ASSURANT Health®

Colorado Health Benefit Plan Description Form

Time Insurance Company

CoreMed

PART A: TYPE OF COVERAGE

1. TYPE OF PLAN	Preferred Provider Plan
2. OUT-OF-NETWORK CARE COVERED?[1]	Yes, but the insured pays more for out-of-network care
3. AREAS OF COLORADO WHERE PLAN IS AVAILABLE	Plan is available throughout Colorado

PART B: SUMMARY OF BENEFITS

Important Note: This form is not a contract, it is only a summary. The contents of this form are subject to the provisions of the policy, which contains all terms, covenants and conditions of coverage. Your plan may exclude coverage for certain treatments, diagnoses, or services not noted below. The benefits shown in this summary may only be available if required plan procedures are followed (e.g., plans may require prior authorization, a referral from your primary care physician, or use of specified providers or facilities). Consult the actual policy to determine the exact terms and conditions of coverage. Coinsurance and copayment options reflect the amount the covered person will pay.

	IN-NETWORK	**OUT-OF-NETWORK**
4. Deductible Type[2]	Calendar Year	
4a. ANNUAL DEDUCTIBLE[2a] a.) Individual [2b] b.) Family [2c]	a.) $500, $1,000, $1,500, $2,000, $3,500, $5,000 or $10,000, $15,000 or $25,000 b.) $1,000, $2,000, $3,000, $4,000, $7,000, $10,000, $20,000, $30,000 or $50,000	a.) $1,500, $2,000, $3,000, $4,000, $7,000, $10,000, $20,000, $30,000 or $26,000 b.) $3,000, $4,000, $6,000, $8,000, $14,000, $20,000, $40,000, $60,000 or $52,000
5. OUT-OF-POCKET ANNUAL MAXIMUM[3] a.) Individual b.) Family c.) Is deductible included in the out-of-pocket maximum?	a.) $2,500 - $25,000 b.) $5,000 - $50,000 c.) No. The out-of-pocket maximum does not include coinsurance for prescription drugs. Coinsurance options available are 50%, 70%, 80%, 100% (not all coinsurance options are available with all deductible options). Copayments or access fees do not apply to out-of-pocket maximums.	a.) $11,500 - $40,000 b.) $23,000 - $80,000 c.) No. The out-of-pocket maximum does not include coinsurance for prescription drugs. 20% reduction in coinsurance Copayments or access fees do not apply to out-of-pocket maximums.
6. LIFETIME OR BENEFIT MAXIMUM PAID BY THE PLAN FOR ALL CARE	$2 or $6 million The maximum lifetime benefit for surgical and nonsurgical treatment for Temporomandibular Joint (TMJ) or Craniomandibular Joint (CMJ) Dysfunction Services is $1,000 per covered person.	

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

	Benefits for sterilization are limited to maximum lifetime benefit of $500 per covered person after a 12-month waiting period.	
7A. COVERED PROVIDERS	Cofinity, Great-West Healthcare Open Access, PHCS or Sloans Lake network provider See provider directory for a complete list of current providers	All providers licensed or certified to provide covered benefits.
7B. With respect to network plans, are all the providers listed in 7A accessible to me through my primary care physician?	Yes	Not applicable.
8. MEDICAL OFFICE VISITS[4] a.) Primary Care Providers b.) Specialists	Office visits with Primary Care Providers and Specialists are subject to deductible; coinsurance and out-of-pocket maximum. Optional Office Visit Copay for participating provider visits – $35 for 4 visits per person per calendar year.	Office visits with Primary Care Providers and Specialists are subject to out-of-network deductible, then plan deductible then out-of-network coinsurance and out-of-pocket maximum.
9. PREVENTIVE CARE 6-month waiting period for the $500 wellness benefit. This 6-month wait does not apply to child wellness, routine mammograms, PAP tests or PSA tests. Copay can be used for Preventive Care Services office visits for CoreMed after the 6-month wait for wellness. a.) Children's Services b.) Adults' Services	Subject to deductible; coinsurance and out-of-pocket maximum. After deductible, pays up to $500 per calendar year. Optional Office Visit Copay for participating provider visits – $35 for 4 visits per person per calendar year.	Office visits are subject to out-of-network deductible, then plan deductible, then out-of-network coinsurance and out-of-pocket maximum. After deductible, pays up to $500 per calendar year.
	a.) Deductible waived; coinsurance and out-of-pocket maximum applies; the $500 Preventive Care Services maximum does not apply to child wellness charges. **0-12 years:** Immunizations recommended by the American Academy of Pediatrics, including chicken pox vaccination. **0-12 months:** 5 well child visits / 1 PKU **13-35 months:** 2 well child visits **3-12 years:** 3 well child visits b) The Preventive Care Services maximum benefit is $500 per person per year – subject to deductible, coinsurance and out-of-pocket maximum. This maximum does not apply to routine mammograms, PAP tests and PSA tests. The plan deductible is waived for routine mammograms, PAP tests and PSA tests. Routine mammography coverage guidelines: * One screening mammogram for women who are 35-39 years of age. * Screening mammogram not less than once every two years for women 40 years of age and under 50 years of age.	

	* At least one screening mammogram a year for women with risk factors to breast cancer as determined by her physician. * One screening mammogram a year for women who are 50 years of age or older. * PSA tests must consist at a minimum of a prostate-specific antigen blood test and a digital rectal exam. * At least one PSA screening a year for men 40-45 with increased risk of developing prostate cancer as determined by his physician. * One PSA screening per year for men who are 50 or older.	
10. MATERNITY a.) Prenatal Care b.) Delivery & inpatient well baby care[5] 90-day waiting period for conception to occur See policy for complications of pregnancy coverage	Maternity Benefit options are available with a $1,000, $2,500, $5,000 and $10,000 maternity deductible.	Maternity Benefit options are available with a $2,000, $5,000, $10,000 and $20,000 maternity deductible.
11. PRESCRIPTION DRUGS[6] Level of coverage and restrictions on prescriptions.	GENERIC: No generic deductible $15 copay BRAND: $500 brand deductible $25 copay + 50% coinsurance If use of brand when a generic is available, insured pays the difference between the brand contracted rate and the generic contracted rate.	
12. INPATIENT HOSPITAL	$0, $200 or $750 per day up to 3 days facility access fee, then deductible; coinsurance and out-of-pocket maximum.	$0, $200 or $750 per day up to 3 days facility access fee, then deductible; 20% reduction in coinsurance selected and out-of-pocket maximum.
13. OUTPATIENT/AMBULATORY SURGERY	Outpatient/Ambulatory Surgery Services are any services performed in an Acute Medical Facility's Outpatient department, a Free-Standing Facility or an Urgent Care Facility; $0 or $200 per outpatient surgery facility access fee, then deductible; coinsurance and out-of-pocket maximum. However, Physical Medicine is covered under the Outpatient Physical Medicine Services.	Outpatient/Ambulatory Surgery Services are any services performed in an Acute Medical Facility's Outpatient department, a Free-Standing Facility or an Urgent Care Facility; $0 or $200 per outpatient surgery facility access fee, then deductible; 20% reduction in coinsurance selected and out-of-pocket maximum. However, Physical Medicine is covered under the Outpatient Physical Medicine Services.
14. DIAGNOSTICS a.) Laboratory & x-ray b.) MRI, nuclear medicine, and other high-tech services	Deductible; coinsurance and out-of-pocket maximum.	

15. EMERGENCY CARE[7 8]	$75 access fee (waived if admitted); then deductible; coinsurance and out-of-pocket maximum.
16. AMBULANCE	Deductible; coinsurance and out-of-pocket maximum.
17. URGENT, NON-ROUTINE, AFTER HOURS CARE	If Emergency room, $75 access fee (waived if admitted) then deductible; coinsurance and out-of-pocket maximum. Non-emergency room services, Deductible; coinsurance and out-of-pocket maximum.
18. BIOLOGICALLY-BASED MENTAL ILLNESS CARE[9]	Plan does not offer coverage for behavioral health
19. OTHER MENTAL HEALTH CARE a.) Inpatient Care b.) Outpatient Care	Plan does not offer coverage for behavioral health
20. ALCOHOL & SUBSTANCE ABUSE	Plan does not offer coverage for Alcohol and Substance Abuse
21. PHYSICAL, OCCUPATIONAL, & SPEECH THERAPY a.) Inpatient: b.) Outpatient:	Deductible; coinsurance and out-of-pocket maximum. a.) 90 days/calendar year b.) Up to $3,000/calendar year
22. DURABLE MEDICAL EQUIPMENT	Deductible; coinsurance and out-of-pocket maximum.
23. OXYGEN	Deductible; coinsurance and out-of-pocket maximum.
24. ORGAN TRANSPLANTS	• Covered transplants are subject to the deductible, coinsurance and out-of-pocket maximum. • Donor expenses are limited to a maximum benefit of $10,000 • Covered Kidney, cornea and skin transplants are subject to the lifetime maximum benefit • Covered lung, heart, simultaneous heart/lung, liver, simultaneous kidney/pancreas, and allogeneic and autolotous bone marrow transplant/stem cell rescue are subject to the maximum transplant benefit (please see list below). • Travel expenses will be covered up to a $10,000 maximum benefit when a designated transplant provider is used. Maximum Transplant Benefits: • Lifetime maximum benefit when using a designated transplant provider • $100,000 maximum benefit per covered person when using a participating or non-participating provider
25. HOME HEALTH CARE	Deductible; coinsurance and out-of-pocket maximum; up to 60 visits per calendar year. Services up to 4 hours are considered 1 visit.
26. HOSPICE CARE	Deductible; coinsurance and out-of-pocket maximum. (Benefits are limited to a maximum of $100/day for 91 days.)
27. SKILLED NURSING FACILITY CARE	Deductible; coinsurance and out-of-pocket maximum; up to 90 days per calendar year.
28. DENTAL CARE	Deductible; coinsurance and out-of-pocket maximum. Only injury resulting from accidental blow to the mouth causing trauma to sound teeth, the gums or supporting structures of the teeth; dental treatment for cleft lip and cleft palate; treatment for anesthesia and hospital and facility charges for a dependent child.
29. VISION CARE	No coverage
30. CHIROPRACTIC CARE	Deductible; coinsurance and out-of-pocket maximum.
31. SIGNIFICANT ADDITIONAL COVERED SERVICES (list up to 5)	Telehealth Services Therapies for Congenital Defects and Birth Abnormalities Newborn Services

PART C: LIMITATIONS AND EXCLUSIONS

32. PERIOD DURING WHICH PRE-EXISTING CONDITIONS ARE NOT COVERED[10]	12 months for all pre-existing conditions unless the covered person is a HIPAA-eligible individual as defined under the Federal and State law, in which case there are no pre-existing condition exclusions.
33. EXCLUSIONARY RIDERS. Can an individual's specific, pre-existing condition be entirely excluded from the policy?	Yes
34. HOW DOES THE POLICY DEFINE A "PRE-EXISTING CONDITION"?	A pre-existing condition is an injury, sickness or pregnancy for which a covered person incurred charges, received medical treatment, consulted a health care professional, or took prescription drugs within 12 months immediately preceding the effective date of coverage.
35. WHAT TREATMENTS AND CONDITIONS ARE EXCLUDED UNDER THIS POLICY?	Exclusions vary by policy. A list of exclusions is available immediately upon request from your carrier, agent, or plan sponsor (e.g., employer). Review the list to see if a service or treatment you may need is excluded from the policy (request Form #29254).

Part D: USING THE PLAN

	IN-NETWORK	**OUT-OF-NETWORK**
36. Does the enrollee have to obtain a referral and/or prior authorization for specialty care in most or all cases?	No – This is not a gatekeeper plan	
37. Is prior authorization required for surgical procedures and hospital care (except in an emergency)?	Yes	
38. If the provider charges more for a covered service than the plan normally pays, does the enrollee have to pay the difference?	No	Yes
39. What is the main customer service number?	800-553-7654	
40. Whom do I write/call if I have a compliant or want to file a grievance?[11]	Assurant Health P.O. Box 3089 Milwaukee, WI 53201 800-553-7654	
41. Whom do I contact if I am not satisfied with the resolution of my complaint or grievance?	Write to: Colorado Division of Insurance ICARE Section 1560 Broadway, Suite 850 Denver, CO 80202	
42. To assist in filing a grievance, indicate the form number of this policy, whether it is individual, small group, or large group; and if it is a short-term policy.	Policy Form Number: 778 Individual	
43. Does the plan have a binding arbitration clause?	No	

Endnotes

1	"Network" refers to a specified group of physicians, hospitals, medical clinics and other health care providers that your plan may require you to use in order for you to get any coverage at all under the plan, or that the plan may encourage you to use because it may pay more of your bill if you use their network providers (ie., go in-network) than if you don't (i.e., go out-of-

	network).
2	"Deductible Type" indicates whether the deductible period is "Calendar Year" (January 1 through December 31) or "Benefit Year" (i.e., based on a benefit year beginning on the policy's anniversary date) or if the deductible is based on other requirements such as a "Per Accident or Injury" or "Per Confinement".
2a	"Deductible" means the amount that you will have to pay for allowable covered expenses under a health plan during a specified time period (e.g., a calendar year or benefit year) before the carrier will cover those expenses. The specific expenses that are subject to deductible may vary by policy. Expenses that are subject to deductible should be noted in boxes 8 through 31.
2b	"Individual" means the deductible amount you and each individual covered by a non-HSA qualified policy will have to pay for allowable covered expenses before the carrier will cover those expenses. "Single" means the deductible amount you will have to pay for allowable covered expenses under an HSA-qualified health plan when you are the only individual covered by the plan.
2c	"Family" is the maximum deductible amount that is required to be met for all family members covered by a non-HSA qualified policy and it may be an aggregated amount (e.g., "$3,000 per family") or specified as the number of individual deductibles that must be met (e.g., "3 deductibles per family"). "Non-single" is the deductible amount that must be met by one or more family members covered by an HSA-qualified plan before any covered expenses are paid.
3	"Out-of-pocket maximum" means the maximum amount you will have to pay for allowable covered expenses under a health plan, which may or may not include the deductibles or copayments, depending on the contract for that plan. The specific deductibles or copayments included in the out-of-pocket maximum may vary by policy. Expenses that are applied toward the out-of-pocket maximum should be noted in boxes 8 through 31.
4	Medical office visits include physician, mid-level practitioner, and specialist visits, including outpatient psychotherapy visits for biologically based mental illness.
5	Well baby care includes an in-hospital newborn pediatric visit and newborn hearing screening. The hospital copayment applies to mother and well-baby together; there are not separate copayments.
6	Prescription drugs, otherwise excluded are not covered, regardless of whether preferred generic, preferred brand name, or non-preferred.
7	"Emergency care" means all services delivered in an emergency care facility that are necessary to screen and stabilize a covered person. The plan must cover this care if a prudent lay person having average knowledge of health services and medicine and acting reasonably would have believed that an emergency medical condition or life or limb threatening emergency existed.
8	Non-emergency care delivered in an emergency room is covered only if the covered person receiving such care was referred to the emergency room by his/her carrier or primary care physician. If emergency departments are used by the plan for non-emergency after-hours care, then urgent care copayments apply.
9	"Biologically based mental illnesses" means schizophrenia, schizoaffective disorder, bipolar affective disorder, major depressive disorder, specific obsessive-compulsive disorder, and panic disorder.
10	Waiver of pre-existing condition exclusions. State law requires carriers to waive some or all of the pre-existing condition exclusion period based on other coverage you recently may have had. Ask your carrier or plan sponsor (e.g., employer) for details.
11	Grievances. Colorado law requires all plans to use consistent grievance procedures. Write the Colorado Division of Insurance for a copy of those procedures.

"Colorado law requires carriers to make available a Colorado Health Benefit Plan Description Form, which is intended to facilitate comparison of health plans. The form must be provided automatically within three (3) business days to a potential policyholder who has expressed interest in a particular

plan or who has selected the plan as a finalist from which the ultimate selection will be made. The carrier also must provide the form, upon oral or written request, within three (3) business days, to any person who is interested in coverage under or who is covered by a health benefit plan of the carrier."