Connect Plus

Short-term medical insurance with a limited benefit for certain pre-existing conditions. Providing peace of mind during times of transition.

THE IHC GROUP

When circumstances leave you temporarily uninsured, short-term medical insurance helps protect you during coverage gaps.

Connect Plus is a short-term medical (STM) insurance policy with a limited benefit for pre-existing conditions. STM, sometimes called short-term medical limited duration insurance, is designed to provide coverage during transitions or gaps in major medical coverage. Most STM plans do not cover healthcare expenses for pre-existing medical conditions. Connect Plus provides a benefit up to a maximum of $25,000 for eligible pre-existing healthcare expenses.

Why STM insurance?

STM plans provide insurance coverage during life transitions. When you are between group insurance or individual major medical policies, STM plans pay for covered medical expenses due to unexpected illnesses or injuries. Covered expenses include diagnostic physician visits, emergency room treatment, hospital stays, surgery, intensive care and more, but do not include maternity care or outpatient prescription drugs.

- **Affordable**

  STM plans are affordable. While STM contains limitations when compared to traditional major medical plans, the premium is generally lower.

- **Customizable**

  Select from various benefit levels which best meet your insurance and premium needs. You can also include other coverage such as dental insurance or a discount prescription drug program. The amount of benefits provided depends on the plan selected.

- **Convenient**

  Coverage can begin as early as the day following your online application. The underwriting process is simple and policy fulfillment, including claims and ID cards, are available online.

An STM policy may be right for you if you:

- Have missed the open enrollment period and aren't eligible for special enrollment under the Affordable Care Act (ACA)
- Are waiting for your ACA coverage to start
- Are waiting for health insurance benefits to begin at a new job
- Are looking for coverage to bridge you to Medicare
- Are needing an alternative to COBRA
- Under age 65

STM policies are not ACA plans

STM policies do not meet ACA standards. The ACA is a Federal law that requires all major medical plans to provide specific benefits and mandates that most Americans have health plans that qualify as Minimum Essential Coverage (MEC). These rules do not apply to STM plans.

Keep the following in mind as you plan for your needs and explore your options:

- STM plans do not meet the Minimum Essential Coverage requirements under the ACA and may result in a tax penalty. STM plans are designed to provide temporary healthcare insurance during unexpected coverage gaps.
- The ACA-compliant medical plans are guaranteed issue, meaning you cannot be denied coverage based on your health history. STM plans are underwritten, which means you must answer a series of medical questions when applying for coverage. Based on your answers, you may be declined for coverage.
- Unlike the ACA plans, which are required to cover the 10 Essential Health Benefits (EHB), STM plans cover some EHBs but not necessarily all. Policies will vary in what they cover, so you should check your policies details carefully.

STM policies provide flexible temporary coverage. It's also important that you understand what you're buying so you can make a fully informed choice for you and your family.

Pre-existing condition limitation

Unlike most STM plans, Connect Plus provides a benefit for eligible pre-existing conditions. The plan provides up to a maximum of $25,000 for eligible medical expenses for a pre-existing condition, per person, per policy. After the $25,000 maximum has been reached, expenses due to pre-existing conditions are not covered. Refer to page five for the definition of a pre-existing condition.

Plan selection

All benefits listed apply per covered person, per coverage period.

Office visit copay The copay applies to the first covered office visit during the policy period. After the copay, the balance of the doctor office visit charge is covered at 100 percent. Additional covered expenses incurred during the office visit, including expenses for laboratory and diagnostic tests, will be subject to plan deductible and coinsurance.	$50 copay
Choose deductible The selected deductible must be paid by the covered person before coinsurance benefits begin. Family deductible maximum: Three individual deductible amounts. When three covered persons in a family each satisfy their deductible, the deductibles for any remaining covered family members are deemed satisfied for the remainder of the coverage period.	▪ $5,000 ▪ $10,000
Choose coinsurance percentage and out-of-pocket After the deductible has been met, you pay the selected percentage of covered expenses until the out-of-pocket amount has been reached. The plan covers the remaining percentage of covered expenses up to the maximum benefit. The out-of-pocket amount is specific to expenses applied to the coinsurance; it does not include the deductible. Once the deductible and coinsurance out-of-pocket amounts have been satisfied, additional covered charges within the coverage period are paid at 100 percent, up to the maximum benefit amount. Benefit-specific maximums may apply. The out-of-pocket does not include the deductible, any precertification penalty amounts or expenses not covered by the plan.	**30% coinsurance** Out-of-pocket: $6,000 **50% coinsurance** Out-of-pocket: $10,000
Maximum benefit	$2,000,000
Pre-existing condition coverage period maximum After maximum is reached, expenses due to pre-existing conditions are not covered. Primary insured Covered spouse Covered child(ren)	 $25,000 $25,000 $25,000

Eligibility

Individuals, spouses and dependents may be covered. Connect Plus is available to the primary applicant from age 18 to 64, his or her spouse age 18 to 64 and dependent children under the age of 26. A child-only plan is available for children age 2 up to age 18. All family members will need to apply and meet the medical requirements of the plan.

Utilize a network provider and save

With your plan, you have the freedom to choose any provider. In certain markets, you also have access to discounted medical services through national preferred provider organizations (PPOs). These network providers have agreed to negotiated prices for their services and supplies. While you have the flexibility to choose any healthcare provider, the discounts available through network providers for covered services may help to lower your out-of-pocket costs. At the time of service, simply present your identification card which will include the network information needed for the provider to correctly process covered billed charges.

Covered expenses

All benefits, except office visits applied to the copay, are subject to the selected plan deductible and coinsurance. Covered expenses are limited by the usual, reasonable and customary charge as well as any benefit-specific maximum. If a benefit-specific maximum does not apply to the covered expense, benefits are limited by the coverage period maximum. Benefits may vary based on your state of residence.

Covered expenses include treatment, services and supplies for:

- Physician services for treatment and diagnosis
- Hospital room and board, doctor visits and general nursing care up to the amount billed for a semi-private room or 90 percent of the private room billed amount
- Intensive care or specialized care unit up to three times the amount billed for a semi-private room or three times 90 percent the private room billed amount
- Prescription drugs administered while hospital confined
- X-ray exams, laboratory tests and analysis
- Mammography, Pap smear and prostate antigen test (covered at specific age intervals, not subject to deductible)
- Emergency room, outpatient hospital surgery or ambulatory surgical center
- Surgeon services in the hospital or ambulatory surgical center
- Services when a doctor administers anesthetics not to exceed 20 percent of the primary surgeon's covered charges
- Assistant surgeon services not to exceed 20 percent of the primary surgeon's covered charges
- Surgeon's assistant services not to exceed 15 percent of the primary surgeon's covered charges
- Ground ambulance services not to exceed $500 per occurrence
- Air ambulance services not to exceed $1,000 per occurrence
- Organ, tissue or bone marrow transplants not to exceed $150,000 per coverage period
- Acquired Immune Deficiency Syndrome (AIDS) not to exceed $10,000 per coverage period
- Blood or blood plasma and their administration, if not replaced
- Oxygen, casts, non-dental splints, crutches, non-orthodontic braces, radiation and chemotherapy services and equipment rental

Pre-existing condition definition

A pre-existing condition is any medical condition or sickness for which medical advice, care, diagnosis, treatment, consultation or medication was recommended or received from a doctor within five years* immediately preceding the covered person's effective date of coverage; or symptoms within the five years* immediately prior to the coverage that would cause a reasonable person to seek diagnosis, care or treatment. This period of time may vary by state.

*Six months in ID, KY, MI, ND, NH, NM, OH, WA, WY; 12 months in CA, CO, CT, IN, LA, MD, ME, MS, NC, NV, SD, VA; 24 months in FL, IL, UT; and 36 months in MT.

Usual, Reasonable and Customary charge

Charges for services and supplies, which are the lesser of:
a) the amount usually charged by the provider for the service or supply given; b) the negotiated rate; or c) the average charged for the service or supply in the locality in which it is received.

With respect to the treatment of medical services, usual and reasonable means treatment that is reasonable in relationship to the service or supply given and the severity of the condition. In reaching a determination as to what amount should be considered as usual and reasonable, we may use and subscribe to an industry reference source that collects data and makes it available to its member companies.

10-Day right to return period

If for any reason you are not satisfied with this policy, you may send a written request to decline your insurance coverage within 10-days after you receive it and you will be issued a refund. The refund will include any premium paid, as well as enrollment and administrative fees. These fees may vary by state. Your coverage issued under the Policy will then be void, as though coverage had not been issued.

Precertification

Precertification is required prior to each inpatient confinement for injury or illness, including chemotherapy or radiation treatment, at least seven days prior to receiving treatment. Emergency admissions must be pre-certified within 48 hours following the admission, or as soon as reasonably possible. Failure to complete precertification will result in a benefit reduction of 50 percent which would have otherwise been paid. Precertification is not a guarantee of benefits.

Renewability of coverage

STM is not renewable. In some states you are allowed to apply for another STM plan. Your application is subject to eligibility, underwriting requirements and state availability of the coverage. The next coverage period is not a continuation of the previous period; it is a new plan with a new deductible, coinsurance and pre-existing condition limitation. Note that based on your state, you may be limited to two or three consecutive terms only.

Coverage termination

Coverage ends on the earliest of the date: the premium is not paid when due; you enter full-time active duty in the armed forces or Independence American Insurance Company determines intentional fraud or material misrepresentation has been made in filing a claim for benefits. A dependent's coverage ends on the earliest of the date: your coverage terminates; the dependent becomes eligible for Medicare; or the dependent ceases to be eligible.

Exclusions

The Policy does not provide any benefits for the following expenses:

- Treatment of pre-existing conditions, as defined in the pre-existing conditions limitation provision, unless applied to the limited pre-existing condition benefit, shown in the policy schedule of benefits
- Incurred prior to the effective date of a covered person's coverage or incurred after the expiration date, regardless of when the condition originated, except in accordance with the extension of benefits provision
- Treatment, services and supplies for complications resulting from treatment, drugs, supplies, devices, procedures or conditions which are not covered under the policy; experimental or investigational services or treatment or unproven services or treatment;
- Amounts in excess of the usual, reasonable and customary charges made for covered services or supplies or you or your covered dependent are not required to pay, or which would not have been billed, if no insurance existed; paid under another insurance plan, including Medicare, government institutions, workers' compensation or automobile insurance
- Expenses incurred by a covered person while on active duty in the armed forces. Upon written notice to us of entry into such active duty, the unused premium will be returned to you on a pro-rated basis
- Treatment, services and supplies resulting from war (declared or undeclared); the commission of engaging in an illegal occupation; normal pregnancy or childbirth, except for complications of pregnancy; a newborn child not yet discharged from the hospital, unless the charges are medically necessary to treat premature birth, congenital injury or sickness, or sickness or injury sustained during or after birth; voluntary termination of normal pregnancy, normal childbirth or elective cesarean section; any drug, including birth control pills, implants, injections, supply, treatment device or procedure that prevents conception or childbirth, including sterilization or reversal of sterilization; sex transformation (unless required by law), penile implants, sex dysfunction or inadequacies and/or diagnosis and treatment of infertility, including but not limited to any attempt to induce fertilization by any method, invitro fertilization, artificial insemination or similar procedures, whether the covered person is a donor, recipient or surrogate.
- Physical exams or prophylactic treatment, including surgery or diagnostic testing, except as specifically covered
- Mental illness or substance use, including alcoholism or drug addiction or loss due to intoxication of any kind unless mandated by law

Exclusions continued

- Tobacco use cessation
- Suicide or attempted suicide or intentionally self-inflicted Injury, while sane or insane
- Dental treatment or care or orthodontia or other treatment involving the teeth or supporting structures, except as specifically covered and the treatment by any method for jaw joint problems including temporomandibular joint dysfunction (TMJ), TMJ pain syndromes, craniomandibular disorders, myofascial pain dysfunction or other conditions of the joint linking the jaw bone and skull and the complex of muscles, nerves and other tissues related to the joint
- Eye care, hearing, including hearing aids and testing
- Cosmetic or reconstructive procedures that are not medically necessary, breast reduction or augmentation or complications arising from these procedures
- Outpatient prescriptions, drugs to treat hair loss
- Feet unless due to accidental bodily injury or disease
- Weight loss programs or diets, obesity treatment or weight reduction including all forms of intestinal and gastric bypass surgery, including the reversal of such surgery
- Transportation expenses, except as specifically covered
- Rest or recuperation cures or care in an extended care facility, convalescent nursing home, a facility providing rehabilitative treatment, skilled nursing facility, or home for the aged, whether or not part of a hospital
- Providing a covered person with (1) training in the requirements of daily living; (2) instruction in scholastic skills such as reading and writing; (3) preparation for an occupation; (4) treatment of learning disabilities, developmental delays or dyslexia; or (5) development beyond a point where function has been demonstrably restored
- Personal comfort or convenience, including homemaker services or supportive services focusing on activities of daily life that do not require the skills of qualified technical or professional personnel, including bathing, dressing, feeding, routine skin care, bladder care and administration of oral medications or eye drops; supplies provided by a member of your immediate family and sleeping disorders
- Expenses incurred in the treatment of injury or sickness resulting from participation in skydiving, scuba diving, hang or ultralight gliding, riding an all-terrain vehicle such as a dirt bike, snowmobile or go-cart, racing with a motorcycle, boat or any form of aircraft, any participation in sports for pay or profit, or participation in rodeo contests
- Bone stimulator, common household items
- Participating in interscholastic, intercollegiate or organized competitive sports
- Medical care, treatment, service or supplies received outside of the United States, Canada or its possessions
- Spinal manipulation or adjustment
- Private duty nursing services
- The repair or maintenance of a wheelchair, hospital-type bed or similar durable medical equipment
- Orthotics
- Marital counseling or social counseling
- Acupuncture
- Expenses for replacement of artificial limbs or eyes
- Removal of breast implants
- Treatment, services or supplies not defined or specifically covered under the policy

These plans are not qualifying health coverage ("Minimum Essential Coverage") that satisfies the health coverage requirement of the Affordable Care Act. If you don't have Minimum Essential Coverage, you may owe an additional payment with your taxes. The termination or loss of this policy does not entitle you to a special enrollment period to purchase a health benefit plan that qualifies as Minimum Essential Coverage outside of an open enrollment period. These products may include a pre-existing condition exclusion provision.

Short-term medical plans are not available in all states. This brochure provides a very brief description of the important features of Connect Plus plans. This brochure is not a policy and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both the policyholder and the insurance company. It is, therefore, important that you READ THE POLICY CAREFULLY. For complete details, refer to the Short Term Medical Expense Insurance Policy Form #IAIC ISTM POL 0913 (Policy number may vary by state).

About Independence American Insurance Company

Independence American Insurance Company is domiciled in Delaware and licensed to write property and/or casualty insurance in all 50 states and the District of Columbia. Its products include short-term medical, hospital indemnity, fixed indemnity limited benefit, group and individual dental, and pet insurance. Independence American is rated A- (Excellent) for financial strength by A.M. Best, a widely recognized rating agency that rates insurance companies on their relative financial strength and ability to meet policyholder obligations (an A++ rating from A.M. Best is its highest rating).

About The IHC Group

Independence Holding Company (NYSE: IHC), formed in 1980, is a holding company that is principally engaged in underwriting, administering and/or distributing group and individual specialty benefit products, including disability, supplemental health, pet, and group life insurance through its subsidiaries (Independence Holding Company and its subsidiaries collectively referred to as "The IHC Group"). The IHC Group consists of three insurance companies (Standard Security Life Insurance Company of New York, Madison National Life Insurance Company, Inc. and Independence American Insurance Company), and IHC Specialty Benefits, Inc., a technology-driven full-service marketing and distribution company that focuses on small employer and individual consumer products through general agents, telebrokerage, call centers, advisors, private label arrangements, independent agents, and through the following brands: www.HealtheDeals.com; Health eDeals Advisors; Aspira A Mas; www.PetPartners.com; and www.PetPlace.com.

The Loomis Company

The Loomis Company (Loomis), founded in 1955, has been a leading Third Party Administrator (TPA) since 1978. Loomis has strategically invested in industry leading ERP platforms, and partnered with well-respected companies to enhance and grow product offerings. Loomis supports a wide spectrum of clients from self-funded municipalities, school districts and employer groups, to large fully insured health plans who operate on and off state and federal marketplaces. Through innovation and a progressive business model, Loomis is able to fully support and interface with its clients and carriers to drive maximum efficiencies required in the ever evolving healthcare environment.

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