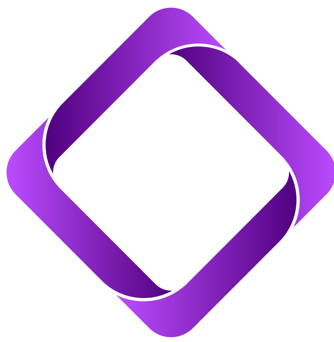


Fusion

Hospital, surgical and critical illness fixed insurance benefits designed to be paired with short-term health insurance

Fusing $0 deductible hospital benefits with large-claim coverage

Fusion fixed-benefit indemnity insurance and Fusion STM short-term medical insurance are 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. These products are not considered Minimal Essential Coverage as defined by the Patient Protection and Affordable Care Act (ACA).

Uninsured? Benefit from this blend

Going without major medical insurance can mean paying 100 percent out of pocket for unexpected healthcare. Fusion allows you to combine a fixed-benefit indemnity plan with Fusion STM, a short-term medical insurance plan. The result? Coverage for a range of medical procedures.

Fusion is a fixed-benefit indemnity plan that pays specified amounts for covered medical expenses related to hospitalization, surgery, chemotherapy and radiation services.

- **No deductible.** Your Fusion fixed benefits are not subject to a plan deductible.
- **No waiting.** Choose one of three plans that provide benefits from your first day of coverage.
- **No complex math.** Fusion pays defined benefit amounts, regardless of what your providers charge for medical services.
- **No open enrollment periods.** Secure coverage any time of year, if you qualify.

Plus, each Fusion plan includes a **$15,000** critical illness benefit for the primary insured and covered spouse. A lump-sum payment is made upon diagnosis of a covered critical illness and can be used any way you choose – medical treatment, daily household expenses, childcare or replacement of lost income while recovering. Covered critical illnesses include cancer, heart attack, stroke, coma, major organ transplant, severe burn and kidney failure.

A fixed-benefit plan may not be right for everyone. Fusion is not major medical insurance; it provides fixed benefits for covered medical expenses, outpatient surgery, chemotherapy, radiation and critical illness. Plans are carefully designed to keep premiums affordable; it is important that you review the benefits and details closely. You may be responsible for the ACA individual shared responsibility payment (tax).

Fusion STM is short-term medical insurance that provides financial protection in the event of an unexpected injury or illness. While Fusion provides first-dollar benefits, Fusion STM is designed to offer additional coverage for large expenses.

- **Added financial protection —** $2 million maximum benefit in case of serious injury or illness
- **Budget-conscious design —** Affordability through deductibles and benefits that work with the fixed-indemnity plan
- **Access to savings —** Get provider discounts through one of the nation's largest independent PPO networks
- **Two plans, true fusion —** All covered claims are credited toward the STM deductible, even if you receive a payout from the fixed-indemnity plan

A powerful pair—plain and simple

Fusion and Fusion STM plans help pay for medical expenses that range from relatively minor to catastrophic. No matter how you use them, they offer a seamless and easy enrollment, customer service and claims processing experience.

Fusion fixed-benefit plan options	Fusion 1	Fusion 2	Fusion 3
Inpatient services (per day, maximum of 10 total days)			
Inpatient hospital confinement Covers room and board, miscellaneous hospital expenses and general nursing while hospital confined. This benefit is not paid if paid under the ICU/CCU confinement benefit.	$1,000	$1,000	$1,500
Inpatient ICU/CCU confinement Covers room and board, miscellaneous hospital expenses and general nursing while confined in the intensive care unit or critical care unit of a hospital. This benefit is paid in lieu of inpatient hospital confinement.	$2,250	$2,250	$3,000
Inpatient physician visits Covers one physician visit per day during inpatient confinement.	$60	$60	$60
Inpatient surgical services (per surgery)			
Total benefit for inpatient surgical service Covers surgery performed during inpatient confinement. If two or more surgical procedures are performed through the same incision, the amount shown applies to the first surgery and 50 percent of the benefit shown applies to the second surgery. If two or more surgeries are performed through different incisions, the benefit shown applies to each surgery.	$2,250	$3,000	$9,000
Surgeon	$1,500	$2,000	$6,000
Assistant Surgeon	$300	$400	$1,200
Anesthesiologist	$450	$600	$1,800
Outpatient surgical services (per surgery)			
Total benefit for outpatient surgical service	$2,100	$3,250	$5,000
Facility Covers services and supplies provided by the outpatient surgical facility such as use of the operating room, general nursing, casts, splints and diagnostics such as radiology and pathology. This benefit is not payable if the surgery is performed in a doctor's office.	$600	$1,000	$2,000
Surgeon Covers surgeon's services when performed at an outpatient surgical facility. If two or more surgical procedures are performed through the same incision, the amount shown applies to the first surgery and 50 percent of the benefit shown applies to the second surgery. If two or more surgeries are performed through different incisions, the benefit shown applies to each surgery.	$1,000	$1,500	$2,000
Assistant Surgeon	$200	$300	$400
Anesthesiologist	$300	$450	$600
Other covered services			
Second surgical opinion Benefit payable for a second opinion prior to a surgery.	$100	$100	$100
Chemotherapy and radiation Covers outpatient chemotherapy treatment including chemotherapy medication and radiation therapy, for the treatment of cancer. Lifetime max of 100 treatments.	$500	$500	$500
Wellness and preventive care Covered services include routine physical examination including diagnostic tests that are performed during the exam, routine Pap smear, screening mammography, immunizations and prostate and colorectal cancer screening; not subject to per injury or illness deductible; coverage is limited to one visit per person, per year.	$200	$200	$200
Outpatient physician office visit or retail health clinic Maximum of four visits per person, per year.	$60	$60	$60
Outpatient urgent care or emergency room visit Maximum of four visits per person, per year.	$100	$100	$100
Critical illness benefit — **Applicant**	$15,000	$15,000	$15,000
Spouse (if covered)	$15,000	$15,000	$15,000
Child(ren)	$2,500	$2,500	$2,500

Fusion STM plan options	Fusion STM 1	Fusion STM 2	Fusion STM 3	Fusion STM 4
Deductible The deductible must be paid by the covered person before coinsurance benefits begin. When three covered persons in a family each satisfy their deductible, the deductibles for any remaining covered family members are deemed satisfied for the remainder of the coverage period.	$15,000	$15,000	$20,000	$20,000
Coinsurance and out-of-pocket After the deductible has been met, you pay the percentage of covered expenses until the out-of-pocket amount has been reached. The Fusion STM plan covers the remaining percentage of covered expenses applied to the out-of-pocket. The out-of-pocket amount is specific to expenses applied to the coinsurance; it does not include the deductible, any precertification penalty amounts or expenses not covered by the plan.	50% to $10,000	30% to $6,000	50% to $10,000	30% to $6,000
Maximum benefit Once the deductible and coinsurance out-of-pocket amounts have been satisfied, additional covered charges within the coverage period are paid at 100 percent, up to the maximum benefit amount. Benefit-specific maximums may apply.	$2,000,000	$2,000,000	$2,000,000	$2,000,000

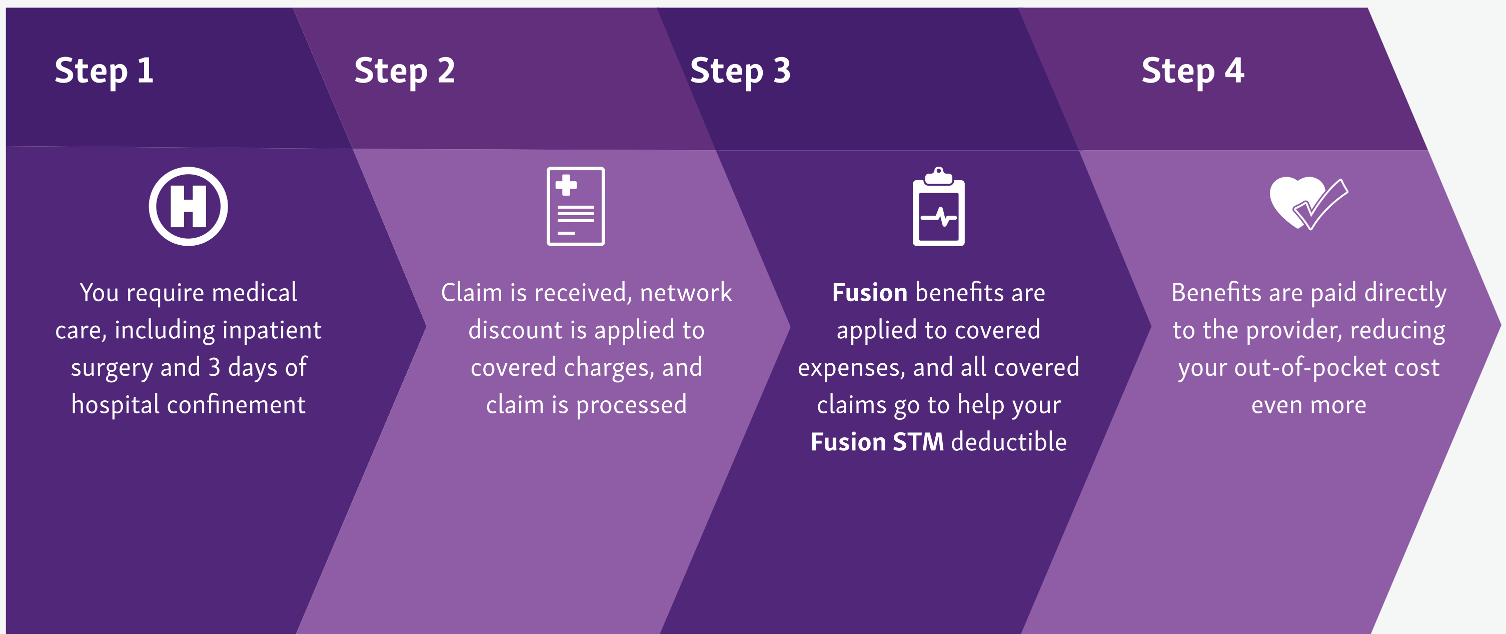
All benefits listed apply per covered person, per coverage period.
Not all Fusion STM plans may be offered with all Fusion limited-benefit plans.

Network savings

Fusion and Fusion STM benefits are available regardless of the medical providers you choose. That means you have the flexibility to use any doctor or hospital in the United States.

If you wish to save even more on out-of-pocket costs, Fusion STM offers discounts through a national PPO network. Providers in the network have agreed to negotiated discounts, which are reflected on your final medical bill.

How Fusion & Fusion STM work together



Fusion fixed-benefit medical plan details

Covered critical illness descriptions

Critical illness benefits payable are subject to the following diagnosis of each covered critical illness. Diagnosis must be made by a legally qualified physician through the use of clinical and/or laboratory findings. The critical illness benefit is not available in Georgia and South Dakota. Additional states may follow.

Cancer in situ: A diagnosis of cancer wherein the tumor cells still lie within the tissue of origin without having invaded neighboring tissue. Cancer in situ must be diagnosed pursuant to a pathological or clinical diagnosis. Cancer in situ includes early prostate cancer diagnosed as T1N0M0 or equivalent staging and melanoma not invading the dermis. Cancer in situ does NOT include: other skin malignancies, pre-malignant lesions (such as intraepithelial neoplasia), or benign tumors or polyps. The critical illness benefit for cancer in situ is 25 percent of the total benefit and is only available after the insured person has been covered at least 90 days.

Major organ transplant: The clinical evidence of major organ(s) failure which requires the malfunctioning organ(s) or tissue of the covered person to be replaced with an organ(s) or tissue from a suitable human donor (excluding the covered person) under generally accepted medical procedures. The organs and tissues covered by this definition are limited to: liver, kidney, lung, entire heart, small intestine, pancreas, pancreas-kidney or bone marrow. In order for the major organ transplant to be covered under this rider, the covered person must be registered by the United Network of Organ Sharing or the National Marrow Donor Program.

Severe burn: The diagnosis, by a legally qualified physician board-certified as a plastic surgeon, that the body has sustained third-degree burns covering at least 20 percent of the surface area of the covered person's body.

Heart attack: An acute myocardial infarction resulting in the death of a portion of the heart muscle due to a blockage of one or more coronary arteries, and resulting in the loss of normal function of the heart. The diagnosis must be made by a legally qualified physician board-certified as a cardiologist and based on both new clinical presentation and electrocardiographic changes consistent with an evolving heart attack and serial measurement of cardiac biomarkers showing a pattern and to a level consistent with the diagnosis of a heart attack. A heart attack does NOT include an established (old) myocardial infarction.

Life-threatening cancer: Life-threatening cancer is a malignant neoplasm characterized by the uncontrolled growth and spread of malignant cells and the invasion of tissue unless specifically excluded. Leukemia or lymphoma are included. Cancer must be diagnosed pursuant to a pathological or clinical diagnosis. Life-threatening cancer does not include: pre-malignant lesions (such as intraepithelial neoplasia), benign tumors or polyps, any skin cancer (other than invasive malignant melanoma in the dermis or deeper or skin malignancies that have become metastatic), or early prostate cancer diagnosed as T1N0M0 or equivalent staging. If life-threatening cancer is diagnosed within the first 90 days of coverage, then the plan will pay 10 percent of the total benefit.

Kidney (renal) failure: End-stage renal failure is a chronic and irreversible failure of both kidneys, which requires the covered person to undergo periodic and ongoing dialysis. The diagnosis must be made by a legally qualified physician board-certified in nephrology.

Stroke: Any acute cerebrovascular accident producing neurological impairment and resulting in paralysis or other measurable objective neurological deficit persisting for at least 96 hours and expected to be permanent. The diagnosis must be made by a legally qualified physician board-certified as a neurologist. A stroke does NOT include transient ischemic attack (mini-stroke), head injury, chronic cerebrovascular insufficiency and reversible ischemic neurological deficits.

Coma: The diagnosis, by a legally qualified physician board-certified as a neurologist, that a covered person is in a state of unconsciousness from which the person cannot be aroused, in which external stimulation will produce no more than primitive avoidance reflexes, and that this state has persisted continuously for at least 96 hours.

Eligibility

If you are a dues-paying member of America's Business Benefit Association (ABBA), 18 to 64-and-a-half years of age and a permanent resident of the United States, you and your eligible dependents may apply to purchase the Fusion Plan. You can apply by completing an application for insurance; you and your eligible dependents, if applying, must qualify for coverage based on the plan's underwriting guidelines. Eligible dependents include your lawful spouse/domestic partner under 64-and-a-half years of age, and your unmarried child(ren) under age 26.

Effective date

You may request that your coverage become effective on a future date that is not more than 60 days after the application date, including the next day following the application date. We must receive your application before the requested effective date. If your application is approved, your coverage will become effective on the requested effective date following approval. Your applicable premium must be paid before your coverage under the Policy goes into effect. If the company is unable to approve your application within 60 days of the application date, the requested effective date will not be honored and a new, currently dated application may be required.

Precertification

Precertification is a screening process used to determine if the proposed inpatient confinement, outpatient chemotherapy or radiation treatment is medically necessary and appropriate. Failure to obtain the required precertification will result in no benefits being paid. Precertification is required at least seven days prior to each non-emergency inpatient confinement and within 48 hours of inpatient admission or as soon as reasonably possible for emergency inpatient confinement. Precertification is also required seven days prior to receiving outpatient chemotherapy and radiation therapy. Precertification is not pre-authorization or pre-approval of coverage and it does not guarantee payment of benefits. Payment of benefits will be determined in accordance with and subject to all the terms, conditions, limitations and exclusions of the Policy.

Right to return period

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

Termination of insurance

A covered person's insurance under the Policy will terminate on the earliest of the following: the date of termination of the Policy; the premium due date following the date a written request to terminate coverage is received; the date the premium is not paid; the date of death; the last day of the month following the date of attainment of age 65; the last day of the month following the date of Medicare eligibility; the last day of the month following termination of membership with the policyholder; or the date the person enters the armed forces. A dependent spouse's coverage also terminates on the premium due date following a divorce or legal separation. A dependent child's coverage will terminate on the premium due date following the date the child ceases to meet the definition of an eligible dependent. Intentional misrepresentation or fraud on the application for coverage may result in rescission or reformation of coverage.

Coordination of benefits

The Fusion plan does not coordinate benefits with other health insurance plans.

Plan and benefit details

Daily hospital room and board and miscellaneous hospital services inpatient indemnity benefit

The daily hospital room and board benefit is paid for each day of inpatient confinement and general nursing furnished by the hospital. The benefit includes hospital miscellaneous medical services and supplies, X-rays, laboratory tests and other diagnostic tests, chemotherapy or radiation services for the treatment of cancer, services of a radiologist or radiology group, and for services of a pathologist or pathology group for interpretation of diagnostic tests or studies necessary for the treatment of the covered person while confined inpatient. This benefit does not include fees charged for take-home drugs, personal convenience items or items not intended primarily for the use of the covered person while confined inpatient. This benefit is not paid if benefits are paid under the daily hospital intensive care benefit.

Daily hospital intensive care and miscellaneous hospital services inpatient indemnity benefit

The daily hospital intensive care benefit is paid for each day of inpatient confinement in the hospital's intensive care or cardiac care unit, burn unit or other specialized care unit of a hospital. The benefit includes hospital miscellaneous medical services and supplies, X-rays, laboratory tests and other diagnostic tests, chemotherapy or radiation services for the treatment of cancer, services of a radiologist or radiology group and for services of a pathologist or pathology group for interpretation of diagnostic tests or studies necessary for the treatment of the covered person while confined inpatient. This benefit does not include fees charged for take-home drugs, personal convenience items or items not intended primarily for the use of the covered person while confined inpatient. This benefit is paid in lieu of the daily hospital room and board benefit.

Surgeon benefit

The surgeon benefit is paid per surgery and is based on whether it was performed while admitted as an inpatient or performed at an outpatient surgical facility. If two surgeries are performed through the same incision, then 100 percent of the surgeon benefit is paid for the first surgery and 50 percent of the surgeon benefit is paid for the second and subsequent surgeries. If two surgeries are performed through different incisions, then 100 percent of the surgeon benefit is paid for each surgery.

Assistant surgeon benefit

The assistant surgeon benefit is paid for services rendered by an assistant surgeon or by a licensed surgical assistant who is performing duties within the scope of his or her license. The benefit is paid per surgery and is based on whether the surgery was performed while admitted as an inpatient or performed at an outpatient surgical facility.

Anesthesiologist benefit

The anesthesiologist inpatient benefit or the anesthesiologist outpatient benefit is paid per surgery when a covered person receives anesthesia. The benefit paid is based on whether the related surgery was performed while admitted as an inpatient or performed at an outpatient surgical facility.

Outpatient surgical facility benefit

The outpatient surgical facility benefit is paid per outpatient surgery in an outpatient surgical facility and includes services and supplies furnished by the facility, such as use of the operating and recovery rooms, administration of drugs and medicines during surgery, dressings, casts, splints and diagnostic services including radiology, laboratory or pathology performed at the time of surgery. Benefits are not payable when surgery is performed in a physician's office.

Outpatient chemotherapy and radiation therapy for cancer treatment benefit

The outpatient chemotherapy and radiation therapy for cancer treatment benefit is paid per outpatient treatment for chemotherapy, including chemotherapy medication and radiation therapy for the treatment of cancer, limited to a lifetime maximum benefit of 100 treatments.

Second surgical opinion office visit benefit

This benefit pays $100 for a second surgical opinion prior to the surgery. If the second surgical opinion disagrees with the first opinion, a $100 second surgical opinion benefit will be paid for a third opinion. The benefit is only payable if the physicians providing the second and third opinions are not affiliated with each other or the original physician who will perform the surgery, or financially associated with the original physician, and do no assist in the surgery.

Hospital definition

A hospital is an institution that: operates pursuant to law; has 24-hour nursing services by registered nurses; has a staff of one or more doctors; provides inpatient therapeutic and diagnostic services for illness or injury; provides facilities for major surgery or has a formal arrangement with another institution for surgical facilities; and is approved by the Joint Commission on the Accreditation of Health Care Facilities as a hospital (JCAHO); the American Hospital Association (AHA); the American Osteopathic Healthcare Association (AOHA); the American Osteopathic Association accreditation (AOA); or the Commission on Accreditation of Rehabilitation Facilities (CARF) accreditation. The definition of a hospital does not include: a rest or nursing home, home for the aged or convalescent home; a skilled nursing facility; an extended care facility; hospice; a place for custodial care; or a birthing center.

Pre-existing conditions

A pre-existing condition is a disease, accidental bodily injury, illness or physical condition for which a covered person had treatment, incurred a charge, took medication, or received a diagnosis or advice from a doctor during the 12-month period immediately preceding the insured person's coverage effective date. Covered benefits are payable for a pre-existing condition after the insured person has been continuously covered under the Policy for 12 consecutive months. This does not apply to a newborn or newly adopted child placed for adoption under age 18 if such child is enrolled for coverage within 31 days from the date of birth, date of adoption or placement for adoption.

Fusion fixed-indemnity exclusions

Consult the Certificate of Insurance for a complete list of exclusions and description of the benefits not covered. Except as specifically provided for in the Policy, the plan does not provide any benefits when a covered person receives any of the following treatments, services or supplies:

- A pre-existing condition, as defined
- Treatment that is not medically necessary, not recommended by a doctor, or is not due to an injury or illness
- Any treatment provided by a government-owned or government-operated facility or by government-employed health care providers
- A weekend hospital confinement occurring between noon on any Friday and noon the following Sunday for non-emergency procedures, unless medically necessary or unless surgery is scheduled for the next day
- Physical or psychological examinations required by any third party, such as by a court or for employment, licensing, insurance, school, sports or recreational purposes
- An injury or illness incurred while on active duty with the military of any country or international organization, or resulting from war, act of war or participation in a riot or insurrection
- An injury or illness incurred during the commission or attempted commission of a crime or felony, or while engaged in an illegal act or while imprisoned
- An injury or illness incurred due to or contracted as a consequence of a covered person being intoxicated or under the influence of illegal narcotics or other drugs, unless the drug is administered by a doctor and taken in accordance with the prescribed dosage
- An injury or illness for which treatment, services or supplies were received or purchased outside the United States unless the charges are incurred while traveling on business or for pleasure for a period not to exceed 90 days, and the charges are incurred for an emergency provided the treatment, services or supplies used in connection with the emergency are approved for use in the United States
- Treatment, services or supplies for breast augmentation, the removal of breast implants unless medically necessary and related to surgery performed as reconstructive surgery due to an illness, and breast reduction surgery unless medically necessary due to an illness
- Surgery to correct refractive errors
- Routine eye exams, glasses or contact lenses or visual therapy
- Routine hearing exams or hearing aids
- Penile implants, fertility and sterility studies
- Voluntary abortion, infertility including impregnation techniques, or reversal of sterilization
- Mental illness disorders, substance abuse and tobacco-cessation programs and products
- Marriage or family counseling, recreational therapy, equine therapy, educational therapy, social therapy, sex therapy or sexual reassignments, dysfunctions or inadequacies
- Preventive care, including routine physical examinations and immunizations (unless the Preventive Care Benefit rider is shown as included on the schedule of benefits)
- Meridian therapy (acupuncture) or spinal manipulation
- Orthotics; treatment, services or supplies related to the feet by means of posting, strapping or range-of-motion studies or related to paring or removal corns, calluses, bunions or toenails
- Obesity or weight reduction including all forms of surgery and complications resulting from such surgery or education and training material
- Treatment for which the covered person is not required to pay, treatment rendered by a person who ordinarily resides in your household or is a member of your immediate family
- Custodial care, domiciliary care or rest cures regardless of who prescribes or renders such care, and inpatient personal convenience items
- An illness or injury which arises out of or in the course of any employment for wage or profit or an illness or injury for which you or your covered dependent spouse has or had a right to recovery under any Workers' Compensation Law or Occupational Disease Law. This exclusion does not apply to an employment related injury or illness if you or your covered dependent spouse is a sole proprietor, partner, or owner eligible under state law to legally elect to not be covered under workers' compensation and who is not insured under, and who does not have or had a right to recovery for such employment related injury or illness under any Workers' Compensation Law or Occupational Disease Law.
- An injury or illness resulting from participation in hazardous avocations including mountain or rock climbing, skydiving, hang gliding, motor vehicle racing, scuba diving, rodeo or private aviation
- Telephone consultations, missed appointment fees and fees for completing claim forms
- Treatment, services or supplies for complications of conditions that are not covered under the policy
- Outpatient prescription medications
- Treatment, services or supplies related to the teeth, gums, or any other associated structures
- Treatment for temporomandibular joint (TMJ) dysfunction
- Experimental or investigational procedures, drugs or treatment methods
- Intentionally self-inflicted injury or illness while sane except a self-inflicted injury or illness that is the result of a medical condition
- Outpatient treatment, services and supplies except as specifically provided for in the Policy
- Physical, speech or occupational therapy
- Hospice or home health care
- Treatment, services or supplies to improve the appearance or self-perception of a covered person which does not restore a bodily function including, without limitation, cosmetic or plastic surgery, hair loss or skin wrinkling, or the complications of any such treatment
- Pregnancy, except complications of pregnancy

Fusion STM short-term medical

Covered expenses

All benefits are subject to the plan deductible and coinsurance. Covered expenses are limited by the usual and reasonable charge as well as any benefit-specific maximum. If a benefit-specific maximum does not apply to the covered expense, benefits are limited by the coverage period maximum. Benefits may vary based on your state of residence.

Covered expenses include treatment, services and supplies for:

- Physician services for treatment and diagnosis
- X-ray exams, laboratory tests and analysis
- Mammography, Pap smear and prostate antigen test (covered at specific age intervals, not subject to 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 ambulance services up to $500 per occurrence
- Air ambulance services up to $1,000 per occurrence
- Organ, tissue, or bone marrow transplants up to $150,000 per coverage period
- Acquired Immune Deficiency Syndrome (AIDS) up to $10,000 per coverage period
- Blood or blood plasma and their administration, if not replaced
- Oxygen, casts, non-dental splints, crutches, non-orthodontic braces, radiation and chemotherapy services and equipment rental

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

Eligibility

Fusion STM is available to the primary applicant from age 18 to 64, his or her spouse age 18 to 64 and dependent children under the age of 26.

Pre-existing conditions

Fusion 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 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 an industry reference source that collects data and makes it available to its member companies.

Right to return period

If you are not completely satisfied with the Fusion STM 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 intentional fraud or material misrepresentation has been made in filing a claim for benefits. A dependent's coverage ends on the earliest of the date: your coverage terminates; the dependent becomes eligible for Medicare; or the dependent ceases to be eligible.

Fusion STM exclusions

The following is a partial list of services or charges not covered by Fusion STM short-term medical. 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 temporomandibular 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.

Important plan information

Fusion fixed-indemnity and Fusion STM are two seperate policies. The benefits do not coordinate. Fusion fixed-benefit indemnity insurance and Fusion STM short-term medical expense coverage are not available in all states. 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 either 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.

This brochure provides a very brief description of the important features of the Fusion fixed-benefit indemnity plan and the Fusion STM short-term medical plan. The 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 OR CERTIFICATE OF INSURANCE CAREFULLY. For complete details about the Fusion plan, refer to the Certificate Form #IAIC HICERT D610 (may vary by state). For details about the Fusion STM plan, refer to the Short Term Medical Expense Insurance Policy Form #IAIC ISTM POL 0913 (may vary by state).

About Independence American Insurance Company

Independence American Insurance Company is domiciled in Delaware and licensed to write property and/or casualty insurance in all 50 states and the District of Columbia. Its products include short-term medical, hospital indemnity, fixed indemnity limited benefit, group and individual dental, and pet insurance. Independence American is rated A- (Excellent) for financial strength by A.M. Best 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).

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.

America's Business Benefit Association (Fusion fixed-indemnity plan only)

America's Business Benefit Association (ABBA) is a national, not-for-profit association that provides individuals, small businesses and self-employed consumers with business benefits, services and health-related options, including access to valuable association-endorsed health insurance benefits.

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