Secure STM

Short-term medical insurance
for individuals and families

Residents of California

Underwritten by Standard Security Life Insurance Company of New York, a member of The IHC Group. For more information about Standard Security Life and The IHC Group, visit www.ihcgroup.com.

THE IHC GROUP

Brochure SSL Secure STM California 0517

Secure STM short-term medical insurance offers protection when circumstances leave you temporarily uninsured.

Secure STM offers short-term medical coverage with an affordable premium, achieved through carefully selected benefit limitations. Coverage is available in California 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 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.

When to consider a short-term medical 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.
- **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.

Coverage can begin as early as the day following your online application, if approved, and last up to 90 days.

Secure STM plan selections

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

Deductible The selected deductible must be paid by the covered person before coinsurance benefits begin. Family deductible maximum is three individual deductible amounts.	• $1,000 • $2,500 • $5,000
Coinsurance percentage and out-of-pocket After the deductible has been met, the Secure STM plan pays the selected percentage of covered charges. The covered person is responsible for the remaining percentage of covered charges until the selected out-of-pocket amount has been reached. The out-of-pocket amount is specific to charges applied to coinsurance; it does not include the deductible.	• 20% coinsurance Out-of-pocket: • $2,000 • 50% coinsurance Out-of-pocket: • $5,000
Coverage-period maximum benefit	$2,000,000

Family deducticle

When three covered family members each meet their deductible, the deductibles for any remaining covered family members are considered met for the rest 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. The coinsurance out-of-pocket does not include any precertification penalty amounts or expenses not covered by the plan. Benefit-specific maximums may apply.

Payment options

Secure STM offers monthly premium payments using credit card or automatic bank withdrawal.

Utilize a network provider and save

With a Secure STM plan, you have access to discounted medical services through two 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.

MultiPlan—www.multiplan.com
One of the nation's largest networks, MultiPlan has more than 650,000 providers in 50 states, including physicians, and inpatient and outpatient facilities.

ACS—www.anci-care.com
A comprehensive network of 38,000 ancillary service providers, ACS represents providers of outpatient services, including lab and diagnostic testing, but it does not include physicians.

To search for a network healthcare provider or facility, please visit the websites listed above. At the time of service, simply present your identification card which will include the network information needed for the provider to correctly process covered charges.

MultiPlan and ACS are not affiliated with Standard Security Life Insurance Company of New York, nor are they part of this insurance plan.

Covered expenses

All benefits are subject to the selected plan deductible and coinsurance. Covered expenses are limited by the Usual, Reasonable and Customary 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:

- Doctor services for treatment and diagnosis
- X-ray exams, laboratory tests and analysis
- Mammography, Pap smear and prostate antigen test (covered at specific age intervals, not subject to the deductible)
- Emergency room, outpatient hospital surgery or ambulatory surgical center
- Surgeon services in the hospital or ambulatory surgical center
- 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
- Ground and air ambulance services, up to $250 per occurrence
- Organ, tissue, or bone marrow transplants, up to $150,000 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
- Knee injury or disorder, up to $2,500 per coverage period for both left and right knees
- Gallbladder surgery, up to $2,500 per coverage period
- Osteoporosis for services related to diagnosis, treatment, and appropriate management of osteoporosis,
- Prostate Cancer for screening and diagnosis,
- Severe Mental Illness – The coinsurance percentage for diagnosis and medically necessary treatment of severe mental illnesses of a covered person of any age and of "serious emotional disturbances" of a child under the age of 18 years, to include out-patient, in-patient and partial hospital services.
- Diabetes - self-management training and equipment
- Cancer screening tests for all generally medically accepted cancer screening tests.
- Child dental care for general anesthesia and associated facility charges for dental procedures rendered in a Hospital or surgical center setting
- Temporomandibular and Craniomandibular Joint Disease (TMJ/CMJ) for treatment of TMJ or CMJ when said treatment has been determined by the attending physician as being Medically Necessary. This provision does not include dental treatment.
- Clinical trials for cancer
- Preventive child care

Pre-existing condition limitation
Secure STM 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 6 months immediately preceding the covered person's effective date of coverage; or symptoms within the 6 months immediately prior to the coverage that would cause a reasonable person to seek diagnosis, care or treatment.

Usual, Reasonable and Customary Charge
The Usual, Reasonable and Customary 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 treatment of medical services, Usual, Reasonable and Customary 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, Reasonable and Customary, we may use and subscribe to a standard industry reference source that collects data and makes it available to its member companies.

Eligibility
Secure STM is available to all members of Communicating for America, Inc. (CA) from age 18 to 64, their spouse age 18 to 64 and dependent children up to age 26. Each applicant must qualify based on the plan's application questions and underwriting guidelines. Child-only coverage is available for children ages 2 to 17.

Effective date
Coverage can begin as early as the day following your online application submission. You may request a later effective date up to 60 days after the application date. All coverage is subject to approval and payment of the first premium.

Right to return period
If you are not completely satisfied with this coverage and have not filed a claim, you may return the Policy/Certificate of Insurance within 10 days and receive a premium refund.

Precertification
You must notify the professional review organization 10 days prior to an elective or nonemergency hospital admission or surgery and 48 hours following an emergency admission to the hospital, or as soon as reasonably possible. Failure to precertify will result in a benefit reduction of 50 percent. Precertification is not a guarantee of benefits.

Continuing coverage
Although Secure STM is not renewable, if your need for temporary health insurance continues, California allows you to apply for another Secure STM plan. Your application is subject to eligibility and underwriting requirements. 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 earlier of the date: the premium is not paid when due; you become eligible for Medicare; you enter full-time active duty in the armed forces; or fraud or misrepresentation has been made in filing a claim for benefits. A dependent's coverage ends on the earlier of the date: your coverage terminates; the dependent become eligible for Medicare; or the dependent ceases to be eligible. Additional events or circumstances may cause coverage to terminate; refer to the Policy/Certificate of Insurance for complete details.

Exclusions

The following is a partial list of services or charges not covered by Interim Coverage. Check your Certificate/Policy for a full listing.

Expenses for the 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, expenses to treat complications resulting from treatment, drugs, supplies, devices, procedures or conditions; expenses incurred for experimental or investigational services or treatment or unproven services or treatment; expenses for purposes determined by us to be educational; 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, or which would not have been billed, if no insurance existed; expenses to the extent that they are paid or payable under another group insurance or medical prepayment plan; charges that are eligible for payment by Medicare or any other government program except Medicaid; expenses for care in government institutions unless you or your covered dependent are obligated to pay for such care; expenses for which benefits are paid or payable under workers' compensation; medical expenses which are payable under any automobile insurance policy without regard to fault; expenses incurred by a covered person while on active duty in the armed forces; expenses resulting from a declared or undeclared war, or from voluntary participation in a riot or insurrection; 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; charges for a covered dependent who is 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; expenses for voluntary termination of normal pregnancy, normal childbirth or elective cesarean section; expenses incurred for any drug, including birth control pills, implants, injections, supply, treatment device or procedure that prevents conception or childbirth; expenses for the 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; expenses for sterilization or reversal of sterilization; expenses related to sex transformation or penile implants or sex dysfunction or inadequacies; expenses for physical exams or other services not needed for medical treatment, except as specifically covered; expenses for prophylactic treatment, including surgery or diagnostic testing, except as specifically covered; expenses for the treatment of alcoholism or alcohol abuse, chemical dependency, substance abuse 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 unless administered on the advice of a doctor. intoxication shall be established conclusively by a blood alcohol level of .10 or the legal limit in the state where the incident occurred, whichever is less; expenses incurred in connection with programs, treatment, or procedures for tobacco use cessation; expenses resulting from suicide or attempted suicide or intentionally self-inflicted injury, while sane or insane; expenses for dental treatment or care or orthodontia or other treatment involving the teeth or supporting structures; expenses of 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; expenses for routine hearing exams to assess the need for or change to hearing aids, or the purchase, fittings or adjustments of hearing aids; expenses for cosmetic or reconstructive procedures, services or supplies except as specifically covered; expenses for breast reduction or augmentation or complications arising from these procedures; outpatient prescription or legend drugs, medications, vitamins, and mineral or food supplements, including pre-natal vitamins, or any over-the-counter medicines, whether or not ordered by a doctor; expenses incurred in connection with any drug or other item used to treat hair loss; expenses incurred in the treatment of weak, strained, flat, unstable, or unbalanced feet, metatarsalgia, bunions, spurs, or the removal of corms, 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; expenses incurred in the treatment of acne, or varicose veins; the expenses of weight loss programs or diets and transportation expenses.

Exclusions Continued

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; expenses for 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; expenses for services or supplies furnished or provided by a member of your immediate family; expenses for diagnosis or treatment of a sleeping disorder; expenses incurred in the treatment of injury or sickness resulting from participation in skydiving, scuba diving, hang or ultra-light 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; expenses for the purchase of a noninvasive osteogenesis stimulator (bone stimulator); expenses for services or supplies of a common household use, such as exercise cycles, air or water purifiers, air conditioners, allergenic mattresses, and blood pressure kits; expenses during the first 6-months after the effective date of coverage for a covered person for a (a.) total or partial hysterectomy, unless it is medically necessary due to a diagnosis of carcinoma ; (b.) tonsillectomy; (c.) adenoidectomy; (d.) repair of deviated nasal septum or any type of surgery involving the sinus; (e.) myringotomy; (f.) tympanotomy; (g.) herniorraphy; or (h.) cholecystectomy; (subject to all other coverage provisions, including but not limited to, the pre-existing conditions exclusion); expenses for participating in interscholastic, intercollegiate or organized competitive sports; medical care, treatment, service or supplies received outside of the United States, Canada or its possessions; expenses for spinal manipulation or adjustment; expenses for private duty nursing services; expenses for the repair or maintenance of a wheelchair, hospital-type bed or similar durable mechanical equipment; expenses for 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 marital counseling or social counseling; expenses for acupuncture; 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 development beyond a point where function has been demonstrably restored; expenses for replacement of artificial limbs or eyes; expenses for removal of breast implants; or expenses that do not meet the definition of or are not specifically identified under the group policy as covered expenses.

About Standard Security Life Insurance Company of New York

Standard Security Life was founded in 1958, and is domiciled in the State of New York and headquartered in New York City. It is licensed in all 50 states, the District of Columbia, the Virgin Islands, and Puerto Rico. Standard Security Life provides various lines of life, health and disability insurance, including: employer medical stop-loss, disability benefit law (DBL), short-term medical, group major medical, individual and group dental and vision, individual accident and health insurance, group term life, specialty programs designed for volunteer emergency service personnel, including group life insurance and service awards programs. Standard Security Life is rated A- (Excellent) by 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).

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., a technology-driven insurance sales and marketing company that creates value for insurance producers, carriers and consumers (both individuals and small businesses) through a suite of proprietary tools and products (including ACA plans and small group medical stop-loss). All products are placed with highly rated carriers.

"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.

Important information

This brochure provides a brief description of the benefits, exclusions and other provisions of the Policy/Certificate of Insurance. For complete listings, see the Policy/Certificate of Insurance. Short-term medical expense coverage is available to members of Communicating for America, Inc. (CA), the Group Policyholder. Coverage is offered under a group Certificate of Insurance, Form No. SSL-STMP-1104. CA is a national, non-profit 501(c)3 association headquartered in Fergus Falls, Minn., with an office in Washington, D.C., that has been providing valued member benefits and savings since 1972. Your enrollment as a member of CA is completed upon receipt of the association dues. CA is not affiliated with Standard Security Life Insurance Company of New York, nor is it part of the insurance coverage.

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.

THE IHC GROUP