

LIMITATIONS AND EXCLUSIONS:

Pre-existing conditions are not covered. A pre-existing condition is any condition or complication thereof which required medical treatment, consultation, or expense during the 3 years immediately before the Insured person's Effective Date of Insurance, or which produces symptoms within 3 years immediately prior to the Insured person's Effective Date of Insurance.* These symptoms must be significant enough to establish manifestation or onset by one of the following tests: (1) they would allow a physician to make diagnosis of the disorder; (2) they would cause an reasonable person to seek diagnosis or treatment.

Surgery - Eligible Expenses for the first six months of coverage do not include a total or partial hysterectomy, unless it is Medically Necessary due to a diagnosis of carcinoma (subject to all other policy provisions, including but not limited to the pre-existing condition exclusion); tonsillectomy; adenoidectomy; repair of deviated nasal septum or any type of surgery involving the sinus; myringotomy; tympanotomy; or herniorrhaphy. Benefits are not payable for expenses resulting from: eye examinations; eye glasses; hearing aids and surgery; dental work; orthodontic work; prognathism, retrognathism, micrognathism, reposition the maxilla (upper jaw) mandible (lower jaw) or both maxilla and mandible; (war, riot or any act incident to war or riot; while committing an assault or felony; intentionally self-inflicted injuries; suicide or attempted suicide (while sane or insane); military service, insured newborn dependent child not yet discharged from the hospital, unless incurred as the result of premature birth, congenital injury or sickness, or sickness or injury sustained during or after birth; any work-related accidental bodily injury or sickness covered under Worker's Compensation Act or similar law; pregnancy or any complication there from or elective termination of pregnancy, except a complication of pregnancy as defined in the Group Policy; any services furnished by the member, a dependant, or his immediate family; services or supplies rendered to a transplant donor of any organ or bodily element; any treatment for the purpose of causing a pregnancy, or complication caused by or resulting from such treatment; sterilization or reversal of sterilization; participation in skydiving, scuba diving, hang or ultra light gliding, riding an all terrain vehicle such as a dirt bike, snowmobile, or go-carts, racing with motorcycle, boats or any form of aircraft or any participation in sports for pay or profit and rodeo contests; voluntary inhalation or ingestion of any gas, poison or poisonous substance; cosmetic, reconstructive or plastic surgery; custodial maintenance, routine physical or premarital examinations, check-ups, diagnostic or other tests, immunizations, screenings and research studies, preventative or routine care; except as specifically covered under the Group Policy; testing, diagnosis or treatment of learning disabilities, attention deficit disorder, hyperactivity, autism or related conditions; experimental services, supplies or treatments; travel, even though prescribed by a physician; obesity including any treatment, advise, consultation, medication or surgery; weak, strained or flat feet; instability or imbalance of the foot; metatarsalgia, bunions, corns, calluses or toenails; gender change modification, sterilization or elective reversal surgical procedures; breast reduction or breast enlargement for any reason; sexual dysfunction; common household items, i.e. exercise cycles; air or water purifiers; air conditioners; allergenic mattresses; and blood pressure kits; outpatient prescription drugs, medicine, vitamins, mineral or food supplements, contraceptives, prenatal vitamins or any over the counter medicines; injury or sickness occurring while under the influence of alcohol, illegal drugs, hallucinogenic or narcotics unless prescribed by a physician; testing or treating a sleeping disorder.

* The pre-existing condition limitation may vary by state. Please see the specific state's Certificate of Insurance for details.

COVERAGE TERMINATION:

Coverage will end if the premium is not paid when due, you enter full-time active duty in the Armed Forces, become eligible for Medicare, you cease to be a Member of the Association, the Group Master Policy terminates, the expiration of the 12 Month Coverage Period, if Clarendon National Insurance Company determines fraud or misrepresentation has been made in filing a claim for benefits, or on the date a dependent ceases to be eligible.

COORDINATION OF BENEFITS:

Benefits may be reduced if you have other health care coverage, so that the total paid does not exceed the allowable expenses.

EXTENSION OF COVERAGE AFTER TERMINATION:

If a member, or insured dependent, is receiving benefits for a hospital confinement on the date that the Group Policy or his coverage terminates, benefits will continue in accordance with the terms of the Group Policy for as long as that confinement remains continuous and the Member or insured dependent is Totally Disabled by reason of such injury or Sickness. However, in no event will coverage continue beyond the end of 90 days following the date the Group Policy or his coverage terminates. Benefits payable after the Coverage Period in which insurance under the Group Policy terminates are subject to a new Deductible Amount and satisfaction of Co-insurance Limit.

SATISFACTION GUARANTEE:

If you are not completely satisfied with the plan for any reason, and you have filed no claims, you may return the Certificate of Insurance within 30 days and receive a full refund of all monies paid.

ABOUT THE INSURANCE COMPANY:

Clarendon National Insurance Company's home office is located in New York, NY. They are rated A (Excellent) for financial condition by the A.M. Best Company, independent analysts of the insurance industry (A.M. Best ratings are from A+ to D).

ABOUT THE ADMINISTRATOR:

HPA, Inc. is a fully licensed, full service Third Party Administrator transacting business worldwide. HPA is a third generation company dating back to 1939. Industry leading services include: professional customer service, prompt claims payment, state of the art billing and reporting.

This brochure provides only a brief description of the benefits, exclusions and other provisions of the Master Policy CNL-6000-ST- MP. This brochure is not a contract of insurance. To the extent any information in this brochure is inconsistent with the Master Policy, the terms of the Master Policy will control. Because the Master Policy is issued and delivered in the District of Columbia, laws of other states may not apply in all instances. Benefits may vary in different states.

Coverage may not be available in all states; please contact HPA for the most up-to-date information: 1-800-277-3323

Flex-Term Med 12x3

Temporary Major Medical

- **Pay premiums monthly, up to 12 months**
- **Option for up to 36 months of coverage** (Three 12 month coverage periods, with continuous claims coverage. Please see details inside.)
- **No PPO or HMO, choose any doctor or hospital**
- **24-Hour coverage worldwide**



Perfect for:

Self-employed, part-time & temporary employees; students & graduates; group coverage waiting periods; COBRA alternative; laid off; unemployed; or anyone without medical coverage for any reason.

\$1,000,000 Lifetime Maximum Per Insured Person

Insured By: Clarendon National Insurance Company
Rated A (Excellent) by A.M. Best Reports

Administered By:  **HPA, Inc., Rockford, Illinois**

Marketed By:



Flex-Term Med 12x3

Temporary Major Medical Insurance

\$1,000,000 Lifetime Maximum Per Insured Person

A NEW kind of Temporary Major Medical Insurance Plan that is flexible and satisfies your medical insurance needs for up to 12 months at a time. You can pay for the coverage you need now, or pay it monthly for up to 12 months, so it's easy on your budget. If you continue to need major medical insurance at the end of the 12 month period, you can apply for another 12 month coverage period. You can apply for up to three consecutive 12 month coverage periods.

HERE'S HOW IT WORKS:

Once you and your dependents have satisfied the eligibility requirements on the application form, and have paid your first monthly premium, the Certificate of Insurance will be issued for a **12 Month Coverage Period**. You can pay your premium by monthly installments (includes an administrative fee); or you can pay by Automatic Pre-authorized Bank Withdrawal or MasterCard, Visa and Discover cards are accepted.

*When your coverage period is almost over, you will receive an application form to apply for another 12 month coverage period. If you re-apply within 30 days prior to the end of your current coverage period your insurance and your monthly installments will not be interrupted. Furthermore, any condition(s) for which benefits were paid during a coverage period will not be subject to the pre-existing conditions limitation during any subsequent coverage period, provided the application form is received and approved by HPA, Inc. on time. However, any condition(s) that were excluded because of a pre-existing condition under the prior coverage period will continue to be subject to the pre-existing conditions limitation under the following coverage period.

BENEFIT OPTIONS PER INSURED PERSON FOR EACH 12 MONTH COVERAGE PERIOD

<p>You pay the Deductible: \$250, \$500, \$1,000 or \$2,500 of Covered Expenses.</p>	<p>Option A: Pays 80%* of the NEXT \$5,000 of Covered Expenses.</p>	<p>Option B: Pays 50%* of the NEXT \$5,000 of Covered Expenses.</p>	<p>The Plan then pays: 100% of the REMAINING Covered Expenses up to a Lifetime Maximum of \$1,000,000</p>
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EFFECTIVE DATE OF COVERAGE:

The earliest date the Plan can begin is 12:00 a.m. on the day following the U.S. postmark stamp (not a meter stamp) on the enrollment envelope. If the original envelope is not included, the effective date would then be the date the enrollment was received by Health Plan Administrators, Inc. However, you can request a later effective date, but, no more than 60 days after the application date. All coverage is subject to approval of your application, and payment of the first premium.

COVERAGE ELIGIBILITY:

*Available to members of the Association and their spouses (through age 59) and their dependent children under the age of 19 years old (or under age 25 years old and enrolled and attending as a full-time student at an accredited college, university, vocational or technical school); who have a social security number and can answer "NO" to questions 1 through 5 on the application. Children age 19 and over must apply separately. Child(ren) alone can apply and are to use the adult 0-24 premium rate (male or female, based on their gender) for the youngest child; and the per child rate for each of the siblings to be insured. The minimum age for a child only coverage is 2 years old. The application must be completed and signed by the parent or legal guardian.

WHAT IS A REASONABLE AND CUSTOMARY CHARGE?

A charge which is: (1) made by a Physician or supplier of services, medicines, or supplies; and (2) the customary charges made by others rendering or furnishing such services, medicines, or supplies within an area in which the charge is incurred for Sickness or Injuries comparable in severity and nature to the Sickness or Injury being treated. The term area as it would apply to any particular service, medicine or supply, means a county or such greater area as is necessary to obtain a representative cross section of level of charges.

* You must be less than the maximum age of 59 to apply or reapply for coverage.

COVERED MEDICAL EXPENSES:

- **Hospital Charges** - medical care and treatment
- **Ambulatory Surgical Center** charges
- **Physicians Services** for diagnosis, treatment and surgery
- **Intensive Care** - up to 3 times the average semi private room rate
- **Skilled Nursing Facility** - up to \$30 per day for 30 days
- **Private Duty Nursing** - up to \$75 per 8 hour shift. Maximum 90 shifts per coverage period.
- **X-ray exams, laboratory** tests and analyses.
- **X-ray and radioactive isotope** therapy
- **Anesthesia, oxygen, casts, splints, crutches, braces, surgical dressings, artificial limbs or eyes, rental of necessary medical supplies**
- **Blood or blood derivatives** and their administration.
- **Ambulance Services** - \$250 per emergency
- **Organ Transplants** - Lifetime Maximum \$50,000
- **Spinal Manipulation or Adjustment** - Lifetime Maximum \$1,000
- **Foreign Travel** - Lifetime Maximum \$25,000 (This benefit is payable after a \$250 Deductible.)
- **Mental and Nervous Disorders** - as a Bed Patient; or as Outpatient at a maximum of \$30 per day up to 30 visits - Lifetime Maximum of \$5,000*
- **Alcoholic and Drug Disorders** - Lifetime Maximum of \$1,000*
- **Acquired Immune Deficiency Syndrome (AIDS)** Lifetime Maximum of \$10,000
- **Home Health Care** - up to 40 visits maximum
- **Mammography, pap smear and screens**

* Benefits for Mental, Nervous, Alcohol and Drug Disorders are paid at 50%. The benefit amount shown is the "Maximum Lifetime Benefit Per Insured Person."

PRE-ADMISSION CERTIFICATION :

This plan requires a Pre-Admission Certificate by "Medical Cost Management" prior to in-patient hospitalization or surgery of a Member or Insured Dependent within 48 hours. If you fail to pre-certify, benefits will be reduced 50%. To pre-certify call Medical Cost Management at: 1-800-367-9938.