ASSURANT Health®

CoreMed℠ major medical plans | California

for individuals and families

Trust Assurant Health's CoreMed plans to provide you with broad benefits and strong financial protection.

- 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

All plans are minimum essential coverage under the Affordable Care Act.

Find plans in all metal levels

Time Insurance Company

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

ASSURANT Health®

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, December 2012.

With Assurant Health, you get broad protection and:

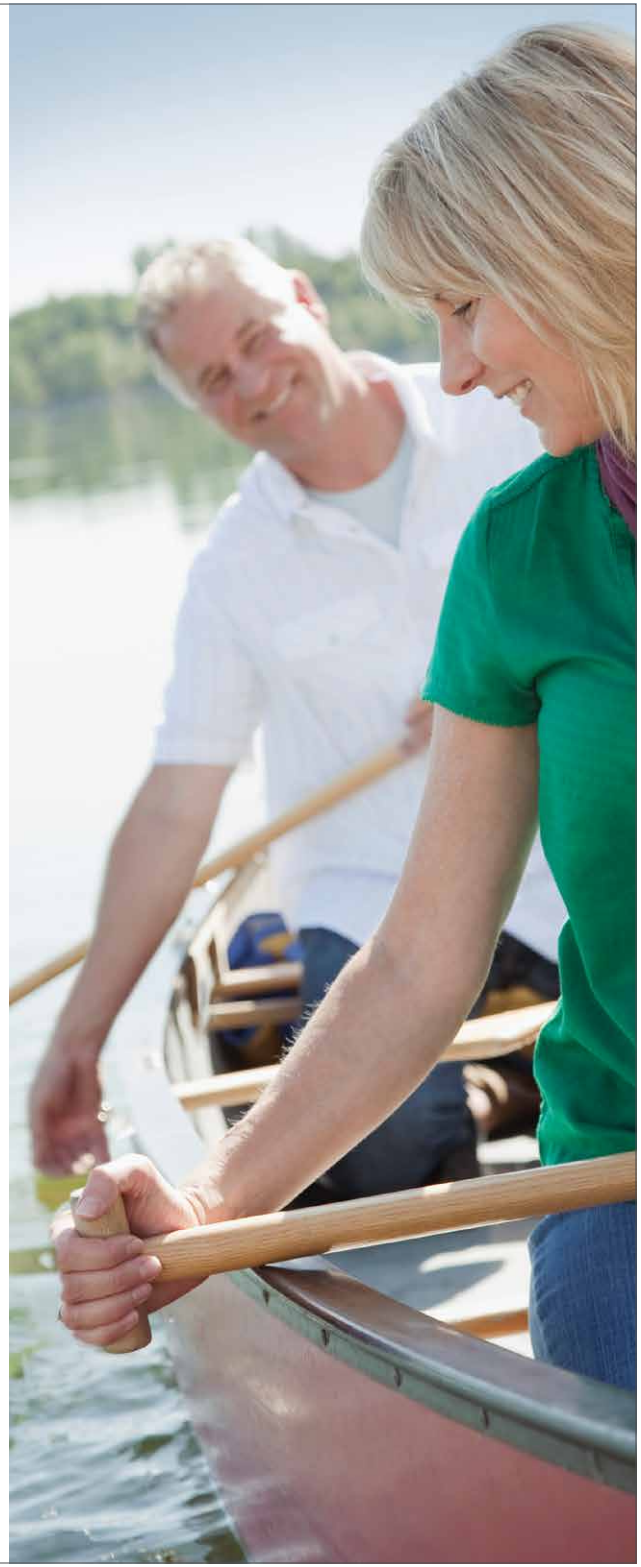
✓ **Extensive networks of doctors and hospitals**, including the Aetna Signature Administrators® PPO Network, which has more than one million doctors and 7,600 hospitals nationwide

✓ **Personalized assistance and support** from:

- Specially trained health care advocates who can help you:
  - Save time and money by finding doctors and hospitals that are part of your network and comparing the amounts they charge *before you receive services*
  - Work through any billing or claims issues *after you receive services*
- Registered nurses who can help you manage complex conditions and serve as liaisons between you and your doctors

✓ **Opportunities to enhance your coverage with supplemental plans**, including dental plan options for adults and families as well as plans that pay added benefits when you have an accident

Supplemental products are separate contracts available at an additional cost.



ASSURANT Health®

Get the benefits you need

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

- ✓ Glasses and contact lenses for children (see benefit chart for details)
- ✓ Urgent care
- ✓ Emergency services and ambulance
- ✓ Inpatient and outpatient hospitalization
- ✓ Outpatient physical medicine
- ✓ Surgical centers
- ✓ 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.

Pediatric dental benefits

- ✓ Pay no deductible, copay or coinsurance for annual dental checkups (not applicable to Silver 5 Standard plan)
- ✓ Choose any dentist you wish
- ✓ Save 5 to 40% on routine dental exams, cleanings and major services including orthodontics and specialists' fees at Careington Dental Network providers

Pediatric vision benefits

- ✓ Pay no deductible, copay or coinsurance for annual eye exams
- ✓ Choose any provider

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

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 for children under age 19**
- ✓ **Flu immunizations for children and adults**

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BRONZE LEVEL PLANS	IN-NETWORK SERVICES								OUT-OF-NETWORK SERVICES		
	DEDUCTIBLE	COINSURANCE *(We pay)*	OUT-OF-POCKET MAXIMUM	OFFICE VISIT COPAY	PRESCRIPTION DRUGS[1]	DIAGNOSTIC/ X-RAY/LAB BENEFIT	ER ACCESS FEE	HSA COMPATIBLE	DEDUCTIBLE	COINSURANCE *(We pay)*	OUT-OF-POCKET MAXIMUM
Bronze 1	$6,000	100%	$6,000	No copay; subject to deductible and coinsurance	Subject to deductible and coinsurance	Subject to deductible and coinsurance	$100	Yes	$18,000	100%	$18,000
Bronze 2	$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	$100	No	$15,000	55%	$19,050
Bronze 3	$2,500	50%	$6,350	No copay; subject to deductible and coinsurance	Subject to deductible and coinsurance	Subject to deductible and coinsurance	$100	Yes	$7,500	30%	$19,050
Bronze 4	$5,000	75%	$6,350	No copay; subject to deductible and coinsurance	$25/$50/$75 $500 brand deductible ^	Subject to deductible and coinsurance	$100	No	$15,000	55%	$19,050
Bronze 5	$3,500	50%	$6,350	No copay; subject to deductible and coinsurance	$25/$50/$75 $500 brand deductible ^	Subject to deductible and coinsurance	$100	No	$10,500	30%	$19,050

Deductible and out-of-pocket maximum shown are for an individual. Family deductible and out-of-pocket maximum are 2x the individual amounts.

Dental *benefits for children under the age of 19*

	CHECKUPS	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‡

Vision *benefits for children under the age of 19*

	ANNUAL EYE EXAM	GLASSES/CONTACTS FROM DESIGNATED PROVIDERS
All plans	We pay 100%; not subject to deductible	We pay 100%; not subject to deductible

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.

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.

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.

Assurant Health offers plans in all metal levels. See **assuranthealth.com** or talk to your agent for details on other plan levels.

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SILVER LEVEL PLANS	IN-NETWORK SERVICES								OUT-OF-NETWORK SERVICES		
	DEDUCTIBLE	COINSURANCE *(We pay)*	OUT-OF-POCKET MAXIMUM	OFFICE VISIT COPAY	PRESCRIPTION DRUGS[1]	DIAGNOSTIC/ X-RAY/LAB BENEFIT	ER ACCESS FEE	HSA COMPATIBLE	DEDUCTIBLE	COINSURANCE *(We pay)*	OUT-OF-POCKET MAXIMUM
Silver 1	$3,500	100%	$3,500	No copay; subject to deductible and coinsurance	Subject to deductible and coinsurance	Subject to deductible and coinsurance	$100	Yes	$10,500	100%	$10,500
Silver 2	$2,000	50%	$6,350	$30 for 10 visits, then subject to deductible and coinsurance	$15/$35/$60*	Subject to deductible and coinsurance	$100	No	$6,000	30%	$19,050
Silver 3	$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	$100	No	$3,750	30%	$15,000
Silver 4	$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	$100	No	$5,550	30%	$19,050

Deductible and out-of-pocket maximum shown are for an individual. Family deductible and out-of-pocket maximum are 2x the individual amounts.

Dental *benefits for children under the age of 19*

	CHECKUPS	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‡

Vision *benefits for children under the age of 19*

	ANNUAL EYE EXAM	GLASSES/CONTACTS FROM DESIGNATED PROVIDERS
All plans	We pay 100%; not subject to deductible	We pay 100%; not subject to deductible

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.

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CoreMed major medical plans | California

GOLD LEVEL PLANS	IN-NETWORK SERVICES								OUT-OF-NETWORK SERVICES		
	DEDUCTIBLE	COINSURANCE *(We pay)*	OUT-OF-POCKET MAXIMUM	OFFICE VISIT COPAY	PRESCRIPTION DRUGS[1]	DIAGNOSTIC/ X-RAY/LAB BENEFIT	ER ACCESS FEE	HSA COMPATIBLE	DEDUCTIBLE	COINSURANCE *(We pay)*	OUT-OF-POCKET MAXIMUM
Gold 1	$2,000	100%	$2,000	No copay; subject to deductible and coinsurance	Subject to deductible and coinsurance	Subject to deductible and coinsurance	$100	No	$5,000	50%	$10,000
Gold 2	$0	75%	$6,350	$25 for unlimited visits	$15/$35/$60*	Subject to deductible and coinsurance	$100	No	$5,000	50%	$10,000

Deductible and out-of-pocket maximum shown are for an individual. Family deductible and out-of-pocket maximum are 2x the individual amounts.

Dental *benefits for children under the age of 19*

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

Vision *benefits for children under the age of 19*

	ANNUAL EYE EXAM	GLASSES/CONTACTS FROM DESIGNATED PROVIDERS
All plans	We pay 100%; not subject to deductible	We pay 100%; not subject to deductible

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.

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PLATINUM LEVEL PLANS	IN-NETWORK SERVICES								OUT-OF-NETWORK SERVICES		
	DEDUCTIBLE	COINSURANCE *(We pay)*	OUT-OF-POCKET MAXIMUM	OFFICE VISIT COPAY	PRESCRIPTION DRUGS[1]	DIAGNOSTIC/ X-RAY/LAB BENEFIT	ER ACCESS FEE	HSA COMPATIBLE	DEDUCTIBLE	COINSURANCE *(We pay)*	OUT-OF-POCKET MAXIMUM
Platinum 1	$950	100%	$950	No copay; subject to deductible and coinsurance	Subject to deductible and coinsurance	Subject to deductible and coinsurance	$100	No	$5,000	50%	$10,000
Platinum 2	$0	75%	$2,000	$25 for unlimited visits	$10/$30/$50*	Subject to deductible and coinsurance	$100	No	$5,000	50%	$10,000

Deductible and out-of-pocket maximum shown are for an individual. Family deductible and out-of-pocket maximum are 2x the individual amounts.

Dental *benefits for children under the age of 19*

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

Vision *benefits for children under the age of 19*

	ANNUAL EYE EXAM	GLASSES/CONTACTS FROM DESIGNATED PROVIDERS
All plans	We pay 100%; not subject to deductible	We pay 100%; not subject to deductible

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.

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STANDARD PLANS	IN-NETWORK SERVICES									OUT-OF-NETWORK SERVICES		
	DEDUCTIBLE	COINSURANCE *(We pay)*	OUT-OF-POCKET MAXIMUM	OFFICE VISIT COPAY	PRESCRIPTION DRUGS[1]	DIAGNOSTIC/ X-RAY/LAB BENEFIT	ER COPAY/ER TRANSPORTATION COPAY	URGENT CARE COPAY	HSA COMPATIBLE	DEDUCTIBLE	COINSURANCE *(We pay)*	OUT-OF-POCKET MAXIMUM
Bronze 6 Standard	$4,500	60%	$6,350	No copay; subject to deductible and coinsurance	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Yes	$13,500	40%	$19,050
Silver 5 Standard	$2,000	80%	$6,350	$45 Primary $65 Specialty for unlimited visits	$19/$50/$70 $250 brand deductible ^	$45 copay per lab test; $65 copay per x-ray/diagnostic image; other imaging subject to deductible and coinsurance	$250/$250	$90	No	$6,000	60%	$19,050
Gold 3 Standard	$0	80%	$6,350	$30 Primary $50 Specialty for unlimited visits	$19/$50/$70*	$30 copay per lab test; $50 copay per x-ray/diagnostic image; other imaging subject to deductible and coinsurance	$250/$250	$60	No	$5,000	50%	$10,000
Platinum 3 Standard	$0	90%	$4,000	$20 Primary $40 Specialty for unlimited visits	$5/$15/$25*	$20 copay per lab test; $40 copay per x-ray/diagnostic image; other imaging subject to deductible and coinsurance	$150/$150	$40	No	$5,000	50%	$10,000

Deductible and out-of-pocket maximum shown are for an individual. Family deductible and out-of-pocket maximum are 2x the individual amounts.

Dental *benefits for children under the age of 19*

	CHECKUPS	BASIC SERVICES	MAJOR SERVICES AND ORTHODONTICS
Bronze 6 Standard	We pay 100% after $60 deductible	We pay 50%‡ after $60 deductible	We pay 50%‡ after $60 deductible
Silver 5 Standard	We pay 100% after $60 deductible	We pay 50%‡ after $60 deductible	We pay 50%‡ after $60 deductible
Gold 3 Standard Platinum 3 Standard	We pay 100%; not subject to deductible	We pay 80%‡ after $50 deductible	We pay 50%‡ after $50 deductible

Vision *benefits for children under the age of 19*

	ANNUAL EYE EXAM	GLASSES/CONTACTS FROM DESIGNATED PROVIDERS
All plans	We pay 100%; not subject to deductible	We pay 100%; not subject to deductible

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.

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.

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

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 state variations, or ask your agent for a complete listing of benefits, exclusions and terms of coverage.

Assurant Health offers plans in all metal levels. See **assuranthealth.com** or talk to your agent for details on other plan levels.

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, doctor office 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. Pediatric dental and vision benefits are considered at the in-network level regardless of provider.

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. Benefits are reduced for transplants and specialty pharmaceuticals when not preauthorized.

TRANSPLANTS
Benefits for transplants are the same as for any other illness. There is a $10,000 limit on travel expenses for the covered person and a companion, available at an in-network provider or designated transplant provider.

DIABETIC SERVICES
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.

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 reimbursed by Medicare or expenses for which other coverage is available
- Illness or injury caused by felony or influence of an illegal substance
- Charges for routine dental or orthodontic treatment, drug, service or supply for persons 19 years of age and older
- Vision therapy, surgery to correct vision or routine foot care that is not medically necessary
- Treatment of "quality of life" or "lifestyle" concerns, including but not limited to hair loss unless otherwise required by law
- Cosmetic services such as chemical peels, plastic surgery and medications
- Charges for non-medical items
- Charges for custodial care, private duty nursing, telemedicine or phone consultations
- Charges for treatment of sexual inadequacy
- Charges for gender/sex reassignment surgery are not covered unless the health care services involved are otherwise available under the policy. This exclusion does not permit the denial of coverage if the health care services involved are otherwise available under the policy, including but not limited to hormone therapy, hysterectomy, mastectomy and vocal training. Also, this exclusion does not permit the denial of coverage for health care services available to a covered person of one sex due only to the fact that the covered person is enrolled as belonging to the other sex or has undergone, or is in the process of undergoing, a gender transition
- Charges for umbilical cord storage, counseling or services
- Charges for diagnosis and treatment of infertility or surrogate pregnancy
- Chelation therapy
- Charges for testing and treatment related to vocational or work hardening programs, transitional living or services provided through a school system
- Charges for alternative medicine, including naturopathic medicine
- Drugs not approved by the FDA
- Charges by a medical provider who is an immediate family member or who resides with a covered person
- 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 or when medically necessary
- 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 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

EXCLUSIONS FOR PEDIATRIC DENTAL AND VISION BENEFITS

- Charges for fixed bridges used to replace missing posterior teeth when the abutment teeth are dentally sound and would be crowned only for the purpose of supporting a pontic
- Charges for fixed bridges provided in connection with a partial denture on the same arch
- Charges for replacement of a fixed bridge when it could have been made satisfactory by repair
- Charges for crown or bridgework in excess of 5 units per arch
- 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 or retention of orthodontic relationships
- 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