Major medical plans for individuals and families

Trust Assurant Health major medical plans to provide you with strong financial protection and the benefits you need.

- Coverage for preventive care, everyday care and unexpected illnesses and accidents
- Plans in all metal levels, with a wide range of deductibles, coinsurance and out-of-pocket limits
- Plans with office visit copays and prescription drug copays available
- Health Savings Account (HSA) compatible plans available
- Broad networks of doctors and hospitals

Assurant Health gives you broad network access to more than 1,000,000 doctors and 7,600 hospitals nationwide with the Aetna Signature Administrators® PPO Network

ALL PLANS ARE MINIMUM ESSENTIAL COVERAGE UNDER THE AFFORDABLE CARE ACT.
Feel secure.
We have 120 years' of experience and an A- (Excellent) rating.

Feel confident.
You have access to convenient resources that make health care easier to understand and help you save money.

Feel respected.
No matter your question, concern or request, you can contact us knowing we’ll treat you with respect.

Get strong protection and:

EXTENSIVE NETWORKS of doctors and hospitals, featuring the Aetna Signature Administrators® PPO Network, which has more than 1,000,000 doctors and 7,600 hospitals nationwide,* including nationally recognized premier facilities.

Opportunities to enhance your coverage with supplemental plans, including dental plan options for adults and families as well as plans that pay cash benefits when you have an accident or are diagnosed with a critical illness:
- Dental plans pay cash benefits for checkups and treatment, and give you the freedom to keep your own dentist
- Cash benefits help you pay your deductible and other expenses after an accident-related injury or critical illness diagnosis

Personalized assistance and support from:
- Customer care specialists who can help you:
  - Find doctors and hospitals in your network, making it easier to save money on medical services
  - Understand how your plan works, so you can make the most of your benefits
  - Work through any issues with claims or medical billing after you receive services
- Registered nurses who can help you manage complex conditions and can serve as liaisons between you and your doctors

*Information provided by Aetna Signature Administrators PPO Network.

Not all supplemental plans are available in all states or through all distribution channels. Supplemental products are separate contracts available at an additional cost.

SUPPLEMENTAL PLANS HAVE LIMITED BENEFITS.
Get the **benefits** you need

*All Assurant Health major medical plans include the essential health benefits required in your state by the Affordable Care Act*

- Inpatient hospitalization and outpatient services
- Urgent care
- Emergency services and ambulance
- Outpatient physical medicine
- Surgical centers
- Glasses and contact lenses for children

- Maternity and newborn care
- Transplants
- Mental health and substance abuse
- Home health care, 45 visits per year
- Subacute rehabilitation and skilled nursing facilities, 90 days per year

**Preventive care paid at 100%**

To help you prevent illness and diagnose any existing conditions as early as possible, we encourage you to use your preventive care benefits such as routine exams, mammograms and child immunizations.

Your Assurant Health plan pays 100% of preventive services recommended under the Affordable Care Act when you use in-network doctors. That means you won’t pay any deductible, copay or coinsurance for covered preventive services like these:

- Women’s health
- Annual eye exams and dental checkups and cleanings for children under age 19
- Flu immunizations for children and adults

**PEDIATRIC DENTAL BENEFITS**

- Pay no deductible, copay or coinsurance for annual dental checkups and cleanings
- Receive benefits for basic and major services including orthodontics and specialists’ fees at network providers
- Save 5 to 40% when you choose a dentist in the Careington Dental Network, which has approximately 160,000 dentists nationwide

**PEDIATRIC VISION BENEFITS**

- Pay no deductible, copay or coinsurance for annual eye exams
- Receive in-network benefits for services from designated providers and glasses in designated collections
- Choose from two large providers offering glasses and contact lenses through retail locations and online

Information provided by Careington Platinum PPO Network.

Learn more about pediatric dental and vision benefits and how they work. Visit assuranthealth.com/pediatric for details.

For more details, see the benefits chart, the summary of provisions and exclusions, and your state variations document.
## IN-NETWORK SERVICES

<table>
<thead>
<tr>
<th>BRONZE PLANS</th>
<th>BROAD NETWORKS AVAILABLE</th>
<th>DEDUCTIBLE</th>
<th>COINSURANCE (We pay)</th>
<th>OUT-OF-POCKET MAXIMUM</th>
<th>OFFICE VISIT COPAY</th>
<th>PRESCRIPTION DRUGS</th>
<th>DIAGNOSTIC X-RAY/LAB BENEFIT</th>
<th>HSA COMPATIBLE</th>
<th>DEDUCTIBLE</th>
<th>COINSURANCE (We pay)</th>
<th>OUT-OF-POCKET MAXIMUM</th>
</tr>
</thead>
<tbody>
<tr>
<td>BRONZE 001</td>
<td>✓</td>
<td>$6,000</td>
<td>100%</td>
<td>$6,000</td>
<td>No copay; subject to deductible and coinsurance</td>
<td>Subject to deductible and coinsurance</td>
<td>Subject to deductible and coinsurance</td>
<td>Yes</td>
<td>$18,000</td>
<td>100%</td>
<td>$18,000</td>
</tr>
<tr>
<td>BRONZE 002</td>
<td>✓</td>
<td>$5,000</td>
<td>75%</td>
<td>$6,350</td>
<td>No copay; subject to deductible and coinsurance</td>
<td>Subject to deductible and coinsurance</td>
<td>Subject to deductible and coinsurance</td>
<td>No</td>
<td>$15,000</td>
<td>55%</td>
<td>$19,050</td>
</tr>
<tr>
<td>BRONZE 003</td>
<td>✓</td>
<td>$2,600</td>
<td>50%</td>
<td>$6,350</td>
<td>No copay; subject to deductible and coinsurance</td>
<td>Subject to deductible and coinsurance</td>
<td>Subject to deductible and coinsurance</td>
<td>Yes</td>
<td>$7,800</td>
<td>30%</td>
<td>$19,050</td>
</tr>
<tr>
<td>BRONZE 004</td>
<td>✓</td>
<td>$5,000</td>
<td>75%</td>
<td>$6,350</td>
<td>No copay; subject to deductible and coinsurance</td>
<td>Subject to deductible and coinsurance</td>
<td>Subject to deductible and coinsurance</td>
<td>No</td>
<td>$15,000</td>
<td>55%</td>
<td>$19,050</td>
</tr>
<tr>
<td>BRONZE 005</td>
<td>✓</td>
<td>$3,500</td>
<td>50%</td>
<td>$6,350</td>
<td>No copay; subject to deductible and coinsurance</td>
<td>Subject to deductible and coinsurance</td>
<td>Subject to deductible and coinsurance</td>
<td>No</td>
<td>$10,500</td>
<td>30%</td>
<td>$19,050</td>
</tr>
</tbody>
</table>

The deductible and out-of-pocket maximum shown are for an individual. The family deductible and out-of-pocket maximum are 2X the individual amounts and can be met collectively by two or more family members. With a family plan, you get this advantage:

- We’ll pay benefits for a family member once the family member meets the individual deductible. And then, we’ll pay at 100% for the family member once the family member meets the individual out-of-pocket maximum.

Plans have an ER access fee of $100. Remaining amounts are subject to plan deductible. ER access fee is waived if you are admitted into the hospital.

### In-network dental benefits for children under the age of 19

<table>
<thead>
<tr>
<th>CHECKUPS AND CLEANINGS</th>
<th>BASIC SERVICES</th>
<th>MAJOR SERVICES AND ORTHODONTICS</th>
</tr>
</thead>
<tbody>
<tr>
<td>NON-HSA PLANS</td>
<td>We pay 100%; not subject to deductible</td>
<td>We pay 80%;‡ not subject to deductible</td>
</tr>
<tr>
<td>HSA-COMPATIBLE PLANS</td>
<td>We pay 100%; not subject to deductible</td>
<td>Subject to deductible and coinsurance ‡</td>
</tr>
</tbody>
</table>

### In-network vision benefits for children under the age of 19

<table>
<thead>
<tr>
<th>ANNUAL EYE EXAMS</th>
<th>GLASSES/CONTACTS FROM DESIGNATED PROVIDERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>ALL PLANS</td>
<td>We pay 100%; not subject to deductible</td>
</tr>
</tbody>
</table>

Look for this symbol to know which plans are also available on the Marketplace.

If you are eligible for a premium tax credit (also known as a premium subsidy), it may only be applied to plans purchased on the Marketplace.

Services from doctors and hospitals that are not in your network may be subject to limitations.

‡ Generic/preferred brand/non-preferred brand copays; for plans with prescription drug deductible, preferred and non-preferred brand drugs are subject to prescription deductible before copay applies.

‡ Many specialty pharmaceuticals are paid according to medical plan benefits, not prescription drug benefits.

‡ We pay 100% once you meet out-of-pocket maximum.

This product reference guide provides summary information. Please refer to the insurance policy or ask your agent for a complete listing of benefits, exclusions and terms of coverage.

Out-of-pocket maximum includes deductible, coinsurance, office visit copays, prescription deductible and copays, and any applicable access fees. We pay 100% once you meet the out-of-pocket maximum.
### In-network Services

<table>
<thead>
<tr>
<th>SILVER PLANS</th>
<th>BROAD NETWORKS AVAILABLE</th>
<th>DEDUCTIBLE</th>
<th>COINSURANCE (We pay)</th>
<th>OUT-OF-POCKET MAXIMUM</th>
<th>OFFICE VISIT COPAY</th>
<th>PRESCRIPTION DRUGS¹</th>
<th>DIAGNOSTIC X-RAY/LAB BENEFIT</th>
<th>HSA COMPATIBLE</th>
<th>DEDUCTIBLE</th>
<th>COINSURANCE (We pay)</th>
<th>OUT-OF-POCKET MAXIMUM</th>
</tr>
</thead>
<tbody>
<tr>
<td>SILVER 001</td>
<td>✓</td>
<td>$3,500</td>
<td>100%</td>
<td>$3,500</td>
<td>No copay; subject to deductible and coinsurance</td>
<td>Subject to deductible and coinsurance</td>
<td>Yes</td>
<td>$10,500</td>
<td>100%</td>
<td>$10,500</td>
<td></td>
</tr>
<tr>
<td>SILVER 002</td>
<td>✓</td>
<td>$2,000</td>
<td>50%</td>
<td>$6,350</td>
<td>$30 for 10 visits, then subject to deductible and coinsurance</td>
<td>$15/$35/$60*</td>
<td>Subject to deductible and coinsurance</td>
<td>No</td>
<td>$6,000</td>
<td>30%</td>
<td>$19,050</td>
</tr>
<tr>
<td>SILVER 003</td>
<td>✓</td>
<td>$1,250</td>
<td>50%</td>
<td>$5,000</td>
<td>No copay; subject to deductible and coinsurance</td>
<td>Subject to deductible and coinsurance</td>
<td>First $500 paid @100%, then subject to deductible and coinsurance</td>
<td>No</td>
<td>$3,750</td>
<td>30%</td>
<td>$15,000</td>
</tr>
<tr>
<td>SILVER 004</td>
<td>✓</td>
<td>$1,850</td>
<td>50%</td>
<td>$6,350</td>
<td>$30 for 10 visits, then subject to deductible and coinsurance</td>
<td>$15/$35/$60*</td>
<td>First $500 paid @100%, then subject to deductible and coinsurance</td>
<td>No</td>
<td>$5,550</td>
<td>30%</td>
<td>$19,050</td>
</tr>
</tbody>
</table>

The deductible and out-of-pocket maximum shown are for an individual. The family deductible and out-of-pocket maximum are 2X the individual amounts and can be met collectively by two or more family members. With a family plan, you get this advantage:

- We’ll pay benefits for a family member once the family member meets the individual deductible. And then, we’ll pay at 100% for the family member once the family member meets the individual out-of-pocket maximum.

Plans have an ER access fee of $100. Remaining amounts are subject to plan deductible. ER access fee is waived if you are admitted into the hospital.

### In-network Dental Benefits for Children under the Age of 19

<table>
<thead>
<tr>
<th>CHECKUPS AND CLEANINGS</th>
<th>BASIC SERVICES</th>
<th>MAJOR SERVICES AND ORTHODONTICS</th>
</tr>
</thead>
<tbody>
<tr>
<td>NON-HSA PLANS</td>
<td>We pay 100%; not subject to deductible</td>
<td>We pay 80%;¹ not subject to deductible</td>
</tr>
<tr>
<td>HSA-COMPATIBLE PLANS</td>
<td>We pay 100%; not subject to deductible</td>
<td>Subject to deductible and coinsurance¹</td>
</tr>
</tbody>
</table>

### In-network Vision Benefits for Children under the Age of 19

<table>
<thead>
<tr>
<th>ANNUAL EYE EXAMS</th>
<th>GLASSES/CONTACTS FROM DESIGNATED PROVIDERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>ALL PLANS</td>
<td>We pay 100%; not subject to deductible</td>
</tr>
</tbody>
</table>

Services from doctors and hospitals that are not in your network may be subject to limitations.

1 Many specialty pharmaceuticals are paid according to medical plan benefits, not prescription drug benefits.

* Generic/preferred brand/non-preferred brand copays.

† We pay 100% once you meet out-of-pocket maximum.

This product reference guide provides summary information. Please refer to the insurance policy or ask your agent for a complete listing of benefits, exclusions and terms of coverage.

Out-of-pocket maximum includes deductible, coinsurance, office visit copays, prescription deductible and copays, and any applicable access fees. We pay 100% once you meet the out-of-pocket maximum.

ASSURANT HEALTH OFFERS PLANS IN ALL METAL LEVELS. TALK TO YOUR AGENT FOR DETAILS ON OTHER PLAN LEVELS.
### In-Network Services

<table>
<thead>
<tr>
<th></th>
<th>GOLD PLAN</th>
<th>OUT-OF-NETWORK SERVICES</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>GOLD PLAN</strong></td>
<td>DEDUCTIBLE</td>
<td>COINSURANCE</td>
</tr>
<tr>
<td><strong>GOLD 002</strong></td>
<td>$0</td>
<td>75%</td>
</tr>
</tbody>
</table>

The deductible and out-of-pocket maximum shown are for an individual. The family deductible and out-of-pocket maximum are 2X the individual amounts and can be met collectively by two or more family members. With a family plan, you get this advantage:

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*Plan has an ER access fee of $100. Remaining amounts are subject to plan deductible. ER access fee is waived if you are admitted into the hospital.*

### In-Network Dental Benefits for Children under the Age of 19

<table>
<thead>
<tr>
<th>CHECKUPS AND CLEANINGS</th>
<th>BASIC SERVICES</th>
<th>MAJOR SERVICES AND ORTHODONTICS</th>
</tr>
</thead>
<tbody>
<tr>
<td>We pay 100%; not subject to deductible</td>
<td>We pay 80%;‡ not subject to deductible</td>
<td>We pay 50%;‡ not subject to deductible</td>
</tr>
</tbody>
</table>

### In-Network Vision Benefits for Children under the Age of 19

<table>
<thead>
<tr>
<th>ANNUAL EYE EXAMS</th>
<th>GLASSES/CONTACTS FROM DESIGNATED PROVIDERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>We pay 100%; not subject to deductible</td>
<td>Subject to deductible and coinsurance‡</td>
</tr>
</tbody>
</table>

Services from doctors and hospitals that are not in your network may be subject to limitations.

1 Many specialty pharmaceuticals are paid according to medical plan benefits, not prescription drug benefits.

‡ Generic/preferred brand/non-preferred brand copays.

‡‡ We pay 100% once you meet out-of-pocket maximum.

This product reference guide provides summary information. Please refer to the insurance policy or ask your agent for a complete listing of benefits, exclusions and terms of coverage.

*Out-of-pocket maximum includes deductible, coinsurance, office visit copays, prescription deductible and copays, and any applicable access fees. We pay 100% once you meet the out-of-pocket maximum.*
### IN-NETWORK SERVICES

<table>
<thead>
<tr>
<th>Broad Networks Available</th>
<th>Deductible</th>
<th>Coinsurance (We pay)</th>
<th>Out-of-Pocket Maximum</th>
<th>Office Visit Copay</th>
<th>Prescription Drugs¹</th>
<th>Diagnostic X-Ray/Lab Benefit</th>
<th>HSA Compatible</th>
<th>Deductible</th>
<th>Coinsurance (We pay)</th>
<th>Out-of-Pocket Maximum</th>
</tr>
</thead>
<tbody>
<tr>
<td>PLATINUM PLAN</td>
<td>$0</td>
<td>75%</td>
<td>$2,000</td>
<td>$25 for unlimited visits</td>
<td>$10/$30/$50*</td>
<td>Subject to deductible and coinsurance</td>
<td>No</td>
<td>$5,000</td>
<td>50%</td>
<td>$10,000</td>
</tr>
</tbody>
</table>

The deductible and out-of-pocket maximum shown are for an individual. The family deductible and out-of-pocket maximum are 2X the individual amounts and can be met collectively by two or more family members. With a family plan, you get this advantage:

- We’ll pay benefits for a family member once the family member meets the individual deductible. And then, we’ll pay at 100% for the family member once the family member meets the individual out-of-pocket maximum.

* Plan has an ER access fee of $100. Remaining amounts are subject to plan deductible. ER access fee is waived if you are admitted into the hospital.

#### In-network dental benefits for children under the age of 19

<table>
<thead>
<tr>
<th>Checkups and Cleanings</th>
<th>Basic Services</th>
<th>Major Services and Orthodontics</th>
</tr>
</thead>
<tbody>
<tr>
<td>We pay 100%; not subject to deductible</td>
<td>We pay 80%;¹ not subject to deductible</td>
<td>We pay 50%;¹ not subject to deductible</td>
</tr>
</tbody>
</table>

#### In-network vision benefits for children under the age of 19

<table>
<thead>
<tr>
<th>Annual Eye Exams</th>
<th>Glasses/Contacts from Designated Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>We pay 100%; not subject to deductible</td>
<td>Subject to deductible and coinsurance²</td>
</tr>
</tbody>
</table>

Services from doctors and hospitals that are not in your network may be subject to limitations.

1 Many specialty pharmaceuticals are paid according to medical plan benefits, not prescription drug benefits.

* Generic/preferred brand/non-preferred brand copays.

† We pay 100% once you meet out-of-pocket maximum.

This product reference guide provides summary information. Please refer to the insurance policy or ask your agent for a complete listing of benefits, exclusions and terms of coverage.

Out-of-pocket maximum includes deductible, coinsurance, office visit copays, prescription deductible and copays, and any applicable access fees. We pay 100% once you meet the out-of-pocket maximum.

---

Look for this symbol to know which plans are also available on the Marketplace.

If you are eligible for a premium tax credit (also known as a premium subsidy), it may only be applied to plans purchased on the Marketplace.
## Catastrophic Plan

<table>
<thead>
<tr>
<th>IN-NETWORK SERVICES</th>
<th>OUT-OF-NETWORK SERVICES</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CATASTROPHIC PLAN</strong></td>
<td></td>
</tr>
<tr>
<td>Broad Networks Available</td>
<td>Deductible (We pay)</td>
</tr>
<tr>
<td>IN-NETWORK SERVICES</td>
<td>COINSURANCE</td>
</tr>
<tr>
<td><strong>CATASTROPHIC</strong></td>
<td>$6,600</td>
</tr>
</tbody>
</table>

The deductible and out-of-pocket maximum shown are for an individual. The family deductible and out-of-pocket maximum are 2X the individual amounts and can be met collectively by two or more family members. With a family plan, you get this advantage:

- We'll pay benefits for a family member once the family member meets the individual deductible. And then, we’ll pay at 100% for the family member once the family member meets the individual out-of-pocket maximum.

Plan has an ER access fee of $100. Remaining amounts are subject to plan deductible. ER access fee is waived if you are admitted into the hospital.

### In-network dental benefits for children under the age of 19

- **CHECKUPS AND CLEANINGS**
  - We pay 100%; not subject to deductible

- **BASIC SERVICES**
  - Subject to deductible and coinsurance

- **MAJOR SERVICES AND ORTHODONTICS**
  - Subject to deductible and coinsurance

### In-network vision benefits for children under the age of 19

- **ANNUAL EYE EXAMS**
  - We pay 100%; not subject to deductible

- **GLASSES/CONTACTS FROM DESIGNATED PROVIDERS**
  - Subject to deductible and coinsurance

Services from doctors and hospitals that are not in your network may be subject to limitations.

1 Many specialty pharmaceuticals are paid according to medical plan benefits, not prescription drug benefits.

This product reference guide provides summary information. Please refer to the insurance policy or ask your agent for a complete listing of benefits, exclusions and terms of coverage.

Out-of-pocket maximum includes deductible, coinsurance, office visit copays, prescription deductible and copays, and any applicable access fees. We pay 100% once you meet the out-of-pocket maximum.

Special eligibility criteria apply for the Catastrophic plan. You must be:

- Age 29 or younger or
- Age 30 or older and have received a certificate for a hardship exemption obtained from your Marketplace.
Terms and provisions

RECEIVING ANCILLARY SERVICES
As long as you use hospitals and admitting physicians that are part of your network, your covered charges will be handled as in-network services even when affiliated physicians and other health care providers (e.g., radiologists, anesthesiologists, pathologists or surgeons) are not part of your network. All charges are subject to the maximum allowable amount.

EMERGENCY CARE BENEFIT
In emergency situations, covered charges will be handled as in-network services, no matter where services are performed. All charges are subject to the maximum allowable amount.

OUT-OF-NETWORK SERVICES
If you use a doctor or hospital that is not part of your network, you will not receive network discounts and you may incur additional expenses. For instance, office visit copays are not accepted by providers who are not part of your network, and the services will be handled as any other out-of-network service, subject to the maximum allowable amount.

MAXIMUM ALLOWABLE AMOUNT
The maximum allowable amount is the most your plan pays for covered services. If you use an out-of-network provider, you are responsible for any balance in excess of the maximum allowable amount.

MEDICALLY NECESSARY CARE
To be covered, treatment, services and supplies must be medically necessary.

UTILIZATION REVIEW
Authorization is required before receiving certain types of inpatient and outpatient treatment. Failure to authorize services for transplants and specialty pharmacy will result in a reduction or exclusion of coverage.

SPECIALTY PHARMACEUTICAL DRUGS
Specialty drugs must be obtained from a designated specialty pharmacy provider as designated by Assurant Health to be considered at the in-network benefit level. Specialty drugs obtained from a non-designated provider will not be covered. Benefits will not be paid for any specialty drugs that are not authorized by the medical review manager.

TRANSPLANTS
Benefits for kidney, cornea and skin transplants are the same as for any other illness. Benefits for other covered transplants (e.g., heart, bone marrow, liver) have no special limits when using in-network providers. There is a limit of $10,000 for travel expenses for the covered person and a companion when you use an in-network provider. Donor expenses are covered to a maximum of $10,000.

DIABETIC SERVICES
Eye exams are limited to one exam on both eyes per calendar year, and foot exams are limited to two exams on both feet per calendar year. Nutritional counseling is covered at first diagnosis and upon change in condition.

PEDIATRIC DENTAL AND VISION BENEFITS
Dental exams are limited to one exam every six months. Eyewear benefits consist of a choice of one pair of glasses (frames and lenses) or an annual supply of contact lenses per calendar year.

MATERNITY AND NEWBORN CARE
Postpartum home visit benefits are limited to one visit per delivery.

RENEWABILITY
Coverage is renewable provided there is compliance with the plan provisions, including dependent eligibility requirements; there has been no discontinuation of the plan or Assurant Health’s business operations in this state; and/or you have not moved to a state where this plan is not offered. Assurant Health has the right to change premium rates upon providing appropriate notice.

Exclusions
We want you to understand your plan and your coverage. To help you do that, here is a summary of what is not covered by your plan. Complete details are included in your insurance contract.
We will not pay benefits for any of the following:
1. Charges for which our liability cannot be determined because a covered person, health care practitioner, facility, or other individual or entity within 30 days of our request, failed to:
   a. Authorize the release of all medical records to us and other information we requested.
   b. Provide us with information we requested about pending claims, other insurance coverage or proof of creditable coverage.
   c. Provide us with information as required by any contract with us or a network, including but not limited to repricing information.
   d. Provide us with information that is accurate and complete.
   e. Have any examination completed as we requested.
   f. Provide reasonable cooperation to any requests made by us.
2. Charges that:
   a. Are not specifically listed as a covered charge in the Medical Benefits section.
   b. Are complications of a non-covered service.
   c. Are incurred before the covered person’s effective date or after the termination date of coverage.
   d. Are not documented in the health care practitioner’s or medical supply provider’s records.
   e. Are related to the supervision of laboratory services that do not involve written consultation by a health care practitioner, including but not limited to laboratory interpretation.
   f. Are complications resulting from leaving a licensed medical facility against the advice of the covered person’s health care practitioner.
3. Charges that are:
   a. Payable or reimbursable by Medicare Part A, Part B or Part D, where permitted by law.
   b. Provided by a non-participating provider.
   c. For free treatment provided in a federal, veteran’s, state or municipal medical facility.
   d. For free services provided in a student health center.
   e. For services that a covered person has no legal obligation to pay or for which no charge would be made if the covered person did not have a health plan or insurance coverage.
4. Charges for particular treatment, services, supplies or drugs that are billed by a non-participating provider that waives the covered person's payment obligation of any copayment, coinsurance and/or deductible amounts for treatment, services, supplies or drugs, except as provided for under contract with agreement with us.
5. Charges for work-related sickness or injury eligible for benefits under worker’s compensation, employers’ liability or similar laws, even when the covered person does not file a claim for benefits. This exclusion will not apply to any of the following:
   a. The sole proprietor, if the covered person's employer is a proprietorship.
   b. A partner of the covered person's employer, if the employer is a partnership.
   c. A covered person who is not required to have coverage under any worker’s compensation, employers’ liability or similar law and does not have such coverage.
6. Charges for which a covered person is entitled to payment under any motor vehicle medical payment or premises medical expense coverage. Coverage under this plan is secondary to medical payment or medical expense coverage available to the covered person, regardless of whether such other coverage is described as secondary, excess or contingent.
7. Charges caused by or contributed to by:
   a. War or any act of war, whether declared or undeclared.
   b. Participation in the military service of any country or international organization, including non-military units supporting such forces.
8. Charges for:
   a. Glasses, except as otherwise covered for outpatient diabetic services in the Medical Benefits section.
   b. Contact lenses, except as otherwise covered for outpatient diabetic services in the Medical Benefits section.
   c. Bridges, crowns, caps, dentures, dental implants or other dental prostheses; dental braces or dental appliances, except as otherwise covered under the Durable Medical Equipment section; extraction of teeth; orthodontic charges, except as otherwise covered for any appliance, medical or surgical organization, including non-military units supporting such forces.
11. Charges for:
   a. Malocclusion or Mandibular Protrusion or Recession.
   b. Maxillary or Mandibular Hyperplasia.
   c. Maxillary or Mandibular Hypoplasia.
13. Charges for any diagnosis, supplies, treatment or regimen, whether medical or surgical, for purposes of controlling the covered person’s weight or related to obesity or morbid obesity, whether or not weight reduction is medically necessary or appropriate or regardless of potential benefit to the covered person. Charges for morbid or obesity, except as otherwise covered in the Outpatient Medical Services provision in the Medical Benefits section; weight reduction or weight control surgery, treatment or programs, except as otherwise covered in the Outpatient Medical Services provision in the Medical Benefits section; any type of medical or surgical termination of pregnancy, except as otherwise covered in the Outpatient Medical Services provision in the Medical Benefits section; suction lpectomy; physical fitness programs, exercise equipment or exercise therapy, including health club membership fees or services; nutritional counseling, except as otherwise covered in the Outpatient Medical Services and Preventive Medicine and Wellness Services provisions in the Medical Benefits section.

14. Charges for transplant services that are:
   a. Authorized by us to treat a specific medical condition if they are performed to treat a different medical condition that would not have been authorized by us.
   b. Not specifically listed as a covered transplant in the Inpatient Hospitalization Services provision in the Medical Benefits section.
   c. For multiple organ, tissue and cellular transplants during one operative session, except for a simultaneous heart/lung, double lung, simultaneous small bowel/liver, simultaneous kidney/liver or simultaneous kidney/pancreas transplant.
   d. For any non-human (including animal or mechanical) to human organ transplant.
   e. For the purchase price of an organ or tissue that is sold rather than donated.

15. Charges for chemical peels, reconstructive or plastic surgery that does not alleviate a functional impairment and other charges that are primarily a cosmetic service, except as otherwise covered in the Outpatient Medical Services provision in the Medical Benefits section.

16. Charges for revision of breast surgery for capsular contraction, removal or replacement of a prosthesis or augmentation or reduction mammoplasty, except as otherwise covered in the Outpatient Medical Services provision in the Medical Benefits section.

17. Charges for prophylactic treatment, services or surgery, including but not limited to prophylactic mastectomy or mammography tests for BRCA gene and the covered person meets our medical policies for breast cancer risk management.

18. Charges for:
   a. A private duty nurse; a private duty professional skilled nursing service; a masseur, masseuse or massage therapist; a rolfer; a home health aide or personal care attendant, with similar training and experience; a family, a health care practitioner or provider.
   b. Charges that are not medically necessary.
   c. Charges in excess of the maximum allowable amount, as determined by us.
   d. Charges that do not meet the definition of a covered charge in this plan, including but not limited to:
      a. Charges in excess of the maximum allowable amount, as determined by us under this plan except as otherwise shown in the Benefit Summary.
      b. Charges that are not medically necessary.

19. Charges for growth hormone therapy, including growth hormone medication and its derivatives or other drugs used to stimulate, promote or delay growth or to delay puberty to allow for increased growth, except as otherwise covered growth hormone therapy services in the Medical Benefits section.

20. Charges related to non-spontaneous abortion.

21. Charges related to the following conditions, regardless of underlying causes: sex transformation; gender dysphoric disorder; gender reassignment; treatment of sexual function, dysfunction or inadequacy; treatment to enhance, restore or improve sexual energy, performance or desire.

22. Charges for:
   a. Genetic testing or counseling, except for BRCA genetic testing, genetic services and related procedures for screening purposes, including but not limited to amniocentesis and chorionic villi testing.
   b. Infertility treatment for males or females, including but not limited to drugs and medications regardless of intended use, artificial insemination, invitro fertilization, reversal of reproductive sterilization and related tests, services or procedures and any treatment to promote conception, except as otherwise covered infertility diagnostic evaluation and testing services in the Medical Benefits section.

23. Charges for:
   a. Genetic testing or counseling, except for BRCA genetic testing, genetic services and related procedures for screening purposes, including but not limited to amniocentesis and chorionic villi testing.
   b. Inpatient treatment of chronic pain disorders, except as medically necessary.
   c. The treatment or prevention of hair loss.
   d. Health care practitioner administrative expenses, including but not limited to expenses for claim filing, contacting utilization review organizations or case management fees.
   e. Missed appointments.
   f. Sales tax; gross receipt tax.
   g. Living expenses; travel; transportation, except as otherwise covered in the Emergency and Ambulance Services provision, or transplants organizations or case management fees.
   h. Treatment of obesity or morbid obesity, whether or not weight or related to obesity or morbid obesity, except as otherwise covered in the Outpatient Medical Services provision in the Medical Benefits section.
   i. Treatment or services that are furnished primarily for the personal comfort or convenience of the covered person, covered person’s family, a health care practitioner or provider.

24. Charges related to the following conditions, regardless of underlying causes: sex transformation; gender dysphoric disorder; gender reassignment; treatment of sexual function, dysfunction or inadequacy; treatment to enhance, restore or improve sexual energy, performance or desire.

25. Charges for:
   a. Charges for services ordered, directed or performed by a health care practitioner or supplies purchased from a medical supply provider who ordinarily resides with a covered person.
   b. Charges incurred for experimental or investigational services, except for drugs and medicines prescribed for treatment of a sickness or an injury that is not covered under this plan. Charges for drugs, medications or other substances that are illegal under federal law, such as marijuana, even if they are prescribed for a medical use in a state. This includes but is not limited to items dispensed by a health care practitioner.

26. Charges related to the following conditions, regardless of underlying causes: sex transformation; gender dysphoric disorder; gender reassignment; treatment of sexual function, dysfunction or inadequacy; treatment to enhance, restore or improve sexual energy, performance or desire.

27. Charges for:
   a. Authorized by us to treat a specific medical condition if they are performed to treat a different medical condition that would not have been authorized by us.
   b. Not specifically listed as a covered transplant in the Inpatient Hospitalization Services provision in the Medical Benefits section.
   c. For multiple organ, tissue and cellular transplants during one operative session, except for a simultaneous heart/lung, double lung, simultaneous small bowel/liver, simultaneous kidney/liver or simultaneous kidney/pancreas transplant.
   d. For any non-human (including animal or mechanical) to human organ transplant.
   e. For the purchase price of an organ or tissue that is sold rather than donated.

28. Charges for services provided by or through a school system.

29. Charges related to the following conditions, regardless of underlying causes: sex transformation; gender dysphoric disorder; gender reassignment; treatment of sexual function, dysfunction or inadequacy; treatment to enhance, restore or improve sexual energy, performance or desire.

30. Charges for: vocational or work hardening programs; transitional living.

31. Charges for:
   a. Authorized by us to treat a specific medical condition if they are performed to treat a different medical condition that would not have been authorized by us.
   b. Not specifically listed as a covered transplant in the Inpatient Hospitalization Services provision in the Medical Benefits section.
   c. For multiple organ, tissue and cellular transplants during one operative session, except for a simultaneous heart/lung, double lung, simultaneous small bowel/liver, simultaneous kidney/liver or simultaneous kidney/pancreas transplant.
   d. For any non-human (including animal or mechanical) to human organ transplant.
   e. For the purchase price of an organ or tissue that is sold rather than donated.

32. Charges for:
   a. Authorized by us to treat a specific medical condition if they are performed to treat a different medical condition that would not have been authorized by us.
   b. Not specifically listed as a covered transplant in the Inpatient Hospitalization Services provision in the Medical Benefits section.
   c. For multiple organ, tissue and cellular transplants during one operative session, except for a simultaneous heart/lung, double lung, simultaneous small bowel/liver, simultaneous kidney/liver or simultaneous kidney/pancreas transplant.
   d. For any non-human (including animal or mechanical) to human organ transplant.
   e. For the purchase price of an organ or tissue that is sold rather than donated.

33. Charges for services ordered, directed or performed by a health care practitioner or supplies purchased from a medical supply provider who ordinarily resides with a covered person.

34. Charges for:
   a. Charges in excess of the maximum allowable amount, as determined by us.
   b. Charges that are not medically necessary.
   c. Charges in excess of the maximum allowable amount, as determined by us under this plan except as otherwise shown in the Benefit Summary.
   d. Charges that are not medically necessary.

35. Charges for:
   a. Charges in excess of the maximum allowable amount, as determined by us under this plan except as otherwise shown in the Benefit Summary.
   b. Charges in excess of the maximum allowable amount, as determined by us under this plan except as otherwise shown in the Benefit Summary.

36. Charges for:
   a. Charges in excess of the maximum allowable amount, as determined by us under this plan except as otherwise shown in the Benefit Summary.
   b. Charges in excess of the maximum allowable amount, as determined by us under this plan except as otherwise shown in the Benefit Summary.

37. Charges for:
   a. Charges in excess of the maximum allowable amount, as determined by us under this plan except as otherwise shown in the Benefit Summary.
   b. Charges in excess of the maximum allowable amount, as determined by us under this plan except as otherwise shown in the Benefit Summary.

38. Charges for:
   a. Charges in excess of the maximum allowable amount, as determined by us under this plan except as otherwise shown in the Benefit Summary.
   b. Charges in excess of the maximum allowable amount, as determined by us under this plan except as otherwise shown in the Benefit Summary.

39. Charges for:
   a. Charges in excess of the maximum allowable amount, as determined by us under this plan except as otherwise shown in the Benefit Summary.
Charges for vitamins and/or vitamin combinations even if they are prescribed by a health care practitioner except for: a) Legend prenatal vitamin prescription drugs when the prenatal vitamins are prescribed during pregnancy; b) clinically proven vitamin deficiency syndromes that cannot be corrected by dietary intake; or c) vitamins covered in accordance with the Preventive Medicine and Wellness Services provision of the Medical Benefits section.

Charges for any over-the-counter or prescription products, drugs or medications in the following categories, whether or not prescribed by a health care practitioner: a) Herbal or homeopathic medicines or products. b) Minerals. c) Health and beauty aids. d) Batteries, except as otherwise covered in the Durable Medical Equipment and Personal Medical Equipment provision in the Medical Benefits section. e) Appetite suppressants. f) Dietary or nutritional substances or dietary supplements. g) Nutraceuticals.

t. Tube feeding formulas and infant formulas, except those in accordance with the Outpatient Medical Services and Preventive Medicine and Wellness Services provisions of the Medical Benefits section.
i. Medical foods, except as otherwise covered in the Outpatient Medical Services provision of the Medical Benefits section.

Charges for any over-the-counter drugs or medications in the following categories, whether or not prescribed by a health care practitioner: NSAIDs, H2 antagonists, laxatives, protectants, PPI’s, and antihistamines.

Charges for cranial orthotic devices that are used to redirect growth of the skull bones or reduce cranial asymmetry, except following cranial surgery.

Charges for: home traction units; home defibrillators; or other medical devices designed to be used at home, except as otherwise covered in the Durable Medical Equipment and Personal Medical Equipment provision or covered diabetic services under the Medical Benefits section.

Charges for: any injectable medications that are not specifically authorized by us under the Medical Benefits section or Outpatient Prescription Drug Benefits section; any administrative charge for drug injections.

Charges for: drugs dispensed at or by a health care practitioner’s office, clinic, hospital or other non-pharmacy setting for take home by the covered person; amounts above the contracted rate for participating pharmacy or designated specialty pharmacy provider reimbursement; the difference between the cost of the prescription order at a nonparticipating pharmacy and the contracted rate that would have been paid for the same prescription order had a participating pharmacy or designated specialty pharmacy provider been used.

Charges for: home traction units; home defibrillators; or other medical devices designed to be used at home, except as otherwise covered in the Durable Medical Equipment and Personal Medical Equipment provision or covered diabetic services under the Medical Benefits section.

Charges for: any injectable medications that are not specifically authorized by us under the Medical Benefits section or Outpatient Prescription Drug Benefits section; any administrative charge for drug injections.

Charges for: home traction units; home defibrillators; or other medical devices designed to be used at home, except as otherwise covered in the Durable Medical Equipment and Personal Medical Equipment provision or covered diabetic services under the Medical Benefits section.

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Charges for: any injectable medications that are not specifically authorized by us under the Medical Benefits section or Outpatient Prescription Drug Benefits section; any administrative charge for drug injections.

Charges for: drugs dispensed at or by a health care practitioner’s office, clinic, hospital or other non-pharmacy setting for take home by the covered person; amounts above the contracted rate for participating pharmacy or designated specialty pharmacy provider reimbursement; the difference between the cost of the prescription order at a nonparticipating pharmacy and the contracted rate that would have been paid for the same prescription order had a participating pharmacy or designated specialty pharmacy provider been used.

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Charges for: any injectable medications that are not specifically authorized by us under the Medical Benefits section or Outpatient Prescription Drug Benefits section; any administrative charge for drug injections.

Charges for: drugs dispensed at or by a health care practitioner’s office, clinic, hospital or other non-pharmacy setting for take home by the covered person; amounts above the contracted rate for participating pharmacy or designated specialty pharmacy provider reimbursement; the difference between the cost of the prescription order at a nonparticipating pharmacy and the contracted rate that would have been paid for the same prescription order had a participating pharmacy or designated specialty pharmacy provider been used.

Charges for: home traction units; home defibrillators; or other medical devices designed to be used at home, except as otherwise covered in the Durable Medical Equipment and Personal Medical Equipment provision or covered diabetic services under the Medical Benefits section.

Charges for: any injectable medications that are not specifically authorized by us under the Medical Benefits section or Outpatient Prescription Drug Benefits section; any administrative charge for drug injections.

Charges for: drugs dispensed at or by a health care practitioner’s office, clinic, hospital or other non-pharmacy setting for take home by the covered person; amounts above the contracted rate for participating pharmacy or designated specialty pharmacy provider reimbursement; the difference between the cost of the prescription order at a nonparticipating pharmacy and the contracted rate that would have been paid for the same prescription order had a participating pharmacy or designated specialty pharmacy provider been used.

Charges for: home traction units; home defibrillators; or other medical devices designed to be used at home, except as otherwise covered in the Durable Medical Equipment and Personal Medical Equipment provision or covered diabetic services under the Medical Benefits section.

Charges for: any injectable medications that are not specifically authorized by us under the Medical Benefits section or Outpatient Prescription Drug Benefits section; any administrative charge for drug injections.

Charges for: drugs dispensed at or by a health care practitioner’s office, clinic, hospital or other non-pharmacy setting for take home by the covered person; amounts above the contracted rate for participating pharmacy or designated specialty pharmacy provider reimbursement; the difference between the cost of the prescription order at a nonparticipating pharmacy and the contracted rate that would have been paid for the same prescription order had a participating pharmacy or designated specialty pharmacy provider been used.

Charges for: home traction units; home defibrillators; or other medical devices designed to be used at home, except as otherwise covered in the Durable Medical Equipment and Personal Medical Equipment provision or covered diabetic services under the Medical Benefits section.

Charges for: any injectable medications that are not specifically authorized by us under the Medical Benefits section or Outpatient Prescription Drug Benefits section; any administrative charge for drug injections.

Charges for: drugs dispensed at or by a health care practitioner’s office, clinic, hospital or other non-pharmacy setting for take home by the covered person; amounts above the contracted rate for participating pharmacy or designated specialty pharmacy provider reimbursement; the difference between the cost of the prescription order at a nonparticipating pharmacy and the contracted rate that would have been paid for the same prescription order had a participating pharmacy or designated specialty pharmacy provider been used.

Charges for: home traction units; home defibrillators; or other medical devices designed to be used at home, except as otherwise covered in the Durable Medical Equipment and Personal Medical Equipment provision or covered diabetic services under the Medical Benefits section.

Charges for: any injectable medications that are not specifically authorized by us under the Medical Benefits section or Outpatient Prescription Drug Benefits section; any administrative charge for drug injections.

Charges for: drugs dispensed at or by a health care practitioner’s office, clinic, hospital or other non-pharmacy setting for take home by the covered person; amounts above the contracted rate for participating pharmacy or designated specialty pharmacy provider reimbursement; the difference between the cost of the prescription order at a nonparticipating pharmacy and the contracted rate that would have been paid for the same prescription order had a participating pharmacy or designated specialty pharmacy provider been used.

Charges for: home traction units; home defibrillators; or other medical devices designed to be used at home, except as otherwise covered in the Durable Medical Equipment and Personal Medical Equipment provision or covered diabetic services under the Medical Benefits section.

Charges for: any injectable medications that are not specifically authorized by us under the Medical Benefits section or Outpatient Prescription Drug Benefits section; any administrative charge for drug injections.

Charges for: drugs dispensed at or by a health care practitioner’s office, clinic, hospital or other non-pharmacy setting for take home by the covered person; amounts above the contracted rate for participating pharmacy or designated specialty pharmacy provider reimbursement; the difference between the cost of the prescription order at a nonparticipating pharmacy and the contracted rate that would have been paid for the same prescription order had a participating pharmacy or designated specialty pharmacy provider been used.

Charges for: home traction units; home defibrillators; or other medical devices designed to be used at home, except as otherwise covered in the Durable Medical Equipment and Personal Medical Equipment provision or covered diabetic services under the Medical Benefits section.

Charges for: any injectable medications that are not specifically authorized by us under the Medical Benefits section or Outpatient Prescription Drug Benefits section; any administrative charge for drug injections.

Charges for: drugs dispensed at or by a health care practitioner’s office, clinic, hospital or other non-pharmacy setting for take home by the covered person; amounts above the contracted rate for participating pharmacy or designated specialty pharmacy provider reimbursement; the difference between the cost of the prescription order at a nonparticipating pharmacy and the contracted rate that would have been paid for the same prescription order had a participating pharmacy or designated specialty pharmacy provider been used.

Charges for: home traction units; home defibrillators; or other medical devices designed to be used at home, except as otherwise covered in the Durable Medical Equipment and Personal Medical Equipment provision or covered diabetic services under the Medical Benefits section.

Charges for: any injectable medications that are not specifically authorized by us under the Medical Benefits section or Outpatient Prescription Drug Benefits section; any administrative charge for drug injections.
11. Charges for: drugs administered or dispensed by an acute medical facility, rest home, sanitarium, extended care facility, convalescent care facility, subacute rehabilitation facility or similar institution; drugs administered or dispensed by a health care practitioner, who is not a participating pharmacy, unless authorized by us under the Outpatient Prescription Drug Benefits section before they are dispensed; drugs consumed, injected or otherwise administered at the prescribing health care practitioner's office; drugs that are dispensed at or by a health care practitioner's office, clinic, hospital or other non-pharmacy setting for take home by the covered person.

12. Charges for: any drug used for cosmetic services as determined by us; drugs used to treat onychomycosis (nail fungus); botulinum toxin and its derivatives.

13. Charges for: drugs prescribed for dental services except when covered under the Child Dental Services provision, or unit-dose drugs.

14. Charges for Retin A (tretinoin) and other drugs used in the treatment or prevention of acne or related conditions for a covered person age 30 or older.

15. Charges for: duplicate prescriptions; replacement of lost, stolen, destroyed, spilled or damaged prescriptions; prescriptions refilled more frequently than the prescribed dosage indicates.

16. Charges for drugs used to treat, impact or influence quality of life or lifestyle concerns, including but not limited to: athletic performance; body conditioning, strengthening, or energy; prevention or treatment of hair loss; prevention or treatment of excessive hair growth or abnormal hair patterns; anabolic steroids are not excluded if medically necessary.

17. Charges for drugs used to treat, impact or influence: obesity; morbid obesity; weight management; sex transformation; gender dysphoric disorder; gender reassignment; sexual function, dysfunction or inadequacy sexual energy, performance or desire; skin coloring or pigmentation; social phobias; slowing the normal processes of aging; memory improvement or cognitive enhancement; daytime drowsiness; dry mouth; excessive salivation; or hyperhidrosis (excessive sweating).

18. Charges for drugs or drug categories that exceed any maximum benefit limit under this plan.

19. Charges for drugs designed or used to diagnose, treat, alter, impact, or differentiate a covered person's genetic make-up or genetic predisposition.

20. Charges for prescriptions, dosages or dosage forms used for the convenience of the covered person or the covered person's immediate family member or health care practitioner.

21. Charges for drugs obtained from pharmacy provider sources outside the United States, except for covered charges that are received for emergency treatment.

22. Charges for: postage, handling and shipping charges for any drugs.

23. Charges for: vaccines and other immunizing agents; biological sera; blood or blood products, except as otherwise covered in the Outpatient Medical Services provision in the Medical Benefits section.

24. Charges for drugs for which prior authorization is required by us and is not obtained.

25. Charges for treatment, services, supplies or drugs provided by or through any employer of a covered person or the employer of a covered person’s family member. For purposes of this exclusion, “employer” includes but is not limited to any corporation, partnership, sole proprietorship, self-employment, or similar business arrangement, regardless of whether any such arrangement is a for-profit or not-for-profit employer.

26. Charges for treatment, services, supplies or drugs provided by or through any entity in which a covered person or his/her family member receives, or is entitled to receive, any direct or indirect financial benefit, including but not limited to an ownership interest in any such entity.

For purposes of this exclusion, “entity” includes but is not limited to any corporation, organization, partnership, sole proprietorship, self-employment, or similar business arrangement, regardless of whether any such arrangement is a for-profit or not-for-profit employer.

Additional information

QUALIFIED HEALTH PLANS
Qualified health plans are plans that are certified to be sold on the Marketplace.

Assurant Health is the brand name for products underwritten and issued by Time Insurance Company.

This product reference guide provides summary information. Please refer to the insurance policy or ask your agent for a premium quote and a complete listing of benefits and terms of coverage.

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Plans are also available for purchase off the Marketplace statewide.

Arizona

Assurant Health offers plans on the Arizona Marketplace statewide for 2015. Please note that plans will be available through the Marketplace starting November 15th in the following counties: Santa Cruz, Pima, Pinal, Gila, Maricopa and Yavapai. Plans are expected to be available through the Marketplace starting in early December in the remaining counties: Yuma, La Paz, Mohave, Coconino, Navajo, Apache, Greenlee, Graham, and Cochise. All plans are also available outside of the Marketplace state-wide beginning November 15.

Assurant Health is the brand name for products underwritten and issued by Time Insurance Company.

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