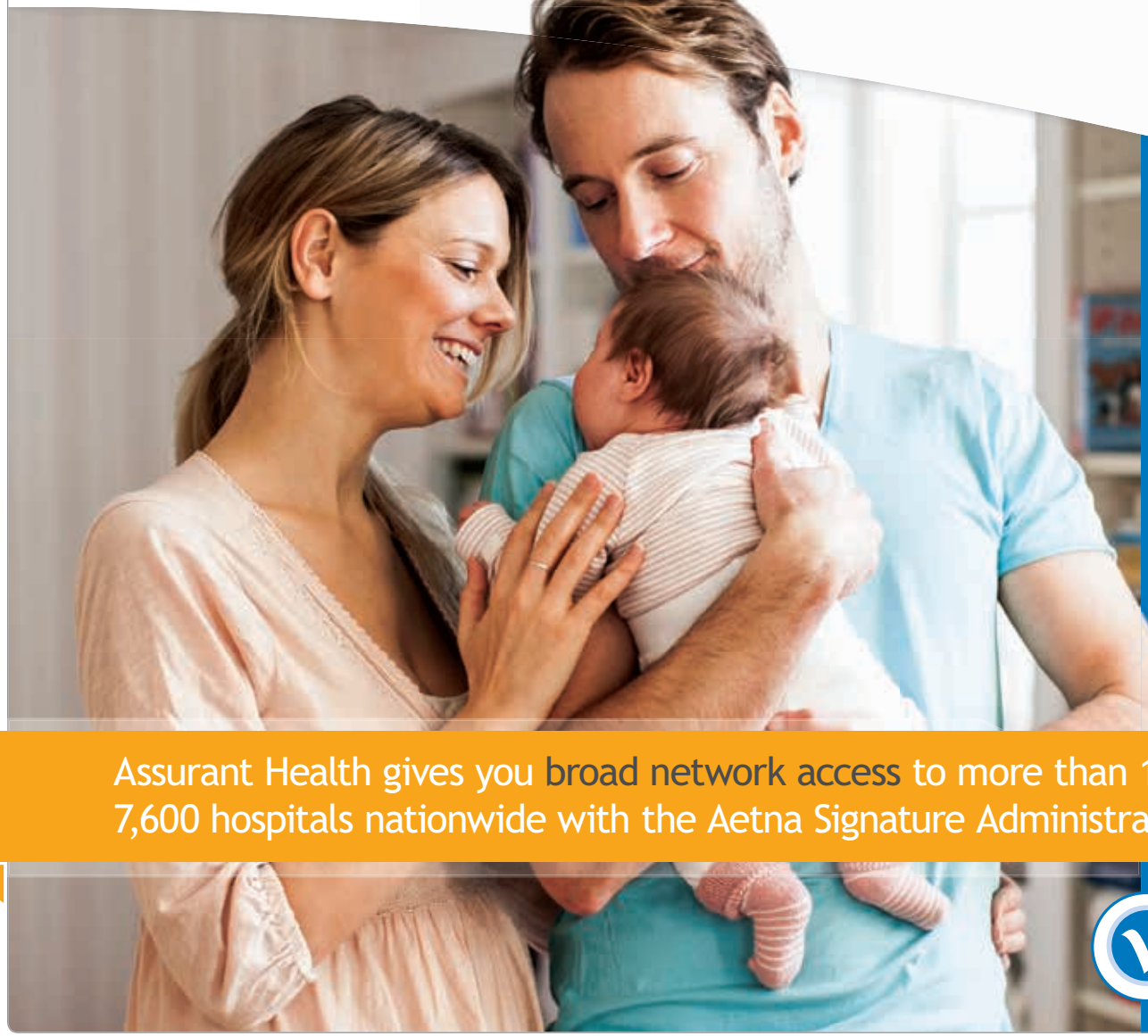
Major medical plans *for individuals and families*

ASSURANT Health®

Idaho



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.

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

Find plans in all metal levels.

CHOOSE ASSURANT HEALTH

Feel secure.

We have 120 years[1] of experience and an A- (Excellent) rating.[2]

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.

1 Assurant Health is the brand name for products underwritten and issued by Time Insurance Company (est. 1892).

2 Source: A.M. Best Ratings and Analysis of Time Insurance Company, November 2013.

ASSURANT Health®

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

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.

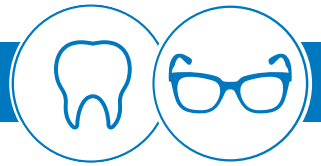
Get the **benefits** you need

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*
- Inpatient rehabilitation facility*
- Subacute rehabilitation and skilled nursing facilities*

*Your state may apply specific limits on visits. Please refer to your state variations document for details.

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



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

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

For more details, see the benefits chart, the summary of provisions and exclusions, and your state variations document.

Bronze *plans* | Idaho

ASSURANT Health®

	IN-NETWORK SERVICES								OUT-OF-NETWORK SERVICES		
BRONZE PLANS	BROAD NETWORKS AVAILABLE	DEDUCTIBLE	COINSURANCE *(We pay)*	OUT-OF-POCKET MAXIMUM	OFFICE VISIT COPAY	PRESCRIPTION DRUGS[1]	DIAGNOSTIC X-RAY/LAB BENEFIT	HSA COMPATIBLE	DEDUCTIBLE	COINSURANCE *(We pay)*	OUT-OF-POCKET MAXIMUM
BRONZE 001	✓	$6,000	100%	$6,000	No copay; subject to deductible and coinsurance	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Yes	$18,000	100%	$18,000
BRONZE 002	✓	$5,000	75%	$6,350	$35 for 4 visits, then subject to deductible and coinsurance	Subject to deductible and coinsurance	Subject to deductible and coinsurance	No	$15,000	55%	$19,050
BRONZE 003	✓	$2,600	50%	$6,350	No copay; subject to deductible and coinsurance	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Yes	$7,800	30%	$19,050
BRONZE 004	✓	$5,000	75%	$6,350	No copay; subject to deductible and coinsurance	$25/$50/$75 $500 brand deductible ^	Subject to deductible and coinsurance	No	$15,000	55%	$19,050
BRONZE 005	✓	$3,500	50%	$6,350	No copay; subject to deductible and coinsurance	$25/$50/$75 $500 brand deductible ^	Subject to deductible and coinsurance	No	$10,500	30%	$19,050

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*

	CHECKUPS AND CLEANINGS	BASIC SERVICES	MAJOR SERVICES AND ORTHODONTICS
NON-HSA PLANS	We pay 100%; not subject to deductible	We pay 80%;‡ not subject to deductible	We pay 50%;‡ not subject to deductible
HSA-COMPATIBLE PLANS	We pay 100%; not subject to deductible	Subject to deductible and coinsurance‡	Subject to deductible and coinsurance‡

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

	ANNUAL EYE EXAMS	GLASSES/CONTACTS FROM DESIGNATED PROVIDERS
ALL PLANS	We pay 100%; not subject to deductible	Subject to deductible and coinsurance‡

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.

1 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.

ASSURANT HEALTH OFFERS PLANS IN ALL METAL LEVELS. TALK TO YOUR AGENT FOR DETAILS ON OTHER PLAN LEVELS.

Silver *plans* | Idaho

ASSURANT Health®

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

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*

	CHECKUPS AND CLEANINGS	BASIC SERVICES	MAJOR SERVICES AND ORTHODONTICS
NON-HSA PLANS	We pay 100%; not subject to deductible	We pay 80%;‡ not subject to deductible	We pay 50%;‡ not subject to deductible
HSA-COMPATIBLE PLANS	We pay 100%; not subject to deductible	Subject to deductible and coinsurance‡	Subject to deductible and coinsurance‡

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

	ANNUAL EYE EXAMS	GLASSES/CONTACTS FROM DESIGNATED PROVIDERS
ALL PLANS	We pay 100%; not subject to deductible	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.

* 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.

Gold *plan* | Idaho

ASSURANT Health®

	IN-NETWORK SERVICES								OUT-OF-NETWORK SERVICES		
GOLD PLAN	BROAD NETWORKS AVAILABLE	DEDUCTIBLE	COINSURANCE *(We pay)*	OUT-OF-POCKET MAXIMUM	OFFICE VISIT COPAY	PRESCRIPTION DRUGS[1]	DIAGNOSTIC X-RAY/LAB BENEFIT	HSA COMPATIBLE	DEDUCTIBLE	COINSURANCE *(We pay)*	OUT-OF-POCKET MAXIMUM
GOLD 002	✓	$0	75%	$6,350	$25 for unlimited visits	$15/$35/$60*	Subject to deductible and coinsurance	No	$5,000	50%	$10,000

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	BASIC SERVICES	MAJOR SERVICES AND ORTHODONTICS
We pay 100%; not subject to deductible	We pay 80%;‡ not subject to deductible	We pay 50%;‡ not subject to deductible

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

ANNUAL EYE EXAMS	GLASSES/CONTACTS FROM DESIGNATED PROVIDERS
We pay 100%; not subject to deductible	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.

* 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.

Platinum *plan* | Idaho

ASSURANT Health®

	IN-NETWORK SERVICES								OUT-OF-NETWORK SERVICES		
PLATINUM PLAN	BROAD NETWORKS AVAILABLE	DEDUCTIBLE	COINSURANCE *(We pay)*	OUT-OF-POCKET MAXIMUM	OFFICE VISIT COPAY	PRESCRIPTION DRUGS[1]	DIAGNOSTIC X-RAY/LAB BENEFIT	HSA COMPATIBLE	DEDUCTIBLE	COINSURANCE *(We pay)*	OUT-OF-POCKET MAXIMUM
PLATINUM 002	✓	$0	75%	$2,000	$25 for unlimited visits	$10/$30/$50*	Subject to deductible and coinsurance	No	$5,000	50%	$10,000

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	BASIC SERVICES	MAJOR SERVICES AND ORTHODONTICS
We pay 100%; not subject to deductible	We pay 80%;‡ not subject to deductible	We pay 50%;‡ not subject to deductible

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

ANNUAL EYE EXAMS	GLASSES/CONTACTS FROM DESIGNATED PROVIDERS
We pay 100%; not subject to deductible	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.

* 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.

Catastrophic *plan* | Idaho

ASSURANT Health®

	IN-NETWORK SERVICES								OUT-OF-NETWORK SERVICES		
CATASTROPHIC PLAN	BROAD NETWORKS AVAILABLE	DEDUCTIBLE	COINSURANCE *(We pay)*	OUT-OF-POCKET MAXIMUM	OFFICE VISIT COPAY	PRESCRIPTION DRUGS[1]	DIAGNOSTIC X-RAY/LAB BENEFIT	HSA COMPATIBLE	DEDUCTIBLE	COINSURANCE *(We pay)*	OUT-OF-POCKET MAXIMUM
CATASTROPHIC	✓	$6,600	100%	$6,600	First 3 primary care visits paid at 100%, then subject to deductible and coinsurance	Subject to deductible and coinsurance	Subject to deductible and coinsurance	No	$19,800	100%	$19,800

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	BASIC SERVICES	MAJOR SERVICES AND ORTHODONTICS
We pay 100%; not subject to deductible	Subject to deductible and coinsurance	Subject to deductible and coinsurance

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

ANNUAL EYE EXAMS	GLASSES/CONTACTS FROM DESIGNATED PROVIDERS
We pay 100%; not subject to deductible	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 exclusion of coverage.

SPECIALTY PHARMACEUTICAL DRUGS
Specialty pharmaceuticals must be obtained from a designated specialty pharmacy provider to be considered at the in-network benefit level. Specialty pharmaceuticals will not be covered unless they have been authorized in accordance with the utilization review provisions and the medical review manager/our specialty pharmacy program.

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. If services are performed at an out-of-network transplant provider, there is a $100,000 per organ maximum.

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. Self-management education services are 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. No benefits are provided for the following, except where state mandates apply.

Charges that are:

- Payable or reimbursable by Medicare Part A, Part B or Part D, where permitted by law. If a covered person at any time was eligible to enroll in the Medicare program (including Part B and Part D) but did not do so, the benefits under this plan will be reduced by any amount that would have been reimbursed by Medicare
- Payable or reimbursable by any other government law or program, except Medicaid (Medi-Cal in California)
- For free treatment provided in a federal, veteran's, state or municipal medical facility
- For free services provided in a student health center
- 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
- 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:
    - The sole proprietor, if the covered person's employer is a proprietorship
    - A partner of the covered person's employer, if the employer is a partnership
    - A covered person who is not required to have coverage under any workers' compensation, employers' liability or similar law and does not have such coverage
- Charges for vision care that is routine and glasses, except as otherwise covered for outpatient diabetic services or Child Vision Services in the Medical Benefits section
- Charges for hearing care that is routine and hearing aids
- Charges for foot conditions including but not limited to expenses for:
    - Flat foot conditions
    - Care of corns; calluses; fallen arches; weak feet; chronic foot strain; or symptomatic complaints of the feet
- Charges for dental care that is routine; dental charges; bridges, crowns, caps, dentures, dental implants or other dental prostheses; dental braces or dental appliances; extraction of teeth; orthodontic charges; odontogenic cysts; any other expenses for treatment or complications of the teeth and gum tissue, except for outpatient dental services and Child Dental Services listed in the Medical Benefits section
- Charges for custodial care; respite care except when provided as part of hospice care; rest care; supportive care; homemaker services
- Charges for services ordered, directed or performed by a health care practitioner or supplies purchased from a medical supply provider who is a covered person, an immediate family member, or a person who ordinarily resides with a covered person
- Charges incurred outside of the United States, unless the services would have been covered under this plan if the services had been received in the United States
- Charges related to health care practitioner assisted suicide
- Charges for 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 non-participating pharmacy and the contracted rate that would have been paid for the same prescription order had a participating pharmacy been used; prescription drugs or supplies requiring injectable parenteral administration or use, except insulin or Imitrex, unless pre-authorized before they are dispensed; any administrative charge for drug injections or administrative charges for any other drugs
- 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
- 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

Exclusions for pediatric vision benefits

- Charges for visual therapy
- Charges for two pairs of glasses in lieu of bifocals
- Charges for nonprescription (plano) lenses
- Charges for lost or stolen eyewear; insurance premium for contact lenses or eyewear
- Charges for any vision treatment, service, eyewear, or supply not listed in the Child Vision Services provision

Exclusions for pediatric dental benefits

- Charges for TMJ dysfunction arthrogram and other TMJ dysfunction films; tomographic surveys
- Charges for Cone Beam CT, Cone Beam multiple images 2 dimension, and Cone Beam multiple images 3 dimension
- Charges for viral culture
- Charges for saliva analysis, including chemical or biological diagnostic saliva analysis
- Charges for caries testing
- Charges for adjunctive pre-diagnostic testing
- Charges for declassification procedures; special stains, either for or not for microorganisms; immunohistochemical stains; tissue in-situ-hybridization
- Charges for electron microscopy; direct immunofluorescence; consultation on slides prepared by another provider; consultation with slide preparation; accession transepithelial
- Charges for nutritional counseling; tobacco counseling; instruction on oral hygiene
- Charges for removal of fixed space maintainer
- Charges for screw retained surgical replacement; surgical replacement with or without surgical flap; TMJ disorder appliances and therapy; sinus augmentation with bone or bone substitutes; appliance removal; intraoral placement of a fixation device
- Charges for gold foil surfaces; provisional crown(s); post removal; temporary crown(s); coping; endodontic implant; intentional re-implantation; surgical isolation of tooth; canal preparation; anatomical crown exposure; splinting, either intracoronal or extracoronal; complete interim denture, either upper or lower; partial interim denture, either upper or lower; precision attachment; replacement precision attachment; fluoride gel carrier; custom abutment; provisional pontic; interim pontic; interim retainer crown; connector bar; stress breaker
- Charges for orthodontic services and supplies that are not medically necessary; charges for orthodontic treatment for cosmetic purposes
- Charges for repair of damaged orthodontic appliances; lost or missing orthodontic appliances or replacement thereof

- Charges for equilibration, periodontal splinting, full mouth rehabilitation, restoration for misalignment of teeth, or other orthodontic services that restore or maintain the occlusion or alter vertical dimension
- Charges for any other dental or orthodontic treatment, service or supply not listed in the Child Dental Services provision

The following additional exclusions apply only to the Outpatient Prescription Drug Benefits section. We will not pay benefits for any of the following:

- Charges for that part of any prescription order exceeding a 30 consecutive day supply per prescription order. Charges for that part of any prescription order exceeding a 90 consecutive day supply if the prescription drug is dispensed through a 90-day prescription drug provider
- Charges for that part of any prescription order exceeding 3 vials or a 30 consecutive day supply of one type of insulin. Charges for that part of any prescription order exceeding 9 vials or a 90 consecutive day supply if it is dispensed through a 90-day prescription drug provider
- Charges for that part of any prescription order exceeding 100 disposable insulin syringes or needles, 100 disposable blood/urine/glucose/acetone testing agents or 100 lancets or a 30 consecutive day supply. Charges for that part of any prescription order exceeding 300 disposable blood/urine/glucose/acetone testing agents or 300 lancets or a 90 consecutive day supply if the supplies are dispensed through a 90-day prescription drug provider
- Charges for drugs that are paid under another plan sponsor or payer as primary payer
- Charges for drugs that are not listed in a drug list. Charges for any ancillary charge or any difference between the cost of the prescription order at a non-participating 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 prescription drugs or supplies requiring injectable parenteral administration or use, except insulin, unless pre-authorized under the Outpatient Prescription Drug Benefits section before they are dispensed. Charges for any injectable prescription drugs, unless pre-authorized under this Outpatient Prescription Drug Benefits section before they are dispensed. Any administrative charge for drug injections or administrative charges for any other drugs
- Charges for devices or supplies including but not limited to blood/urine/glucose/acetone testing devices, needles and syringes, support garments, bandages and other non-medical items regardless of intended use, except as described under a prescription order
- Charges for over-the-counter (OTC) medications that can be obtained without a health care practitioner's prescription order, except for injectable insulin; or drugs that have an over-the-counter equivalent or contain the same or therapeutically equivalent active ingredient(s) as over-the-counter medication, unless specifically authorized for coverage by us on our drug list
- Charges for compounded medications that contain one or more active ingredients that are not covered under this plan; combination drugs or drug products manufactured and/or packaged together and containing one or more active ingredients that are not covered under this plan; combination drugs or drug products that are manufactured and/or packaged together, unless pre-authorized under this Outpatient Prescription Drug Benefits section before they are dispensed
- Charges for prescription order refills in excess of the number specified on the health care practitioner's prescription order; prescriptions refilled after one year from the health care practitioner's original prescription order; amounts above the contracted rate for participating pharmacy or designated specialty pharmacy provider reimbursement
- 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 pre-authorized under this 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
- Charges for drugs prescribed for dental services except when covered under the Child Dental Services provision, or unit-dose drugs
- Charges for duplicate prescriptions; replacement of lost, stolen, destroyed, spilled or damaged prescriptions; prescriptions refilled more frequently than the prescribed dosage indicates
- 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
- Charges for drugs used to treat, impact or influence slowing the normal processes of aging; memory improvement or cognitive enhancement
- Charges for drugs or drug categories that exceed any maximum benefit limit under this plan
- Charges for drugs designed or used to diagnose, treat, alter, impact, or differentiate a covered person's genetic make-up or genetic predisposition
- 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
- Charges for drugs obtained from pharmacy provider sources outside the United States, except for covered charges that are received for emergency treatment
- Charges for postage, handling and shipping charges for any drugs
- Charges for vaccines and other immunizing agents; biological sera; blood or blood products
- Charges for drugs for which prior authorization is required by us and is not obtained
- 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
- 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

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, exclusions and terms of coverage.

Assurant Health is the brand name for products underwritten and issued by Time Insurance Company. Form 30740-ID (09/2014)

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