by name or specific description by either the Policy or any riders, endorsements, or amendments attached to the Policy;
- any loss to which a contributing cause was the Insured's being voluntarily engaged in an illegal occupation or illegal activity;
- participation in aviation, except as fare-paying passenger traveling on a regular scheduled commercial airline flight;
- cosmetic surgery or cosmetic dentistry, except for Dentally Necessary cosmetic surgery which is incidental to or following surgery resulting from trauma or infection to correct a normal bodily function;
- Temporomandibular Joint Disorder (TMJ) and Craniomandibular Disorder (CMD);
- treatment received outside of the United States;
- treatment on or to the teeth or gums for cosmetic purposes, including charges for personalizations, characterizations or Dentures;
- replacement of lost or stolen prosthetics;
- restorative services (i.e. the initial placement of a complete or Partial Denture or for Fixed Bridgework) or Endodontic therapy if it involves the replacement of one or more natural teeth missing on the Issue Date of the Policy or when initial preparations were started prior to the Issue Date as shown on the Policy Schedule;
- restorative services for one (1) or more natural teeth missing on the Issue Date as shown on the Policy Schedule of the Policy will be considered Covered Dental Service if incurred five (5) years after the Issue Date;
- dental services performed in a hospital and any related expenses;
- replacement of an appliance or prosthetic device, Crown, cast restoration or a Fixed Bridge within five (5) years after the date it was last placed. This exclusion does not apply if replacement is due to accidental Dental Injury received while covered under the Policy;
- treatment of cleft palate, except for a newborn child covered under the Policy from birth, andontia or mandibular prognathicism;
- general anesthesia, except as specifically provided in the COVERED DENTAL EXPENSES section;
- placement of bone grafts or extra-oral substances in the treatment of periodontal disorders;
- the use of unilateral, removable prosthetics;
- Orthodontic diagnosis or treatment, except as provided in the COVERED ORTHODONTIC EXPENSE provision;
- charges incurred by an Insured due to broken or cancelled appointments;
- Crowns for teeth that are restorable by other means or for the purpose of periodontal splinting;
- Crowns, fillings or appliances that are used to correct (splint) teeth, or change or alter the way the teeth meet, including altering the vertical dimension, restoring the bite (occlusion) or for cosmetic purposes;
- orthognathic surgery; and
- expenses which exceed 100% of those actually incurred by the covered Insured.

SecureDental Saver Plus Plan Limitations

In addition to any other provisions of the Policy, Benefits and coverage are limited as follows:

- The amount of the Calendar Year Maximum Dental Benefit Per Insured shall not exceed the sum of $1,000.
- No Benefits are payable under the BASIC DENTAL CARE provision unless they are incurred at least six (6) months after the Issue Date.
- No Benefits are payable under the MAJOR DENTAL CARE provision unless they are incurred at least twelve (12) months after the Issue Date.

SecureDental Saver Plus Plan Non-Covered Items

Coverage under the Policy is limited as provided by the definitions, terms, conditions, limitations, and exclusions contained in each and every section of the Policy. In addition, the Policy does not provide coverage for professional and dental services Provided to an Insured or any payment obligation for Us under the Policy for any of the following, all of which are excluded from coverage:

- any expenses for treatment, care, procedures, services or supplies which are not Covered Dental Expenses incurred by a Covered Insured, and which are not specifically enumerated in the COVERED DENTAL EXPENSE section of the Policy;
- treatments, care, procedures, services or supplies received before the Policy Issue Date;
- Covered Dental Expense received after the Policy terminates, regardless of when the condition originated;
- Covered Dental Expenses that exceed the amount of the Calendar Year Maximum Dental Benefit Per Insured;
- Prescription Drugs;
- any treatments, care, procedures, services or supplies which are not specifically enumerated in the COVERED DENTAL EXPENSES section of the Policy and any optional coverage rider attached to the Policy;
- any professional services for which the Insured and/or any covered family member are not legally liable for payment;
- any professional services for which the Insured and/or any covered family member were once legally liable for payment, but from which liability the Insured and/or family member were released;
- Dental Injury or Dental Sickness due to any act of war (whether declared or undeclared);
- services provided by any state or federal government agency, including the Veterans Administration unless, by law, an Insured must pay for such services;
- any dental conditions for which the covered Insured has received or is entitled to receive compensation for that particular dental condition under any Worker's Compensation or Occupational Disease Law;
- expenses incurred for oral hygiene instructions, a plaque control program or dietary instructions;
- expenses incurred for dental care which is not customarily performed, which is experimental in nature or which is not considered acceptable by the American Dental Association or Federal Drug Administration;
- any professional and dental services provided an Insured in treatment of a Dental Sickness or Dental Injury caused or contributed to by such Insured's being intoxicated or under the influence of any drug, narcotic or hallucinogens unless administered on the advice of a Provider, and taken in accordance with the limits of such advice;
- intentionally self-inflicted Dental Injury, suicide or any suicide attempt while sane or insane;
- Dental Sickness or Dental Injury while serving in one of the branches of the armed forces of the United States of America;
- Dental Sickness or Dental Injury while in a foreign country and serving on active duty in the United States Army, Navy, Marine Corp or Air Force Reserves or the National Guard;
- Dental Sickness or Dental Injury while serving on active duty in the armed forces of any foreign country or any international authority;
- any services Provided by You or a provider who is a member of an Insured's family;
- any dental condition excluded by name or specific description by either the Policy or any riders, endorsements, or amendments attached to the Policy;
- any loss to which a contributing cause was the Insured's being voluntarily engaged in an illegal occupation or illegal activity;
- participation in aviation, except as fare-paying passenger traveling on a regular scheduled commercial airline flight;
- cosmetic surgery or cosmetic dentistry, except for Dentally Necessary cosmetic surgery which is incidental to or following surgery resulting from trauma or infection to correct a normal bodily function;
- Temporomandibular Joint Disorder (TMJ) and Craniomandibular Disorder (CMD);
- treatment received outside of the United States;
- treatment on or to the teeth or gums for cosmetic purposes, including charges for personalizations, characterizations or Dentures;
- replacement of lost or stolen prosthetics;
- restorative services (i.e. the initial placement of a complete or Partial Denture or for Fixed Bridgework) or Endodontic therapy if it involves the replacement of one or more natural teeth missing on the Issue Date of the Policy or when initial preparations were started prior to the Issue Date as shown on the Policy Schedule;
- restorative services for one (1) or more natural teeth missing on the Issue Date as shown on the Policy Schedule of the Policy will be considered Covered Dental Service if incurred five (5) years after the Issue Date;
- dental services performed in a hospital and any related expenses;
- replacement of an appliance or prosthetic device, Crown, cast restoration or a Fixed Bridge within five (5) years after the date it was last placed. This exclusion does not apply if replacement is due to accidental Dental Injury received while covered under the Policy;
- treatment of cleft palate, except for a newborn child covered under the Policy from birth, andontia or mandibular prognathicism;
- general anesthesia, except as specifically provided in the COVERED DENTAL EXPENSES section;
- placement of bone grafts or extra-oral substances in the treatment of periodontal disorders;
- the use of unilateral, removable prosthetics;
- Orthodontic diagnosis or treatment;
- charges incurred by an Insured due to broken or cancelled appointments;
- Crowns for teeth that are restorable by other means or for the purpose of periodontal splinting;
- Crowns, fillings or appliances that are used to correct (splint) teeth, or change or alter the way the teeth meet, including altering the vertical dimension, restoring the bite (occlusion) or for cosmetic purposes;
- orthognathic surgery; and
- expenses which exceed 100% of those actually incurred by the covered Insured.

SecureDental Saver Plan Limitations

In addition to any other provisions of the Policy, Benefits and coverage are limited as follows:

- The amount of the Calendar Year Maximum Dental Benefit Per Insured shall not exceed the sum of $500.
- No Benefits are payable under the BASIC DENTAL CARE provision unless they are incurred at least six (6) months after the Issue Date.

SecureDental Saver Plan Non-Covered Items

Coverage under the Policy is limited as provided by the definitions, terms, conditions, limitations, and exclusions contained in each and every section of the Policy. In addition, the Policy does not provide coverage for professional and dental services Provided to an Insured or any payment obligation for Us under the Policy for any of the following, all of which are excluded from coverage:

- any expenses for treatment, care, procedures, services or supplies which are not Covered Dental Expenses incurred by a Covered Insured, and which are not specifically enumerated in the COVERED DENTAL EXPENSE section of the Policy;
- treatments, care, procedures, services or supplies received before the Policy Issue Date;
- Covered Dental Expense received after the Policy terminates, regardless of when the condition originated;
- Covered Dental Expenses that exceed the amount of the Calendar Year Maximum Dental Benefit Per Insured;
- Prescription Drugs;
- any treatments, care, procedures, services or supplies which are not specifically enumerated in the COVERED DENTAL EXPENSES section of the Policy and any optional coverage rider attached to the Policy;
- any professional services for which the Insured and/or any covered family member are not legally liable for payment;
- any professional services for which the Insured and/or any covered family member were once legally liable for payment, but from which liability the Insured and/or family member were released;
- Dental Injury or Dental Sickness due to any act of war (whether declared or undeclared);
- services provided by any state or federal government agency, including the Veterans Administration unless, by law, an Insured must pay for such services;
- any dental conditions for which the covered Insured has received or is entitled to receive compensation for that particular dental condition under any Worker's Compensation or Occupational Disease Law;
- expenses incurred for oral hygiene instructions, a plaque control program or dietary instructions;
- expenses incurred for dental care which is not customarily performed, which is experimental in nature or which is not considered acceptable by the American Dental Association or Federal Drug Administration;
- any professional and dental services provided an Insured in treatment of a Dental Sickness or Dental Injury caused or contributed to by such Insured's being intoxicated or under the influence of any drug, narcotic or hallucinogens unless administered on the advice of a Provider, and taken in accordance with the limits of such advice;
- intentionally self-inflicted Dental Injury, suicide or any suicide attempt while sane or insane;
- Dental Sickness or Dental Injury while serving in one of the branches of the armed forces of the United States of America;
- Dental Sickness or Dental Injury while in a foreign country and serving on active duty in the United States Army, Navy, Marine Corp or Air Force Reserves or the National Guard;
- Dental Sickness or Dental Injury while serving on active duty in the armed forces of any foreign country or any international authority;
- any services Provided by You or a provider who is a member of an Insured's family;
- any dental condition excluded by name or specific description by either the Policy or any riders, endorsements, or amendments attached to the Policy;
- any loss to which a contributing cause was the Insured's being voluntarily engaged in an illegal occupation or illegal activity;
- participation in aviation, except as fare-paying passenger traveling on a regular scheduled commercial airline flight;
- cosmetic surgery or cosmetic dentistry, except for Dentally Necessary cosmetic surgery which is incidental to or following surgery resulting from trauma or infection to correct a normal bodily function;
- Temporomandibular Joint Disorder (TMJ) and Craniomandibular Disorder (CMD);
- treatment received outside of the United States;
- treatment on or to the teeth or gums for cosmetic purposes, including charges for personalizations, characterizations or Dentures;
- replacement of lost or stolen prosthetics;
- restorative services (i.e. the initial placement of a complete or Partial Denture or for Fixed Bridgework) or Endodontic therapy if it involves the replacement of one or more natural teeth missing on the Issue Date of the Policy or when initial preparations were started prior to the Issue Date as shown on the Policy Schedule;
- restorative services for one (1) or more natural teeth missing on the Issue Date as shown on the Policy Schedule of the Policy will be considered Covered Dental Service if incurred five (5) years after the Issue Date;
- dental services performed in a hospital and any related expenses;
- replacement of an appliance or prosthetic device, Crown, cast restoration or a Fixed Bridge within five (5) years after the date it was last placed. This exclusion does not apply if replacement is due to accidental Dental Injury received while covered under the Policy;
- treatment of cleft palate, except for a newborn child covered under the Policy from birth, andontia or mandibular prognathicism;
- general anesthesia, except as specifically provided in the COVERED DENTAL EXPENSES section;
- placement of bone grafts or extra-oral substances in the treatment of periodontal disorders;
- the use of unilateral, removable prosthetics;
- Orthodontic diagnosis or treatment;
- charges incurred by an Insured due to broken or cancelled appointments;
- Crowns for teeth that are restorable by other means or for the purpose of periodontal splinting;
- Implants, including any appliances and/or Crowns and the surgical insertion or removal of Implants;
- Crowns, fillings or appliances that are used to correct (splint) teeth, or change or alter the way the teeth meet, including altering the vertical dimension, restoring the bite (occlusion) or for cosmetic purposes;
- orthognathic surgery; and
- expenses which exceed 100% of those actually incurred by the covered Insured.

⋆Optional Vision⋆

If additional coverage for vision expenses is appropriate for You and/or Your family, You may be interested in the PremierVision Plan.

PremierVision[1]

VISION INSURANCE

SEE THE WORLD MORE CLEARLY[2]

How Much You Can Save!

The following is an example of what You might pay for a pair of glasses for Yourself or Your child with PremierVision vs. what You would pay without PremierVision. Let's say You or Your child get an eye exam and choose a frame with single vision lenses. Now let's see the difference . . .

Example 1 - Adult's Glasses	PremierVision	No Coverage
Comprehensive eye exam	$0.00	$100.00
Standard progressive lenses	$0.00	$230.00
Lens copay	$10.00	
Standard scratch guard coating*	$0.00	$28.00
Frame	$163.00	$163.00
-$120 allowance	($120.00)	
-30% discount off $43 balance*	($12.90)	
Frame copay	$10.00	
YOU PAY→	**$50.10**	**$521.00**

Example 2 - Child's Glasses	PremierVision	No Coverage
Comprehensive eye exam	$0.00	$100.00
Single vision plastic lenses	$0.00	$70.00
Lens copay	$10.00	
Child Polycarbonate lenses	$0.00	$125.00
Standard scratch guard coating*	$0.00	$28.00
Frame	$159.00	$159.00
-$120 allowance	($120.00)	
-30% discount off $39 balance*	($11.70)	
Frame copay	$10.00	
YOU PAY→	**$47.30**	**$482.00**

90% Savings on Glasses!!** and up to 72% on Contact Lenses!*

**Non-insurance benefit provided through the Spectera Eyecare Network. **Savings based on example above and using a Provider in the Spectera Eyecare Network.*

Benefits	In-Network Benefits	Out-of-Network Benefits
Comprehensive Eye Exam[3]	$0 Copay per Insured; 100% Coinsurance	100% Up to an Allowance of $35
Frames[4]	$10 Copay per Insured; 100% Coinsurance Up to an Allowance of $120	100% Up to an Allowance of $60
Corrective Standard Lenses[4]		
Single Vision Lenses	$10 Copay per Insured; 100% Coinsurance	100% Up to an Allowance of $35
Lined Bifocal Lenses	$10 Copay per Insured; 100% Coinsurance	100% Up to an Allowance of $55
Lined Trifocal Lenses	$10 Copay per Insured; 100% Coinsurance	100% Up to an Allowance of $90
Standard Progressive Lenses	$10 Copay per Insured; 100% Coinsurance	100% Up to an Allowance of $90
Premium Progressive Lenses	$10 Copay per Insured; 100% Coinsurance	100% Up to an Allowance of $90
Corrective Contact Lenses[5]		
Conventional	$10 Copay per Insured; 100% Coinsurance Up to an Allowance of $120	100% Up to an Allowance of $100
Disposable	$10 Copay per Insured; 100% Coinsurance Up to an Allowance of $120	100% Up to an Allowance of $100

[1]The Plan is underwritten by National Foundation Life Insurance Company.
[2]The PremierVision Plan provides benefits for covered vision services only. The PremierVision Plan is considered an "excepted benefit plan" under the ACA and is not a "minimum essential coverage" plan under the ACA. The ACA generally requires individuals to maintain "minimum essential coverage" or be subject to the payment of the annual shared responsibility payment with the payment of their taxes to the federal government from 2014 – 2018. Congress eliminated the shared responsibility payment in 2019 and beyond for individuals who do not maintain ACA "minimum essential coverage" during 2019 or any year thereafter. (See page 23 of this brochure for details.)
[3]Limited to 1 Comprehensive Eye Examination every 12 months from the last date of service, per Insured.
[4]In lieu of Corrective Contact Lenses, limited to 1 purchase every 12 months from the last date of service, per Insured. In no event will Benefits be payable for both glasses and corrective contact lenses.
[5]In lieu of Corrective Standard Lenses and Frames, limited to 1 purchase every 12 months from the last date of service, per Insured. In no event will Benefits be payable for both glasses and corrective contact lenses.

★Optional Vision★

Non-Insurance Benefits and Discounts Provided by the Spectera Eyecare Network to Those Covered Under PremierVision	
Exam Options	
Standard Contact Lens Fit & Follow-Up	Up to $60
Premium Contact Lens Fit & Follow-Up	Up to $60
Lens Options	
UV Treatment	Member pays $15
Tint (Solid and Gradient)	Member pays $14
Standard Plastic Scratch Coating	Member pays $0
Standard Polycarbonate - Adults	Member pays $33
Standard Polycarbonate - Kids under 19	Member pays $0
Standard Anti-Reflective Coating	Member pays $40
Polarized	Member receives 20% off Retail price
Photocromatic/Transitions Plastic	Member pays $67
Premium Anti-Reflective	
Tier 1	Member pays $57
Tier 2	Member pays $68
Tier 3	Member pays 80% of charge
Other Add-Ons	20% off Retail Price

- *Save up to 35% off the national average price of laser vision correction at more than 1,000 QualSight® LASIK locations nationwide.*
- *Visit www.myvisionlenses.com for all of your contact lens needs. Take 10% off every order just for being a Spectera Eyecare Network member.*
- *Any unused portion of the Benefit Allowance at the initial time of service will not carry forward to other services.*
- *Member benefits and discounts will not apply to certain brand name Vision Materials on which the manufacturer imposes a no discount practice.*

PremierVision Plan Features

Renewability and Termination

Coverage under the PremierVision Plan is guaranteed renewable to age 65 or in the event an Insured otherwise becomes a Medicare enrollee subject to the termination provisions.

Coverage under the PremierVision Plan will end on the earlier of the following: with respect to Your Spouse who is covered under the PremierVision Plan, the premium due date in the month following the effective date of Your divorce decree, annulment or court approved separation; with respect to Your child(ren) who are covered under the PremierVision Plan, Your covered child(ren) reaches the limiting age as defined by Your state; the date an Insured becomes eligible for Medicare; the due date of any unpaid Monthly Renewal Premium, subject to the grace period; the date You terminate coverage by notifying Us of the date You desire coverage to terminate for the applicable Insured whose coverage You want to terminate; the applicable date We are required by the order of an appropriate regulatory authority to non-renew or cancel the PremierVision Plan; the date We elect to discontinue offering this type of vision insurance coverage in Your state and to terminate all such policies in Your state; and the date We receive due proof that fraud or intentional misrepresentation of material fact existed in applying for the PremierVision Plan or in filing a claim for Benefits under the PremierVision Plan.

PremierVision Limitations at a Glance - Insurance Benefits

Coverage under the PremierVision Plan is limited as provided by the definitions, limitations, exclusions, and terms contained in each and every section of the PremierVision Plan, as well as the following limitations:

- in no event will coverage exceed the lesser of: (i) the actual cost of Covered Vision Expenses or materials, (ii) the negotiated fee for services rendered by a Participating Provider, or (iii) the Allowance as shown on the PremierVision Plan Schedule when services are rendered by a Participating Provider or a Non-Participating Provider;
- if the Participating Provider's or Non-Participating Provider's charge is less than the Allowance specified on the PremierVision Plan Schedule, We will only pay up to the Participating Provider's or Non-Participating Provider's charge; and
- materials covered by the PremierVision Plan that are lost or stolen will only be replaced at the intervals stated on the PremierVision Plan Schedule.

⋆Optional Vision⋆

PremierVision Non-Covered Items at a Glance - Insurance Benefits

Coverage under the PremierVision Plan is limited as provided by the definitions, terms, conditions, limitations, and exclusions contained in each and every section of the PremierVision Plan. In addition, the PremierVision Plan does not provide coverage for professional and vision services Provided to an Insured or any payment obligation for Us under the PremierVision Plan for any of the following, all of which are excluded from coverage:

- orthoptic or vision training and any associated supplemental testing;
- plano lenses;
- lens coating;
- two pair of glasses, in lieu of bifocals or trifocals;
- medical or surgical treatment of the eyes;
- any type of corrective vision surgery, including LASIK surgery;
- any eye examination, or any corrective eyewear, required by an employer as a condition of employment;
- any services or supplies when paid under any Worker's Compensation or similar law;
- Tier 4 Premium Progressive Lenses;
- photochromic transition or polycarbonate lenses;
- lenticular lenses;
- sub-normal vision aids or non-prescription lenses;
- service rendered or supplies purchased outside the U.S. or Canada, unless the Insured resides in the U.S. or Canada and the charges are incurred while on a business or pleasure trip;
- eyeglasses when the change in prescription is less than .5 Diopter;
- experimental or investigational or non-conventional treatment or device;
- eyeglass lens treatments, including "add-ons", UV coating, anti-reflective coating, scratch resistant coating, tinting or edge polishing;
- oversized lenses;
- lost or broken lenses, frames, glasses, or contact lenses will not be replaced until twelve (12) months after the last date of service;
- medically necessary contact lenses;
- high index lenses of any material type;
- fitting for corrective contact lenses;
- follow-up visits;
- charges incurred after the PremierVision Plan has terminated or coverage has ended;
- any expenses for treatments, care, procedures, services or supplies which are not Covered Vision Expenses incurred by an Insured and which are not specifically enumerated in the VISION EXPENSE BENEFITS AND CLAIM PROCEDURES section of the PremierVision Plan;
- treatments, care, procedures or supplies received before the PremierVision Plan Issue Date;
- any professional services for which the Insured and/or any covered family member are not legally liable for payment;
- any professional services for which the Insured and/or any covered family member were once legally liable for payment, but from which liability the Insured and/or family member were released;
- services provided by any state or federal government agency, including the Veterans Administration unless, by law, an Insured must pay for such services;
- any services Provided by You or a Provider who is a member of an Insured's family;
- charges that are payable or reimbursable by either: a) a plan or program of any governmental agency (except Medicaid); or b) Medicare Part A, Part B and/or Part D (If the applicable Insured does not enroll in Medicare, We will estimate the charges that would have been paid if such enrollment had occurred);
- cosmetic items;
- broken appointment fees;
- refitting or change in lens design after the initial fitting; and
- expenses which exceed 100% of those actually incurred by the Insured.

ACA Individual Mandate & Shared Responsibility Payment

The ACA generally required individuals to maintain "minimum essential coverage" or be subject to the payment of what is described in the federal regulations as a "shared responsibility payment" with the payment of their taxes to the federal government from 2014 – 2018. The "shared responsibility payment" for 2014 – 2018 has also been referred to in the media as the ACA individual tax or ACA individual penalty. The "shared responsibility payment" was applicable to individuals who did not maintain ACA "minimum essential coverage" from 2014 – 2018, or otherwise receive an exemption from the federal government from the ACA individual mandate for those years. The amount of the "shared responsibility payment" for 2014 – 2018 was based in part, upon the individual's household income each year.

Congress eliminated the ACA "shared responsibility payment" in 2019 and beyond. This means that individuals who do not maintain ACA "minimum essential coverage" during 2019 or any year thereafter are no longer required to pay the federal government any "shared responsibility payment" if they do not maintain ACA "minimum essential coverage" in-force during 2019 and beyond. For more information on the elimination of the ACA "shared responsibility payment" for 2019 and beyond or other ACA matters, please visit www.healthcare.gov, which is the federal government's website.

The information shown here and in any accompanying literature is a brief description only and does not contain the full specifications, limits, and exclusions applicable to the coverage. Important limitations, reductions, and exclusions will apply. The Policy sets forth, in detail, the rights and obligations of both You and the insurance company, and only the Policy defines and controls the rights and obligations of the parties. It is, therefore important that You READ THE POLICY CAREFULLY!

Insurance coverage underwritten by:
National Foundation Life Insurance Company
A member company of USHEALTH Group®
P.O. Box 1719 | Fort Worth, TX 76101
1-800-221-9039

USHEALTH® GROUP

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