ASSURANT Health®

Colorado Health Plan Description Form Exclusions

Time Insurance Company

Form TIM.POL.PAYDED0.CO and Form TIM.POL.PAYDED.CO
Assurant Clarity $0 Deductible Plan and
Assurant Clarity High Deductible Plans

We will not pay benefits for any of the following:

1. Charges for which our liability cannot be determined because a covered person, health care practitioner, facility, or other individual or entity within 30 days of Our request, failed to:
   a. Authorize the release of all medical records to us and other information we requested.
   b. Provide us with information we requested about pending claims, other insurance coverage or proof of creditable coverage.
   c. Provide us with information as required by any contract with us or a network including, but not limited to, repricing information.
   d. Provide us with information that is accurate and complete.
   e. Have any examination completed as we requested.
   f. Provide reasonable cooperation to any requests made by us.

2. Charges that are related to or a complication of a pre-existing condition.

3. Charges that:

   a. Are not specifically listed as a covered charge in the Medical Benefits section or Outpatient Prescription Drug Benefits section of the policy.
   b. Are complications of a non-covered service.
   c. Are incurred before the covered person's effective date or after the termination date of coverage.
   d. Are complications of any sickness or injury that existed prior to the effective date.
   e. Are not documented in the health care practitioner's or medical supply provider's records.
   f. Are related to the supervision of laboratory services that do not involve written consultation by a Health care practitioner including, but not limited to, laboratory interpretation.
   g. Are complications resulting from leaving a licensed medical facility against the advice of the covered person's health care practitioner.

4. Charges that are:
   a. Payable or reimbursable by Medicare Part A, Part B or Part D, where permitted by law. If a covered person at any time was eligible to enroll in the Medicare program (including Part B and Part D) but did not do so, the benefits under this plan will be reduced by any amount that would have been reimbursed by Medicare.
   b. Payable or reimbursable by any other government law or program, except Medicaid (Medi-Cal in California).
   c. For free treatment provided in a federal, veteran's, state or municipal medical facility.
   d. For free services provided in a student health center.
   e. For services that a covered person has no legal obligation to pay or for which no charge would be made if the covered person did not have a health plan or insurance coverage.

5. Charges for work-related sickness or injury eligible for benefits under worker's compensation, employers' liability or similar laws even when the covered person does not file a claim for benefits. This exclusion will not apply to any of the following:
   a. The sole proprietor, if the covered person's employer is a proprietorship.
   b. A partner of the covered person's employer, if the employer is a partnership.

c. A covered person who is not required to have coverage under any workers' compensation, employers' liability or similar law and does not have such coverage.

6. Charges for which a covered person is entitled to payment under any motor vehicle medical payment or premises medical expense coverage. Coverage under this plan is secondary to medical payment or medical expense coverage available to the covered person, regardless of whether such other coverage is described as secondary, excess or contingent.

7. Charges caused by or contributed to by:
   a. War or any act of war, whether declared or undeclared.
   b. Participation in the military service of any country or international organization, including non-military units supporting such forces.
   c. Foreign or domestic acts of terrorism that result in a nationwide epidemic.

8. Charges for: vision care that is routine, except as otherwise covered in the Diabetic Services provision in the Medical Benefits section; glasses; contact lenses, except when used to aid in healing an eye or eyes due to a sickness or an injury; vision therapy, exercise or training; surgery including any complications arising therefrom to correct visual acuity including, but not limited to, lasik and other laser surgery, radial keratotomy services or surgery to correct astigmatism, nearsightedness (myopia) and/or farsightedness (presbyopia).

9. Charges for: hearing care that is routine except as provided under the Medical Benefits section; any artificial hearing device, cochlear implant, auditory prostheses or other electrical, digital, mechanical or surgical means of enhancing, creating or restoring auditory comprehension except as provided under the Medical Benefits section.

10. Charges for foot conditions including, but not limited to, expenses for:
    a. Flat foot conditions.
    b. Foot supportive devices, including orthotics and corrective shoes.
    c. Foot subluxation treatment.
    d. Care of corns; bunions, except capsular or bone surgery; calluses; toenails, except for ingrown toenails; fallen arches; weak feet; chronic foot strain; or symptomatic complaints of the feet.
    e. Hygienic foot care that is routine, except as otherwise covered in the Diabetic Services provision in the Medical Benefits section.

11. Charges for: dental care that is routine; dental charges; bridges, crowns, caps, dentures, dental implants or other dental prostheses; dental braces or dental appliances; extraction of teeth; orthodontic charges; odontogenic cysts; any other expenses for treatment or complications of the teeth and gum tissue, except as otherwise covered in the Dental Services provision in the Medical Benefits section.

12. Charges for treatment of temporomandibular joint dysfunction and craniomandibular joint dysfunction, except as otherwise covered in the Temporomandibular Joint (TMJ) or Craniomandibular Joint (CMJ) Dysfunction provision in the Medical Benefits section, that include, but are not limited to:
    a. Any electronic diagnostic modalities.
    b. Occlusal analysis.
    c. Muscle testing.

13. Charges for any appliance, medical or surgical expenses for:
    a. Malocclusion or protrusion or recession of the mandible.
    b. Maxillary or mandibular hyperplasia.
    c. Maxillary or mandibular hypoplasia.

14. Charges for: any diagnosis, supplies, treatment or regimen, whether medical or surgical, for purposes of controlling the covered person's weight or related to obesity or morbid obesity, whether or not weight reduction is medically necessary or appropriate or regardless of potential benefits for co-morbid conditions; weight reduction or weight control surgery, treatment or programs; any type of gastric bypass surgery; suction lipectomy; physical fitness programs, exercise equipment or exercise therapy, including health club membership fees or services; nutritional counseling, except as otherwise covered in the Diabetic Services provision in the Medical Benefits section.

15. Charges for transplant services that are:
    a. Authorized by us to treat a specific medical condition if they are performed to treat a different medical condition that would not have been authorized by us.
    b. Not specifically listed as a covered transplant in the Transplants provision in the Medical Benefits section or in the Benefit Summary.
    c. For multiple organ, tissue and cellular transplants during one operative session, except for a simultaneous heart/lung, double lung or simultaneous kidney/pancreas transplant.
    d. For any non-human (including animal or mechanical) to human organ transplant.
    e. For the purchase price of an organ or tissue that is sold rather than donated.

16. Charges for chemical peels, reconstructive or plastic surgery that does not alleviate a functional impairment and other charges that are primarily a cosmetic service, except as otherwise covered in the Reconstructive Surgery provision in the Medical Benefits section.

17. Charges for revision of breast surgery for capsular contraction, removal or replacement of a prosthesis or augmentation or reduction mammoplasty, except as otherwise covered in the Reconstructive Surgery provision in the Medical Benefits section.

18. Charges for prophylactic treatment, services or surgery including, but not limited to, prophylactic mastectomy or any other treatment, services or surgery performed to prevent a disease process from becoming evident in the organ or tissue at a later date.

19. Charges for:
    a. A private duty nurse; a private duty professional skilled nursing service; a masseur, masseuse or massage therapist; a rolfer; a home health aide or personnel with similar training and experience; a stand-by health care practitioner, except as otherwise covered in the Outpatient Physical Medicine Services provision in the Medical Benefits section.
    b. Custodial care; respite care; rest care; supportive care; homemaker services.
    c. A health care practitioner who is not properly licensed or authorized in the state where services are rendered.
    d. Phone consultations.
    e. Health care practitioner administrative expenses including, but not limited to, expenses for claim filing, contacting utilization review organizations or case management fees.
    f. Missed appointments.
    g. Sales tax; gross receipt tax.
    h. Living expenses; travel; transportation, except as otherwise covered in the Professional Ground or Air Ambulance Services provision, or Transplants provision in the Medical Benefits section.
    i. Treatment or services that are furnished primarily for the personal comfort or convenience of the covered person, covered person's family, a health care practitioner or provider.

20. Charges for growth hormone therapy, including growth hormone medication and its derivatives or other drugs used to stimulate, promote or delay growth or to delay puberty to allow for increased growth, except as otherwise covered in the Growth Hormone Therapy Services provision in the Medical Benefits section.

21. Charges related to maternity or pregnancy or non-spontaneous abortion, except as otherwise covered in the Maternity Care Services provision or Complications of Pregnancy provision in the Medical Benefits section.

22. Charges related to the following conditions, regardless of underlying causes: sex transformation; gender dysphoric disorder; gender reassignment; treatment of sexual function, dysfunction or inadequacy; treatment to enhance, restore or improve sexual energy, performance or desire.

23. Charges for:
    a. Genetic testing or counseling, genetic services and related procedures for screening purposes including, but not limited to, amniocentesis and chorionic villi testing.
    b. Infertility diagnosis and treatment for males or females including, but not limited to, drugs and medications regardless of intended use, artificial insemination, in vitro fertilization, reversal of reproductive sterilization and related tests, services or procedures and any treatment to promote conception.
    c. Family planning.
    d. Cryopreservation of sperm or eggs.
    e. Surrogate pregnancy.
    f. Umbilical cord stem cell or other blood component harvest and storage in the absence of a Sickness or an Injury.

24. Charges for treatment, services, supplies or drugs designed or used to diagnose, treat, alter, impact, or differentiate a covered person's genetic make-up or genetic predisposition.

25. Charges for contraceptive procedures, drugs or devices.

26. Charges for chelation therapy, except for laboratory proven toxic states as defined by peer-reviewed published studies.

27. Charges to address quality of life or lifestyle concerns and similar charges for non-functional conditions.

28. Charges for: Behavior modification or behavioral (conduct) problems; learning disabilities; educational testing, training or materials except as otherwise covered in the Diabetic Services provision in the Medical Benefits section; cognitive enhancement or training; vocational or work hardening programs; transitional living.

29. Charges for services provided by or through a school system.

30. Charges for:

    a. Non-medical items, self-care or self-help programs.
    b. Aroma therapy.
    c. Meditation or relaxation therapy.
    d. Naturopathic medicine.
    e. Treatment of hyperhidrosis (excessive sweating).
    f. Acupuncture; biofeedback; neurotherapy; electrical stimulation; or aversion therapy.
    g. Inpatient treatment of chronic pain disorders.
    h. Applied behavior therapy treatment for autistic spectrum disorders.
    i. Smoking cessation.
    j. Snoring.
    k. The treatment or prevention of hair loss.
    l. Change in skin pigmentation.
    m. Stress management.

31. Charges for: Drugs that have not been fully approved by the FDA for marketing in the United States; drugs limited by federal law to investigational use; drugs that are used for experimental or investigational services, even when a charge is made; drugs with no FDA-approved indications for use; FDA approved drugs used for indications, dosage or dosage regimens or administration outside of FDA approval; drugs that are undergoing a review period, not to exceed 12 months, following FDA approval of the drug for use and release into the market; drugs determined by the FDA as

lacking in substantial evidence of effectiveness for a particular condition, disease or for symptom control.

32. Charges for treatment or services Incurred due to Sickness or Injury of which a contributing cause was the covered person's voluntary attempt to commit, participation in or commission of a felony, whether or not charged.

33. Charges for prescription drugs, medications or other substances dispensed or administered in an outpatient setting. Charges for drugs and medicines, unless otherwise noted as a covered charge in the Medical Benefits section. Charges for drugs and medicines prescribed for treatment of a sickness or an injury that is not covered under this plan. Charges for drugs, medications or other substances that are illegal under federal law, such as marijuana, even if they are prescribed for a medical use in a state. This includes, but is not limited to, items dispensed by a health care practitioner.

34. Charges for services ordered, directed or performed by a health care practitioner or supplies purchased from a medical supply provider who is a covered person, an immediate family member, or a person who ordinarily resides with a covered person.

35. Charges for any amount in excess of the maximum lifetime benefit or any other maximum benefit for covered services.

36. Charges that do not meet the definition of a covered charge in this plan including, but not limited to:
    a. Charges in excess of the maximum allowable amount, as determined by us under this plan except as otherwise shown in the Benefit Summary.
    b. Charges that are not medically necessary.

37. Charges incurred for experimental or investigational services.

38. Charges incurred outside of the United States, unless the services would have been covered under this plan if the services had been received in the United States.

39. Charges for drugs obtained from pharmacy provider sources outside the United States, except as otherwise covered in the World Wide Coverage provision in the Medical Benefits section.

40. Charges for sickness or injury caused or aggravated by suicide, attempted suicide or self-inflicted sickness or injury, unless committed while insane, even if the covered person did not intend to cause the harm which resulted from the action which led to the self-inflicted sickness or injury.

41. Charges related to health care practitioner assisted suicide.

42. Charges for vitamins and/or vitamin combinations even if they are prescribed by a health care practitioner except for: a) Legend prenatal vitamin prescription drugs if the covered person has the optional Maternity Care Services provision in the Medical Benefits section coverage in effect, as shown in the Benefit Summary, and the prenatal vitamins are prescribed during pregnancy; or b) Clinically proven vitamin deficiency syndromes that cannot be corrected by dietary intake.

43. Charges for any over-the-counter or prescription products, drugs or medications in the following categories, whether or not prescribed by a health care practitioner:
    a. Herbal or homeopathic medicines or products.
    b. Minerals.
    c. Health and beauty aids.
    d. Batteries.
    e. Appetite suppressants.

f. Dietary or nutritional substances or dietary supplements except as provided under the Medical Benefits section.
g. Nutraceuticals.
h. Tube feeding formulas and infant formulas.

44. Charges for cranial orthotic devices that are used to redirect growth of the skull bones or reduce cranial asymmetry, except following cranial surgery.

45. Charges for: Home traction units; home defibrillators; or other medical devices designed to be used at home, except as otherwise covered in the Durable Medical Equipment and Personal Medical Equipment provision or the Diabetic Services provision in the Medical Benefits section.

46. Charges for: Any injectable medications that are not specifically authorized by us under the Medical Benefits section or Outpatient Prescription Drug Benefits section; any administrative charge for drug injections.

47. Charges for: Drugs dispensed at or by a health care practitioner's office, clinic, hospital or other non-pharmacy setting for take home by the covered person; amounts above the contracted rate for participating pharmacy reimbursement; the difference between the cost of the prescription order at a non-participating pharmacy and the contracted rate that would have been paid for the same prescription order had a participating pharmacy been used; prescription drugs or supplies requiring injectable parenteral administration or use, except insulin or Imitrex, unless authorized by us before they are dispensed; any administrative charge for drug injections or administrative charges for any other drugs.

48. 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, but not limited to, the following: Participating, or instructing, or demonstrating, or guiding or accompanying others in parachute jumping, or hang-gliding, or bungee jumping, or racing any motorized or non-motorized vehicle, skiing or rodeo activities. Also excluded are treatment and services required due to Injury received while practicing, exercising, undergoing conditioning or physical preparation for any such compensated activity.

49. Charges for the treatment of Pervasive Developmental Disorders (Autistic Spectrum Disorders), including but not limited to autistic disorder, as defined by the Diagnostic and Statistical Manual of Mental Disorders (DSM).

In addition to the exclusions listed above, the following additional exclusions apply only to the Outpatient Prescription Drug Benefits section. We will not pay benefits for any of the following:

1. Charges for that part of any prescription order exceeding a 30 consecutive day supply per prescription order. Charges for that part of any prescription order exceeding a 90 consecutive day supply if the prescription drug is dispensed through a mail service prescription drug vendor.

2. Charges for that part of any prescription order exceeding 3 vials or a 30 consecutive day supply of one type of insulin. Charges for that part of any prescription order exceeding 9 vials or a 90 consecutive day supply if it is dispensed through a mail service prescription drug vendor.

3. Charges for that part of any prescription order exceeding 100 disposable insulin syringes or needles, 100 disposable blood/urine/glucose/acetone testing agents or 100 lancets or a 30 consecutive day supply. Charges for that part of any prescription order exceeding 300 disposable blood/urine/glucose/acetone testing agents or 300 lancets or a 90 consecutive day supply if the supplies are dispensed through a mail service prescription drug vendor.

4. Charges for drugs that are paid under another plan sponsor or payor as primary payor.

5. Charges for drugs that are not listed in a drug list. Charges for any ancillary charge or any difference between the cost of the prescription order at a non-participating pharmacy and the contracted rate that would have been paid for the same prescription order had a participating pharmacy been used.

6. Charges for contraceptive drugs or devices or oral contraceptives.

7. Charges for prescription drugs or supplies requiring injectable parenteral administration or use, except insulin or Imitrex, unless authorized by us under this Outpatient Prescription Drug Benefits section before they are dispensed. Charges for any injectable prescription drugs, unless authorized by us under this Outpatient Prescription Drug Benefits section before they are dispensed. Any administrative charge for drug injections or administrative charges for any other drugs.

8. Charges for devices or supplies including, but not limited to, blood/urine/glucose/acetone testing devices, needles and syringes, support garments, bandages and other non-medical items regardless of intended use, except as described under a prescription order.

9. Charges for over-the-counter (OTC) medications that can be obtained without a health care practitioner's prescription order, except for injectable insulin; or drugs that have an over-the-counter equivalent or contain the same or therapeutically equivalent active ingredient(s) as over-the-counter medication, as determined by Us, unless specifically authorized for coverage by us on our drug list.

10. Charges for: Compounded medications that contain one or more active ingredients that are not covered under this plan; combination drugs or drug products manufactured and/or packaged together and containing one or more active ingredients that are not covered under this plan; combination drugs or drug products that are manufactured and/or packaged together, unless authorized by us under this Outpatient Prescription Drug Benefits section before they are dispensed.

11. Charges for: Prescription order refills in excess of the number specified on the health care practitioner's prescription order; prescriptions refilled after one year from the health care practitioner's original prescription order; amounts above the contracted rate for participating pharmacy reimbursement.

12. Charges for: Drugs administered or dispensed by an acute medical facility, rest home, sanitarium, extended care facility, convalescent care facility, subacute rehabilitation Facility or similar institution; drugs administered or dispensed by a health care practitioner, who is not a participating pharmacy, unless authorized by us under this Outpatient Prescription Drug Benefits section before they are dispensed; drugs consumed, injected or otherwise administered at the prescribing health care practitioner's office; drugs that are dispensed at or by a health care practitioner's office, clinic, hospital or other non-pharmacy setting for take home by the covered person.

13. Charges for any drug used for cosmetic services as determined by us; drugs used to treat onychomycosis (nail fungus); botulinum toxin and its derivatives.

14. Charges for drugs: Prescribed for dental services, or unit-dose drugs; drugs used in the treatment of chronic fatigue or related syndromes or conditions; drugs containing nicotine or its derivatives.

15. Charges for DDAVP (desmopressin acetate) or other drugs used in the treatment of nocturnal enuresis (bedwetting) for a covered person under the age of 8.

16. Charges for Retin-A (tretinoin) and other drugs used in the treatment or prevention of acne, rosacea or related conditions for a covered person age 30 or older.

17. Charges for: Duplicate prescriptions; replacement of lost, stolen, destroyed, spilled or damaged prescriptions; prescriptions refilled more frequently than the prescribed dosage indicates.

18. Charges for drugs used to treat, impact or influence quality of life or lifestyle concerns including, but not limited to: Smoking deterrence or cessation; athletic performance; body conditioning, strengthening, or energy; prevention or treatment of hair loss; prevention or treatment of excessive hair growth or abnormal hair patterns.

19. Charges for drugs used to treat, impact or influence: Obesity; morbid obesity; weight management; sex transformation; gender dysphoric disorder; gender reassignment; sexual function, dysfunction or inadequacy sexual energy, performance or desire; skin coloring or pigmentation; social phobias; slowing the normal processes of aging; memory improvement or cognitive enhancement; daytime drowsiness; overactive bladder; dry mouth; excessive salivation; or hyperhidrosis (excessive sweating).

20. Charges for drugs or drug categories that exceed any maximum benefit limit under this plan.

21. Charges for drugs designed or used to diagnose, treat, alter, impact, or differentiate a covered person's genetic make-up or genetic predisposition.

22. Charges for prescriptions, dosages or dosage forms used for the convenience of the covered person or the covered person's immediate family member or health care practitioner.

23. Charges for drugs obtained from pharmacy provider sources outside the United States, except for covered Charges that are received for emergency treatment.

24. Charges for: Postage, handling and shipping charges for any drugs.

25. Charges for: Vaccines and other immunizing agents; biological sera; blood or blood products.

26. Charges for drugs for which prior authorization is required by us and is not obtained.

"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."