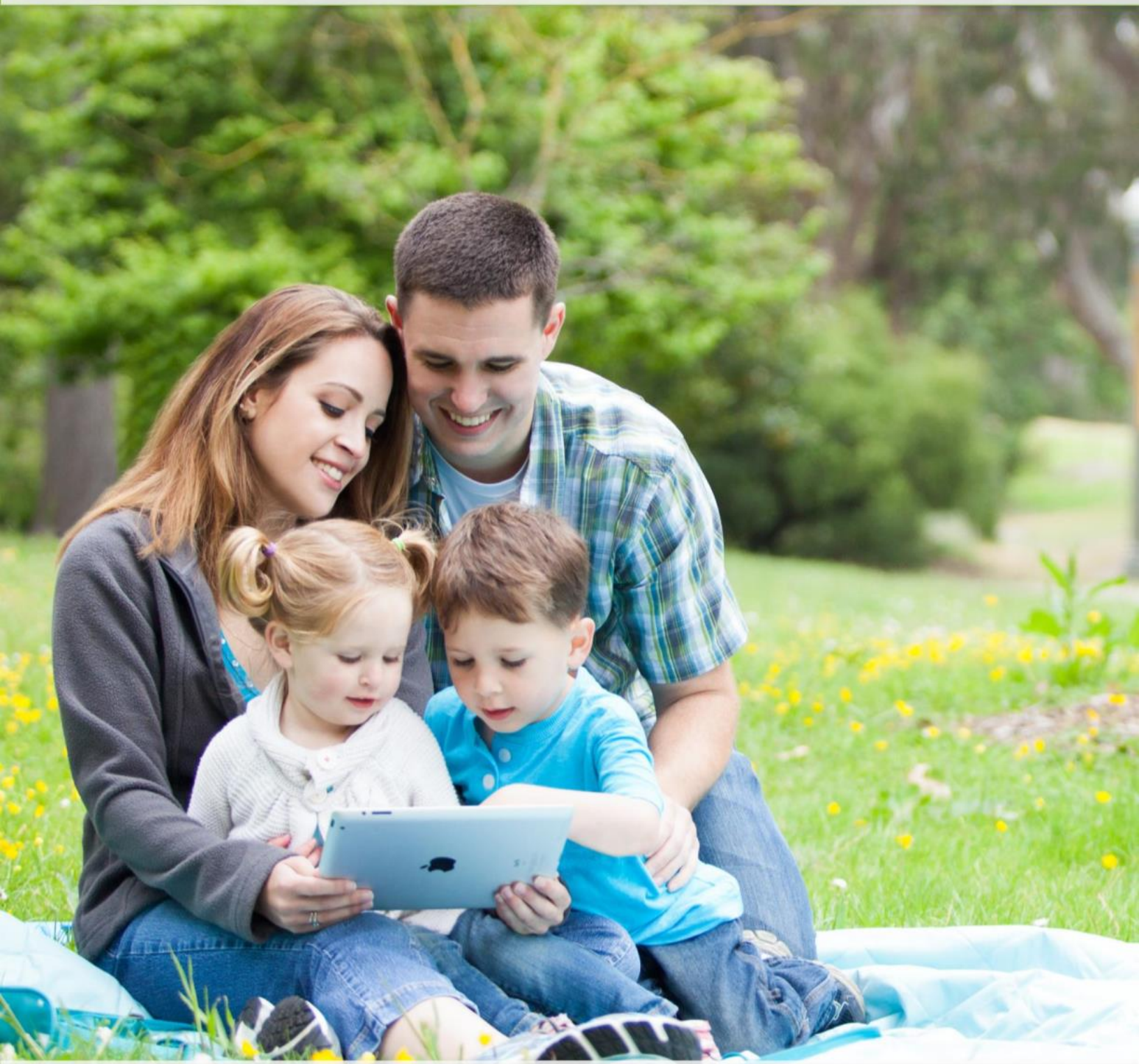
Short-Term Health Insurance

Short-term medical 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. This product is not considered to be Minimum Essential Coverage as defined by the Patient Protection and Affordable Care Act (ACA).

Independence American Insurance Company
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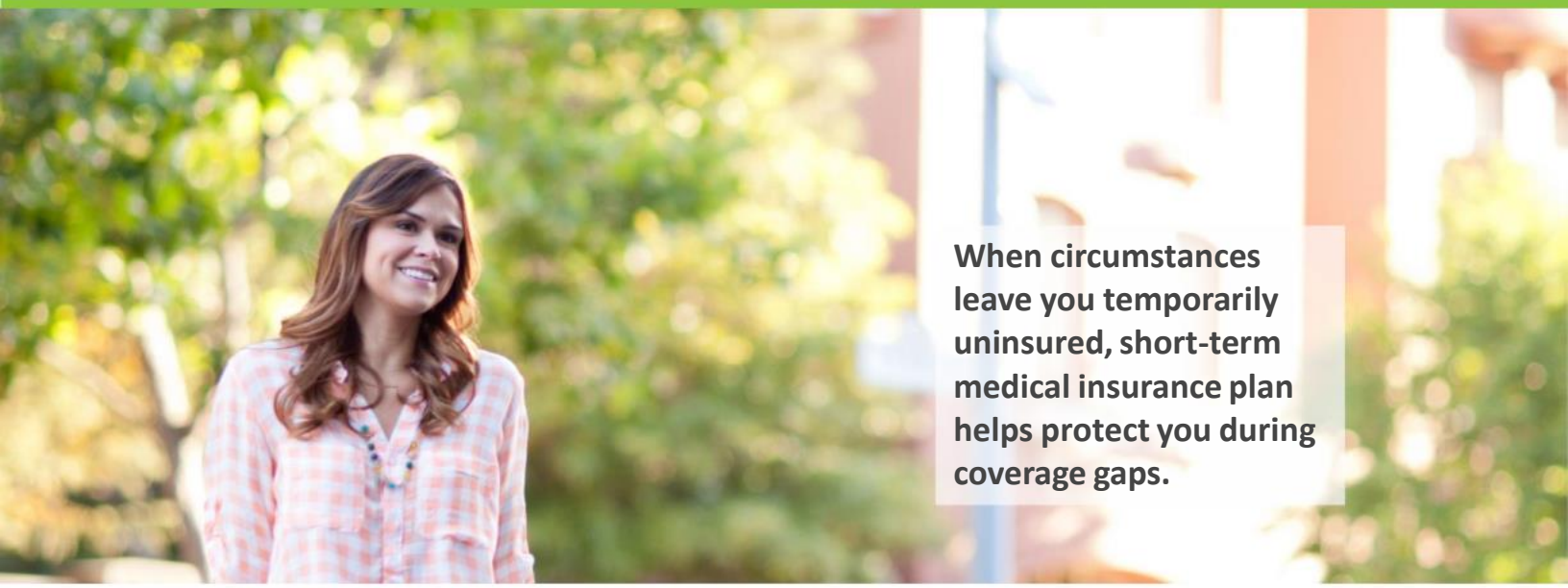

Short-Term Health Insurance offers several benefit options that allow you to find the right answer for your specific coverage needs. Short-term Medical (STM) provides limited duration insurance coverage for 30 to 364 days, which varies by state. Not all states allow for durations of 364 days.

Why STM insurance?

STM insurance plans provide insurance coverage during life transitions. When you are between group insurance or individual major medical policies, STM insurance 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.

Plan selection

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

Physician visit copay* After the copay, the balance of the doctor office visit charge is covered at 100 percent. Additional covered expenses incurred during the office visit, including expenses for laboratory and diagnostic tests will be subject to plan deductible and coinsurance. Once the visit limit is exceeded, additional covered office visits are subject to plan deductible and coinsurance.	**$50 copay per visit, subject to limits below** - 30-90 day coverage period: not to exceed one visit - 91-180 day coverage period: not to exceed two visits - 180-364 day coverage period: not to exceed three visits
Deductible The selected deductible maximum is an amount of money that must be paid by the covered person before coinsurance benefits begin. Family deductible maximum: When three covered persons in a family each satisfy their deductible, the deductibles for any remaining covered family members are considered satisfied for the remainder of the coverage period.	• $1,000 • $1,500 • $2,500 • $5,000 • $7,500 • $10,000
Coinsurance percentage and out-of-pocket maximum After the deductible maximum amount has been met, you pay the selected coinsurance percentage of covered expenses until the out-of-pocket maximum amount has been reached. The out-of-pocket maximum amount is specific to expenses applied to the coinsurance percentage; it does not include covered expenses applied to the deductible, precertification penalty amounts, or expenses not covered under the policy. Once the deductible and out-of-pocket maximum amounts have been satisfied, additional covered expenses within the coverage period are paid at 100 percent, not to exceed the coverage period maximum benefit amount. Benefit-specific maximums may also apply.	Coinsurance / Out-of-pocket 20% / $1,000 $2,000 $3,000 $4,000 30% / $1,500 $3,000 $4,500 $6,000 50% / $2,500 $5,000 $7,500 $10,000
Coverage period maximum benefit	$1,000,000

* Office visit copay is not applicable in NH

Payments to suit your situation

Short-Term Insurance offers a single or monthly premium payment using credit card or automatic bank withdrawal.

Covered expenses*

All benefits, except physician office visits applied to the copay, are subject to the selected plan deductible maximum 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 as listed in the schedule of benefits. If a benefit-specific maximum does not apply to the covered expense, benefits are limited by the coverage period maximum. Benefits may vary based on state of residence.

* Check your policy for specific details regarding covered expenses.

Covered expenses include treatment, services and supplies for:

- Physician services for treatment and diagnosis
- X-ray exams, laboratory tests and analysis
- Emergency room, outpatient hospital surgery or ambulatory surgical center
- Surgeon services in the hospital or ambulatory surgical center
- Services when a doctor administers anesthetics not to exceed 20 percent of the primary surgeon's covered charges
- Assistant surgeon services not to exceed 20 percent of the primary surgeon's covered charges
- Surgeon's assistant services not to exceed 15 percent of the primary surgeon's covered charges
- Ground ambulance services not to exceed $500 per occurrence
- Air ambulance services not to exceed $1,000 per occurrence
- Organ, tissue, or bone marrow transplants not to exceed $150,000 per coverage period
- Acquired Immune Deficiency Syndrome (AIDS) not to exceed $10,000 per coverage period
- Blood or blood plasma and their administration, if not replaced
- Oxygen, casts, non-dental splints, crutches, non-orthodontic braces, radiation and chemotherapy services and equipment rental

These services are not subject to the deductible:

- Mammography, pap smear and prostate antigen test (covered at specific age intervals and when recommended by a physician)

Inpatient covered expenses:

- Hospital room and board, doctor visits and general nursing care up to the amount billed for a semi-private room or 90 percent of the private room billed amount
- Intensive care or specialized care unit not to exceed three times the amount billed for a semi-private room or three times 90 percent the private room billed amount
- Prescription drugs administered while hospital confined for a covered illness or injury

Eligibility

Short-Term Insurance is available to the primary applicant from age 18 to 64, his or her spouse age or domestic partner 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.

Hospital and confinement definitions

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

- It is engaged primarily in providing medical care and treatment to sick and injured persons on an inpatient basis at the patient's expense;
- It provides 24-hour-a-day nursing service by a nurse;
- It is under the supervision of a staff of duly-licensed physicians;
- It provides organized facilities for diagnosis and for major operative surgery either on its premises or in facilities available on a prearranged basis

Hospital does not mean primarily a clinic, nursing home, rest or convalescent home, extended care facility, hospice or similar establishment nor, other than incidentally, a place providing care for persons with mental illness or nervous disorders, the aged, or those suffering from alcoholism or drug addiction.

Confinement in a special unit of a hospital used primarily as a nursing, rest, or convalescent home shall be deemed to be confinement in an institution other than a hospital.

Pre-existing condition limitation and definition[1]

A pre-existing condition is defined as any medical condition or illness 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.[2] Consultation means evaluation, diagnosis, or medical advice was given with or without the necessity of a personal examination or visit. Pre-existing conditions are not covered under this policy, defined below, please see Exclusions and Limitations.

[1]Definition varies by state.
[2]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.

Usual, reasonable and customary charge

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

10-day right to return period[3]

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.

Precertification

Precertification is required prior to each inpatient confinement for injury or illness and prior to receiving outpatient chemotherapy or radiation treatment, at least 10-days prior to each non-Emergency inpatient confinement or receiving treatment. Emergency inpatient confinements must be pre-certified within 48 hours following the admission, or as soon as reasonably possible. Precertification services may also conduct a continued stay review for any 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 payment and is not required in some states. Payment of benefits will be determined in accordance with and subject to all the terms, conditions, limitations and exclusions of the policy.

[3]Varies by state.

Renewability of coverage

STM is 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 grace period; you enter full-time active duty in the armed forces; or 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

- Treatment of Preexisting Conditions, as defined in the Preexisting 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;
- Complications resulting from treatment, drugs, supplies, devices, procedures or conditions which are not covered under the Policy except for Complications of Pregnancy or voluntary abortion;
- Experimental or Investigational services or treatment or unproven services or treatment;
- Educational except as specifically provided under the Policy;
- Amounts in excess of the Usual, Reasonable and Customary charges made for covered services or supplies;
- Expenses You or Your Covered Dependent are not required to pay;
- Eligible for payment by Medicare or any other government program except Medicaid;
- Care in government institutions unless You or Your Covered Dependent are obligated to pay for such care;
- Benefits are paid under workers' compensation or similar laws;
- Paid under any automobile insurance policy without regard to fault;
- 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;
- War, declared or undeclared, or from voluntary participation in a riot or insurrection;
- Expenses incurred as a result of engaging in an illegal act or occupation;
- Treatment of 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;
- The diagnosis and treatment of infertility, including any attempt to induce fertilization by any method, in vitro fertilization, artificial insemination or similar procedures, whether the Covered Person is a donor, recipient or surrogate;
- Sterilization or reversal of sterilization;
- Sex transformation or penile implants or sex dysfunction or inadequacies;
- Physical exams or other services not needed for medical treatment, except as specifically covered;
- Prophylactic Treatment, including surgery or diagnostic testing, except as specifically covered;
- The treatment of Mental Illness Disorders;
- The treatment of Substance Use Disorders;
- Programs, treatment, or procedures for tobacco use cessation;
- Suicide or attempted suicide or intentionally self-inflicted Injury, while sane;
- Dental treatment or care or 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;
- Radial keratotomy or correction of refractive error, eye refractions, vision therapy, routine vision exams to assess the initial need for, or changes to prescription eyeglasses or contact lenses, the purchase, fitting or adjustment of eyeglasses or contact lenses, or treatment of cataracts;
- Routine hearing exams to assess the need for or change to hearing aids, or the purchase, fittings or adjustments of hearing aids;
- Cosmetic or reconstructive procedures;
- Breast reduction or augmentation or complications arising from these procedures;
- Outpatient Prescriptions;
- Any drug or other item used to treat hair loss;
- The treatment of weak, strained, flat, unstable, or unbalanced feet, metatarsalgia, bunions, spurs, or the removal of corns, calluses or toenails, unless specifically for the treatment of a metabolic or peripheral vascular disease or for the prompt repair of an Injury sustained while coverage is in force for the Covered Person;
- The treatment of acne, or varicose veins;
- Weight loss programs or diets;
- Transportation Expenses;
- 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;
- Services or supplies for 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 but not limited to bathing, dressing, feeding, routine skin care, bladder care and administration of oral medications or eye drops;
- Services or supplies furnished or provided by a member of your Immediate Family;
- Diagnosis or treatment of a sleeping disorder;
- 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;
- The purchase of a noninvasive osteogenesis stimulator (bone stimulator);
- Services or supplies of a common household use, such as exercise cycles, air or water purifiers, air conditioners, allergenic mattresses, and blood pressure kits;
- 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;

- The repair or maintenance of a wheelchair, hospital-type bed or similar durable medical equipment;
- Orthotics, special shoes, spine and arch supports, heel wedges, sneakers or similar devices unless they are a permanent part of an orthopedic leg brace;
- Obesity treatment or weight reduction including all forms of intestinal and gastric bypass surgery, including the reversal of such surgery even if the Covered Person has other health conditions that might be helped by a reduction of obesity or weight;
- Marital counseling or social counseling;
- Acupuncture;
- A service or supply whose primary purpose is to provide a Covered Person with (1) training in the requirements of daily living; (2) instruction in scholastic skills such as reading and writing; (3) preparation for an occupation; (4) treatment of learning disabilities, developmental delays or dyslexia; or (5) development beyond a point where function has been demonstrably restored;
- Replacement of artificial limbs or eyes;
- Removal of breast implants unless Medically Necessary; or
- Do not meet the definition of or are not specifically identified under the Policy as Covered Expenses

This coverage is not required to comply with certain federal market requirements for health insurance, principally those contained in the Affordable Care Act. Be sure to check your policy carefully to make sure you are aware of any exclusions or limitations regarding coverage of pre-existing conditions or health benefits. 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.

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

This brochure provides a very brief description of the important features of Short-Term Insurance. 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). 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.

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 Medicare Supplement, 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 own the following agencies: (i) PetPartners 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, career agents, and Independence Brokerage Group; and (iii) The INSX Cloud Platform through My1HR, our wholly-owned Web-Based Entity. Our InsureTech division is comprised of our call centers, field and career agents, in-house MarTech artificial intelligence capabilities, and domains, including www.healthedeals.com; www.healthinsurance.org; www.medicareresources.org; www.petplace.com; and www.mypetinsurance.com.