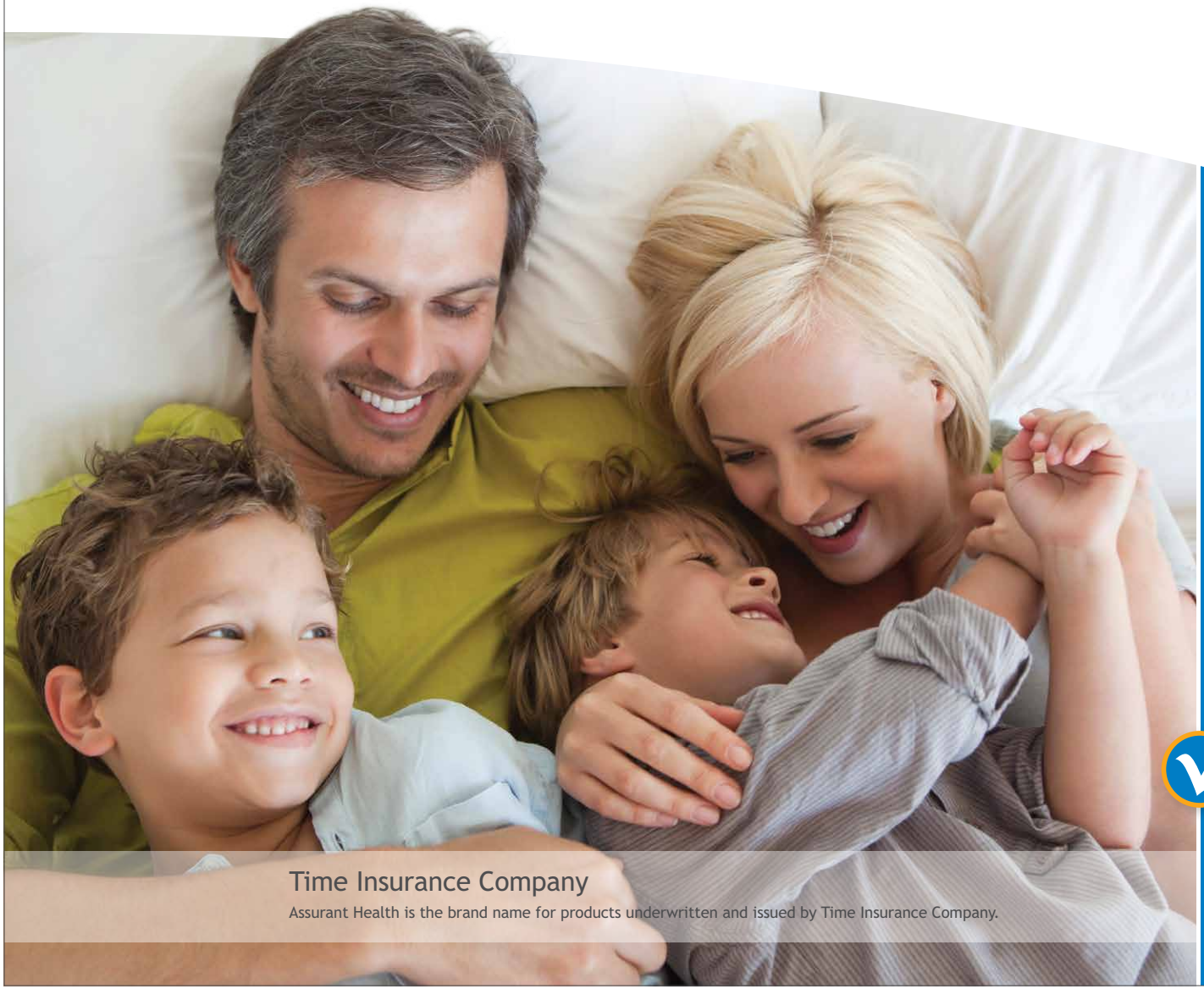
ASSURANT Health®

CoreMed℠ major medical plans

for individuals and families



For broad benefits and strong financial protection, trust Assurant Health's CoreMed plans. Choose from a number of designs to fit your specific needs.

- Office visit copays and prescription drug copays available
- Health Savings Account (HSA) compatible plans available
- Wide range of deductibles, coinsurance and out-of-pocket limits

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®

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

- ✓ **Broad 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 services are received
  - Work through any billing or claims issues after services are received
- ✓ **Add Assurant Supplemental Coverage plans,** including Dental plan options for adults, as well as Accident and Critical Illness plans

Assurant Supplemental Coverage plan availability varies by state.
Supplemental products are separate contracts available at an additional cost. Additional provisions may apply.

Depend on Assurant Health for all the plan benefits you need.

CoreMed plans include coverage for the following services, subject to deductible, coinsurance and any applicable copay.

- ✓ 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.

For more details, see the benefits chart and the summary of provisions and exclusions.

For state-specific information, please see your state variations document.

Preventive care paid at 100%

- ✓ Preventive services, *including women's health*, recommended under the Affordable Care Act when you use doctors in your network
- ✓ Annual eye exams and dental checkups for children under the age of 19

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CoreMed major medical plans | Kansas

BRONZE LEVEL PLANS	IN-NETWORK BENEFITS								OUT-OF-NETWORK BENEFITS		
	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	$7,000	80%	$18,000
Bronze 2	$5,000	75%	$6,350	$35 for 4 visits	Subject to deductible and coinsurance	Subject to deductible and coinsurance	$100	No	$6,000	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	$3,500	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	$6,000	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	$4,500	30%	$19,050

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

	CHECKUPS	BASIC SERVICES	MAJOR SERVICES AND ORTHODONTICS
Non-HSA plans	We pay 100%	We pay 80%†	We pay 50%†
HSA-compatible plans	We pay 100%	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%	Subject to deductible and coinsurance†

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

^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 policyholder has met out-of-pocket maximum.

For more details, see the summary of provisions and exclusions.

Out-of-pocket maximum includes deductible, coinsurance, office visit copays, prescription deductible and copays, and any applicable access fees.

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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CoreMed major medical plans | Kansas

SILVER LEVEL PLANS	IN-NETWORK BENEFITS								OUT-OF-NETWORK BENEFITS		
	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	$4,500	80%	$10,500
Silver 2	$2,000	50%	$6,350	$30 for 10 visits	$15/$35/$60	Subject to deductible and coinsurance	$100	No	$3,000	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	$2,250	30%	$15,000
Silver 4	$1,850	50%	$6,350	$30 for 10 visits	$15/$35/$60	First $500 paid @100%, then subject to deductible and coinsurance	$100	No	$2,850	30%	$19,050

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

	CHECKUPS	BASIC SERVICES	MAJOR SERVICES AND ORTHODONTICS
Non-HSA plans	We pay 100%	We pay 80%†	We pay 50%†
HSA-compatible plans	We pay 100%	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%	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.

† We pay 100% once policyholder has met out-of-pocket maximum.

For more details, see the summary of provisions and exclusions.

Out-of-pocket maximum includes deductible, coinsurance, office visit copays, prescription deductible and copays, and any applicable access fees.

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GOLD LEVEL PLANS	IN-NETWORK BENEFITS								OUT-OF-NETWORK BENEFITS		
	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	$3,000	50%	$10,000
Gold 2	$0	75%	$6,350	$25 for Unlimited visits	$15/$35/$60	Subject to deductible and coinsurance	$100	No	$1,000	50%	$10,000

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

	CHECKUPS	BASIC SERVICES	MAJOR SERVICES AND ORTHODONTICS
Non-HSA plans	We pay 100%	We pay 80%†	We pay 50%†
HSA-compatible plans	We pay 100%	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%	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.

† We pay 100% once policyholder has met out-of-pocket maximum.

For more details, see the summary of provisions and exclusions.

Out-of-pocket maximum includes deductible, coinsurance, office visit copays, prescription deductible and copays, and any applicable access fees.

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PLATINUM LEVEL PLANS	IN-NETWORK BENEFITS								OUT-OF-NETWORK BENEFITS		
	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	$1,950	50%	$10,000
Platinum 2	$0	75%	$2,000	$25 for Unlimited visits	$10/$30/$50	Subject to deductible and coinsurance	$100	No	$1,000	50%	$10,000

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

	CHECKUPS	BASIC SERVICES	MAJOR SERVICES AND ORTHODONTICS
Non-HSA plans	We pay 100%	We pay 80%†	We pay 50%†
HSA-compatible plans	We pay 100%	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%	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.

† We pay 100% once policyholder has met out-of-pocket maximum.

For more details, see the summary of provisions and exclusions.

Out-of-pocket maximum includes deductible, coinsurance, office visit copays, prescription deductible and copays, and any applicable access fees.

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	IN-NETWORK BENEFITS								OUT-OF-NETWORK BENEFITS		
CATASTROPHIC PLANS	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
Catastrophic	$6,350	100%	$6,350	Paid at 100% first 3 visits	Subject to deductible and coinsurance	Subject to deductible and coinsurance	$100	No	$7,350	80%	$19,050

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

	CHECKUPS	BASIC SERVICES	MAJOR SERVICES AND ORTHODONTICS
Non-HSA plans	We pay 100%	We pay 100%	We pay 100%
HSA-compatible plans	We pay 100%	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%	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.

† We pay 100% once policyholder has met out-of-pocket maximum.

For more details, see the summary of provisions and exclusions.

Out-of-pocket maximum includes deductible, coinsurance, office visit copays, prescription deductible and copays, and any applicable access fees.

Special eligibility criteria apply for all Catastrophic plans. Ask your agent for details.

Terms and provisions

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.

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.

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.

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.

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. No benefits will be paid under the plan for any genetic molecular testing that is not authorized by the Medical Review Manager prior to testing.

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. In addition, $10,000 is available 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 $10,000.

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
- Illness or injury caused by acts of war, felony, influence of an illegal substance or hazardous activity for which compensation is received
- 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, telemedicine, or phone consultations
- Growth hormone stimulation treatment to promote or delay growth
- Charges for sex transformation, 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 testing and treatment related to the diagnosis of behavioral conduct or developmental problems, educational testing or training, vocational or work hardening programs, transitional living or services provided through a school system
- Charges for alternative medicine, including acupuncture and 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
- 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
- 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 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

OUTLINE OF COVERAGE AVAILABLE
An outline of coverage is available from the agent or the insurer. Please refer to the outline

of coverage for a description of the important features of this health benefit plan.

IMPORTANT NOTICE: YOU AND YOUR COVERED DEPENDENTS ARE FREE TO USE ANY PROVIDER YOU AND YOUR COVERED DEPENDENTS CHOOSE. IT IS THE COVERED PERSON'S RESPONSIBILITY TO DETERMINE IF A PROVIDER IS A PARTICIPATING PROVIDER OR A NON-PARTICIPATING PROVIDER BEFORE ANY SERVICES ARE RENDERED. PLEASE SEE THE BENEFIT SUMMARY FOR SPECIFIC BENEFIT LEVELS. NON-PARTICIPATING PROVIDERS MAY BILL SUBSTANTIALLY MORE THAN WE DETERMINE TO BE A MAXIMUM ALLOWABLE AMOUNT AND THE COVERED PERSON IS RESPONSIBLE FOR PAYMENT OF ANY AMOUNT BILLED ABOVE THE MAXIMUM ALLOWABLE AMOUNT. THE COVERED PERSON IS NOT RESPONSIBLE FOR PAYMENT OF AMOUNTS BILLED BY A PARTICIPATING PROVIDER IN EXCESS OF THE MAXIMUM ALLOWABLE AMOUNT FOR COVERED CHARGES RECEIVED WITHIN THE COVERED PERSON'S NETWORK.