FIXED INDEMNITY INSURANCE POLICY

State of Domicile: Utah

StartHealth

[10421 South Jordan Gateway, Suite 350

South Jordan, Utah 84095]

This coverage is underwritten by MotivHealth Insurance Company, Inc.

IMPORTANT NOTICES:

NOTICE OF RIGHT TO EXAMINE POLICY FOR THIRTY (30) DAYS: Member may return this Policy to Company's home office or to the agent through whom it was purchased within thirty (30) days of its delivery if, after examination of the Policy, Member is not satisfied with it for any reason.

Upon return, Company will refund all Premium paid by Member, including any policy fees or other charges. The Policy shall be void from the beginning, and the parties shall be in the same position as if no policy had been issued.

This Policy is issued in the State of Utah. It is governed by the laws of the State where it was issued. This Policy is a legal contract between Member and Company.

Notice to Buyer: This is a fixed indemnity policy. This policy provides limited benefits. Benefits provided are supplemental and are not intended to cover all medical expenses.

THIS POLICY IS NOT A MEDICARE SUPPLEMENT POLICY. If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from the Company.

IMPORTANT NOTICE: This Policy was issued based on the information entered in Member's application, which becomes part of the Policy. Members agree that they have read and reviewed their application and that it is accurate. Omissions or misrepresentations in Member's application could cause a claim to be denied or Member's Policy to be rescinded if (i) the omission or statements were fraudulent, (ii) they were material to Company's issuance of this Policy, and (iii) Company would not have issued this Policy if misrepresented or omitted facts had been known. If, to the best of Member's knowledge and belief, there is any misstatement in Member's application or if any information concerning Member's medical history has been omitted, Member should advise Company immediately regarding the incorrect or omitted information; otherwise, Member's Policy may not be a valid contract.

MotivHealth ("Company") agrees to provide insurance to Member, in consideration of Member's application and for the payment of the required premium. Coverage is subject to the terms and

conditions described in this Policy. Member and Company have agreed to all the terms and conditions of this Policy.

NOTE: THIS POLICY IS RENEWABLE. When this Policy expires on the Termination Date stated on the Schedule of Benefits, the Policyholder may continue only by applying and gaining approval for a renewal policy. The Policyholder will be subject to underwriting as required at the time of reapplication, and the premium rates will be those in effect at the time of the renewal application.

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SECTION 1- SCHEDULE OF BENEFITS

Policy Number:	**[STHLTHUT2024]**
Policy Effective Date:	**[01/01/2001] at 12:00 A.M.**
Policy Termination Date:	**[01/01/2001] at 11:59 P.M.**
Insured:	**[Member Name]**
Insured Address:	**[Member Address]**
Premium Mode:	**Monthly**
Premium Monthly	**$ [0.00-100,000]**

INDEMNITY BENEFIT	**INDEMNITY AMOUNT**	**MAXIMUM BENEFIT**
Deductible: • Individual • Family (More than one on the Policy)		[$1,000-$6,000] [$2,000-$12,000]
Indemnity Benefit	Indemnity Amount, as shown at StartHealth.com, subject to any applicable Deductible	Maximum Benefit
Inpatient Hospital Confinement	Indemnity Benefit Amount	Limited to 30 Days per Policy period combined total Inpatient
Inpatient Intensive Care Unit	Indemnity Benefit Amount	Limited to 30 Days per Policy period combined total Inpatient
In-hospital Provider's Fee	Indemnity Benefit Amount	Limited to 30 Days per Policy period combined total Inpatient
Surgery Expense (Inpatient and Outpatient)		Unlimited surgeries per Policy Year
Surgeon Services	Indemnity Benefit Amount	Unlimited procedures per Policy Year

Assistant Surgeon Services	Indemnity Benefit Amount	Unlimited procedures per Policy Year
Anesthesiologist Services	Indemnity Benefit Amount	Unlimited procedures per Policy Year
Emergency Room	Indemnity Benefit Amount	Unlimited procedures per Policy Year
Outpatient Radiation Therapy and Chemotherapy	Indemnity Benefit Amount	Unlimited procedures per Policy Year
Outpatient Diagnostic Imaging	Indemnity Benefit Amount	Unlimited procedures per Policy Year
Outpatient Laboratory and X-ray Examinations	Indemnity Benefit Amount	Unlimited tests per Policy Year
Outpatient Dialysis and Filtration Procedures	Indemnity Benefit Amount	Unlimited procedures per Policy Year
Outpatient Facility	Indemnity Benefit Amount	Unlimited days per Policy Year
Ambulance Ground or Water Transportation	Indemnity Benefit Amount	Unlimited transports per Policy Year
Air Transportation	Indemnity Benefit Amount	Unlimited transports per Policy Year
Office Visit/Nurse/Urgent Care Center	Indemnity Benefit Amount	Unlimited Covered Service instances per Policy Year, except that the following categories of benefits are limited to: Physical Therapy—20 Covered Service instances per Policy Year Occupational Therapy—20 Covered Service instances per Policy Year Speech Therapy—20 Covered Service instances per Policy Year

		Chiropractor—12 Covered Service instances per Policy Year Psychiatric Therapy—48 Covered Service instances per Policy Year
Second Surgical Opinion	Indemnity Benefit Amount	Unlimited services per Policy Year
Outpatient Prescription Drug		Unlimited drug fills per Policy Year.
Prescription Drug	Indemnity Benefit Amount	Unlimited drug fills per Policy Year.
Wellness Visit	Indemnity Benefit Amount	Deductible waived for yearly exams

SECTION 2- DEPENDENT COVERAGE

This section will only apply if You have selected and been approved to add Dependents.

DEPENDENT ELIGIBILITY

Your dependents become eligible to apply for insurance on the later of:

- The date you became insured under this policy; or
- The first day of the calendar month after the date of becoming your dependent.

EFFECTIVE DATES FOR INITIAL DEPENDENTS

The effective date for Your initial dependents, if any, is shown on the data page. Only dependents included in the application for this policy and approved by Us will be covered on your effective date.

ADDING A NEWBORN CHILD

An eligible child born to you or your spouse will be covered from the moment of birth until the thirty-first (31st) day after its birth unless you or your spouse advises us not to add the newborn child to the policy. The newborn child will be covered for a loss from the moment of its birth. Additional premium may be required to continue coverage beyond the 31st day after the date of birth of the child. If required, the premium will be calculated from the child's date of birth. Coverage of the child will terminate on the 31st day after its birth, unless we have received both written notice of the child's birth and the required premium within ninety (90) days of the child's birth.

ADDING AN ADOPTED CHILD

An eligible child legally placed for adoption with you or your spouse will be covered for the first days following the:

- Moment of birth if the date of placement for adoption occurs within thirty (30) days after child's birth; or
- Date of placement for adoption if that date occurs 30 days or more after the child's birth, unless the placement for adoption is disrupted prior to legal adoption and the child is removed from You or your spouse's custody.

Additional premium may be required to continue coverage beyond the 31st day following placement for adoption of the child. If required, the premium will be calculated from the date of placement for adoption. Coverage of the child will terminate on the 31st day following placement, unless We have received both written notice of You or your spouse's intent to adopt the child and any additional premium required for the addition of the child within 90 days of the date of placement for adoption.

As used in this provision, "placement for adoption" means the assumption and retention by a covered person of a legal obligation for total or partial support of a child in anticipation of the adoption.

ADDING A DISABLED ELIGIBLE CHILD

You or your spouse's disabled child is eligible for coverage if:

- You apply in writing for insurance for the disabled child;
- The disabled child has been continuously covered, with no break of more than 63 days, under any accident and health insurance policy before they reached the age of 26;
- You furnish proof of the disabled child's physical impairment or mental impairment; and
- You pay any required premium.

The effective date will be the earliest of:

- The day after we receive the application; or
- The requested effective date.

If your disabled child has a break in coverage of more than 63 days, we will follow the Adding Other Dependents provision.

ADDING OTHER DEPENDENTS

If:

- You apply in writing for insurance on a dependent;
- You pay the required premiums; and
- We agree to insure the eligible dependent, then the effective date will be shown in the written notice to you that the dependent is insured.

SECTION 3- DEFINITIONS

For the purposes of this Policy, the capitalized terms used herein are defined as follows. Additional terms may be defined within the benefit to which they apply. The male/female/or plural pronouns may be used interchangeably.

Accident, Accidental

"Injury" or "Injuries" means accidental bodily injury sustained by the insured person that is the direct cause of the condition for which benefits are provided, independent of disease or bodily infirmity or any other cause, and that occurs while the insurance is in force.

Adverse Benefit Determination

Means a:

- denial of a benefit;
- reduction of a benefit;
- termination of a benefit; or
- failure to provide or make payment, in whole or in part, for a benefit.

"Adverse benefit determination" also includes:

- denial, reduction, termination, or failure to provide or make payment that is based on a determination of a member's or a beneficiary's eligibility to participate in a plan;
- denial, reduction, or termination of, or a failure to provide or make payment, in whole or in part, for, a benefit resulting from the application of a utilization review; or
- failure to cover an item or service for which benefits are otherwise provided because it is determined to be:
    - experimental;
    - investigational; or
    - not medically necessary or appropriate.

Appeal

An Appeal is a written complaint requesting a change to a previous claim decision, claims payment, the handling or reimbursement of healthcare services, or other matters pertaining to your coverage and our contractual relationship.

Benefit Card

Means the debit card issued to You through StartHealth. The Benefit Card (also referred to as the Start Benefit Card) may only be used to pay for a Covered Service as defined in the Policy and for no other purchases. If We suspect fraud or have evidence that the Benefit Card is being used in a fraudulent manner, We may, at Our discretion, suspend the use of the Benefit Card. A suspension of the Benefit Card does not limit Your ability to obtain Indemnity Benefits for Covered Services.

Child means:

1. Your child, including a natural child from the moment of birth, stepchild, foster or legally adopted child; or
2. a child Placed for Adoption (the assumption and retention by You for total or partial support of a child in anticipation of the adoption of the child.); or
3. a child for whom You are required by a court order or administrative order to provide medical support until the end of their twenty-sixth (26^{th}) birth month.

Company, We, Us, or Our

Means MotivHealth Insurance Company domiciled in Utah.

Complication of Pregnancy

Means diseases or conditions the diagnoses of which are distinct from pregnancy but are adversely affected or caused by pregnancy and not associated with a normal pregnancy.

1. Complications of Pregnancy include:
    a. acute nephritis,
    b. nephrosis,
    c. cardiac decompensation,

d. ectopic pregnancy which is terminated,
e. a spontaneous termination of pregnancy when a viable birth is not possible,
f. puerperal infection,
g. eclampsia,
h. pre-eclampsia, and
i. toxemia.

2. Complication of Pregnancy will not include:

a. false labor;
b. occasional spotting;
c. Provider-prescribed rest during the period of pregnancy;
d. morning sickness; and
e. conditions of comparable severity associated with management of a difficult pregnancy.

Covered Service

Means any drug, device, procedure, service, or supply for which an Indemnity Benefit Amount is payable under this Policy.

Deductible

The amount paid by a Member for eligible charges before any benefits will be paid under the plan.

Domestic Partner

Means an opposite or same sex partner who, for at least twelve (12) consecutive months, has resided with the Insured and shared financial assets/obligations with the Insured. Both the Insured and the Domestic Partner must: (a) intend to be life partners; (b) be at least the age of consent in the state in which they reside; and (c) be mentally competent to contract. Neither the Insured nor the Domestic Partner can be related by blood to a degree of closeness that would prohibit a legal marriage, be married to anyone else, or have any other Domestic Partner. The Company requires proof of the Domestic Partner relationship in the form of a signed and completed Affidavit of Domestic Partnership.

Emergency Care

Means a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, who possesses an average knowledge of medicine and health, would reasonably expect the absence of immediate medical attention through a hospital emergency department to result in:

1. placing the Insured's health, or with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy;

2. serious impairment to bodily functions; or

3. serious dysfunction of any bodily organ or part.

Emergency Room

Means a place used primarily for providing Emergency Care.

Estimated Benefit

Means 80% of the charged amount less any deductible amount for a Covered Service before We receive a Medical Invoice for the Covered Service. You will be responsible for any remaining amount of the total healthcare charge. If Your portion of any Deductible is more than the Estimated Benefit, We may reduce the Estimated Benefit to $0 until Your portion of the Deductible is less than the Estimated Benefit. In such case, the Estimated Benefit will be the Indemnity Benefit Amount minus Your remaining portion of the Deductible. If You have not uploaded a Medical Invoice for a previous charge made on Your Benefit Card, at Our discretion, We may suspend Your use of the Benefit Card or adjust the Estimated Benefit to $0 for any new charges. For example: if Your remaining portion of the Deductible is ten dollars ($10) and You use Your Benefit Card to pay a healthcare charge of one hundred dollars ($100) at the time You receive a Covered Service, Your Estimated Benefit would be one hundred dollars ($100) minus $10, or $90. You would be responsible for the difference between the Estimated Benefit of $90 and the total charge of $100. You would still need to submit a Medical Invoice to Us so We can calculate the Indemnity Benefit Amount.

Experimental Treatment

Means medical treatment, services, supplies, medications, drugs, or other methods of therapy or medical practices, which are not accepted as a valid course of treatment by the Utah Medical Association, the U.S. Food and Drug Administration, the American Medical Association, or the Surgeon General.

Hospital

Means a facility that is licensed and operating within the scope of such license. This definition may not preclude the requirement of medical necessity of hospital confinement or other treatment.

Hospital Confinement/Hospital Confined

Means a stay of at least twenty-four (24) consecutive hours at a Hospital or for which a room and board charge is made at the Hospital.

Immediate Family Member(s)

Are considered to be (for purposes of this Policy) spouse, children, son-in-law, daughter-in-law, brother, sister, brother-in-law, sister-in-law, mother, father, mother-in-law, father-in-law, stepparents, stepchildren, grandparents, grandchildren, uncles, aunts, nieces, nephews, domestic partners, and adult designees.

Indemnity Benefit

Means the benefit under this Policy as shown on the Schedule of Benefits. You may request a paper copy of all the Indemnity Benefits by contacting StartHealth via the toll-free number, [800-894-9454], and requesting the same.

Indemnity Benefit Amount

Means, with respect to an Indemnity Benefit, the benefit amount payable to You when you meet all conditions including any cost share such as any deductibles. The Indemnity Benefit Amounts are fixed and remain the same during the entire term of Your Policy. You may view the Indemnity Benefit Amount for any Covered Service at [StartHealth.com] or by contacting StartHealth via the toll-free number, [800-894-9454], and requesting the same. You may also request a paper copy of the Indemnity Benefit Amount for all Covered Services by contacting StartHealth. Anything on the website is subject to change, however, the Indemnity Benefit Amount shall not change during the term of the policy.

Independent External Review

means a process that:

- Is a voluntary option for the resolution of a Final Adverse Benefit Determination;
- Is conducted at the discretion of the Policyholder;
- Is conducted by an Independent Review Organization designated by the Commissioner;
- Renders an independent and impartial decision on a Final Adverse Benefit Determination; and
- May not require the Policyholder to pay a fee for requesting the Independent Review.

Injury

Means bodily harm which results, directly and independently of disease or bodily infirmity, from an Accident. All injuries sustained by the Insured in one Accident, including all related conditions and recurring symptoms of the Injuries, will be considered one Injury.

Inpatient

Means a person who is provided Covered Services while He is Hospital Confined.

Insured

Means the Policyholder who is issued this Policy as shown on the Schedule of Benefits.

Intensive Care Unit

Means a designated ward, unit, or area within a Hospital for which a specified extra daily surcharge is made and which is staffed and equipped to provide, on a continuous basis, specialized or intensive care or services not regularly provided within such Hospital.

Medical Invoice

Means the fully itemized bill or document provided to You by the Provider for medical services rendered. The Medical Invoice must be in a form that identifies the Covered Service including

medical billing codes, the amount charged for such Covered Service, the Provider's name, Your name, and the date of service.

Medically Necessary or Medical Necessity

Medically Necessary or Medical Necessity Means:

A. Healthcare services or products that a prudent healthcare professional would provide to a patient for the purpose of preventing, diagnosing, or treating an illness, injury, disease or its symptoms in a manner that is:
    a. in accordance with generally accepted standards of medical practice in the United States;
    b. clinically appropriate in terms of type, frequency, extent, site, and duration;
    c. not primarily for the convenience of the patient, Provider, or other healthcare Provider;
    d. billed appropriately including industry standards including but not limited to Medicare National Correct Coding Initiative (NCCI); and
    e. covered under the Plan;
B. When a medical question-of-fact exists, medical necessity shall include the most appropriate available supply or level of service for the individual in question, considering potential benefits and harms to the individual, and known to be effective. For interventions not yet in widespread use, the effectiveness shall be based on scientific evidence. For established interventions, the effectiveness shall be based on:
    a. Scientific evidence;
    b. Professional standards; and
    c. Expert opinion.
C. Codes billed that could be considered as part of other billed codes are not available for separate benefits. For example, a code that identifies part of treatment where another code is charged that encompasses that treatment, only the more comprehensive code will be considered for benefits.

We will determine Medical Necessity upon receipt of Your Medical Invoice for a Covered Service. If You use Your Benefit Card prior to submitting a Medical Invoice to Us, We will retroactively determine Medical Necessity of the Covered Service upon receipt and inform You if We determine that the service was not Medically Necessary. In such event, We will deny the claim, and You will have the right to appeal Our determination.

The purchasing or renting of air conditioners, air purifiers, motorized transportation equipment, escalators or elevators in private homes, swimming pools or supplies for them, and general exercise equipment are not considered Medically Necessary.

Nurse

Means either a professional, licensed, graduate registered nurse (R.N.) or a professional, licensed practical nurse (L.P.N.).

Outpatient

Means a person who is provided Covered Services at Provider's offices and freestanding clinics, and at Hospitals when not admitted as an Inpatient.

Outpatient Facility

Means a licensed facility with a medical staff of Providers that operates pursuant to law for the purpose of performing surgical procedures, and that does not provide accommodations for patients to stay overnight. This does not include facilities such as acute-care clinics, Urgent Care Centers, ambulatory-care clinics, free-standing emergency facilities, and Provider offices.

Personal Account

Means a credit card, debit card, or other account which You have authorized to be debited in order to facilitate payment of the amount of a Medical Invoice that exceeds the benefit payable under this Policy for any Covered Service identified on the Medical Invoice.

Policyholder, You, or Your

Means the person to whom this insurance Policy has been issued as shown as the "Insured" on the Schedule of Benefits and for whom insurance under the Policy is in force.

Policy Termination Date

Means the date that is twelve (12) months after the Policy Effective Date as shown in the Schedule of Benefits.

Policy Year

Means, initially, the period of time from the Effective Date of the Policy until twelve (12) months thereafter. A Policy will consist of only one (1) Policy Year as shown in the Schedule of Benefits.

Portal

Means any StartHealth.com, web-based application, or other digital platform identified by StartHealth through or by which You may access Indemnity Benefit Amount information or exchange information with StartHealth. Items on the website are subject to change.

Prescription Drugs

Means drugs which may only be dispensed by a licensed pharmacist by written prescription under Federal law and approved for general use by the Food and Drug Administration. Only specifically listed drugs are covered under this Policy, and only for the conditions as approved by the Food and Drug Administration.

Private Duty Nursing Services or Skilled Nursing Services

Means nursing services that include skilled nursing twenty-four (24) hours a day, seven (7) days a week, under the supervision of a Nurse at least five (5) days per week. The emphasis is on skilled nursing care, with restorative, physical, occupational, and other therapies available. The

service provided must be directed towards the patient achieving independence in activities of daily living, improving the patient's condition, and facilitating discharge.

Provider

A licensed practitioner of the healing arts acting within the scope of the Provider's practice and licensing.

Sickness

Means illness, disease, or disorder of an insured person.

Spouse

Means Your lawful spouse, if not legally separated or divorced. The term Spouse shall also mean and include Your Domestic Partner or Your civil union partner as defined by state law. A party to a civil union or a party to a domestic partnership with You shall therefore be included in any definition or use of terms referenced throughout this Policy such as Spouse, family, dependent, next of kin, and other terms description of spousal relationships. This includes the terms 'marriage' or 'married' or variations thereon.

Urgent Care Center

Means a medical facility separate from a hospital emergency department where ambulatory patients can be treated on a walk-in basis without an appointment and receive immediate, non-routine urgent care for an Injury or Sickness presented on an episodic basis.

You, Your, or Member

Means the individual who is eligible to enroll for insurance and for whom coverage is provided under the Policy and this Certificate.

SECTION 4- TERMINATION OF INSURANCE

The Company may not terminate this Policy during its term except as provided below. You may terminate the Policy at any time by written notice delivered or mailed to the Company, or by calling Us. The termination will be effective on the next monthly anniversary of the Policy Effective Date. In the event of termination, the Company will promptly return the unearned portion of any premium paid and any Indemnity Benefit Amounts remaining in Your account on the Portal.

This Policy terminates automatically on the earliest of:

1) the Policy Termination Date shown in the Schedule of Benefits;
2) the date for which premiums have been paid if premiums are not paid when due, subject to the Grace Period;
3) the next monthly anniversary of the Policy Effective Date that the Company receives a request form You to terminate the Policy;
4) the date You perform an act or practice that constitutes fraud or made an intentional misrepresentation of material fact related to this Policy, or

5) the date of Your death.

If termination occurs because of item (2), the Company will provide written notice delivered to You, or mailed to Your last address as shown by the Company's records, stating when the termination is effective. Termination takes effect at 12:01 A.M. local time at Your address on file with the Company on the date of termination. If the Company terminates the policy with cause, any unearned premium shall be computed pro rata and refunded along with any Indemnity Benefit Amounts remaining in Your account on the Portal, less any reimbursements You owe StartHealth.

Termination of coverage will not affect a claim for a Covered Service that occurred while Your coverage was in force under this Policy. Any unearned premium will be refunded promptly to You or Your estate upon notification of Your death or the Policy's termination.

SECTION 5-PREMIUM PROVISIONS

Premiums

The Company provides insurance in return for premium payments and for furnishing accurate information to Us. The premium shown in the Schedule of Benefits is payable to the Company in the manner described. The Company sets the premiums that apply to the coverage provided under this Policy based on rates currently in force, the plan, and the amount of insurance in force. The Company has the right to adjust the premium rate on any premium due date when the terms of this Policy are changed. You will be given notice of such premium adjustment at least forty-five (45) days before the date it is to take effect. Absent a change to the terms of this Policy, Your premium rate is guaranteed for the term of the Policy. All premiums must be paid to the Company prior to the start of the term for which coverage is selected. In no event will coverage become effective prior to the date of enrollment and required premiums are received by the Company.

Grace Period

A Grace Period of fifteen (15) days will be granted for the payment of each premium falling due after the first premium. During that period, this Policy shall continue in force subject to the right of the Company to terminate the Policy in accordance with Section 4 – Termination of Insurance. You shall be liable to the Company for the payment of the premium for the period this Policy continues in force and any outstanding difference between any Estimated Benefit paid in excess of the Indemnity Benefit Amount payable under this Policy.

SECTION 6 REINSTATEMENT

IF ANY RENEWAL PREMIUM IS NOT PAID WITHIN THE TIME GRANTED YOU FOR PAYMENT, A SUBSEQUENT ACCEPTANCE OF PREMIUM BY THE COMPANY OR BY ANY AGENT DULY AUTHORIZED BY US TO ACCEPT THE PREMIUM, WITHOUT ALSO REQUIRING AN APPLICATION FOR REINSTATEMENT, SHALL REINSTATE THE POLICY. HOWEVER, IF WE OR OUR AGENT REQUIRES AN APPLICATION FOR REINSTATEMENT AND ISSUES A CONDITIONAL RECEIPT FOR THE PREMIUM TENDERED, THE POLICY SHALL BE REINSTATED UPON APPROVAL OF THIS APPLICATION FROM THE INSURER OR, LACKING THIS APPROVAL, UPON THE FORTY-FIFTH (45TH) DAY FOLLOWING THE DATE OF THE CONDITIONAL RECEIPT, UNLESS COMPANY HAS PREVIOUSLY NOTIFIED THE INSURED IN WRITING OF ITS DISAPPROVAL OF THE APPLICATION.

THE REINSTATED POLICY SHALL COVER ONLY LOSS RESULTING FROM SUCH ACCIDENTAL INJURY AS MAY BE SUSTAINED AFTER THE DATE OF REINSTATEMENT AND LOSS DUE TO SUCH SICKNESS AS MAY BEGIN MORE THAN TEN (10) DAYS AFTER THAT DATE. IN ALL OTHER RESPECTS THE INSURED AND INSURER HAVE THE SAME RIGHTS UNDER THE REINSTATED POLICY AS THEY HAD UNDER THE POLICY IMMEDIATELY BEFORE THE DUE DATE OF THE DEFAULTED PREMIUM, SUBJECT TO ANY PROVISIONS ENDORSED ON OR ATTACHED TO THIS POLICY IN CONNECTION WITH THE REINSTATEMENT.

SECTION 7- DESCRIPTION OF INDEMNITY BENEFITS

The Indemnity Benefit Amount depends upon the particular service provided under each type of coverage. Indemnity Benefit Amounts are listed in the Portal.

Inpatient Hospital Confinement Benefit
The Company will pay the Inpatient Hospital Confinement Benefit amount as shown in the Schedule of Benefits for each Inpatient stay in a Hospital under the orders of a Provider.

Inpatient Intensive Care Unit Benefit
The Company will pay the Inpatient Intensive Care Unit Benefit amount as shown in the Schedule of Benefits for each stay as an Inpatient in an Intensive Care Unit under the order of a Provider.

In-Hospital Provider's Fees Benefit
The Company will pay the In-Hospital Provider's Fee Benefit amount as shown in the Schedule of Benefits when You are visited by a Provider while You are an Inpatient in a Hospital.

Surgery Expense Benefit (Inpatient and Outpatient)
The Company will pay the Surgery Expense Benefit (Inpatient and Outpatient) consisting of the following surgery services:

A. Surgeon Services: The Company will pay the applicable amount as shown in the Schedule of Benefits for each procedure You require Inpatient or Outpatient surgery as prescribed by a Provider. Surgeries may be performed in a Hospital Inpatient setting, an Outpatient Facility, or a Provider's office/clinic.

"Surgeon Services" means services by a Provider for:

a) a Surgical Procedure;
b) a necessary preoperative treatment during a Hospital stay in connection with such procedure; and
c) usual postoperative treatment.

"Surgical Procedure" means:

a) a cutting procedure;
b) suturing of a wound;
c) treatment of a fracture;
d) reduction of a dislocation;
e) radiotherapy (excluding radioactive isotope therapy), if used in lieu of a cutting operation for removal of a tumor;
f) electrocauterization;
g) diagnostic and therapeutic endoscopic procedures;
h) injection treatment of hemorrhoids and varicose veins;
i) an operation by means of laser beam;
j) casting;
k) removal of a foreign body;
l) drainage or aspiration;

m) implant;
n) catheter placement;
o) microsurgery.

B. Assistant Surgeon Services: The Company will pay the applicable amount as shown in the Schedule of Benefits for each procedure You receive services from an assistant surgeon for Inpatient or Outpatient surgery as prescribed by a Provider.

C. Anesthesiologist Services: The Company will pay the applicable amount as shown in the Schedule of Benefits for each procedure You are administered anesthesia by an anesthesiologist for Inpatient or Outpatient surgery as prescribed by a Provider.

Anesthesia does not include topical anesthetic.

Emergency Room Benefit
The Company will pay the Emergency Room Benefit amount as shown in the Schedule of Benefits for each procedure You receive services for Emergency Room care.

Outpatient Radiation Therapy and Chemotherapy Benefit
The Company will pay the Radiation and/or Chemotherapy Benefit amount as shown in the Schedule of Benefits for each procedure You receive radiation therapy or chemotherapy medication for the treatment of cancer while You are not Inpatient.

Outpatient Diagnostic Imaging Benefit
The Company will pay the Outpatient Diagnostic Imaging Services Benefit amount as shown in the Schedule of Benefits for each Outpatient diagnostic imaging services procedure received by You. Outpatient diagnostic imaging services consist of the following tests:

A. Angiogram, arteriogram, and thallium stress test.
B. Electroencephalogram (EEG).
C. Myelogram.
D. Positron Emission Tomography (PET) scan.
E. Magnetic Resonance Imaging (MRI).
F. Computed Tomography (CT) scan.

Outpatient Laboratory and X-Ray Examinations Benefit
The Company will pay the Outpatient Laboratory and X-ray Benefit amount as shown in the Schedule of Benefits for each Outpatient laboratory test or X-ray received by You that is not a routine screening examination or preventive testing.

Outpatient Dialysis and Filtration Procedures Benefit
The Company will pay the Outpatient Dialysis and Filtration Procedures Benefit amount as shown in the Schedule of Benefits for each Outpatient dialysis and filtration procedure received by You.

Outpatient Facility Benefit
The Company will pay the Outpatient Facility Benefit amount as shown in the Schedule of Benefits for each day You have Outpatient surgery in an Outpatient Facility while not in a period of Hospital Confinement.

Ambulance Benefit
The Company will pay the applicable specified Ambulance Benefit amount as shown in the Schedule of Benefits when licensed professional ground, water, or air ambulance service is used to transport You to a Hospital or emergency care facility to receive Emergency Care or due to a Sickness or Injury.

The Ambulance Benefit is limited to emergency transportation to a Hospital or transportation between Hospitals during a period of Hospital Confinement when a higher level of care is Medically Necessary. The Company will pay the air transport only if ground transport is not efficient due to Your medical condition.

Office Visit/Nurse/Urgent Care Center Benefit
Office Visit: The Company will pay the Office Visit/Nurse/Urgent Care Benefit amount as shown in the Schedule of Benefits when You receive services for a visit rendered by a Provider while You are not an Inpatient.

Nurse: The Company will pay the Office Visit/Nurse/Urgent Care Benefit amount as shown in the Schedule of Benefits when You receive services rendered by a Nurse while You are not an Inpatient.

Urgent Care: The Company will pay the Office Visit/Nurse/Urgent Care Benefit amount as shown in the Schedule of Benefits for each day You receive urgent care in an Urgent Care Center.

For this benefit to be payable, office, nurse and/or urgent care visits must relate to Emergency Care or a covered Sickness or Injury. Office visits, nurse, and/or urgent care visits are limited only to visits that do not relate solely to alternative treatments, including acupressure, acupuncture, aroma therapy, hypnotism, massage therapy, rolfing, and other forms of alternative treatment as defined by the National Center for Complementary and Integrative Health of the National Institutes of Health.

Second Surgical Opinion Benefit
The Company will pay the Second Surgical Opinion Benefit amount as shown in the Schedule of Benefits for each service when You obtain a second surgical opinion from another Provider prior to non-emergency Surgical Procedure recommended by Your Provider.

This benefit is only payable if the Providers providing the second and, if necessary, third surgical opinion:

A. Are not affiliated with each other or with the original Provider who will perform the surgery;
B. Are not financially associated with the original Provider;
C. Do not assist in the surgery; and

D. Are board certified in the medical field relating to the Surgical Procedure being proposed.

Outpatient Prescription Drug Benefit
The Company will pay the Outpatient Prescription Drug Benefit amount as shown in the Schedule of Benefits and as provided in the Portal when You receive an Outpatient Prescription Drug prescribed by a Provider and dispensed at a licensed pharmacy, while You are not an Inpatient.

Wellness Visit Benefit
The Company will pay the Wellness Visit Benefit amount shown in the Schedule of Benefits for each visit where You undergo any of the following routine screening examinations or preventive testing:

A. Annual physical examination;
B. Routine gynecological examination including pap smear;
C. Immunizations;
D. Routine non-surgical cancer screening tests such as mammography or digital rectal examination; or
E. Blood screenings including but not limited to prostate-specific antigen testing.

Services must be recommended by or received under the supervision of a Provider. No covered Sickness or Injury is required for this Wellness Visit Benefit to be payable.

Maternity Benefit
Any inpatient maternity stay that exceeds forty-eight (48) hours following a vaginal delivery or ninety-six (96) hours following delivery by Cesarean section.

SECTION 8 – EXCLUSIONS AND LIMITATIONS

This Policy does not pay benefits for loss caused by or resulting from:

1. Any treatment, service or supply which is not Medically Necessary other than coverage available under the Wellness Visit Benefit.
2. Any treatment, service or supply for which a member would not be billed for in the absence of this policy. This exclusion does not limit payment for services covered by another insurance policy.
3. Treatment, services, drugs, device, procedures or supplies that are Experimental or Investigational.
4. Rest cures or custodial care; care provided in: rest homes; health resorts; homes for the aged; halfway houses; college infirmaries or places mainly for domiciliary or custodial care; or extended care in treatment or substance abuse facilities for domiciliary or custodial care.
5. Day care and foster care.
6. Personal comfort or beautification, cosmetic services and supplies.

7. Vision services and devices, including but not limited to, routine vision screenings, contact lenses, and eyeglasses, when the primary purpose is to correct or screen for myopia (nearsightedness), hyperopia (farsightedness), presbyopia (aging eye), or astigmatism (blurring).
8. Eye surgery such as radial keratotomy when the primary purpose is to correct myopia (nearsightedness), hyperopia (farsightedness), presbyopia (aging eye), or astigmatism (blurring).
9. Cosmetic procedures including but not limited to breast augmentation, liposuction, abdominoplasty, and vaginal rejuvenation. This exclusion does not apply to reconstructive surgery when the service is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part, or reconstructive surgery because of congenital disease or anomaly of a covered dependent child that has resulted in a functional defect.
10. Any services rendered by Your Immediate Family Member.
11. Treatment for obesity including, but not limited to, prescription or over the counter medications, food, diet or exercise programs, surgery, weight management, nutrition programs, eating disorders such as bulimia and anorexia and weight reduction. Prescription medication prescribed by a Provider that are Medically Necessary to treat obesity will be covered under the Outpatient Prescription Drug benefit.
12. Vitamins, food supplements and over the counter medicines.
13. Wellness benefits such as exercise classes, health club membership or smoking cessation products.
14. Diagnostic procedures and treatment related to infertility including, but not limited to, in vitro fertilization, artificial insemination, and use of egg donor or surrogate.
15. Sterilization or sterilization reversal, including surgical procedures and devices.
16. Sexual reassignment surgery and related therapy, whether before or after surgery, including, but not limited to, treatment for gender dysphoria.
17. Body piercing.
18. Treatment of complications of procedures not covered under this Policy.
19. Dental services and devices, including, but not limited to, routine dental services, new, repair or replacement of dentures, bridges, dental implants, dental bands or braces or other dental appliances, crowns, caps, inlays or onlays, fillings or any other treatment of the teeth or gums.
20. Adoption costs.
21. Therapy that exceeds the number of services specified on the Schedule of Benefits for physical therapy, occupational therapy, speech therapy, chiropractic services and psychiatric therapy.
22. As a result of committing or attempting to commit an assault or felony or voluntary participation in a felony, riot, illegal activity, insurrection or civil commotion.
23. Private Duty Nursing or Skilled Nursing Services.

SECTION 9 - CLAIM PROVISIONS

Overview

This is a fixed indemnity product which provides a Benefit Card that integrates with StartHealth Portal. If You need a medical service, You are encouraged to call around to different healthcare providers to ask the cash price for the needed service. In StartHealth app and StartHealth.com, You can search and find the Indemnity Benefit Amounts by simple terms medical terms or CPT codes.

Regardless of what the provider charges, or whether or not You have other insurance coverage, You will always receive the Indemnity Benefit Amount for the service received less any deductibles. If, after meeting any deductibles required, You go to a provider who charges $160 for an office visit and the Indemnity Benefit Amount is $130, You will get $130 and pay $30 out of pocket. If You go to a provider who charges $100 for the checkup, You still receive $130 and get to keep the $30 difference.

The exact Indemnity Benefit Amount under this Policy for Your particular Covered Service is confirmed when You provide a Medical Invoice to Us. However, by using Your Benefit Card, You may receive an Estimated Benefit for a given service before submitting the actual Medical Invoice. In situations where the billed amount is less than $2,000, Your Benefit Card will allow 80% of the billed amount charged to the card as the Estimated Benefit. The other 20% will come from Your attached account that You have chosen. You must still submit the Medical Invoice to Us and then We will adjudicate Your claim and determine the actual Indemnity Benefit Amount for the given service. Following that adjudication, We will notify You whether Your Indemnity Benefit Amount exceeds the Estimated Benefit, in which case We will pay You the difference. Alternatively, if following Our adjudication of the claim, We determine that the Indemnity Benefit Amount is less than the Estimated Benefit, We will notify You that You must reimburse Us the difference.

If You have other insurance coverage, Your coverage and benefits under this Policy do not change. You can submit a Medical Invoice from a provider provided to You to receive the Indemnity Benefit Amount for a Covered Service.

The foregoing is an overview of the plan and its claims process. If You have a question, You can contact StartHealth by calling the toll-free number [800-894-9454].

Notice Of Claim

A written notice of claim must be given to StartHealth within ninety (90) days after a Covered Service, or as soon thereafter as is reasonably possible. Failure to give notice within such time shall not invalidate nor reduce any claim if it shall be shown not to have been reasonably possible to give such notice and was given as soon as was reasonably possible. A notice for each individual claim given by or on behalf of You or Your beneficiary must be given either by: (1) using the Benefit Card; (2) submitting a claim in the Portal; or (3) mailing a written claim to StartHealth with information sufficient to identify You.

(1) If using the Benefit Card, a claim is initiated, and notice of claim is deemed given when an electronic transaction for payment of a Medical Invoice is initiated by using Your Benefit

Card. Upon receipt of a notice of claim using the Benefit Card, StartHealth will verify Your coverage and calculate the Estimated Benefit.

(2) You may initiate a claim through the Portal by uploading a picture of the Medical Invoice, in which event StartHealth will verify Your coverage and calculate Your Indemnity Benefit Amount payable under this Policy.

(3) Alternatively, You may initiate a claim by mailing Us a copy of the Medical Invoice. Upon receipt of the Medical Invoice, StartHealth will verify Your coverage and calculate Your Indemnity Benefit Amount payable under this Policy.

You may elect to initiate and give notice of a claim in a different manner from one claim to the next.

Payment of Claims Timeliness
Benefits payable under this Policy will be paid immediately upon StartHealth's receipt and verification of the Medical Invoice, but in no event more than thirty (30) days from receipt of proof of claim.

Payment of Claims
All benefits payable under this Policy will be paid to You either by: (1) crediting the amount of the benefit payable to Your Benefit Card; or (2) mailing You, Your beneficiary, or Your assignee a paper check in the amount of the benefit payable.

If You provide notice of a claim using the Benefit Card, StartHealth will verify Your coverage and calculate the Estimated Benefit. If the Covered Service occurs either (1) at a Provider's office, Hospital, Outpatient Facility, freestanding emergency facility, Urgent Care Center, or freestanding pharmacy, and the Estimated Benefit is less than $2,000:

A. StartHealth shall credit the full amount of the Estimated Benefit to Your Benefit Card; and

B. If the amount of the Medical Invoice exceeds the Estimated Benefit, the amount equaling the difference between the Estimated Benefit and the Medical Invoice will be transferred from Your Personal Account to Your Benefit Card.

At the time in which the Benefit Card has been credited with the Estimated Benefit and the difference between the Estimated Benefit and the Medical Invoice (if any), then the Benefit Card may be used to pay the Medical Invoice.

If Your Personal Account does not contain funds sufficient to pay the difference between the Estimated Benefit and the Medical Invoice, the charge to Your Benefit Card will be denied in its entirety. In that event, You may identify and authorize a different Personal Account to be used to transfer an amount equal to the difference between the Estimated Benefit and the Medical Invoice so as to have sufficient funds on the Benefit Card to pay the Medical Invoice using Your Benefit Card.

If an Estimated Benefit credited to Your Benefit Card by StartHealth is less than the Indemnity Benefit Amount, We will pay You the remainder of the benefit by crediting Your Benefit Card or by issuing You a paper check in such amount.

If an Estimated Benefit credited to Your Benefit Card by StartHealth is greater than the Indemnity Benefit Amount, You are required to reimburse StartHealth the difference between the Estimated Benefit payment received and the Indemnity Benefit Amount payable under this Policy. You may reimburse StartHealth such difference either by submitting an electronic payment through the Portal, or by mailing a check to StartHealth. If You fail to reimburse StartHealth within thirty (30) days of the date on which StartHealth notifies You of the reimbursement amount through the Portal, Your failure will constitute constructive fraud, and this Policy may be terminated according to the Termination Provisions.

Alternatively, if You provide notice of a claim through the Portal by uploading a picture of the Medical Invoice or by submitting a Medical Invoice by mail to StartHealth, then StartHealth (after verifying Your coverage and calculating the Indemnity Benefit Amount) will give You the option to receive Your Indemnity Benefit Amount either by (1) crediting such amount to Your Benefit Card or (2) issuing You, Your beneficiary, or Your assignee a paper check for such amount.

If at any time You wish to receive the Indemnity Benefit Amount, or any accrued Indemnity Benefit Amounts that have been credited to Your Benefit Card, in the form of a paper check, You may so notify StartHealth using the Portal or by contacting StartHealth at the toll-free number and requesting a paper check. Upon receipt of such notice, StartHealth will pay You the payable amounts by issuing You a paper check in such amounts and deducting such amounts from Your Benefit Card. You may choose to receive Your Indemnity Benefit Amount as a credit to Your Benefit Card for one claim and in the form of a paper check for a different claim.

Appeal Process

When You submit a claim and that claim is denied, we will provide a written statement containing the reasons for the Adverse Benefit Determination. You have the right to request a review of a Company decision or action pertaining to our contractual relationship and to appeal any adverse claim determination we've made by filing an Appeal. These procedures have been developed to ensure a full investigation of an Appeal through a formal process.

Complaints

You, your authorized representative, or a provider acting on your behalf may submit an oral complaint to us within one hundred eighty (180) days after an event that causes a dispute. Calling us allows You to discuss your complaint or concerns and gives us the opportunity to immediately resolve the problem.

If we don't have all the information necessary to review your complaint, we will request any additional information within five (5) business days of receiving your complaint. After we receive all the necessary information, we will provide You, your authorized representative, or a Provider acting on Your behalf with Our written decision within thirty (30) days after receiving the complaint and all necessary information.

If the problem cannot be resolved in this manner, You still have the right to submit a written request for the complaint to be reviewed through the Formal Appeal Procedure, as outlined below.

Formal Appeal Procedure
A formal Appeal may be submitted by You, your authorized representative, or in the event of an Adverse Benefit Determination, by a Provider acting on Your behalf within one hundred eighty (180) days after an event that causes a dispute, or if You have previously submitted an oral complaint through the informal Appeal procedure above, then within sixty (60) days after receiving Our written decision provided through the informal Appeal procedure.

If You file a formal Appeal, You will have the opportunity to submit written comments, documents, records and other information You feel are relevant to the Appeal, regardless of whether those materials were considered in the initial Adverse Benefit Determination.

First Level Review
Within ten (10) working business days after receiving the Appeal, we must acknowledge the Appeal and provide You, Your authorized representative or a Provider with the name, address, and telephone number of the coordinator handling the Appeal and information on how to submit written material. The person(s) who reviews the Appeal will not be the same person(s) who made the initial Adverse Benefit Determination. During the review, all information, documents, and other materials submitted relating to the claim will be considered, regardless of whether they were considered in making the previous claim decision. The Insured will not be allowed to attend, or have a representative attend, a First Level Review. The Insured may, however, submit written material for consideration by the reviewer(s).

When the Appeal is based in whole or in part on a medical judgment, the review will be conducted by, or in consultation with, a medical doctor with appropriate training and expertise to evaluate the matter. Following our review of your Appeal, we must issue a written decision to You within thirty (30) days after receiving the Appeal. The written decision must include:

1. The name(s), title(s) of any person(s) participating in the First Level Review process.
2. A statement of the reviewer's understanding of the Appeal.
3. The specific reason(s) for the reviewer's decision in clear terms and the contractual basis or medical rationale used as the basis for the decision in sufficient detail for the Insured to respond further to Our position.
4. A reference to the evidence or documentation used as the basis for the decision.
5. If the claim denial is based on medical necessity, experimental treatment or similar exclusion, instructions for requesting an explanation of the scientific or clinical rationale used to make the determination.
6. A statement advising You of Your right to request a Second Level Review, if applicable, and a description of the procedure and timeframes for requesting a Second Level Review.

Second Level Review
The Second Level Review process is available if You are not satisfied with the outcome of the First Level Review for an Adverse Benefit Determination. Within ten (10) business days after receiving a request for a Second Level Review, w e will convene a review panel and hold a review

meeting within forty-five (45) days after receiving a request for a Second Level Review. We must issue a written decision to You within ten (10) business days after completing the review meeting. Our internal appeals process will be exhausted upon completion of the Second Level Review.

Expedited Review

You are eligible for an expedited review when the timeframes for an Informal, formal First Level review or Second Level review would reasonably appear to seriously jeopardize your life or health, or your ability to regain maximum function. An expedited review is also available for all Appeals concerning an admission, availability of care, continued stay or healthcare service for a person who has received emergency services, but who has not been discharged from a facility.

A request for an expedited review may be submitted orally or in writing. An expedited review must be evaluated by an appropriate clinical peer. If we don't have the information necessary to decide an appeal, we will send You notification of precisely what is required within one working business day of our receipt of your Appeal. All necessary information, including our decision, will be transmitted by telephone, facsimile, or the most expeditious method available. Provided we have enough information to make a decision, You will be notified of the determination as quickly as the medical condition requires, but in no event more than seventy-two (72) hours after the review has commenced. Written confirmation of our decision will be provided within two (2) working business days of the decision and will contain the same items described in the written decision requirements for First Level Reviews.

If the expedited review does not resolve the situation, You may submit a written Appeal, and it will be treated as a First Level Appeal. We will not provide an expedited review for retrospective reviews of Adverse Benefit Determinations.

Standard Independent External Review

Upon receipt of a request for an Independent External Review, the Commissioner shall send a copy of the request to Us for an eligibility review.

Within five (5) business days following receipt of the copy of the request, We will determine whether:

1) The Policyholder was insured at the time the health care service was requested or provided;
2) If a health care service is the subject of the Adverse Benefit Determination, the health care service is a Covered Charge;
3) The Policyholder has exhausted Our Internal Appeal process; and
4) The Policyholder has provided all the information and forms required to process an Independent Review.

Within one (1) business day after completion of the eligibility review, We will notify the Commissioner and Policyholder in writing whether:

1) The request is complete; and
2) The request is eligible for Independent Review.

If the request:

1) Is not complete, We will inform the Policyholder and Commissioner in writing what information or materials are needed to make the request complete; or
2) Is not eligible for Independent Review, We will:
    a. Inform the Policyholder and Commissioner in writing the reasons for ineligibility;
    b. Inform the Policyholder that the determination may be appealed to the Commissioner; and
    c. The Commissioner may determine that a request is eligible for Independent Review notwithstanding Our initial determination that the request is ineligible and require that the request be referred for Independent Review.

Upon receipt of Our determination that the request is eligible for an Independent Review, the Commissioner will:

1) Assign on a random basis an Independent Review Organization from the list of approved Independent Review Organizations based on the nature of the health care service that is the subject of the review;
2) Notify Us of the assignment and that We shall within five (5) business days provide to the assigned Independent Review Organization the documents and any information considered in making the Adverse Benefit Determination; and
3) Notify the Policyholder that the request has been accepted and that the Policyholder may submit additional information to the Independent Review Organization within five (5) business days of receipt of the Commissioner's notification. The Independent Review Organization shall forward to Us within one (1) business day of receipt any information submitted by the Policyholder.

Within forty-five (45) calendar days after receipt of the request for an Independent Review, the Independent Review Organization shall provide written notice of its decision to uphold or reverse the Adverse Benefit Determination to:

1) The Policyholder;
2) Us; and
3) The Commissioner.

Within one (1) business day of receipt of notice that an Adverse Benefit Determination has been overturned, We will:

1) Approve the coverage that was the subject of the Adverse Benefit Determination; and
2) Process any benefit that is due.

An expedited Independent Review process is available if the Adverse Benefit Determination:

1) Involves a medical condition of the Policyholder which would seriously jeopardize the life or health of the Policyholder or would jeopardize the Insured Person's ability to regain maximum function;
2) In the opinion of the Policyholder’s attending Provider, would subject the Policyholder to severe pain that cannot be adequately managed without the care or treatment that is the subject of the Adverse Benefit Determination; or

3) Concerns an admission, availability of care, continued stay or health care service for which the Insured Person received Emergency Services, but has not been discharged from a facility.

Upon receipt of a request for an expedited Independent Review, the Commissioner will immediately send a copy of the request to Us for an eligibility review.

Immediately upon receipt of the request, We will determine whether:

1) The individual is or was an insured under the Policy at the time the health care service was requested or provided;
2) The health care service that is the subject of the Adverse Benefit Determination is a Covered Charge; and
3) The Policyholder has provided all the information and forms required to process an expedited Independent Review.

We will immediately notify the Commissioner and Policyholder whether:

1) The request is complete; and
2) The request is eligible for an expedited Independent Review.
3) If the request:
   a) Is not complete, We will inform the Policyholder and Commissioner in writing what information or materials are needed to make the request complete; or
   b) Is not eligible for Independent Review, We will:
      i. Inform the Policyholder and Commissioner in writing the reasons for ineligibility; and
      ii. Inform the Policyholder that the determination may be appealed to the Commissioner.

The Commissioner may determine that a request is eligible for an expedited Independent Review notwithstanding Our initial determination that the request is ineligible and shall require that the request be referred for an expedited Independent Review.

Upon receipt of Our determination that the request is eligible for an Independent Review, the Commissioner shall immediately:

1) Assign an Independent Review Organization from the list of approved Independent Review Organizations;
2) Notify Us of the assignment and that We, within one (1) business day provide to the assigned Independent Review Organization all documents and information considered in making the Adverse Benefit Determination; and
3) Notify the Policyholder that the request has been accepted and that the Policyholder may within one (1) business day submit additional information to the Independent Review Organization. The Independent Review Organization shall forward to Us within one (1) business day of receipt any information submitted by the Policyholder.

The Independent Review Organization shall as soon as possible, but no later than seventy-two (72) hours after receipt of the request for an expedited Independent Review, make a decision to uphold or reverse the Adverse Benefit Determination and shall notify:

1) Us;
2) The Policyholder; and
3) The Commissioner.

If notice of the Independent Review Organization's decision is not in writing, the Independent Review Organization shall provide written confirmation of its decision within forty-eight (48) hours after the date of the notification of the decision.

Within one (1) business day of receipt of notice that an Adverse Benefit Determination has been overturned, We will:

1) Approve the coverage that was the subject of the Adverse Benefit Determination; and
2) Process any benefit that is due.

A request for an Independent Review based on experimental or investigational service or treatment shall be submitted with certification from the Policyholder's doctor that:

1) Standard health care service or treatment has not been effective in improving the Policyholder's condition;
2) Standard health care service or treatment is not medically appropriate for the Policyholder; or
3) There is no available standard health care service or treatment covered by Us that is more beneficial than the recommended or requested health care service or treatment.

Upon receipt of a request for an Independent Review involving experimental or investigational service or treatment, the Commissioner shall send a copy of the request to Us for an eligibility review.

Within five (5) business days following receipt of the copy of the request, one (1) business day for an expedited review, We will determine whether:

1) The individual is or was an insured under the Policy at the time the health care service was requested or provided;
2) The health care service or treatment that is the subject of the Adverse Benefit Determination is a Covered Charge except for Our determination that the service or treatment is experimental or investigational for a particular medical condition and is not explicitly listed as an excluded benefit under the Policy;
3) The Policyholder has exhausted Our Internal Appeal process unless the request is for an expedited review; and
4) The Policyholder has provided all the information and forms required to process the Independent Review.

Within one (1) business day after completion of the eligibility review, We will notify the Commissioner and Policyholder in writing whether:

1) The request is complete; and
2) The request is eligible for Independent Review.
3) If the request:
   a) Is not complete, We will shall inform the Policyholder and Commissioner in writing what information or materials are needed to make the request complete; or
   b) Is not eligible for Independent Review, We will:
      i. Inform the Policyholder and Commissioner in writing the reasons for ineligibility; and
      ii. Shall inform the Policyholder that the determination may be appealed to the Commissioner.

The Commissioner may determine that a request is eligible for Independent Review notwithstanding Our initial determination that the request is ineligible and require that the request be referred for Independent Review.

Upon receipt of Our determination that the request is eligible for an Independent Review, the Commissioner shall:

1) Assign an Independent Review Organization from the list of approved Independent Review Organizations;
2) Notify Us of the assignment and that We shall within five (5) business days, one (1) business day for an expedited review, provide to the assigned Independent Review Organization the documents and any information considered in making the Adverse Benefit Determination; and
3) Notify the Policyholder that the request has been accepted and that the Policyholder may within five (5) business days, one (1) business day for an expedited review, submit additional information to the Independent Review Organization. The Independent Review Organization shall forward to Us within one (1) business day of receipt any information submitted by the Policyholder.

Within one (1) business day after receipt of the request, the Independent Review Organization shall select one or more Clinical Reviewers to conduct the review.

The Clinical Reviewer shall provide to the Independent Review Organization a written opinion within twenty (20) calendar days, five (5) calendar days for an expedited review, after being selected.

The Independent Review Organization shall make a decision based on the Clinical Reviewer's opinion within twenty (20) calendar days, forty-eight (48) hours for an expedited review, of receiving the opinion and shall notify:

1) The Policyholder;
2) Us; and
3) The Commissioner.

Within one (1) business day of receipt of notice that an Adverse Benefit Determination has been overturned, We will:

1) Approve the coverage that was the subject of the Adverse Benefit Determination; and
2) Process any benefit that is due.

The following requirements apply in addition to the requirements for a Standard Independent External Review, an expedited Independent Review and an Independent Review of experimental or investigational service or treatment.

1) We will pay the cost of the Independent Review Organization for conducting the Independent Review.
2) An Independent Review is available to the Policyholder regardless of the dollar amount of the claim involved.
3) The Policyholder shall have one hundred eighty (180) calendar days after the receipt of a notice of a Final Adverse Benefit Determination to file a request with the Utah Commissioner of Insurance for an Independent Review.
4) The Policyholder shall use the Independent Review Request Form available on the Commissioner's website at www.insurance.utah.gov, or a substantially similar form, to file the request.
5) A request for an Independent Review sent to Us instead of the Commissioner will be forwarded to the Commissioner by Us within one (1) business day of receipt.
6) The Independent Review decision is binding on Us and the Policyholder except to the extent that other remedies are available under federal or state law.

Complaint Procedure
If You have a complaint, problem, or claim concerning benefits or services, please contact Us by:

1) Sending an email to: [Support@StartHealth.com]
2) Calling Us at Our toll-free number: [800-894-9454]
3) Writing Us at the following address:

StartHealth
Attn: Complaints
[10421 S. Jordan Gateway, Suite 350
South Jordan, Utah 84095]

You may submit Your complaint by letter or by telephone call. If Your complaint involves issues of Covered Services, You may be asked to sign a release of information form so We can request records for Our review.

You will be notified of the resolution of Your complaint if a claim or request for benefits is denied in whole or in part. We will explain why benefits were denied and describe Your rights under the Appeal Procedure.

No Policyholder who exercises the right to file an appeal shall be subject to disenrollment or otherwise penalized due to the filing of an appeal and shall not inhibit/hamper the claims process.

Physical Examination And Autopsy

The Company at its own expense has the right to have a Provider examine You when and as often as it deems reasonably necessary while there is a claim pending under this Policy and to make an autopsy in case of death where it is not forbidden by law.

Legal Actions
No action at law or in equity shall be brought to recover on this Policy within sixty (60) days after written proof of loss has been furnished in accordance with the requirements of this Policy. No such action shall be brought after the expiration of three (3) years from the time that proof of loss was required to be furnished.

SECTION 10 – GENERAL PROVISIONS

Entire Contract

This Policy, the application for such Policy, and any attached papers make up the entire contract between You and the Company.

No change in this Policy shall be valid unless approved by an officer of the Company. The approval must be noted on or attached to this Policy. No agent has authority to change this Policy or to waive any of its provisions.

No change will be made during the term of the Policy unless the change is in writing and agreed upon by all parties impacted by the modification.

Renewable

This Policy is renewable. After this Policy terminates, the Policyholder may apply for a renewal policy, subject to the Company's underwriting and premium rates then in effect.

Recovery Of Overpayment

If benefits are overpaid or paid in error, We have the right to recover the amount overpaid or paid in error by any of the following methods:

1) A request for lump sum payment of the amount overpaid or paid in error; or
2) Reduction of any proceeds payable under this Policy by the amount overpaid or paid in error.

Assignment Of Ownership Or Rights

This Policy is non-assignable. You may not assign any of Your ownership rights or privileges under this Policy.

Assignment Of Benefits

You may assign Your benefit payments under this Policy. By using Your Benefit Card to pay for healthcare services, You are deemed to have affirmatively assigned Your benefits under this Policy to such Provider or other healthcare provider. The Company is not responsible for the

validity of assignments. The assignee only takes such rights as the assignor possessed, and such rights are subject to state and federal laws and the terms of this Policy.

Misstatement Of Age

If premiums for You are based on age and You have misstated Your age, there will be a fair adjustment of premiums based on Your true age. If the benefits for which You are insured are based on age and You have misstated Your age, there will be an adjustment of said benefit based on Your true age. The Company may require satisfactory proof of age before paying any claim. Misstatements of Age may lead to cancellation or revocation of the Policy at Company's sole discretion.

Misstatement Of Health or Condition

Your premium is based on Your response to the health questions asked on Your application. If You have intentionally or unintentionally misstated Your answers to those health questions, this policy may be rescinded effective to the original effective date.

At the option of the Company, if the Company determines that a Policy would not have been issued to You had Your answers to the health questions been stated correctly, the Company can deny any claim for that condition due to Your misstated answers for that condition.

Conformity Of Law

Any provision of this Policy which, on its effective date, conflicts with the statutes of the state in which it was issued is hereby amended to conform to the minimum requirements of such statutes.

Clerical Error

Clerical errors, whether by You or the Company, will not void Your insurance if that insurance would otherwise have been in effect nor extend Your insurance if that insurance would otherwise have ended or been reduced as provided in this Policy.

Portal

For so long as this Policy remains in effect, You may access information about this Policy, including the Indemnity Benefit Amount for any Covered Service, through StartHealth, at [www.StartHealth.com] or through the StartHealth App or via the toll-free number, [800-894-9454]. StartHealth also provides access to navigational tools offering information about healthcare providers and costs, as described more fully from time to time on StartHealth.com or through the StartHealth App. You are encouraged to review benefits, either through StartHealth.com, app, or phone, prior to receiving a Covered Service. Through StartHealth.com or the StartHealth App, You can search and download forms You may wish to use to submit claims under this Policy and/or to withdraw Your consent to electronic communication. You may also contact StartHealth via the toll-free number, [800-894-9454], to request the same.

The Portal is not a part of the Policy and therefore, if there is any conflict in language between the Policy and the Portal, the Policy language will control.

Privacy

The Company values your business and your trust. In order to administer insurance policies and provide you with effective customer service, we must collect certain information about our customers. We want You to know that we are committed to protecting your private information, and we will comply with all federal and state privacy laws. Below is a Privacy Notice describing our policy regarding the collection and disclosure of personal information. Please review this Notice and keep a copy of it with your records.

Your Privacy Is Our Concern

When You apply to The Company for insurance or make a claim against a policy written by The Company, You disclose information about yourself to Us. There are legal requirements governing the collection, use, and disclosure of such information. The Company maintains physical, electronic, and procedural safeguards that comply with state and federal regulations to guard your personal information. We also limit employee access to personally identifiable information to those with a business reason for knowing such information. The Company instructs Our employees as to the importance of the confidentiality of personal information and takes measures to enforce employee privacy responsibilities.

What Kind Of Information Do We Collect About You And From Whom?

We obtain most of our information from You. The application or claim form You complete, as well as any additional information You provide, generally gives us most of the information we need to know. Sometimes we may contact You by phone or mail to obtain additional information. We may use information about You from other transactions with us, our affiliates, or others. Depending on the nature of your insurance transaction, we may need additional information about You or other individuals proposed for coverage. We may obtain the additional information we need from third parties, such as other insurance companies or agents, government agencies, medical personnel, the state motor vehicle department, information clearinghouses, credit reporting agencies, courts, or public records. A report from a consumer reporting agency may contain information as to creditworthiness, credit standing, credit capacity, character, general reputation, hobbies, occupation, personal characteristics, or mode of living.

What Do We Do With The Information We Collect About You?

If coverage is declined or the charge for coverage is increased because of information contained in a consumer report we obtained, we will inform You, as required by state law or the federal Fair Credit Reporting Act. We will also give You the name and address of the consumer reporting agency making the report. We may retain information about our former customers and may disclose that information to affiliates and non-affiliates only as described in this notice.

To Whom Do We Disclose Information About You?

We may disclose all the information that we collect about You, as described above. We may disclose such information about You to our affiliated companies, such as:

1) Insurance companies;

2) Insurance agencies;
3) Third party administrators;
4) Medical bill review companies; and
5) Reinsurance companies.

We may also disclose nonpublic personal information about You to affiliated and nonaffiliated third parties as permitted by law. You have a right to access and correct the personal information we collect, maintain, and disclose about You.

How To Contact Us?

You may obtain a more detailed description of the information practices prescribed by law by contacting us at the address below. Remember to include your name, address, policy number, and daytime phone number.

StartHealth
[10421 S. Jordan Gateway, Suite 350
South Jordan, UT 84095]

NOTICE OF PROTECTION PROVIDED BY THE UTAH LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION

This disclaimer provides a brief summary of the Utah Life and Health Insurance Guaranty Association (Association) and the protection it provides for policyholders. The safety net was created under Utah law, which determines who and what is covered and the amounts of coverage.

The Association was established to provide protection in the unlikely event that your life, annuity, or health insurance company becomes financially unable to meet its obligations and is taken over by the Utah Department of Insurance. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with Utah law, with the funding from assessments paid by other insurance companies. (For the purposes of this notice, the terms "insurance company" and "insurer" include health maintenance organizations (HMOs) and limited health plans.)

The basic protections provided by the Association are:

1. Life Insurance
    a. $500,000 in death benefits
    b. $200,000 in cash surrender or withdrawal values
2. Accident and Health Insurance
    a. $500,000 for health benefit plans
    b. $500,000 in disability income insurance benefits
    c. $500,000 in long-term care insurance benefits
    d. $500,000 in other types of health insurance benefits

3. Annuities

    a. $250,000 in the present value of annuity benefits in aggregate, including any net cash surrender and net cash withdrawal values

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is $500,000. Special rules may apply with regard to health benefit plans.

Note: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion(s) of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. There are also various residency requirements and other limitations under Utah law.

Benefits provided by a long-term care rider to a life insurance policy or annuity contract shall be considered the same type of benefit as the base life insurance policy or annuity contract to which it relates.

To learn more about the above protections, please visit the Association's at www.ulhiga.org, or contact:

Utah Life & Health Insurance Guaranty Association
466 South 500 East,
Suite 100
Salt Lake City, UT 84102

Utah Insurance Department
4315 S 2700 W
Suite 2300
Taylorsville, UT 84129