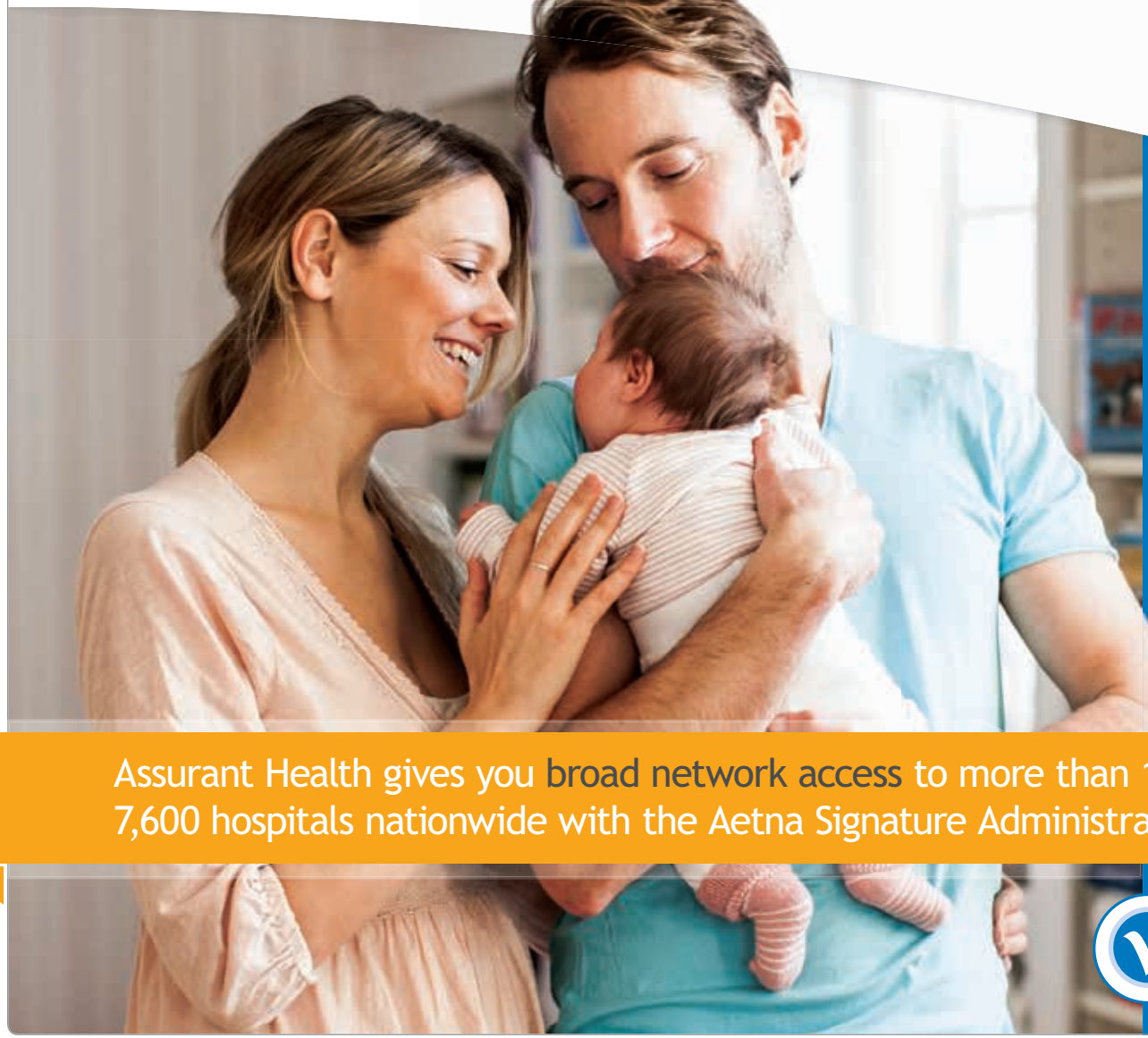
Major medical plans *for individuals and families*

ASSURANT Health®

Oregon



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.

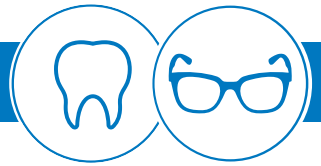
Get the **benefits** you need

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

Pediatric dental benefits are not included in Standard plans.

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* | Oregon

ASSURANT Health®

BRONZE 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
BRONZE 001	✓	$6,000	100%	$6,000	No copy; 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 copy; 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 copy; 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 copy; subject to deductible and coinsurance	$25/$50/$75 $500 brand deductible ^	Subject to deductible and coinsurance	No	$10,500	30%	$19,050
BRONZE 006± STANDARD PLAN	✓	$5,000	50%	$6,350	Subject to deductible, then $60 Primary $100 Specialty	Subject to deductible, then $20/$80/50% coinsurance	Subject to deductible and coinsurance	No	$15,000	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.

All plans except the Bronze 006 Standard plan, 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.

± Pediatric dental benefits are not included. In-network urgent care visits are subject to deductible, then $120 copay.

^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* | Oregon

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
SILVER 005± STANDARD PLAN	✓	$2,500	70%	$6,350	$35 Primary $70 Specialty	$15/$50/50% coinsurance*	Subject to deductible and coinsurance	No	$7,500	50%	$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.

All plans except the Silver 005 Standard plan, 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.

± Pediatric dental benefits are not included. In-network urgent care visits are subject to $90 copay.

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* | Oregon

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.

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

Platinum *plan* | Oregon

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.

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. No benefits will be paid under this plan for any genetic testing, biofeedback or chelation therapy services that are not authorized by the Medical Review Manager prior to receiving the services.

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. If services are performed at an out-of-network transplant provider, there is a $100,000 per organ maximum. Donor expenses are covered to a maximum of $8,000 on Bronze 005 and Silver 006 plans, and $10,000 on all other plans.

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. Services, medications and supplies for diabetes management during pregnancy and six-week postpartum are not subject to deductible and coinsurance.

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.

- Treatment not listed in the Covered Medical Services provision
- Complications of an excluded service
- Charges reimbursable by Medicare, Workers' Compensation or automobile insurance carriers, or expenses for which other coverage is available
- Charges billed by a non-participating provider that waives the covered person's payment obligation of any copayment, coinsurance and/or deductible amounts for the billed treatment, services, supplies or drugs, except as provided for under contract or agreement with us
- Charges caused by or contributed to by war or any act of war or military service
- Illness or injury caused by or contributed to by voluntary attempts to commit or take part in or commission of a felony, whether or not charged
- Charges for treatment or services required due to injury received while engaging in any hazardous occupation or other activity for which compensation is received, including while practicing or conditioning for such activity
- Charges for routine dental or orthodontic treatment, drug, service or supply for persons 19 years of age and older
- Routine hearing care, vision therapy, surgery to correct vision, foot orthotics, or adult routine vision and foot care unless part of diabetic treatment
- Except as provided in the Medical Benefits section, any correction of malocclusion, protrusion, hypoplasia or hyperplasia of the jaws
- Treatment of "quality of life" or "lifestyle" concerns, including but not limited to obesity, hair loss or cognitive enhancement unless otherwise required by law
- Cosmetic services such as chemical peels, plastic surgery, and medications
- Prophylactic treatment
- Charges for non-medical items
- Charges for custodial care, private duty nursing or phone consultations
- Growth hormone stimulation treatment to promote or delay growth
- Charges for, treatment of sexual dysfunction or inadequacy or to restore or enhance sexual performance or desire
- Charges for umbilical cord storage; genetic testing, counseling or services
- Charges for diagnosis and treatment of infertility, or surrogate pregnancy
- Chelation therapy
- Charges for vocational rehabilitation, work hardening programs; transitional living; functional capacity evaluations; community reintegration services; driving evaluations and training programs.
- Charges for alternative medicine, including acupuncture and naturopathic medicine
- Drugs not approved by the FDA; drugs that are illegal under federal law such as marijuana; drugs dispensed in an outpatient setting other than a pharmacy
- Charges by a medical provider who is an immediate family member or who resides with a covered person
- Charges in excess of any stated benefit maximum
- Experimental or investigational services
- Drugs obtained from sources outside the United States
- Charges related to health care practitioner-assisted suicide
- Charges for over-the counter drugs (unless recommended by the United States Preventive Services Task Force and authorized by a health care provider)
- Cranial orthotic devices, except following cranial surgery
- Charges for medical devices designed to be used at home, except as otherwise covered in the Medical Benefits section of the contract
- 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
- Charges for treatment, services, supplies or drugs provided by or through any entity in which a covered person or a covered person's family member receives, or is entitled to receive, any direct or indirect financial benefit
- Charges for Retin-A (tretinoin) and other drugs used in the treatment or prevention of acne, rosacea or related conditions for anyone age 30 or older
- Charges for devices or supplies, except as described under a prescription order
- Surgical and non-surgical treatment of Temporomandibular Joint Dysfunction and Craniomandivular Joint Dysfunction
- Charges for motion analysis

Exclusions for pediatric dental and vision benefits

- Charges for viral culture; saliva analysis, including chemical or biological diagnostic saliva analysis; caries testing; adjunctive pre-diagnostic testing; electronic diagnostic modalities; occlusal analysis; muscle 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; TMJ dysfunction arthrogram and other TMJ dysfunction films; tomographic surveys; Cone Beam CT, Cone Beam multiple images 2 dimension, and Cone Beam multiple images 3 dimension
- Charges for instruction on oral hygiene
- 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; appliances for tooth movement or guidance; removal of fixed space maintainer
- 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 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 orthodontic services and supplies that are for cosmetic purposes or are not medically necessary; repair of damaged orthodontic appliances; lost or missing orthodontic appliances or replacement thereof; retention of orthodontic relationships
- Charges for resin-based composite restorations for posterior teeth
- Charges for endodontic therapy without crown; crowns in cases of advanced periodontal disease or when a poor crown-to-root ratio exists for any reason

- Charges for visual therapy
- Charges for two pairs of glasses in lieu of bifocals; nonprescription (plano) lenses; lost or stolen eyewear; insurance premium for contact lenses or glasses; replacement lenses within the same calendar year

Exclusions for Oregon standard plans

- Charges for surgical and non-surgical treatment of temporomandibular joint dysfunction and craniomandibular joint dysfunction, including advice and diagnostic examination; injection of muscle relaxants; therapeutic drug injections; diathermy therapy; ultrasound therapy; physical therapy and/or oromyofacial therapy, either directly or indirectly for temporomandibular joint dysfunction, myofascial pain; and any related appliances
- Charges for adjustments and manipulations

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-OR (09/2014)

TIM14.15.POL.OR, TIM14.15.STSLV.POL.OR, TIM14.15.STBR2.POL.OR