



ATLAS

DIRECT

# Hospital Fixed-Indemnity Insurance

This product provides limited benefits.



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THE ATLAS DIRECT<sup>SM</sup> INSURANCE PRODUCT OFFERS SUPPLEMENTAL INSURANCE COVERAGE AND IS NOT A SUBSTITUTE FOR THE MINIMUM ESSENTIAL COVERAGE REQUIRED BY THE AFFORDABLE CARE ACT (ACA). LACK OF MAJOR MEDICAL COVERAGE (OR OTHER MINIMUM ESSENTIAL COVERAGE) MAY RESULT IN AN ADDITIONAL PAYMENT WITH YOUR TAXES.

This product provides benefits in a stated amount regardless of the actual expenses incurred. It is underwritten by Pan-American Life Insurance Company, 601 Poydras Street, New Orleans, LA 70130 under policy form G-NHI23-P and other state variations. Coverage is not available in all states and the product has exclusions and limitations.

Membership in the Direct Care Foundation is required for eligibility and underwriting approval is required to purchase coverage. Refer to the policy and certificate of coverage for complete terms and conditions.

This product is marketed and sold by Atlas Direct Agency LLC (ADA), 95 Broken Rock Drive, Henderson, NV 89074. ADA is a licensed insurance agency (Nevada #4005774) appointed by Pan-American Life Insurance Company to sell this product.

Have questions? Contact ADA at 316-234-1309 or [hello@atlas.direct](mailto:hello@atlas.direct).

## Fixed Indemnity Plan Benefits Underwritten by Pan-American Life Insurance Company

### Federal Disclosure

#### **IMPORTANT: This is a fixed indemnity policy, NOT health insurance**

This fixed indemnity policy may pay you a limited dollar amount if you're sick or hospitalized. You're still responsible for paying the cost of your care.

- The payment you get isn't based on the size of your medical bill.
- There might be a limit on how much this policy will pay each year.
- This policy isn't a substitute for comprehensive health insurance.
- Since this policy isn't health insurance, it doesn't have to include most Federal consumer protections that apply to health insurance.

#### **Looking for comprehensive health insurance?**

- Visit [HealthCare.gov](https://www.healthcare.gov) or call **1-800-318-2596 (TTY: 1-855-889-4325)** to find health coverage options.
- To find out if you can get health insurance through your job, or a family member's job, contact the employer.

#### **Questions about this policy?**

- For questions or complaints about this policy, contact your State Department of Insurance. Find their number on the National Association of Insurance Commissioners' website ([naic.org](https://www.naic.org)) under "Insurance Departments."
- If you have this policy through your job, or a family member's job, contact the employer.

Pan-American Accident & Health is the division for accident and health plans that Pan-American Life Insurance Company (PALIC) provides in the U.S.



The Atlas Direct DPC Program, or simply *Atlas Direct*, enhances people’s relationship with their Direct Primary Care provider by bringing together membership in the Direct Care Foundation with access to a fixed-indemnity insurance product **designed specifically for Direct Primary Care patients.**

That insurance product pays cash benefits for eligible medical services in key healthcare areas. The benefits get paid directly to you and you can use those benefits for any purpose—including to help ease the out-of-pocket costs that major-medical insurance may not cover. **There’s no deductible, copays, or coinsurance!**

## Insurance for “What ifs”

HOSPITAL | SURGICAL | EMERGENCY

We all worry about life’s “What ifs”, like “What if I get sick or hurt?”

While it can’t help with the worries, Atlas Direct’s insurance product *can* help with medical costs. Coverage includes hospital and emergency room benefits in addition to maternity and surgical benefits to help with out-of-pocket expenses from things like hospital stays, baby deliveries, and surgeries.

**Atlas Direct is designed to make healthcare more accessible and more affordable.**

Here’s a situation in which Atlas Direct can benefit you.



### **Trouble strikes.**

You suddenly experience a sharp pain in your side and call your Direct Primary Care physician, who diagnoses you with acute appendicitis.



### **You find yourself in the ER.**

You’re taken by ambulance to the emergency room, where lab tests and diagnostic exams report back that you need surgery right away.



### **Your Atlas Direct insurance coverage helps take out the sting.**

After an overnight stay in the hospital, you’re feeling much better. But hospital bills add up quickly. Cash benefits are paid directly to you, which can help ease the financial stress of your illness.

Atlas Direct’s insurance component pays benefits at set dollar amounts that do not vary based on the actual incurred cost of covered medical services.

**This resource is for informational purposes only, and is current as of the date of publication. This information is not a guarantee of rates, coverage, or benefit levels. This resource does not waive, alter, or modify any provision of the insurance policy issued by Pan-American Life Insurance Company. In the event of a conflict between this guidance and the terms and conditions of the policy, the terms of the policy shall govern.**



# Overview of Coverage and Key Features

Atlas Direct's insurance coverage was designed to work in combination with Direct Primary Care (DPC).

## Covered Services

Our insurance product covers only a limited set of medical services. Those services were chosen on the basis of two primary criteria: They should be things that Direct Primary Care physicians can't provide in their own offices and they should be things that most people consider to be catastrophic medical or financial events.

- Hospital admissions
- Hospital stays
- Emergency room visits
- Skilled nursing
- Ambulance transportation
- Cancer treatments
- Childbirth
- Hospice care
- Up to 439 surgical and diagnostic procedures

Our insurance product, or plan, also includes a \$100,000 per calendar year maximum per covered person.

## Limited Benefits

It is important to emphasize that our insurance plan was intentionally designed to cover a limited set of benefits and that it is *not* a comprehensive major medical plan. Anyone seeking comprehensive health insurance should consult with a licensed insurance agent or visit their state's health insurance marketplace for comprehensive coverage options.

## Cost

Our plan costs substantially less than comprehensive major medical plans but only because it excludes many medical services and products, including infertility treatments, cosmetic surgeries, and substance abuse treatments. We also exclude prescription drugs, basic imaging procedures, and lab work since a large fraction of DPC patients can already access those items at wholesale prices through their Direct Primary Care physicians.

## Maternity Benefits

Our plan provides two maternity benefits: \$5,000 for a vaginal delivery and \$8,000 for a caesarean delivery. These benefits are payable for deliveries with an overnight stay in a hospital or birthing center. Newborns are automatically covered under the plan for their first 31 days at no cost. To continue their coverage beyond 31 days you must add them as a dependent and pay the applicable premium. Please note that the hospital admissions benefit does not apply to maternity stays, and the hospital confinement benefit is only available if your stay exceeds two days for a vaginal delivery or three days for a caesarean delivery.

## Payment Structure

Our insurance product is fixed-indemnity insurance, which means that it pays predetermined, fixed amounts directly to you, the insured, for covered medical services. This is different from major medical plans, which pay variable benefit amounts directly to healthcare providers. Please note that the fixed benefit amounts paid by our plan may not always cover the full cost of a medical service. You are responsible in all cases for paying the provider for the cost of your care and our insurance carrier has no legal responsibility other than to pay you the fixed amounts specified in the Schedule of Benefits.

## No Deductibles or Copays

Like all fixed-indemnity health insurance policies, Atlas Direct has zero deductibles and zero copays since it automatically pays out the full amount listed for each covered service just as long as you have not exceeded any of the policy's benefit limits, including the \$100,000 per calendar year maximum per covered person.

## No Networks

You will *not* have to worry about being "inside or outside a network" because our insurance product will pay out exactly the same amount no matter where you receive a covered treatment or procedure.

## Enroll Any Time

You can enroll instantly, 365 days a year. No waiting for open enrollment periods—just sign up when you're ready.

## Coordination with Other Insurance

Our insurance product is legally classified as a non-coordinated benefit, which means that it pays claims independently and in full, regardless of any other health insurance you may have. Consequently, our coverage will pay the full amount for any covered event, irrespective of what any other insurance plan may decide to pay for the same event.

## Under 65 Only

One last thing should be noted. Our plan is only available to individuals under the age of 65 and cannot be used to replace or supplement Medicare coverage. In particular, our plan is not a Medicare Advantage plan



# Our Schedule of Benefits

<b>Critical Medical Services</b> (PER PERSON)	<b>We Pay</b>
<b>Inpatient Hospital Confinement, Illness/Injury</b> (maximum per calendar year)	<b>\$3,700 per day</b> (26 days)
<b>Intensive Care Unit</b> (maximum per calendar year)	<b>\$5,200 per day</b> (18 days)
<b>Hospital Admission Benefit — First Inpatient Day</b> (maximum admissions per calendar year)	<b>\$1,500 per admission</b> (2 admissions)
<b>Emergency Room</b> (maximum per calendar year)	<b>\$1,500 per day</b> (1 day)
<b>Ground/Water Ambulance</b> (maximum per calendar year)	<b>\$1,500 per day</b> (1 day)
<b>Air Ambulance</b> (maximum per calendar year)	<b>\$5,000 per day</b> (1 day)
<b>Medical Procedures Benefit</b> (PER PERSON)	<b>We Pay</b>
<b>Up to 439 Surgical and Diagnostic Procedures</b> (See next page for details.) (maximum per calendar year)	<b>30 Tiers ranging from \$1,500 to \$30,500 per day</b> (10 procedure days per year)
<b>Maternity Benefits</b> (PER PERSON)	<b>We Pay</b>
<b>Vaginal Delivery</b> (maximum per calendar year)	<b>\$5,000 per delivery</b> (1 delivery)
<b>Caesarean Delivery</b> (maximum per calendar year)	<b>\$8,000 per delivery</b> (1 delivery)
<b>Additional Benefits</b> (PER PERSON)	<b>We Pay</b>
<b>Skilled Nursing Facility, After Hospital Confinement of 3+ Days</b> (maximum per calendar year)	<b>\$300 per day</b> (30 days)
<b>Outpatient Radiation or Chemotherapy</b> (maximum per calendar year)	<b>\$750 per day</b> (40 days)
<b>Hospice Care</b> (maximum per calendar year)	<b>\$300 per day</b> (60 days)

**\$100,000 per calendar year maximum per covered person.**



# Our Surgical and Diagnostic Benefits

Atlas Direct’s insurance plan includes a Medical Procedures Benefit that covers up to 439 different surgical and diagnostic procedures, depending on the state. The procedures are defined by their respective Current Procedural Terminology (CPT) codes. Each procedure has its own cash-payment amount, with the payment amounts organized into 30 different “tiers” ranging from \$1,500 to \$30,500.

The payment amount for the matching tier will be paid each day a covered person receives a covered Medical Procedure.

If multiple covered procedures are performed in a single day, we will pay one amount for the highest-tier procedure.

Limit of 10 days of medical procedures per year. CPT codes are given in parentheses.

Tier	Payment Amount	Examples of Covered Procedures
1	\$1,500	Liver Biopsy (47000), Cervical Myelogram (62302), Skin Cancer Removal (11602), Trabeculectomy for Glaucoma (65855)
2	\$2,500	Percutaneous Renal Biopsy (50200), Carpal Tunnel Surgery (29848), Brain PET Scan (78608)
3	\$3,500	Strabismus Correction (67311), Hemorrhoidopexy (46947), Insertion of Intraocular Lens (66985)
4	\$4,500	Shoulder Arthroscopy (29821), Laryngoscopy (31510), Appendectomy (44950), Cardiac Angiography (93454)
5	\$5,500	Knee Arthroscopy (29883), Umbilical Hernia Repair (49580), Tubal Ligation (58600)
6	\$6,500	Removal of Tonsils and Adenoids (42820), Diagnostic Elbow Arthroscopy (29830), Canaloplasty (66174)
7	\$7,500	Thyroidectomy (60220), Stapedectomy (69660), Unilateral Partial Mastectomy (19301), Ankle Arthroplasty (29892)
8	\$8,500	Sling Incontinence Surgery (57240), Lymphadenectomy (38740), Anterior Cruciate Ligament (29888)
9	\$9,500	Epigastric Hernia Repair (49570), Laparoscopic Colostomy (44188), Complete Cervical Lymphadenectomy (38720)
10	\$10,500	Bilateral Partial Mastectomy (19301-50), Laparoscopic Cholecystenterostomy (47570), Clavicle Osteoplasty (23485)
11	\$11,500	Open Adrenalectomy (60540), Open Fibroid Tumor Removal (58140), Laparoscopic Supracervical Hysterectomy (58543)
12	\$12,500	Posterior Cruciate Ligament (29889), Post-Mastectomy Breast Implant (19342), Partial Colectomy (44160)
13	\$13,500	Splenectomy (38100), Colpopexy (57280), Laparoscopic Repair of Paraesophageal Hernia (43281)
14	\$14,500	Osteoplasty to Length Radius and Ulna (25393), Stomach Tumor Removal (43610), Salpingectomy (58700)Salpingectomy



# Our Surgical and Diagnostic Benefits

<b>Tier</b>	<b>Payment Amount</b>	<b>Examples of Covered Procedures</b>
15	\$15,500	Ruptured Spleen Repair (38115), Total Hip Arthroplasty (27130), Freeing of Bowel Adhesion (44005)
16	\$16,500	Bilateral Complete Mastectomy (19303-50), Total Colectomy with Proctectomy (44156)
17	\$17,500	Laparoscopic Partial Nephrectomy (50543), Laparoscopic Radical Hysterectomy (58548)
18	\$18,500	Total Knee Arthroplasty (27447), Laparoscopic Total Prostatectomy (55866)
19	\$19,500	Laparoscopic Radical Nephrectomy (50545), Total Colectomy with Proctectomy (44158)
20	\$20,500	Ectopic Pregnancy Surgery (59120), Laparoscopic Closure of Enterostomy (44227)
21	\$21,500	Cardiac Ablation for Supraventricular Tachycardia (93653)
22	\$22,500	Removal of Kidney and Ureter (50236), Laparoscopic Partial Prostatectomy (55867)
23	\$23,500	Revision of Total Hip Replacement (27137)
24	\$24,500	Revision of Shoulder Replacement (23473)
25	\$25,500	Laparoscopic Total Colectomy with Proctectomy and Ileostomy (44211)
26	\$26,500	Partial Lung Removal (32484)
27	\$27,500	Transcatheter Closure of Congenital Atrial Septal Birth Defect (93580)
28	\$28,500	Transcatheter Closure of Congenital Ventricular Septal Birth Defect (93581)
29	\$29,500	Lung Lobectomy (32480)
30	\$30,500	Lung Bilobectomy (32482), Insertion of Brain-Cavity Shunt (62220)



## Other Policy Details

This is only a general outline of the basic policy provisions and exclusions. State-specific differences may apply. It is not an insurance contract, nor part of the insurance policy. You will find complete details in the policy and associated certificate of coverage.

### Exclusions and/or Limitations

Benefits are not payable with respect to any charge, service or event excluded as set forth below:

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Charges for medical or dental services of any kind, or any medical supplies or visual aids or hearing aids, or any food, supplement or vitamin, or medicine, it being understood that the Policy shall pay the Indemnity Benefits set forth in the Schedule of Benefits for a hospitalization or other covered event, without regard to the actual charges made by a provider or supplier of goods or services.

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Any claim relating to a hospitalization or other covered event where the hospitalization or other covered event was prior to the Effective Date of coverage under the Policy, or after coverage is terminated.

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Suicide, attempted suicide or any self-inflicted injury, while sane or insane.

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A claim arising out of declared or undeclared war or acts thereof.

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A claim arising out of an Illness or Injury occurring while serving on full time active duty in any Armed Forces of any country or international authority (any premium paid will be returned by us pro rata for any period of active full-time duty).

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A claim related to bodily injuries received while the Covered Person was operating any motorized vehicle under the influence of alcohol as evidenced by a blood alcohol level in excess of the state legal intoxication limit.

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Voluntary intoxication (as defined by the law of the jurisdiction in which such intoxication occurred) or while under the influence of any narcotic, drug or controlled substance, unless administered by or taken according to the instructions of a Physician or Medical Professional.

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A claim arising out of participation in an insurrection or rebellion, participation in a riot, commission of or attempting to commit an assault, battery, felony, or act of aggression.

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Experimental or Investigational procedures, drugs or treatment methods.

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Experimental or Investigational organ transplant procedures.

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A claim or any treatment, services or supplies received from a Physician or other provider if such person is: (a) a person who ordinarily resides in Your household, (b) is a Family Member.

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Any treatment, service or supply which is not Medically Necessary.

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A claim arising from medical services provided to the Covered Person for cosmetic purposes or to improve the self-perception of a person as to his or her appearance, except for: reconstructive plastic surgery following an Accident in order to restore a normal bodily function, or a surgery to improve functional impairment by anatomic alteration made necessary as a result of a birth defect, or breast reconstruction following a mastectomy.

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A claim or any treatment for an illness or injury for which treatment, services or supplies were received or purchased outside the United States, unless said treatment, services or supplies were received or purchased (a) as the result of an Illness or Injury incurred while the Covered Person was traveling abroad on a temporary basis for leisure or business and (b) said Illness or Injury was acute and in need of immediate medical attention that could not be delayed until after returning to the United States.

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A claim or any treatment for the pregnancy of a Dependent Child, unless required by law.

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# Other Policy Details

## Exclusions and/or Limitations Continued

A claim or any treatment for voluntary abortion, except if the life of the mother would be in danger if the fetus were carried to term.

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A claim or any treatment, services or supplies for which no charge is made or for which the Covered Person is not required to pay.

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A claim or any treatment, services or supplies related to: (a) the teeth; and (b) the gums other than tumors; and (c) any other associated structures; (d) the prevention or correction of teeth irregularities and malocclusion of jaws by wire appliances, braces or other mechanical aids; and (e) dental implants, regardless of the cause.

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A claim or any treatment for routine eye exams, glasses, visual therapy, or contact lenses.

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Unless otherwise stated in the Policy or Schedule of Benefits, a claim related to any Outpatient Prescription Drug.

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Any claim arising out of a surgical procedure for the treatment of obesity or the purpose of facilitating weight reduction.

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Any claim related to outpatient therapy or treatment unless otherwise covered under this Policy.

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A claim related to custodial care.

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A claim related to an Injury or Illness arising out of or in the course of work for wage or profit.

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A claim related an Injury or Illness which is covered by any Worker's Compensation Act, Occupational Disease Law or similar law.

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Any claim arising out of treatment of infertility.

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Any claim related to homeopathic treatments or drugs.

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Routine hearing exams to assess the need for, or change to, hearing aids; and the purchase, fittings or adjustments of hearing aids.

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A claim arising from services in the nature of educational or vocational testing or training.

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Any claim or treatment, services or supplies to eliminate or reduce a dependency on or an addiction to tobacco, including nicotine withdrawal programs; nicotine products, such as transdermal patches and gums; hypnotism; and goal oriented behavioral modification.

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Meridian therapy (acupuncture) unless otherwise covered under the Policy.

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Spinal manipulation unless otherwise covered under the Policy.

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Mountaineering using ropes and/or other equipment, parachuting, hang gliding, racing any type of vehicle in an organized or unorganized event, sky diving, scuba diving below 130 feet, motorized racing, parasailing, hang gliding, experimental aviation, ultra-light flying, base jumping, bungee jumping, heli-skiing or heli-snowboarding, rodeo, or private aviation.

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This insurance does not apply to the extent that trade or economic sanctions or other laws or regulations prohibit us from providing insurance, including, but not limited to, the payment of claims.

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# Other Policy Details

## Exclusions and/or Limitations Continued

### Eligibility

At time of application, the primary insured and spouse (as defined by state) must be between 18-64 years of age (drop off on 65th birthday) and eligible children 0-25 years of age (drop off on 26th birthday) or as required by state.

### Misstatement of Age

If the covered person's age has been misstated on the covered person's application for coverage under the policy, any future premiums may be adjusted and past premiums may be refunded or owed to us based on the correct age. If a covered person's age has been misstated and we would not have issued coverage for that covered person, we will refund the premium paid minus any benefit amounts paid by us, and coverage would be void from the effective date.

### Notice of Claim

We must receive notice of claim within 20 days of the date the loss began or as soon as reasonably possible.

### Premium

Premium rates are subject to change and are based on attained age (age at last birthday.) The age and gender of a covered person and type and level of coverage are some factors that could be used to determine your premium rate. We will make no change in your premium solely because of claims made by a covered person under the policy or a change in a covered person's health. Premium rates will increase as covered persons move into higher age bands, with each higher age band having higher rates. For example, a covered male aged 25-29 will have a higher premium than a male aged 20-24. Consequently, a covered male who turns 25 will be charged the higher premium that applies to males 25-29 at his next annual policy renewal.

### Preexisting Conditions

We will not pay benefits for a claim filed by a covered person under this policy for an illness or injury that occurs in the first 12 months following that covered person's effective date if the claim is caused by, contributed to by, or resulting from a pre-existing condition or complications arising from treatment or medications taken for a pre-existing condition.

"Preexisting condition" means an illness or injury for which, during the 12 months immediately preceding the covered person's effective date: treatment was received or recommended by a doctor; prescription drugs or over the counter medications were taken; or an ordinarily prudent person would have sought medical care, advice, diagnosis, treatment, or consultation from a doctor.

### Termination of Coverage

The primary insured's coverage will end on the earlier of the following dates: the date the policy terminates; the date the primary insured is no longer a member of the Direct Care Foundation; the date the primary insured fails to pay the required premium, subject to the grace period provision; the last day of the month of the primary insured's 65th birthday; the date the primary insured notifies the us in writing to discontinue his or her coverage; the date the primary insured dies; the date the primary insured enters full-time active duty in the armed forces of any country or international authority.

A dependent's coverage, if included, will end on the earlier of the following dates: the date the primary insured's coverage under the policy ends; the date the person ceases to qualify as a dependent; the date the primary insured fails to pay the required premium, subject to the grace period provision; the last day of the month of the dependent's 65th birthday; the date dependent coverage is no longer provided under the policy; the date the primary insured notifies us in writing to discontinue his or her dependent coverage; or the date the policy terminates.

### Payment of Benefits

Benefits will be paid directly to: the covered person; or the covered person's beneficiary, or his or her estate if there is no such designation, in the event of his death; or the covered person's guardian if he or she is not legally able to accept it.

### Underwriting

Insurance plans are subject to health underwriting. If you provide incorrect or incomplete information on your application for insurance your coverage may be voided or claims denied.

### Benefit Waiting Periods

Atlas Direct's insurance plan has four benefit waiting periods, which are the periods of time after a covered person's effective date (i.e., their coverage starting date) that no benefits will be paid:

**Illnesses:** 30 Days

**Medical Procedures:** 30 Days

**Vaginal Deliveries:** 12 Months

**Caesarean Deliveries:** 12 Months



# NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

## **MEDICAL INFORMATION PRIVACY NOTICE (Effective January 1, 2024)**

Atlas Direct Agency LLC is required by law to protect the privacy of your health information. We are also required to send you this notice, which explains how we may use and disclose your health information, where “disclose” means the sharing, release, transfer, giving away or other communication of your health information. We are also required to send you this notice, which explains how we may use and disclose your health information and our obligations regarding the terms of this notice.

The terms “information” or “health information” in this notice include any information we maintain that reasonably can be used to identify you and that relates to your physical or mental health condition, the provision of health care to you, or the payment for such health care. We will abide by the privacy practices and policies set forth in this notice and notify you in the event of a breach of your unsecured health information.

We have the right to change our privacy practices and the terms of this notice. If we make a material change to our privacy practices, we will provide to you in our next annual distribution, either a revised notice or information about the material change or how to obtain a revised notice. We will provide this information either by direct mail or electronically in accordance with applicable law. In all cases, we will post the revised notice on our websites, such as [palig.com](http://palig.com) and [atlas.direct](http://atlas.direct). We reserve the right to make any revised or changed notice effective for information we already have and for information that we receive in the future.

We collect and maintain oral, written and electronic information to administer our business and to provide products, services and information of importance to our customers. We maintain physical, electronic and procedural security safeguards in the handling and maintenance of our enrollees’ information, in accordance with applicable state and Federal standards, to protect against risks such as loss, destruction or misuse.

How We Use or Disclose Information. We must use and disclose your health information to provide information:

- To you or someone who has the legal right to act for you (your personal representative)
- To order to administer your rights as described in this notice; and
- In the Secretary of the Department of Health and Human Services, if necessary, to make sure your privacy is protected.

We have the right to use and disclose health information for your treatment, to pay for your health care and to operate our business. We may use or disclose your health information:

- For Payment of premiums due us, to determine your coverage and to process claims for health care services you receive.
- For Treatment. We may use or disclose health information to aid in your treatment or the coordination of your care. For example, we may disclose information to your physicians or hospitals to help them provide medical care to you.



# NOTICE OF PRIVACY PRACTICES

- For Health Care Operations. We may use or disclose health information as necessary to operate and manage our business activities related to providing and managing your health care coverage. For example, we might conduct or arrange for medical review, legal services, and auditing functions, including fraud and abuse detection or compliance programs. We may also de-identify health information in accordance with applicable laws. After that information is de-identified, the information is no longer subject to this notice and we may use the information for any lawful purpose.
- To Provide Information on Health Related Programs or Products such as alternative medical treatments and programs or about health-related products and services.
- To Plan Sponsors. If your coverage is through an employer group health plan, we may share summary health information and enrollment and disenrollment information with the plan sponsor. In addition, we may share other health information with the plan sponsor for plan administration if the plan sponsor agrees to special restrictions on its use and disclosure of the information in accordance with Federal law.
- For Underwriting Purposes. We may use or disclose your health information for underwriting purposes; however, we will not use or disclose your genetic information for such purposes.
- For Reminders. We may use or disclose health information to contact you for appointment reminders with providers who provide medical care to you.

We may use or disclose your health information for the following purposes under limited circumstances:

- As Required by Law. We may disclose information when required to do so by law.
- To Persons Involved With Your Care. We may use or disclose your health information to a person involved in your care, such as a family member, when you are incapacitated or in an emergency, or when you agree or fail to object when given the opportunity. If you are unavailable or unable to object we will use our best judgment to decide if the disclosure is in your best interests. Special rules apply regarding when we may disclose health information to family members and others involved in a deceased individual's care. We may disclose health information to any persons involved, prior to the death, in the care or payment for care of a deceased individual, unless we are aware that doing so would be inconsistent with a preference previously expressed by the deceased.
- For Public Health Activities such as reporting disease outbreaks to a public health authority.
- For Reporting Victims of Abuse, Neglect or Domestic Violence to government authorities, including a social service or protective service agency.
- For Health Oversight Activities such as licensure, governmental audits and fraud and abuse investigations.
- For Judicial or Administrative Proceedings such as in response to a court order or subpoena.
- For Law Enforcement Purposes such as providing limited information to locate a missing person or report a crime.
- To Avoid Serious Threat to Health or Safety by, for example, disclosing information to public health agencies or law enforcement authorities, in the event of an emergency or natural disaster.

Products are underwritten by Pan-American Life Insurance Company and administered by Administrative Concepts Incorporated.

Pan-American Life Insurance Company and the Direct Care Foundation are not affiliated.