



Connect Lite

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, the Connect Lite short-term medical insurance plan helps protect you during coverage gaps.



Connect Lite offers short-term medical coverage with an affordable premium, achieved through carefully selected benefit limitations. 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-compliant plan.

Why short term medical insurance?

When you are temporarily between major medical policies, short-term plans provide benefits to help pay for unexpected healthcare. Covered expenses may include emergency room treatment, hospital stays, surgery, intensive care and more.

Missed open enrollment

If you have missed the opportunity to secure 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.

The maximum coverage period varies by state.

Plan selections

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

| | |
|---|--|
| <p>Office visit copay</p> <p>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.</p> | <p>\$50 copay</p> |
| <p>Deductible</p> <p>The selected deductible must be paid by the covered person before coinsurance benefits begin.</p> <p>Family deductible maximum: Three times the individual deductible amount</p> | <ul style="list-style-type: none"> • \$1,000 • \$2,500 • \$5,000 • \$7,500 • \$10,000 |
| <p>Coinsurance percentage and out-of-pocket</p> <p>After the deductible has been met, you pay the selected percentage of covered expenses until the out-of-pocket amount has been reached.</p> <p>The Connect Lite plan covers the remaining percentage of covered expenses up to the maximum benefit.</p> <p>The out-of-pocket amount is specific to expenses applied to coinsurance; it does not include the deductible.</p> | <p>20% coinsurance</p> <p><u>Out-of-pocket</u></p> <ul style="list-style-type: none"> • \$1,000 • \$2,000 • \$3,000 • \$4,000 <p>50% coinsurance</p> <p><u>Out-of-pocket</u></p> <ul style="list-style-type: none"> • \$2,500 • \$5,000 • \$7,500 • \$10,000 |
| <p>Maximum benefit</p> | <p>\$1,000,000</p> |

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 paid, additional covered charges within the coverage period are paid at 100 percent, up to the maximum benefit amount. Benefit-specific maximums may apply. The coinsurance out-of-pocket does not include any precertification penalty amounts or expenses not covered by the plan.

Payments to suit your situation

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

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
- Emergency room up to \$500 per day
- Office visits not paid through a copay will be subject to deductible and coinsurance, up to a maximum benefit of \$1,000 per covered person
- Outpatient hospital surgery or ambulatory surgical center charges up to \$1,000 per day
- Surgeon services in the hospital or ambulatory surgical center up to \$2,500 per surgery
- 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
- Covered expenses incurred for surgeon services, doctor administering anesthetics, assistant surgeon and surgeon's assistant are limited to a combined maximum benefit of \$2,500 per surgery, not to exceed \$5,000 per coverage period
- Ground or air ambulance services up to \$250 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
- Mammography, Pap smear and prostate antigen test (covered at specific age intervals; not subject to deductible)
- X-ray exams, laboratory tests and analysis
- Oxygen, casts, non-dental splints, crutches, non-orthodontic braces, radiation and chemotherapy services and equipment rental

Inpatient covered expenses:

- Hospital room, board and general nursing care up to the amount billed for a semi-private room or 90 percent of the private room billed amount, up to \$5,000 per day
- 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, up to \$6,250 per day
- Inpatient doctor visits up to \$500 per confinement
- Prescription drugs administered while hospital confined

Eligibility

Connect Lite 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.

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.

Utilize a network provider and save

With your Connect Lite 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. While you have the flexibility to choose any healthcare provider, the discounts available through network providers for covered services may help to lower your out-of-pocket costs.

At the time of service, simply present your identification card, which will include the network information needed for the provider to correctly process covered billed charges.

Pre-existing condition limitation

Connect Lite 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 industry reference source that collects data and makes it available to its member companies.

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

- 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
- Treatment, services and supplies resulting from:
 - war (declared or undeclared);
 - the commission of engaging in an illegal occupation;
 - normal pregnancy or childbirth, except for complications of pregnancy;
 - a newborn child not yet discharged from the hospital, unless the charges are medically necessary to treat premature birth, congenital injury or sickness, or sickness or injury sustained during or after birth;
 - voluntary termination of normal pregnancy, normal childbirth or elective cesarean section;
 - any drug, including birth control pills, implants, injections, supply, treatment device or procedure that prevents conception or childbirth, including sterilization or reversal of sterilization; sex transformation (unless required by law), penile implants, sex dysfunction or inadequacies and/or
 - diagnosis and treatment of infertility, including but not limited to any attempt to induce fertilization by any method, invitro fertilization, artificial insemination or similar procedures, whether the covered person is a donor, recipient or surrogate.
- Physical exams or prophylactic treatment, including surgery or diagnostic testing, except as specifically covered
- Mental illness or substance use, including alcoholism or drug addiction or loss due to intoxication of any kind unless mandated by law
- Tobacco use cessation
- Suicide or attempted suicide or intentionally self-inflicted Injury, while sane or insane
- Dental treatment or care or orthodontia or other treatment involving the teeth or supporting structures, except as specifically covered and the treatment by any method for jaw joint problems including temporomandibular joint dysfunction (TMJ), TMJ pain syndromes, craniomandibular disorders, myofascial pain dysfunction or other conditions of the joint linking the jaw bone and skull and the complex of muscles, nerves and other tissues related to the joint
- Eye care, hearing, including hearing aids and testing
- Cosmetic or reconstructive procedures that are not medically necessary, breast reduction or augmentation or complications arising from these procedures
- Outpatient prescriptions, drugs to treat hair loss
- Feet unless due to accidental bodily injury or disease
- Weight loss programs or diets, obesity treatment or weight reduction including all forms of intestinal and gastric bypass surgery, including the reversal of such surgery
- Transportation expenses, except as specifically covered
- Rest or recuperation cures or care in an extended care facility, convalescent nursing home, a facility providing rehabilitative treatment, skilled nursing facility, or home for the aged, whether or not part of a hospital
- Providing a covered person with (1) training in the requirements of daily living; (2) instruction in scholastic skills such as reading and writing; (3) preparation for an occupation; (4) treatment of learning disabilities, developmental delays or dyslexia; or (5) development beyond a point where function has been demonstrably restored
- Personal comfort or convenience, including homemaker services or supportive services focusing on activities of daily life that do not require the skills of qualified technical or professional personnel, including bathing, dressing, feeding, routine skin care, bladder care and administration of oral medications or eye drops;
- Supplies provided by a member of your immediate family
- Sleeping disorders
- Expenses incurred in the treatment of injury or sickness resulting from participation in skydiving, scuba diving, hang or ultralight gliding, riding an all-terrain vehicle such as a dirt bike, snowmobile or go-cart, racing with a motorcycle, boat or any form of aircraft, any participation in sports for pay or profit, or participation in rodeo contests
- Bone stimulator, common household items
- Participating in interscholastic, intercollegiate or organized competitive sports
- Medical care, treatment, service or supplies received outside of the United States, Canada or its possessions
- Spinal manipulation or adjustment
- Private duty nursing services
- The repair or maintenance of a wheelchair, hospital-type bed or similar durable medical equipment
- Orthotics
- Marital counseling or social counseling
- Acupuncture
- Artificial limbs or eyes, removal of breast implants
- Treatment, services or supplies not defined or specifically covered under the Policy

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

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

This brochure provides a very brief description of the important features of the Connect Lite plan. 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) 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. (IHC SB), a technology-driven full-service marketing and distribution company that focuses on small employer and individual consumer products through general agents, telebrokerage, advisor centers, private label arrangements, and through the following brands: www.HealtheDeals.com; Health eDeals Advisors; Aspira A Mas; www.PetPartners.com; and www.PetPlace.com. IHC creates value for insurance producers, carriers and consumers (both individuals and small businesses) through a suite of proprietary tools and products, all of which are underwritten by IHC’s carriers or placed with highly rated insurance companies.

“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.



Copyright © 2018 The IHC Group. All Rights Reserved.