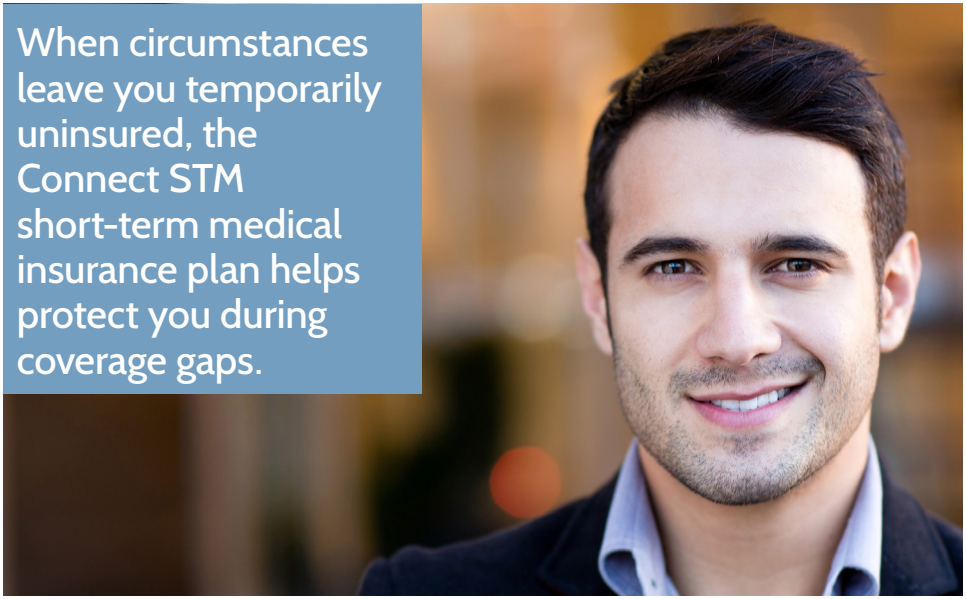
Connect STM

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.

THE IHC GROUP

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



Connect STM offers several different benefit options that allow you to find the right answer for your specific coverage needs. Coverage is available in most states for 30 to 90 days.

Short-term medical insurance is not a substitute for a major medical plan that meets the minimum essential coverage levels as defined by the Patient Protection and Affordable Care Act, also known as ACA. It can, however, offer financial protection in the event of an unexpected injury or illness while you are waiting for coverage to begin under an ACA-qualified plan.

Missed open enrollment

If you have missed the opportunity to Connect coverage during the open enrollment period, you may be ineligible to buy a major medical policy until the next open enrollment period, unless you have a qualifying event.

Newly hired

Often, an employer-sponsored plan includes a waiting period before health insurance benefits begin.

Waiting for an ACA plan

Many plans on the Health Insurance Exchange offer only one effective date, the first of the month. Depending on when you submit your application, you may have to wait up to 45 days for your coverage to begin.

Filling the gap

Coverage can begin as early as the day following your online application, if approved, and last up to 90 days.

The maximum coverage period varies by state.

Plan selection

All benefits listed apply per covered person, per coverage period. Refer to the descriptions below the chart for additional details.

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
Deductible The selected deductible must be paid by the covered person before coinsurance benefits begin. Family deductible maximum: Three individual deductible amounts	• $1,000 • $2,500 • $5,000 • $7,500 • $10,000
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 Connect STM 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.	Coinsurance / Out-of-pocket 20% — • $1,000 • $2,000 • $3,000 • $4,000 30% — • $1,500 • $3,000 • $4,500 • $6,000 50% — • $2,500 • $5,000 • $7,500 • $10,000
Maximum benefit	$2,000,000

Family deductible

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.

Coinsurance percentage and out-of-pocket

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.

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 and reasonable 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
- 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 up to 20 percent of the primary surgeon's covered charges
- Assistant surgeon services up to 20 percent of the primary surgeon's covered charges
- Surgeon's assistant services up to 15 percent of the primary surgeon's covered charges
- Ground ambulance services up to $500 per occurrence
- Air ambulance services up to $1,000 per occurrence
- Organ, tissue, or bone marrow transplants up to $150,000 per coverage period
- Acquired Immune Deficiency Syndrome (AIDS) up to $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

Inpatient covered expenses:

- 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

Payments to suit your situation

Connect STM offers monthly premium payments using credit card or automatic bank withdrawal.

Eligibility
Connect STM 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.

Utilize a network provider and save
With a Connect STM plan, you 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 will 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.

Pre-existing condition
Connect STM will not provide benefits for any loss caused by or resulting from a pre-existing condition. 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.

Usual and reasonable charge
The usual and reasonable charge for medical services or supplies is the lesser of:
a) the amount usually charged by the provider for the service or supply given; or b) 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 a standard industry reference source that collects data and makes it available to its member companies.

Right to return period
If you are not completely satisfied with this coverage and have not filed a claim, you may return the Policy within 10 days and receive a premium refund.

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.

Continuing coverage

If your need for temporary health insurance continues, most states allow you to apply for another short-term medical 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.

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 following is a partial list of services or charges not covered by Connect STM. Check your Policy for full listing.

Expenses for the treatment of pre-existing conditions; expenses incurred prior to the effective date of a covered person's coverage or incurred after the expiration date; expenses that do not meet the definition of or are not specifically identified under the Policy as covered expenses; expenses to treat complications resulting from treatment, drugs, supplies, devices, procedures or conditions which are not covered under the Policy or are experimental or investigational services or treatment; expenses for purposes determined by Us to be educational; amounts in excess of the usual and reasonable charges made for covered services or supplies or which you or your covered dependent are not required to pay; expenses to the extent that they are paid or payable under another insurance or medical prepayment plan, Medicare paid expenses or expenses for care in government institutions; expenses paid under workers' compensation or an automobile insurance policy; expenses incurred by a covered person while on active duty in the armed forces, expenses from war; expenses incurred while engaging in an illegal act or occupation or during the commission, or the attempted commission, of a felony or assault; expenses for the treatment of normal pregnancy or childbirth, except for complications of pregnancy and normal newborn care unless medically necessary due to sickness or injury; expenses for voluntary termination of normal pregnancy or contraception; infertility treatments or sterilization; expenses related to sex transformation or penile implants or sex dysfunction or inadequacies, physical exams, prophylactic treatment; expenses for the treatment of mental illness or nervous disorders; alcoholism or drug addiction; expenses incurred for loss sustained or contracted in consequence of the covered person being intoxicated or under the influence of any narcotic; expenses incurred in connection with programs, treatment, or procedures for tobacco use cessation; expenses resulting from suicide or attempted suicide; expenses for dental treatment or temporomandibular joint dysfunction (TMJ) of any kind except as specifically covered; expenses for radial keratotomy; vision exams, eyeglasses or contact lenses, including the fitting of; treatment of cataracts; routine hearing exams or hearing aids; expenses for cosmetic or reconstructive procedures, services or supplies including breast reduction or augmentation or complications except as specifically covered; outpatient prescriptions, unless shown as included in the

Schedule of Benefits; expenses incurred in connection with any drug or other item used to treat hair loss; treatment of feet unless due to injury or illness; expenses incurred in the treatment of acne, or varicose veins; weight loss programs or diets; expenses for 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; transportation expenses, except as specifically covered; expenses for services or supplies for personal comfort or convenience; expenses provided by immediate family; expenses for 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; participating in interscholastic, intercollegiate or organized competitive sports; expenses for the purchase of a noninvasive osteogenesis stimulator (bone stimulator); expenses for services or supplies of a common household use; medical care, treatment, service or supplies received outside of the United States, Canada or its possessions; expenses for spinal manipulation or adjustment; expenses for acupuncture; expenses for marital counseling or social counseling; private duty nursing services; expenses for the repair or maintenance of a wheelchair, hospital-type bed or similar durable medical equipment; orthotics, special shoes, spine and arch supports, heel wedges, sneakers or similar devices unless they are a permanent part of an orthopedic leg brace; expenses incurred in connection with the voluntary taking of a poison or inhaling gas; expenses incurred in connection with obesity treatment or weight reduction including all forms of intestinal and gastric bypass surgery, including the reversal of such surgery even if the covered person has other health conditions that might be helped by a reduction of obesity or weight; expenses for replacement of artificial limbs or eyes; removal of breast implants; or expenses for a service or supply whose primary purpose is to provide 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.

Short-term medical expense coverage under the Connect STM plan is not available in all states.

THIS IS 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. THIS POLICY INCLUDES A PRE-EXISTING CONDITION EXCLUSION PROVISION.

About Independence American Insurance Company

Independence American Insurance Company is domiciled in Delaware and licensed to write property and casualty insurance in all 50 states and the District of Columbia. Its products include short-term medical, employer medical stop-loss, hospital indemnity, fixed indemnity limited benefit, group and individual dental, pet insurance, and non-subscriber occupational accident insurance in Texas. Independence American is rated A- (Excellent) for financial strength by A.M. Best Company, 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) 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 since 1980. The IHC Group owns 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 insurance sales and marketing company that creates value for insurance producers, carriers and consumers (both individuals and small businesses) through a suite of proprietary tools and products (including ACA plans and small group medical stop-loss). All products are placed with highly rated carriers.

"IHC" and "The IHC Group" are the brand names for plans, products and services provided by one or more of the subsidiaries and affiliate member companies of The IHC Group ("IHC Entities"). Plans, products and services are solely and only provided by one or more IHC Entities specified on the plan, product or service contract, not The IHC Group. Not all plans, products and services are available in each state.

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.

This brochure provides a brief description of the benefits, exclusions and other provisions of the Policy (policy form IAIC ISTM POL 0913). For complete listings, see the Policy.