

# Connect

## Short-Term Medical

## 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, visit www.independenceamerican.com.

This is a limited benefit policy. This coverage is not required to comply with certain federal market requirements for health insurance. This product is not considered to be Minimum Essential Coverage as defined by the Affordable Care Act (ACA).

Brochure Connect OV RX RBP 0621

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

## Select from four unique plans.



### Connect STM OV and Connect STM Rx

This traditional short-term policy offers several deductible and coinsurance options, as well as choice of a plan with an office visit copay or an outpatient prescription drug benefit. Select a Connect Extend option for coverage up to 36 months.

### Connect Plus OV and Connect Plus Rx

Offering a $25,000 benefit for eligible pre-existing healthcare expenses and a choice between an office visit copay or an outpatient prescription drug benefit.



## 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. Exclusions and limitations apply.

### 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 Minimum Essential Coverage as defined by the 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 Extend plans, available in select states. Extended durations must be chosen at time of application. Connect Plus plans do 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 policies do not meet the Minimum Essential Coverage requirements under the ACA. 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 policies are underwritten, which means you must answer a series of medical questions when applying for coverage. Based on your answers, you may not qualify.
- 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.

# Plan selection

All benefits listed apply per covered person. The premiums will vary with the amount of the benefit selected. The maximum lifetime benefit is three times the benefit amount shown in the table below. Plan availability varies by state.

| | Connect STM OV[1] | Connect STM Rx | Connect Plus OV[1] | Connect Plus Rx |
|---|---|---|---|---|
| **Deductible**<br>The selected deductible is an amount of money that must be paid by the covered person before coinsurance benefits begin.<br>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<br>» $5,000<br>» $10,000 | | » $5,000<br>» $10,000 | |
| **Coinsurance percentage and out-of-pocket maximum**<br>Coinsurance is the percentage of costs of a covered health care service you pay after you've paid your deductible.<br>The out-of-pocket maximum is the amount required to be paid by you after the deductible has been met. The deductible is not included in the out-of-pocket maximum.<br>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 maximum<br>» 30% coinsurance; $6,000 out-of-pocket maximum<br>» 50% coinsurance; $5,000 or $10,000 out-of-pocket maximum options | | » 30% coinsurance; $6,000 out-of-pocket maximum<br>» 50% coinsurance; $10,000 out-of-pocket maximum options | |
| **Pre-existing condition[2] coverage**<br>For the Connect Plus OV and Connect Plus Rx plans, after the $25,000 benefit has been reached, expenses resulting from pre-existing conditions are not covered.<br>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 | |

[1] OV plans not available in IA or SD

[2] Definition on page 7

| | Connect STM OV[1] | Connect STM Rx | Connect Plus OV[1] | Connect Plus Rx |
|---|---|---|---|---|
| **Physician office visit copay**<br>After the copay, 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<br><br>The number of office visit copays available is based on the length of coverage period selected:<br><br>» Maximum of 1 visit for 30 – 90 days of coverage<br>» Maximum of 2 visits for 91 – 180 days of coverage<br>» Maximum of 3 visits for 181 – 364 days of coverage | » No copay; subject to deductible and coinsurance | » $50 copay<br><br>The number of office visit copays available is based on the length of coverage period selected:<br><br>» Maximum of 1 visit for 30 – 90 days of coverage<br>» Maximum of 2 visits for 91 – 180 days of coverage<br>» Maximum of 3 visits for 181 – 364 days of coverage | » No copay; subject to deductible and coinsurance |
| **Coverage period maximum benefit** | » $2,000,000 | | | |
| **Outpatient Prescription Drug (Rx) Benefit Rider** | | | | |
| **Outpatient Rx deductible**<br>The outpatient prescription deductible is per covered person and is separate from the plan deductible. | » Not covered | » $2,500 | » Not covered | » $2,500 |
| **Rx copay**<br>After the prescription deductible has been satisfied, a copay benefit is available for generic and brand name drugs. Covered expenses above the copay are paid at 100 percent, up to the outpatient prescription period maximum benefit amount. | » Not covered | » Generic: $20 copay per prescription<br><br>» Brand name drugs: $50 copay per prescription<br><br>» Non-formulary drugs: No coverage, discount only | » Not covered | » Generic: $20 copay per prescription<br><br>» Brand name drugs: $50 copay per prescription<br><br>» Non-formulary drugs: No coverage, discount only |
| **Outpatient Rx maximum benefit**<br>Maximum benefit paid per covered person. | » Not covered | » $2,500 | » Not covered | » $2,500 |

[1] OV plans not available in IA or SD

## Connect Extend OV and Connect Extend Rx

The option to extend coverage beyond the initial 364 day coverage period is available with an Extend plan.
The maximum coverage duration varies by state. Not available on Connect Plus OV or Connect Plus Rx plans.

Extend plans are not available in IL, MD, MI, MN, MT, NV, OH, PA, SD and WI.

## 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 every 12 months after.
- 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 an 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.

| |
|---|
| Emergency room, $250 copay; then subject to deductible and coinsurance |
| Ground ambulance, not to exceed $500 per occurrence |
| Air ambulance, not to exceed $1,000 per occurrence |
| Outpatient hospital surgery or ambulatory surgical center |
| Surgeon services in the hospital or ambulatory surgical center |
| 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 |
| 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 |
| Inpatient physician visits |
| 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[5] |
| Acquired Immune Deficiency Syndrome (AIDS), not to exceed $10,000 per coverage period[5] |
| 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 |

[5] If a Connect Extend plan is selected, coverage-period maximums reset after the initial 364 days and each policy term thereafter.

## 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, NV and WY; 12 months in IN, LA, MI, MO, MS, NC, SD, and WV; 24 months in FL, IL and UT; and 36 months in MT.

**Connect STM OV and Connect STM Rx**: A pre-existing condition will not be a covered benefit.
**Connect Plus OV and Connect Plus Rx**: A benefit of up to $25,000 is available for eligible medical expenses for pre-existing conditions, per person, per policy.

### Eligibility

Connect policies 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. Applicants must be United States residents.

### 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; the reasonable charge as determined by us or a third party vendor that may provide repricing of medical claims to calculate reasonable charges made for the same service or supply in the same geographic area in determining the extent to which a charge is reasonable. The following may be taken into account: the complexity involved; the degree of professional skill involved; data compiled and regularly updated from our records or those of our agents. We use and subscribe to a standard industry reference source that collects data for determining reasonable fees; the condition being treated; any medical complications or unusual circumstances; data reflecting amounts typically reimbursed to physicians facilities providing same or similar services that routinely accepts as full payment from payers after good faith collection efforts; other pertinent factors; and 225 percent of the published rates allowed by the Centers for Medicare and Medicaid Services (CMS) for the same or similar services within the geographic market, except we may apply the following alternative percentages: 225 percent for facility charges (as defined by CMS); 175 percent for professional service charges (as defined by CMS).

### 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.

## Renewability of coverage

Connect STM OV, Connect STM Rx, Connect Plus OV and Connect Plus Rx policies are non-renewable.

Connect Extend plans are 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.

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 of any country or international organization; 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, except if covered under the Outpatient Prescription Medication Benefit Rider
- 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, except if covered under the Outpatient Prescription Medication Benefit Rider
- 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, except if covered under the Outpatient Prescription Medication Benefit Rider 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
- 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, medication, 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
- Medications taken, prescribed or administered while an inpatient at a hospital, rest home, sanitarium, skilled nursing facility, convalescent hospital, nursing home; homeopathic, specialty medications or non-formulary drugs or vitamins under the Outpatient Prescription Medication Rider
- Immunizations and vaccinations

THIS IS NOT A MEDICARE SUPPLEMENT POLICY. If you are eligible for Medicare review the Guide to Health Insurance for People with Medicare available from the Company.

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.

Illinois Policyholders: This coverage is not required to comply with certain federal market requirements for health insurance, principally those contained in the Affordable Care Act. Be sure to check your policy carefully to make sure you are aware of any exclusions or limitations regarding coverage of preexisting conditions or health benefits (such as hospitalization, emergency services, maternity care, preventive care, prescription drugs, and mental health and substance use disorder services). Your policy might also have lifetime and/or annual dollar limits on health benefits. If this coverage expires or you lose eligibility for this coverage, you might have to wait until an open enrollment period to get other health insurance coverage.

**NOTICE: THE SHORT-TERM, LIMITED-DURATION INSURANCE BENEFTITS UNDER THIS COVERAGE DO NOT MEET ALL FEDERAL REQUIREMENTS TO QUALIFY AS "MINIMUM ESSENTIAL COVERAGE" FOR HEALTH INSURANCE UNDER THE AFFORDABLE CARE ACT. THIS PLAN OF COVERAGE DOES NOT INCLUDE ALL ESSENTIAL HEALTH BENEFITS AS REQUIRED BY THE AFFORDABLE CARE ACT. PREEXISTING CONDITIONS ARE NOT COVERED UNDER THIS PLAN OF COVERAGE. BE SURE TO CHECK YOUR POLICY CAREFULLY TO MAKE SURE YOU UNDERSTAND WHAT THE POLICY DOES AND DOES NOT COVER. IF THIS COVERAGE EXPIRES OR YOU LOSE ELIGIBILITY FOR THIS COVERAGE, YOU MIGHT HAVE TO WAIT UNTIL THE NEXT OPEN ENROLLMENT PERIOD TO GET OTHER HEALTH INSURANCE COVERAGE. YOU MAY BE ABLE TO GET LONGER TERM INSURANCE THAT QUALIFIES AS "MINIMUM ESSENTIAL COVERAGE" FOR HEALTH INSURANCE UNDER THE AFFORDABLE CARE ACT NOW AND HELP TO PAY FOR IT AT WWW.HEALTHCARE.GOV.**

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] 0120 (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). Located at 485 Madison Ave., Floor 14, New York, NY 10022.

**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.

THE IHC GROUP

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**Short-Term Medical State Variations - Arizona**

Listed below is an overview of state variations for the Individual Short-Term Medical Expense product line underwritten by Independence American Insurance Company. Benefits listed apply to individuals covered under the short-term Policy. Unless otherwise noted, benefits are subject to the plan deductible, coinsurance, maximums, and limitations. Please refer to the state-specific Policy forms for current information and complete benefit details.

**The following Exclusions have been removed for Arizona:**

- Spinal manipulation or adjustment
- Expenses paid under another insurance plan, including Medicare, government institutions, workers' compensation or automobile insurance

**The following Exclusions have been added for Arizona:**

- Expenses eligible for payment by Medicare or any other government program except Medicaid
- Care received in government institutions unless You or Your Covered Dependent are obligated to pay for such care

**The following Covered Expense has been modified for Arizona:**

- Acquired Immune Deficiency Syndrome (AIDS), paid as any other illness