Connect
Short-Term Medical

Connect offers 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 Minimal Essential Coverage as defined by the Patient Protection and Affordable Care Act (ACA).

Brochure Connect Plans 0320

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

Select from two unique plans.

Connect STM

This traditional short-term policy offers several options and a $2 million coverage-period maximum to provide benefits and protection for you and your family. Select Connect STM Extend for coverage up to 36 months.*

Connect Plus

While most short-term medical policies do not cover expenses for pre-existing medical conditions, Connect Plus provides a $25,000 benefit for eligible pre-existing healthcare expenses.

*Extended duration options are not available in all states.

Why short-term medical insurance?

Short-term insurance plans provide coverage during life transitions. When you are between group insurance or individual major medical policies, short-term insurance helps 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.

Customizable

Select from various benefit levels which best meet your insurance needs and budget.

Convenient

Coverage can begin as early as the day following your online application. Policy forms and ID cards, as well as claims administration, are all available online.

These products are not considered Minimal Essential Coverage as defined by the Patient Protection and Affordable Care Act (ACA).

Is a short-term medical policy right for me and my family?

Consider a short-term policy if you:

- Have missed the open enrollment period and are not 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

How long can I be covered under a short-term medical policy?

Coverage can be selected for 30 to 364 days depending on the state. If coverage is needed longer than 364 days, up to 24 months may be added to the initial coverage duration through the Connect STM Extend plan, available in select states. Extended durations must be chosen at time of application. Connect Plus does not offer a coverage period extension. The maximum allowable duration varies by state.

How do short-term medical policies work with federal healthcare guidelines and requirements?

Short-term medical plans do not meet the Minimum Essential Coverage requirements under the ACA and may result in a state tax penalty. They are designed to provide temporary healthcare insurance during unexpected coverage gaps.

ACA-compliant medical plans are guaranteed issue, meaning you cannot be denied coverage based on your health history. Short-term medical 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 ACA plans, which are required to cover the 10 Essential Health Benefits (EHB), short-term medical policies are not required to cover EHBs at the same benefit level as an ACA plan. Benefits and coverage will vary for each short-term medical policy, so review the policy's details carefully. For example, Connect plans do not provide coverage for maternity and outpatient prescription drugs.

Plan selection

All benefits listed apply per covered person, per coverage period. The amount of benefits provided and premium required are based on your plan selections. Plan availability varies by state.

	Connect STM	Connect Plus
Physician office visit copay[1] After the copy, the balance of the physician 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 the plan deductible and coinsurance. Physician office visits beyond the maximum number allowed for this copay benefit are subject to the plan deductible and coinsurance.	\$50 copay The number of office visit copays available is based on the length of coverage period selected: » Maximum of 1 visit for 30 – 90 days of coverage » Maximum of 2 visits for 91 – 180 days of coverage » Maximum of 3 visits for 181 – 364 days of coverage	
Deductible The selected deductible 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 deemed satisfied for the remainder of the selected coverage period.	» \$2,500 » \$5,000 » \$10,000	» \$5,000 » \$10,000
Coinsurance percentage and out-of-pocket maximum After the deductible amount has been met, you pay the selected coinsurance percentage of covered expenses until the out-of-pocket amount has been reached. The out-of-pocket maximum amount is specific to expenses applied to the coinsurance percentage; it does not include 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, \$4,000 out-of-pocket » 30% coinsurance, \$6,000 out-of-pocket » 50% coinsurance, \$5,000 out-of-pocket » 50% coinsurance, \$10,000 out-of-pocket	» 30% coinsurance, \$6,000 out-of-pocket » 50% coinsurance, \$10,000 out-of-pocket
Pre-existing condition coverage For the Connect Plus plan, after the \$25,000 coverage-period maximum is reached, expenses resulting from pre-existing conditions are not covered. The maximum benefit of \$25,000 is available for the primary insured, covered spouse and each covered child.	Not available; charges resulting from pre-existing conditions are not covered	\$25,000
Coverage period maximum benefit[2]	\$2,000,000	\$2,000,000

[1] Office visit copay is not applicable in NH

[2] Coverage period maximum benefit not applicable in ME

Connect STM Extend

In some states, the option to extend coverage beyond the initial 364 day coverage period is available with Connect STM Extend. The maximum coverage duration varies by state.

If you elect to purchase an Extend plan:

- The extended duration length must be chosen at the time of purchase.
- The deductible, coinsurance, number of office visit copays and coverage-period maximum will all reset after the initial 364-day period, and reset again 12 months after the first reset.
- Examples:
  - If an additional 12 months of short-term coverage is selected, three copays will be available during the first 364 days and another three copays will be available for the additional 12 months. In addition, the deductible and coinsurance reset after the initial 364-day period.
  - If an additional 24 months is selected on a Connect STM Extend plan with a $2,500 deductible and $4,000 out-of-pocket, the initial 364-day period and the two additional 12-month periods (36 months) will require separate deductibles and out-of-pocket maximums. Therefore, depending on medical expenses incurred, it is possible to reach a 36-month total of $7,500 for the deductible and $12,000 for the out-of-pocket maximum.

Covered expenses

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

Covered expenses include treatment, services and supplies for:	Connect STM	Connect Plus
Emergency room, up to the amount shown per day	No daily limit	No daily limit
Ground ambulance, up to the amount shown per occurrence	$500	$500
Air ambulance, up to the amount shown per occurrence	$1,000	$1,000
Outpatient hospital surgery or ambulatory surgical center, up to the amount shown per day	No daily limit	No daily limit
Surgeon services in the hospital or ambulatory surgical center, up to the amount shown per surgery	No surgery limit	No surgery limit
Outpatient miscellaneous medical expense[1] services, up to the amount shown per coverage period*	No miscellaneous services limit	No miscellaneous services limit
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; not to exceed the amount shown per day	No daily limit	No daily limit
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; not to exceed the amount shown per day	No daily limit	No daily limit
Inpatient physician visits; not to exceed the amount shown per day	No daily limit	No daily limit
Prescription drugs administered while hospital confined		
X-ray exams, laboratory tests and analysis		
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		
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		
Oxygen, casts, non-dental splints, crutches, non-orthodontic braces, radiation and chemotherapy services and equipment rental		
Mammography, pap smear and prostate specific antigen test, covered at specific age intervals and when recommended by a physician, NOT subject to the plan deductible		

*If the Connect STM Extend plan is selected, coverage-period maximums reset after the initial 364 days and each 12 month coverage period after.

[1] Refer to the policy for complete details

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.** Consultation means evaluation, diagnosis, or medical advice was given with or without a personal examination or visit.

*Definition varies by state.

**Six months in GA, ID, NH, NV, OH, and WY; 12 months in IN, LA, ME, MI, MD, NC, SD, WI, and WV; 24 months in FL, IL, UT; and 36 months in MT.

Connect STM: A pre-existing condition will not be a covered benefit.

Connect Plus: A benefit of up to $25,000 is available for eligible medical expenses for pre-existing conditions, per person, per policy.

Eligibility

Connect plans are available to the primary applicant age 18 through age 64, his or her spouse or domestic partner 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.

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. Your coverage issued under the policy will then be void, as though coverage had not been issued.

Usual, reasonable and customary charge

Covered expenses are limited to the usual, reasonable and customary charge which is defined as charges for services and supplies, which are the lesser of: the charge usually made for the service or supply by the physician or facility who furnished it; the negotiated rate; and, the reasonable charge made for the same service or supply in the same geographic area.

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 to review 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 of that 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 and is not required in some states.

*Varies by state

Connect STM Extend is renewable. The applicant must select their maximum duration at time of application. Any conditions first diagnosed during the initial term will not be considered pre-existing conditions after the initial 364-day period.

Renewability of coverage

Connect STM and Connect Plus are non-renewable.

All short-term medical applications are subject to eligibility, underwriting requirements and state availability of the coverage. After a policy expires, some states allow you to reapply for a short-term policy under separate and new 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. Your eligibility for subsequent policies may be limited by state law.

Coverage termination

Coverage ends on the earliest of the date: the policy terminates; you become eligible for Medicare; the expiration date of your coverage; the premium is not paid when due, and exceeds the grace period; you enter full-time active duty in the armed forces; intentional fraud or material misrepresentation has been made in filing a claim for benefits; or, 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. Exclusions vary by state, check the policy for a full listing.

- Treatment of Pre-Existing Conditions, as defined in Section 1, Definitions and the Pre-Existing Conditions Limitation provision
- Expenses 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 treatments, drugs, supplies, devices, procedures or conditions which are not covered under the policy
  - Experimental or investigational services or treatment, unproven services or treatment
- Amounts in excess of the usual, reasonable and customary charges made for covered services or supplies, amounts you or your covered dependents are not required to pay or which would not have been billed if no insurance existed
- Expenses 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
- Cosmetic or reconstructive procedures that are not medically necessary, breast reduction, augmentation, implant removal or complications arising from these procedures; drugs to treat hair loss
- Outpatient prescriptions
- Treatment, services and supplies resulting from:
  - War (declared or undeclared)
  - 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, treatment, device or procedure that prevents conception or childbirth, including birth control pills, implants, injections, supply, 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, 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, orthodontia or other treatment involving the teeth or supporting structures, except as specifically covered; 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
- Vision or hearing care and treatment, 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
- Supplies provided by a member of your immediate family
- Sleeping disorders
- Expenses that result from training in the requirements of daily living, instruction in scholastic skills such as reading and writing, preparation for an occupation, treatment of learning disabilities, developmental delays or dyslexia, or 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
- 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 (except as a passenger on a commercial flight), or participation in rodeo contests
- Bone stimulator, common household items
- Participation in intercollegiate sports, or semi-professional and professional organized competitive sports (including practice) for pay or profit
- Medical care, treatment, service or supplies received outside of the United States, Canada or its possessions
- Spinal manipulation or adjustment
- Private duty nursing services
- Repair or maintenance of a wheelchair, hospital-type bed or similar durable medical equipment
- Orthotics
- Acupuncture
- Expenses for replacement of artificial limbs or eyes
- Marital or social counseling
- Treatment, services or supplies not 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 the policy carefully to make sure you are aware of any exclusions or limitations regarding coverage of pre-existing conditions or health benefits. A short-term medical insurance plan may vary from an ACA plan in such benefits as hospitalization, emergency services, maternity care, preventive care, prescription drugs, and mental health and substance use disorder services. A short-term medical policy might also have coverage-period and/or benefit-specific 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.

Florida Policyholders: This policy does not meet the definition of qualifying previous coverage or qualifying existing coverage as defined in s. 627.6699. As a result, if purchased in lieu of a conversion policy or other group coverage, you may have to meet a preexisting condition requirement when renewing or purchasing other coverage.

Short-term medical plans are not available in all states. This brochure provides a very brief description of the important features of the Connect 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 [State] 0119 (Policy number may vary by state). This product is administered by The Loomis Company.

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). We also have three agencies: (i) Pet Partners Inc., our pet insurance administrator; (ii) IHC Specialty Benefits, Inc., a technology-driven full-service marketing and distribution company that focuses on small employer and individual consumer products through its call center, advisors, and brokerage channel; and (iii) The INSX Cloud Platform through My1HR, our wholly-owned Web-Based Entity. IHC also owns the following domains: www.healthedeals.com; www.healthinsurance.org; www.medicareresources.org; and www.petplace.com.

About The Loomis Company

The Loomis Company (Loomis) as an administrator for Independence American Insurance Company, 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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METAL GAP 2

Accident and Critical Illness Insurance

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 Minimal Essential Coverage as defined by the Patient Protection and Affordable Care Act (ACA).

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Brochure Metal Gap 2 1219

Your major medical plan could leave you responsible for deductible and coinsurance expenses in the case of a serious accident or illness. Metal Gap 2 offers options to complement your health plan in the event of a covered illness or accident.

Accident and critical illness insurance benefits allow you to focus on your number one priority: getting better. Metal Gap 2 provides benefits for covered accidents up to the selected maximum amount or the actual expense you incur, whichever is less. Critical illness benefits provide a lump sum payment that can be sent directly to you and can be used for anything you choose.

Critical illnesses and serious accidents are never expected. Metal Gap 2 provides you with additional coverage you need while recovering, and your acceptance is guaranteed.

Metal Gap 2 Plan Designs

Benefits	Protection 2,500	Protection 5,000	Protection 7,500	Protection 10,000
Accident Medical Expense	$2,500	$5,000	$7,500	$10,000
Accidental Death and Dismemberment	$2,500	$5,000	$7,500	$10,000
Critical Illness				
Insured	$2,500	$5,000	$7,500	$10,000
Spouse	$2,500	$5,000	$7,500	$10,000
Dependent	$2,500	$2,500	$2,500	$2,500

Metal Gap 2 Plan Descriptions

Accident Medical Expense

Benefits are payable for medical expenses incurred as the result of each covered accident up to the select maximum benefit amount, or the actual expense you incur, whichever is less.

Accidental Death and Dismemberment

The benefit is paid when an accident results in death or a covered loss or dismemberment. The amount paid will vary based on the nature of the loss. This benefit is available once during the coverage period.

Critical Illness

Covered critical illnesses include life-threatening cancer; heart attack; kidney failure; stroke; coma; coronary artery bypass; loss of sight, speech or hearing; major organ transplant; paralysis and severe burn. (Covered illnesses may vary by state.) The percentage of the benefit paid varies based on the illness diagnosed.

*The Critical Illness benefit is not available in the following states: CT, KY, MO, ND, PA, TN

Eligibility

Metal Gap 2 is available to the primary applicant up to age 64, his or her spouse age 18 to 64 and dependent children under the age of 26. Child-only plans are not available. All benefits terminate when the covered person has attained age 70.

Exclusions and Limitations

The following services are not covered by Metal Gap 2. All benefits terminate when the covered person has attained age 70. This is only a brief list of exclusions. For a complete list of all policy provisions, including limitations and exclusions refer to the policy.

- Treatment which is: not medically necessary; experimental/investigational; not prescribed by a physician; received without charge; received from any family member; not rendered in accordance with generally accepted standards of medical practice; or not specifically listed in the Policy as a covered charge or covered loss.
- Injury received as a result of: suicide or attempted suicide; declared or undeclared war; voluntary participation in a riot or insurrection; engaging in an illegal act; traveling or flying by air, except as a fare-paying passenger; participating in a rodeo; participating in or practicing for any collegiate or professional sports; flying in an ultra-light aircraft, hang gliding, parachuting or bungee-cord jumping, or by flight in a space craft; as well as work-related injury covered under workers' compensation or incurred while on active duty in the armed forces; or injury incurred while intoxicated or under the influence of alcohol.
- Expenses incurred outside the United States, unless such expenses are incurred while traveling less than 90 days.
- Critical Illness Insurance: Refer to the Critical Illness Indemnity Benefit Rider for complete details on each covered critical illness. In the event that a critical illness is diagnosed during the first 30 days after the Covered Person's Effective Date of Coverage, the benefit will be limited to the lesser of $500 or 10 percent of the total amount that would have been paid had the condition been diagnosed after 30 days of the effective date of coverage. Only those conditions listed in the Benefit Rider will be covered.

This insurance 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 product may include a pre-existing condition exclusion provision.

Not all insurance plans or combinations of benefits are available in all states.

This brochure provides a very brief description of the important features of Metal Gap 2. This brochure is not the insurance 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 Accident Medical Expense and Accidental Death and Dismemberment Insurance Policy (IAIC ANC POL 0115) and the Critical Illness Indemnity Benefit Rider (IAIC ANC CIBR 0115).

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Independence Dental

Indemnity and PPO dental insurance for individuals and families

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. The Independence Dental plan series is administered by The Loomis Company.

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Brochure Independence Dental 0419

Indemnity Plan Design

	Independence 1000	Independence Ultra 1500	Independence 1500
Copay[1] *(limit 1 per day, per provider)* Applies to all covered procedures.	$20	$20	None
Calendar-year Deductible	$50	$50	$50
Maximum Benefit *(per covered person, per calendar year)*	$1,000	$1,500	$1,500
	Coinsurance percentage *(listed per covered person)*		
Preventive Care: • Routine oral exams • Cleanings (Prophylaxis) *(limited to two per calendar year)* • Topical Fluoride *(for dependent children, limited to one per calendar year)* • Sealants *(one per tooth every three years for specific permanent molars)* • Space maintenance, including the initial appliance and adjustments *(within six months of installation for a dependent child up to age 16)*	100%[2]	100%[2]	100%[2]
Diagnostic Care: • Bitewing X-rays *(limited to one per calendar year)* • Full-mouth X-rays *(limited to one every three years)*	100%[2]	100%[2]	80% 6 month waiting period
Basic Care: • Simple extractions • Fillings » Amalgam restorations » Composite restorations, which are limited to anterior teeth and bicuspids • Emergency palliative treatment to temporarily relieve pain	50% 6 month waiting period	80% 6 month waiting period	80% 6 month waiting period
Major Care: • Endodontic services • Periodontic services • Oral surgery • Surgical extractions • Dentures and maintenance prosthodontics • Inlays, onlays and crowns • Bridges	50% 12 month waiting period	50% 12 month waiting period	50% 12 month waiting period

Coinsurance and waiting periods for diagnostic, basic and major vary by state.

[1] In CT, the copay only applies to Preventive Care.

[2] Calendar-year deductible does not apply.

PPO Plan Design

	Independence PPO 1000	Independence Ultra PPO 1500	Independence PPO 1500
Copay* *(limit 1 per day, per provider)* Applies to all covered procedures.	$20	$20	None
Calendar-year Deductible	$50	$50	$50
Maximum Benefit *(per covered person, per calendar year)*	$1,000	$1,500	$1,500
	Coinsurance percentage *(listed per covered person)*		
Preventive Care: *(In-Network/Out-of-Network)*[3]			
• Routine oral exams	100%[2]/100%[2]	100%[2]/100%[2]	100%[2]/100%[2]
• Cleanings (Prophylaxis) *(limited to two per calendar year)*	100%[2]/100%[2]	100%[2]/100%[2]	100%[2]/100%[2]
• Topical Fluoride *(for dependent children, limited to one per calendar year)*	100%[2]/100%[2]	100%[2]/100%[2]	100%[2]/100%[2]
• Sealants *(one per tooth every three years for specific permanent molars)*	100%[2]/100%[2]	100%[2]/100%[2]	80%/80%
• Space maintenance, including the initial appliance and adjustments *(within six months of installation for a dependent child up to age 16)*	100%[2]/100%[2]	100%[2]/100%[2]	80%/80%
Diagnostic Care:			
• Bitewing X-rays *(limited to one per calendar year)*	100%[2]/100%[2]	100%[2]/100%[2]	80%/80%
• Full-mouth X-rays *(limited to one every three years)*			6 month waiting period
Basic Care:			
• Simple extractions	50%/50%	80%/80%	80%/80%
• Fillings			
» Amalgam restorations			
» Composite restorations, which are limited to anterior teeth and bicuspids			
• Emergency palliative treatment to temporarily relieve pain	6 month waiting period	6 month waiting period	6 month waiting period
Major Care:			
• Endodontic services	50%/50%	50%/50%	50%/50%
• Periodontic services			
• Oral surgery			
• Surgical extractions			
• Dentures and maintenance prosthodontics			
• Inlays, onlays and crowns			
• Bridges	12 month waiting period	12 month waiting period	12 month waiting period

Coinsurance and waiting periods for diagnostic, basic and major vary by state.

[1] In CT, the copay only applies to Preventive Care.

[2] Calendar-year deductible does not apply.

[3] Covered out-of-network expenses are limited to the maximum allowable charge.

When choosing a PPO plan design

When utilizing **in-network** dental providers:

Network providers have agreed to a negotiated, discounted dollar amount for each covered charge. Therefore, if all dental services are received from network providers, you will not be billed for any charges above the allowed amount, or maximum allowable charge.

When utilizing **out-of-network** providers:

If you receive dental services from a provider that is not included in the network, covered expenses are limited to the maximum allowable charge. You will receive a bill from the provider if out-of-network expenses exceed the maximum allowable charge.

The PPO network available with Independence Dental varies by state. Please refer to the provider directory for a complete list of available network dental providers in your area.

Eligibility

Independence Dental is available to the primary applicant age 18 to 99, their spouse age 18 to 99, and dependent children under the age of 26.

Covered charges

Expenses must be medically/dentally necessary and incurred by a covered person while the plan is inforce. A covered procedure must be performed by a licensed dentist acting within the scope of his or her license, a licensed physician performing dental services within the scope of his or her license, or a licensed dental hygienist acting under the supervision and direction of a dentist.

Coordination of benefits

This plan will be coordinated with any other group, blanket or franchise plan under which an individual will receive benefits. Coordinating benefits is not permitted in all states.

Termination

The plan will continue as long as premium is paid and the primary insured does not become ineligible.

10-day right to return period

If you are not satisfied with this Policy for any reason, you may return it to us within 10-days after you receive it. We will refund any premium paid and your coverage issued under the Policy will be void, as though we had not issued coverage.

Alternative benefits

If we determine that a less expensive service or supply can be used in place of the proposed treatment based on broadly accepted standards of dental care, the benefit payment will be limited to the Reasonable and Customary Charge.

Pre-treatment estimate

Except in an emergency, before a covered person may begin treatment that will cost more than the predetermination amount shown on the Schedule of Benefits, the dentist must submit a claim to us describing the treatment necessary and the cost. This estimate is not a guarantee of payment. We will still consider a claim for which the covered person has not obtained an estimate; however, the claim may be subject to reduced benefits based on our determination of the maximum allowable charge and medically necessary treatment.

Exclusions for Dental

The following exclusions list is an outline of the complete list available in the Independence Dental insurance Policy. Exclusions and limitations may vary by state.

- Treatment, services or supplies which:
  - Are not medically/dentally necessary;
  - Are not prescribed by a dental provider;
  - Are determined to be experimental or investigational in nature by us;
  - Are received without charge or legal obligation to pay;
  - Would not routinely be paid in the absence of insurance;
  - Are received from any family member;
  - Are not rendered in accordance with generally accepted standards of dental practice; or
  - Are not covered services
- Expenses resulting from:
  - Suicide, attempted suicide or intentionally self-inflicted injury, while sane or insane
  - War, or from voluntary participation in a riot or insurrection;
  - Engaging in an illegal act or occupation, the commission of a felony or assault;
  - Fixed or removable bridgework involving replacement of a natural tooth or teeth that were lost prior to the covered person's effective date of coverage;
  - Telephone consultations, failure to keep a scheduled appointment, completion of claim forms or attending dental provider statements;
  - Use of materials, other than fluorides or sealants, to prevent tooth decay
  - Cast restorations, inlays, onlays and crowns for teeth that are not broken down by extensive decay or accidental injury, or for teeth that can be restored by other means;
  - Replacement of third molars;
  - Crowns, inlays and onlays used to restore teeth with micro fractures or fracture lines, undermined cusps, or existing large restorations without overt pathology; or
  - Any service not specifically listed in the Schedule of Benefits
- Expenses incurred by a covered person while on active duty in the armed forces
- Expenses for which benefits are paid or payable under Workers' Compensation Act or similar laws
- Treatment that began before the covered person's effective date of coverage or after the covered person's termination of coverage
- Congenital or developmental malformations existing on the covered person's effective date
- Periodontal splinting
- Replacement of partial or full dentures, fixed bridgework, crowns, gold restorations and jackets more often than once in any 60-month period per tooth
- Relining of dentures more often than once in any 24-month period
- Expenses for lost, stolen or missing appliances of any type, or for duplicates
- Prescription drugs and analgesia pre-medication
- Dental education or training programs, diet and nutrition counseling
- Expenses resulting from the following, unless stated on the Schedule of Benefits:
  - Prosthodontics;
  - Orthodontia;
  - Implants of any type and all related procedures, removal of implants, precision or semi-precision attachments, denture duplication, overdentures and any associated surgery, or other customized services or attachments; or
  - Porcelain on crowns, or pontics posterior to the second bicuspid
- Cosmetic dentistry
- Charges that are payable under any other insurance, unless specifically available under the Coordination of Benefits provision in the Policy
- Charges made by any government entity unless the covered person is required to pay, or by any public entity from which coverage could have been obtained by application or enrollment even if application or enrollment was not actually made
- Bite registrations
- Bacteriologic cultures
- Temporomandibular joint syndrome (TMJ), unless coverage is required by state mandate

This brochure provides a very brief description of the important features of Independence Dental. This brochure is not a certificate of coverage or policy and only the actual certificate or policy provisions will control. The certificate or policy itself sets forth in detail the rights and obligations of both the certificate holder or policy holder and the insurance company. It is, therefore, important that you READ THE CERTIFICATE OR POLICY CAREFULLY. For complete details, refer to the Individual Dental Policy, Policy form number (IAIC IDEN POL 0414).

Not all plans or combinations of benefits are available in all states.

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, 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 Loomis Company

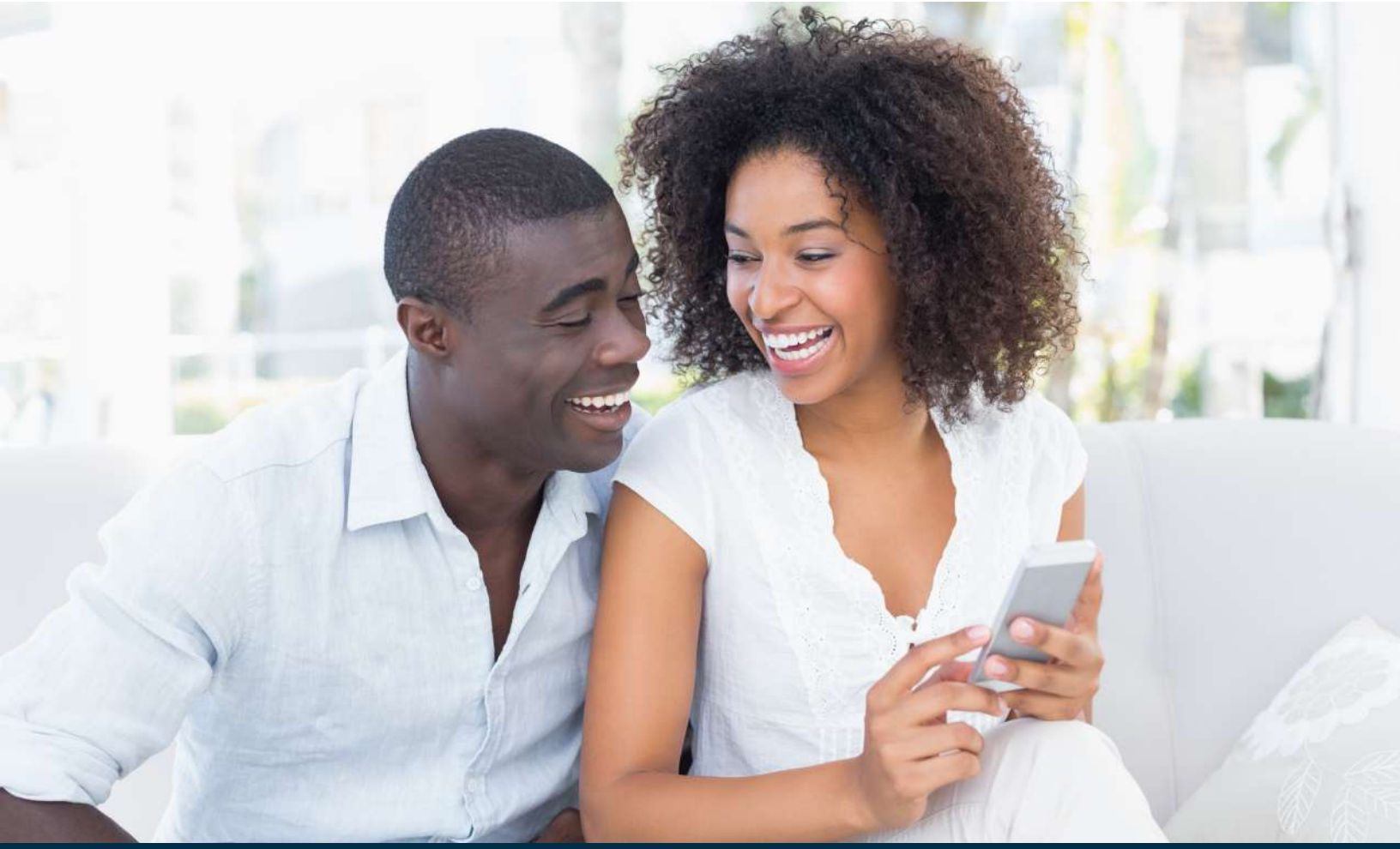
The Loomis Company (Loomis), founded in 1955, has been a leading Third Party Administrator (TPA) since 1978. Loomis has strategically invested in industry leading ERP platforms, and partnered with well-respected companies to enhance and grow product offerings. Loomis supports a wide spectrum of clients 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.

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; www.PetPartners.com; and www.PetPlace.com.

THE IHC GROUP

Independence American Insurance Company
A Member of The IHC Group



Independence Hospital Insurance Plus

Fixed Hospital Indemnity Insurance

At a time when high deductibles and out-of-pocket costs are on the rise, Independence Hospital Insurance Plus provides options to help manage those costs.

THE IHC GROUP

Independence American Insurance Company
A Member of The IHC Group

This policy is underwritten by Independence American Insurance Company (IAIC), a member of The IHC Group.
For more information about IAIC, visit www.independenceamerican.com. This policy is administered by The Loomis Company.

Designed to provide coverage for hospitalizations due to accidents or illnesses, Independence Hospital Insurance Plus features:

- **Apply anytime** – with no open enrollment period requirements, you can apply for coverage year-round
- **Benefits that benefit you** – no deductibles or annual maximum requirements to meet
- **Keep your doctor** – there are no network requirements or limitations, so you can continue visiting any doctor or hospital you like
- **Cancer benefit** – receive a lump-sum benefit if diagnosed with life threatening cancer
- **Flexibility** – with three plan options to choose from, finding the option that best fits your individual needs and budget is easy

Benefit Selection

All benefits listed apply per covered person. The premiums will vary with the amount of the benefit selected.

	Hospital Plus 20	Hospital Plus 30	Hospital Plus 40
Lump-Sum Hospital Benefit pays a lump-sum amount each inpatient hospitalization.	$1,000	$1,500	$2,000
Outpatient Facility Services Benefit pays selected amount one day per calendar year when outpatient surgery is received in an outpatient surgery facility.	$2,000	$3,000	$4,000
Wellness and Preventive Care Benefit pays the amount selected, one visit per calendar year, after the initial three-month waiting period.	$50	$100	$150
Daily Hospital Benefit pays per day, up to 31 days of inpatient hospitalization per calendar year.	$2,000	$3,000	$4,000
Urgent Care Benefit pays the amount selected, one visit per calendar year.	$250		
Physician Office Visit* Benefit pays the amount selected, three visits per calendar year for any illness or injury.	$100		
Cancer Rider** Benefit pays a lump-sum of the amount selected once per lifetime.	$2,000	$3,000	$4,000

**Michigan: Physician Office Visit benefits not available*

***New Mexico: Cancer Rider not available*

Additional benefits included in all three options

Inpatient Hospital Services
Observation Unit - Benefit pays $250, one day per period of care, up to six per calendar year. Period of care is defined as a period after which the covered person is initially admitted to a hospital, receives treatment in an outpatient facility or received outpatient chemotherapy or radiation therapy. A period of care ends 190 consecutive days from which the injury or illness began.
ICU/CCU Confinement - Benefit pays $500, one day per calendar year
Inpatient Physician Visit - Benefit pays $200, one day per calendar year during a hospital, ICU, or CCU stay
Inpatient Surgeon - Benefit pays $2,000 per surgery, unlimited
Inpatient Assistant Surgeon - Benefit pays $800 per surgery, unlimited
Inpatient Anesthesiologist - Benefit pays $600 per surgery, unlimited
Outpatient Services
Outpatient Surgeon - Benefit pays $2,000 per surgery, unlimited
Outpatient Assistant Surgeon - Benefit pays $800 per surgery, unlimited
Outpatient Anesthesiologist - Benefit pays $600 per surgery, unlimited
Diagnostic Services - Benefit pays $200, two tests per calendar year related to illness or injury
Advanced Imaging - Benefit pays $500, two tests per calendar year
Other Services
Emergency Room Visit - Benefit pays $500, two visits per calendar year
Ground or Water Ambulance - Benefit pays $500, one trip per calendar year
Air Ambulance - Benefit pays $500, one trip per calendar year
Second Surgical Opinion - Benefit pays $100, one visit per calendar year

Eligibility

Independence Hospital Insurance Plus is available to the primary applicant age 18 to 64.5, their spouse age 18 to 64.5, and dependent children under the age of 26.

Wellness and Preventive Care Waiting Period

The period following your effective date during which no benefits are payable. For all three plans, there is a three-month waiting period before benefits are payable. There is no waiting period for this benefit in North Dakota, Tennessee and Utah. The Wellness and Preventive Care benefit is not available in Michigan and New Mexico.

Pre-Existing Condition Definition*

A condition for which medical advice, diagnosis, care, or treatment was received or recommended during the pre-existing condition limitation period.

Pre-Existing Condition Limitation

The policy contains a pre-existing condition limitation. This limitation will cease to apply to any covered benefits incurred in connection with a pre-existing condition after the covered person has been continuously covered under the policy for 12 consecutive months from the covered person's effective date for any pre-existing conditions within 12 months** prior to such effective date.

* Definition varies by state
** Six months in MI and UT

Exclusions

The following list of exclusions is a partial list of services or charges not covered. Exclusions vary by state, check the policy for a full listing.

- Preventive care, except as specified in the Wellness and Preventive Care Benefit, as shown in the schedule of benefits
- Any treatment, service or supply which is:
  - Not due to an illness or injury
  - Not recommended by a physician
  - Not medically necessary
  - No charge is made or the covered person is not required to pay
  - Provided by a government owned or operated facility or by government employed health care providers
- Treatment, services or supplies:
  - To improve the appearance or self-perception of a covered person, which does not restore a bodily function including cosmetic or plastic surgery, hair loss or skin wrinkling, or the complications of any such treatment
  - For breast augmentation, the removal of breast implants unless medically necessary and related to surgery performed as reconstructive surgery due to an illness and breast reduction surgery unless medically necessary due to an illness
  - To restore or enhance fertility or to reverse sterilization
  - Impregnation techniques such as artificial insemination or in vitro fertilization; including but not limited to artificial insemination, in vitro zygote and intra-fallopian transfers, gamete intra-fallopian transfer and genetic counseling
  - Received from a physician or other provider if such person is a person who ordinarily resides in your household or a member of your immediate family
  - For complications of conditions that are not covered under the policy
  - Related to the teeth and the gums other than tumors and any other associated structures and the prevention or correction of teeth irregularities and malocclusion of jaws by wire appliances, braces or other mechanical aids and dental implants, regardless of the cause
  - As the result of prognathism, retrognathism, microtrognathism, or any treatment, services or supplies to reposition the maxilla (upper jaw), mandible (lower jaw), or both maxilla and mandible, unless due to an injury to sound natural teeth which occurs while the covered person is covered under the policy and provided such treatment is received within 12 months following the date of the injury, or is to correct growth defects after one year from the date of birth of a covered dependent child
  - 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

- Related to the feet by means of posting or strapping, or range of motion studies or to paring or removal of corns, calluses, bunions or toenails (other than partial or complete removal of nail roots)
- For obesity or weight reduction, including wiring of the teeth and all forms of intestinal bypass surgery and complications resulting from such surgery

› Illness or injury:
- Which arises out of or in the course of any employment for wage or profit or an illness or injury for which the covered person has or had a right to recovery under any workers' compensation or occupational disease law
- Incurred during the commission or attempted commission of a crime or felony or while engaged in an illegal act, while imprisoned or incurred or contracted as a consequence of a covered person being intoxicated, under the influence of any illegal narcotic, barbiturate, hallucinatory or other drug, unless administered by a physician and taken in accordance with a prescribed dosage
- For which treatment, services or supplies were received or purchased outside the United States unless the charges are incurred while traveling on business or for pleasure, for a period not to exceed 90 days, and the charges are incurred for an emergency, provided the treatment, services or supplies used in connection with the emergency are approved for use in the United States
- Resulting from participation in hazardous avocations including mountain or rock climbing, sky diving, hang gliding, motor vehicle racing, scuba diving, rodeo or private aviation

› A weekend hospital confinement occurring between noon on any Friday and noon the following Sunday for non-emergency procedures, unless medically necessary or unless surgery is scheduled for the next day
› Physical or psychological examinations required by any third party, such as by a court or for employment, licensing, insurance, school, sports or recreational purposes
› Surgery to correct refractive errors, such as radial keratotomy or radial keratectomy
› Routine eye exams, glasses, visual therapy, contact lenses
› Routine hearing exams, purchase, fittings or adjustments for hearing aids; purchase, fittings or adjustments of hearing aids
› International travel immunizations
› Penile implants and fertility and sterility studies
› Voluntary abortion, except if the life of the mother would be in danger if the fetus were carried to term
› Mental illness disorders
› Substance abuse, or medical conditions resulting there from
› Marriage or family counseling, recreational therapy, equine therapy, educational therapy, social therapy, or sex therapy
› Sexual reassignments or sexual dysfunctions or inadequacies
› Meridian therapy (acupuncture), or spinal manipulation
› Orthotics
› Custodial Care, domiciliary care or rest cures regardless of who prescribes or renders such care
› Telephone consultations, missed appointment fees and fees for completing claim forms
› Treatment services or supplies provided for temporomandibular joint (TMJ) dysfunction
› Occupational or Speech Therapy (unless covered under the Home Care Services Benefit Rider, if selected)
› Hospice care or home health care
› Experimental or investigational procedures, drugs, treatment methods, organ transplant procedures
› Pregnancy and related services and routine newborn care, except for services related to a complication of pregnancy
› Services related to joint replacement, unless performed due to an Injury
› Intentional self-inflicted illness or injury while sane; except that this exclusion will not apply to any self- inflicted illness or injury that is the result of a medical condition
› Physical Therapy (unless covered under the Home Care Services Benefit Rider, if selected)
› Inpatient personal convenience items including beauty or barber services, radio and television, massages, telephone charges, take home drugs and supplies, guest meals, and motel accommodations

Important Information

This brochure provides a very brief description of the important features of Independence Hospital Insurance Plus. This brochure is not the insurance 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 Fixed Hospital Indemnity Insurance Policy (IAIC HIP POL 0719), and the Cancer Benefit (IAIC HIP CAN 0719).

THIS IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. LACK OF MAJOR MEDICAL COVERAGE (OR OTHER MINIMUM ESSENTIAL COVERAGE) MAY RESULT IN AN ADDITIONAL PAYMENT WITH YOUR TAXES.

THIS POLICY IS NOT A MEDICARE SUPPLEMENT POLICY. It is not intended to replace any Covered Persons' present health insurance. If a Covered Person is eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from Independence American Insurance Company (IAIC).

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A Member of The IHC Group