Connect STM

Short-term medical insurance for individuals and families

THE IHC GROUP

Independence American Insurance Company
A Member of The IHC Group

Underwritten by Independence American Insurance Company (IAIC), a member of The IHC Group. For more information about IAIC and The IHC Group, visit www.ihcgroup.com. This product is not considered to be Minimum Essential Coverage as defined by the Patient Protection and Affordable Care Act (ACA). This product is administered by The Loomis Company.

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

Connect STM offers several benefit options that allow you to find the right answer for your specific coverage needs. Short-term medical provides limited duration insurance coverage for 30 to 364 days, which varies by state. Not all states allow for durations of 364 days.

Why STM insurance?

STM insurance plans provide insurance coverage during life transitions. When you are between group insurance or individual major medical policies, STM insurance policies 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 insurance policies are affordable. While STM contains limitations when compared to traditional major medical plans, the premium is generally lower. While ACA plans can only vary premiums based on geography, age, tobacco use and number of people covered (single vs. family plan), short-term plans can vary rates due to any number of factors, including health conditions.

- **Customizable**
  Select from various benefit levels which best meet your insurance and premium needs. You can also add other coverage such as dental insurance or a discount prescription drug program.

- **Convenient**
  Coverage can begin as early as the day following acceptance of your online application. In addition, policy forms and ID cards as well as claims information 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 provide flexible temporary coverage. It is also important that you understand what you're buying so you can make a fully informed choice for you and your family.

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 requires that most Americans have health plans that qualify as Minimum Essential Coverage (MEC). These rules do not apply to STM policies. Short-term medical insurance is a limited duration medical expense policy and is non-renewable. The amount of benefits provided depends on the plan selected and the premium will vary with the amount of benefits selected. STM is not a replacement for the comprehensive health insurance required under the ACA. This coverage has a pre-existing condition limitation exclusion.

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 policies are not required to cover EHBs at the same benefit level as an ACA plan. Policies will vary in what they cover, so you should check your policy's details carefully.

Eligibility

Connect STM is available to the primary applicant from age 18 through age 64, his or her spouse age 18 through age 64 and dependent children under the age of 26. A child-only plan is available for children age 2 up to age 18.

Payment options to suit your situation

These plans offer a single or monthly premium payment using credit card or automatic bank withdrawal. For policy durations of 91 to 180 days, you may prepay the premium for your entire coverage duration through a single payment option. For durations of 91 days to 6 months, premium payments are made on a monthly basis. Not all states allow for durations greater than 90 days.

Utilize a network provider and save

With your short-term medical 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.

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. If this provider discount is not available, then benefits are paid at the usual, reasonable and customary charge.

10-day right to return period

If for any reason you are not satisfied with the policy, you may return it to us within 10-days after you receive it and you will be issued a refund. The refund will include any premium paid minus the 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.

Usual, reasonable and customary charge

Charges for services and supplies, which are the lesser of: (a) the charge usually made for the service or supply by the physician or facility who furnished it; (b) the negotiated rate; and; (c) the reasonable charge made for the same service or supply in the same geographic area.

Plan selection

All benefits listed apply per covered person, per coverage period. The amount of benefits provided depends on the plan selected and the premium will vary with the amount of benefits selected.

Physician office visit copay 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. Based on your state of residence, you may be limited to a certain number of copays.	**$50 copay, not to exceed one visit per coverage period** 1 copay for 30–90 days of coverage 2 copays for 91-180 days of coverage 3 copays for 180+ days of coverage
Deductible The selected deductible maximum is an amount of money that must be paid by the covered person before coinsurance benefits begin. Family deductible maximum: When three covered persons in a family each satisfy their deductible, the deductibles for any remaining covered family members are considered satisfied for the remainder of the coverage period.	• $2,500 • $5,000 • $10,000
Coinsurance percentage and out-of-pocket maximum After the deductible maximum amount has been met, you pay the selected coinsurance percentage of covered expenses until the out-of-pocket maximum amount has been reached. The out-of-pocket maximum amount is specific to expenses applied to the coinsurance percentage; it does not include covered expenses applied to the deductible, precertification penalty amounts, or expenses not covered under the policy. Once the deductible and out-of-pocket maximum amounts have been satisfied, additional covered expenses within the coverage period are paid at 100 percent, not to exceed the coverage period maximum benefit amount. Benefit-specific maximums may also apply.	**20% coinsurance** Out-of-pocket maximum: $4,000 **30% coinsurance** Out-of-pocket maximum: $6,000 **50% coinsurance** Out-of-pocket maximum: $5,000 or $10,000
Coverage period maximum benefit	$2,000,000

Covered expenses

All benefits, except physician office visits applied to the copay, are subject to the selected plan deductible maximum and coinsurance percentage. Covered expenses are limited by the usual, reasonable and customary charge as well as any benefit-specific maximum as listed in the schedule of benefits. 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.

- Inpatient hospital room and board and general nursing care for the amount billed for a semi-private room or 90 percent of the private room billed amount (only if semi-private is not offered)
- Inpatient intensive care or specialized care unit for 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

Covered expenses include treatment, services and supplies for:

- Inpatient physician office visits
- 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
- Anesthesiologist services 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 limitation and definition

A pre-existing condition is defined as 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 persons' 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 will not be a covered benefit. Consultation means evaluation, diagnosis, or medical advice was given with or without the necessity of a personal examination or visit.

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

Precertification

Precertification is required prior to each inpatient confinement for injury or illness and outpatient chemotherapy or radiation treatment, at least seven days prior to receiving treatment. Emergency inpatient confinements must be pre-certified within 48 hours following the admission, or as soon as reasonably possible. Precertification may also be conducted for a continued stay review for an ongoing inpatient confinement. Benefits are not paid for days of inpatient confinement which extend beyond the number of days deemed medically necessary. Failure to complete precertification will result in a benefit reduction of 50 percent which would have otherwise been paid unless the covered person is incapacitated and unable to contact the administrator.. Precertification is not a guarantee of benefits. Precertification is not required in some states.

Hospital and confinement definitions

Hospital means an institution which is legally constituted and operated in accordance with the laws pertaining to Hospitals in the jurisdiction where it is located, which meets all of the following requirements:

- It is engaged primarily in providing medical care and treatment to sick and injured persons on an inpatient basis at the patient's expense;
- It provides 24-hour-a-day nursing service by a nurse;
- It is under the supervision of a staff of duly-licensed physicians;
- It provides organized facilities for diagnosis and for major operative surgery either on its premises or in facilities available on a prearranged basis; and
- Hospital does not mean primarily a clinic, nursing home, rest or convalescent home, extended care facility, hospice or similar establishment nor, other than incidentally, a place providing care for persons with mental illness or nervous disorders, the aged, or those suffering from alcoholism or drug addiction.

Confinement means the time in which a covered person is a registered bed patient in a hospital on the order of a physician for medically necessary medical treatment. Confinement in a special unit of a hospital used primarily as a nursing, rest, or convalescent home shall be deemed to be confinement in an institution other than a hospital.

Renewability of coverage

STM is not renewable. In some states you are allowed to apply for another STM insurance 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 date the policy terminates; the date you become eligible for Medicare; the expiration date of your coverage; the premium is not paid when due, if such payment has not been made within 31 days following such premium due date; 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 or the date of your death. 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 following list of exclusions is a partial list of services or charges not covered. Check your policy for a full listing:

- Treatment of pre-existing conditions, as defined in the pre-existing conditions limitation provision, shown in the policy
- 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 & 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
- 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
- Tobacco use cessation

Exclusions Continued

- 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
- 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.
- 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
- 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
- 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
- Acupuncture
- Expenses for replacement of artificial limbs or eyes
- Removal of breast implants
- Marital counseling or social counseling
- Treatment, services or supplies not defined or specifically covered under the policy

This coverage is not required to comply with certain federal market requirements for health insurance, principally those contained in the Affordable Care Act. Be sure to check your policy carefully to make sure you are aware of any exclusions or limitations regarding coverage of pre-existing conditions or health benefits (such as hospitalization, emergency services, maternity care, preventive care, prescription drugs, and mental health and substance use disorder services). Your policy might also have lifetime and/or annual dollar limits on health benefits. If this coverage expires or you lose eligibility for this coverage, you might have to wait until an open enrollment period to get other health insurance coverage. Also, this coverage is not "minimum essential coverage." If you don't have minimum essential coverage for any month in 2018, you may have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Short-term medical plans are not available in all states. This brochure provides a very brief description of the important features of Connect STM 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 includes 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.

About 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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