Connect Net

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 IHC GROUP
Independence Holding Company

This plan is not considered to be Minimal Essential Coverage as defined by the Patient Protection and Affordable Care Act (ACA).

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

Connect Net provides short-term medical coverage with affordable premium, achieved through provider and facility discounts. With a nationwide network of more than 840,000 health care professionals and 6,400 hospitals, the Cigna PPO network is able to offer highly competitive discounts which impact your out-of-pocket healthcare dollars.*

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

Missed open enrollment

If you have missed the opportunity to 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.

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.

Newly hired

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

Filling the gap

Coverage can begin as early as the day following your online application, if approved, and last up to 364 days.

**"Cigna PPO" refers to the Cigna PPO for Shared Administration network of health care professionals and facilities. Cigna PPO for Shared Administration network services are administered exclusively by or through operating subsidiaries of Cigna Corporation, including Cigna Health and Life Insurance Company. The Cigna name is a registered mark of Cigna Intellectual Property, Inc.*

The PPO network available may vary based on your residential state and ZIP code.

Plan Selection

All benefits listed apply per covered person, per coverage period. In-network benefits differ from out-of-network benefits. Refer to the descriptions below the chart for additional details.

<table>
<tr><td>Office visit copay
The number of copays available is determined by the selected plan duration.
• 1 copay for 30 – 90 days of coverage
• 2 copays for 91 – 180 (6 months) of coverage
• 3 copays for 181 – 364 days of coverage</td><td>$50 copay per visit</td></tr>
<tr><td>Deductible
The selected deductible must be paid by the insured person before coinsurance benefits begin.

Family deductible maximum: Three individual deductible amounts

Out-of-network deductible: Two times the in-network deductible</td><td>In-network deductible
• $3,500
• $5,000
• $7,500
• $10,000</td></tr>
<tr><td>Coinsurance percentage and out-of-pocket
After the deductible has been met, you pay the selected percentage of in-network covered expenses until the in-network out-of-pocket has been reached. The Connect Net plan covers the remaining percentage of in-network covered charges up to the maximum benefit. The out-of-pocket amount is specific to expenses applied to coinsurance; it does not include the deductible.

Out-of-network coinsurance: 50%
Out-of-network out-of-pocket: Two times the in-network out-of-pocket amount. When 0% in-network coinsurance is selected, the out-of-network out-of-pocket amount is $7,000.</td><td><table><tr><th>In-network Coinsurance</th><th>In-network Out-of-pocket</th></tr><tr><td>0%*</td><td>• $0</td></tr><tr><td>20%</td><td>• $3,500
• $5,000
• $7,500
• $10,000</td></tr><tr><td>30%</td><td>• $3,500
• $5,000
• $7,500
• $10,000</td></tr></table></td></tr>
<tr><td>Maximum benefit</td><td>$2,000,000</td></tr>
</table>

*The $3,500 deductible is not available with the 0% in-network coinsurance selection.

Office visit copay

A $50 copay applies to the physician's consultation charge. After the copay, the plan pays 100 percent of the consultation charge balance. Additional covered expenses incurred during the office visit, including expenses for laboratory and diagnostic tests, will be subject to the plan deductible and coinsurance. Office visits above the allotted number based on the coverage duration are subject to deductible and coinsurance.

Family deductible

When three covered persons in a family each satisfy their in-network deductible, the in-network 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 in-network deductible and coinsurance out-of-pocket amounts have been satisfied, additional in-network covered charges within the coverage period are paid at 100 percent, up to the maximum benefit amount. Benefit-specific maximums may apply. The out-of-pocket does not include the deductible, any precertification penalty amounts or expenses not covered by the plan.

Out-of-network charges

When treatment, services and supplies are provided by a physician or facility that is not part of the preferred provider organization (PPO), charges are subject to a separate out-of-network deductible, coinsurance percentage and out-of-pocket. In-network and out-of-network deductibles and out-of-pocket amounts accumulate separately.

Prescription drug copay

After the plan deductible has been satisfied, a copay benefit is available for outpatient generic and formulary prescription drugs.

- **Generic**: $20 copay per prescription; covered expenses above $20 are paid at 100 percent
- **Formulary brand name**: $50 copay per prescription; covered expenses above $50 are paid at 100 percent

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.

Covered expenses include treatment, services and supplies for:

- Physician services for treatment and diagnosis
- Emergency room, outpatient hospital surgery or ambulatory surgical center charges
- Surgeon, assistant surgeon and surgeon's assistant services in the hospital or ambulatory surgical center
- Ground or air ambulance services
- Organ, tissue, or bone marrow transplants up to $150,000 per coverage period
- Acquired Immune Deficiency Syndrome (AIDS) up to a $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
- Radiation and chemotherapy services
- Oxygen, casts, non-dental splints, crutches, non-orthodontic braces and equipment rental

**The AIDS maximum of $10,000 per coverage period does not apply to policies issued to residents of AZ, CA, DC, ID, MD, ME, MO or NC. The maximum benefit in KS is $75,000 per coverage period.*

Inpatient covered expenses:

- Hospital room and board, doctor visits and general nursing care up to the amount billed for a semi-private room or 90 percent of the private room billed amount
- Intensive care or specialized care unit up to three times the amount billed for a semi-private room or three times 90 percent the private room billed amount
- Prescription drugs administered while hospital confined

Pre-existing condition

Connect Net will not provide benefits for any loss caused by or resulting from a pre-existing condition. A pre-existing condition is any medical condition or sickness for which medical advice, care, diagnosis, treatment, consultation or medication was recommended or received from a doctor within five years immediately preceding the covered person's effective date of coverage; or symptoms within the five years immediately prior to the coverage that would cause a reasonable person to seek diagnosis, care or treatment.

Usual and reasonable charge

The usual and reasonable charge for medical services or supplies is the lesser of: a) the amount usually charged by the provider for the service or supply given; or b) the average charged for the service or supply in the locality in which it is received.

With respect to the treatment of medical services, usual and reasonable means treatment that is reasonable in relationship to the service or supply given and the severity of the condition. In reaching a determination as to what amount should be considered as usual and reasonable, we may use and subscribe to a standard industry reference source that collects data and makes it available to its member companies.

Preferred provider organization (PPO) – In-network and out-of-network coverage

An in-network provider is defined as hospital, physician, pharmacy or any provider of health care services that has agreed to be part of a PPO network and, therefore, provide services and supplies at a predetermined rate. Utilizing in-network providers will result in lower total out-of-pocket costs. Since the provider has agreed to pre-determined rates, in-network charges are not subject to the usual and reasonable charge.

An out-of-network provider has not signed an agreement with the PPO network. Utilizing an out-of-network provider will result in reimbursement at the out-of-network benefit level and higher out-of-pocket costs. Out-of-network charges are subject to the usual and reasonable charge. Out-of-network provider charges in excess of the usual and reasonable charge will be the covered person's responsibility.

Out-of-network services for emergency care will be paid at the in-network benefit level, subject to the usual and reasonable charge. Also, when a covered person receives treatment, services or supplies at an in-network facility from an out-of-network anesthesiologist, assistant surgeon, pathologist or radiologist, covered expenses will be paid at the in-network benefit level, subject to the usual and reasonable charge.

Right to return period

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

Precertification

Precertification is required prior to each inpatient confinement for injury or illness, including chemotherapy or radiation treatment, at least seven days prior to receiving treatment. Emergency admissions must be pre-certified within 48 hours following the admission, or as soon as reasonably possible. Failure to complete precertification will result in a benefit reduction of 50 percent which would have otherwise been paid. Precertification is not a guarantee of benefits.

Continuing coverage

If your need for temporary health insurance continues, most states allow you to apply for another short-term medical plan. Your application is subject to eligibility, underwriting requirements and state availability of the coverage. The next coverage period is not a continuation of the previous period; it is a new plan with a new deductible, coinsurance and pre-existing condition limitation.

Coverage termination

Coverage ends on the earliest of the date: the premium is not paid when due; you enter full-time active duty in the armed forces; or Independence American Insurance Company determines fraud or misrepresentation has been made in filing a claim for benefits. A dependent's coverage ends on the earliest of the date: your coverage terminates; the dependent becomes eligible for Medicare; or the dependent ceases to be eligible.

Exclusions

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

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

eyeglasses or contact lenses, including the fitting of; treatment of cataracts; routine hearing exams or hearing aids; expenses for cosmetic or reconstructive procedures, services or supplies including breast reduction or augmentation or complications except as specifically covered; outpatient prescriptions, unless shown as included in the Schedule of Benefits; expenses incurred in connection with any drug or other item used to treat hair loss; treatment of feet unless due to injury or illness; expenses incurred in the treatment of acne, or varicose veins; weight loss programs or diets; expenses for rest or recuperation cures or care in an extended care facility, convalescent nursing home, a facility providing rehabilitative treatment, skilled nursing facility, or home for the aged, whether or not part of a hospital; transportation expenses, except as specifically covered; expenses for services or supplies for personal comfort or convenience; expenses provided by immediate family; expenses for sleeping disorders; expenses incurred in the treatment of injury or sickness resulting from participation in skydiving, scuba diving, hang or ultralight gliding, riding an all-terrain vehicle such as a dirt bike, snowmobile or go-cart, racing with a motorcycle, boat or any form of aircraft, any participation in sports for pay or profit, or participation in rodeo contests; participating in interscholastic, intercollegiate or organized competitive sports; expenses for the purchase of a noninvasive osteogenesis stimulator (bone stimulator); expenses for services or supplies of a common household use; medical care, treatment, service or supplies received outside of the United States, Canada or its possessions; expenses for spinal manipulation or adjustment; expenses for acupuncture; expenses for marital counseling or social counseling; private duty nursing services; expenses for the repair or maintenance of a wheelchair, hospital-type bed or similar durable medical equipment; orthotics, special shoes, spine and arch supports, heel wedges, sneakers or similar devices unless they are a permanent part of an orthopedic leg brace; expenses incurred in connection with the voluntary taking of a poison or inhaling gas; expenses incurred in connection with obesity treatment or weight reduction including all forms of intestinal and gastric bypass surgery, including the reversal of such surgery even if the covered person has other health conditions that might be helped by a reduction of obesity or weight; expenses for replacement of artificial limbs or eyes; removal of breast implants; or expenses for a service or supply whose primary purpose is to provide a covered person with 1) training in the requirements of daily living; 2) instruction in scholastic skills such as reading and writing; 3) preparation for an occupation; 4) treatment of learning disabilities, developmental delays or dyslexia; or 5) development beyond a point where function has been demonstrably restored.

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

THIS IS A SHORT-TERM HEALTH BENEFIT PLAN THAT IS NOT INTENDED TO QUALIFY AS THE MINIMUM ESSENTIAL COVERAGE REQUIRED BY THE AFFORDABLE CARE ACT (ACA). UNLESS YOU PURCHASE A PLAN THAT PROVIDES MINIMUM ESSENTIAL COVERAGE IN ACCORDANCE WITH THE ACA, YOU MAY BE SUBJECT TO A FEDERAL TAX PENALTY. ALSO, THE TERMINATION OR LOSS OF THIS POLICY DOES NOT ENTITLE YOU TO A SPECIAL ENROLLMENT PERIOD TO PURCHASE A HEALTH BENEFIT PLAN THAT QUALIFIES AS MINIMUM ESSENTIAL COVERAGE OUTSIDE OF AN OPEN ENROLLMENT PERIOD. THIS POLICY INCLUDES A PRE-EXISTING CONDITION EXCLUSION PROVISION.

About Independence American Insurance Company

Independence American Insurance Company (Independence American) is a wholly owned subsidiary of American Independence Corp. (NASDAQ:AMIC), an insurance holding company, and a member of The IHC Group, an organization of insurance carriers and marketing and administrative affiliates. Independence American is rated A- (Excellent) for financial strength by A.M. Best Company, a widely recognized rating agency that rates insurance companies on their relative financial strength and ability to meet policyholder obligations (an A++ rating from A.M. Best is its highest rating.). Independence American is licensed to write property and/or 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. It also sells and reinsures from its affiliate short-term medical products in a majority of the states. Independence American markets its products through IHC Risk Solutions, LLC, IHC Specialty Benefits, Inc., IPA Family, LLC, and IPA Direct, LLC, which are subsidiaries of AMIC, and through independent brokers, producers and agents.

About The IHC Group

The IHC Group is an organization of insurance carriers and marketing and administrative affiliates that has been providing life, health, disability, medical stop-loss and specialty insurance solutions to groups and individuals for over 30 years. Members of The IHC Group include Independence Holding Company (NYSE:IHC), American Independence Corp. (NASDAQ: AMIC), Standard Security Life Insurance Company of New York, Madison National Life Insurance Company, Inc. and Independence American Insurance Company. Each insurance carrier in The IHC Group has a financial strength rating of A- (Excellent) from A.M. Best Company, Inc., 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.) Collectively, the companies in The IHC Group provide insurance coverage to more than one million individuals and groups. For more information about The IHC Group, visit www.ihcgroup.com.

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