



ASSURANT
Health®

Assurant. On your terms.®

Assurant® Self-Funded Health Plans

*Health Plan Administration and Stop-Loss Insurance
for Small Employer Groups*



***Time Insurance Company
John Alden Life Insurance Company***

Assurant Self-Funded Health Plans are a program of services for self-funding employers, developed and marketed by Assurant Health. Stop-loss insurance for self-funded plans is underwritten and issued by Time Insurance Company and John Alden Life Insurance Company.

A Smart, Affordable, Simple Plan for Your Small Business from Assurant Health

Assurant® Self-Funded Health Plans offer an alternative to traditional health insurance that can *lower your group's health care costs* now and for years to come. This unique package of services and protection allows you to gain control over those expenses by helping you *establish and fund your own health benefit plan*.

Smart

Assurant Self-Funded Health Plans enable you to **offer your employees premier health protection**—the kind usually reserved for big businesses. And while you protect your employees, we **protect your small business** from larger-than-expected claims.

Affordable

Self-funding means you **don't pay for more than the amount of health care your group actually uses**. So if your group's claims expenses are less than the norm, your overall savings can be significant. There's even an opportunity to **receive annual refunds if you don't use all your funds**.

Simple

Assurant Health gives you a complete package—all the services for self-funding. You choose your health benefit plan and **all the details are taken care of**—you simply pay a monthly bill.

With Assurant Health, you get more than just protection. You also get the peace of mind that comes from knowing you've chosen an organization with the commitment and financial resources to be there when you need them.

- Tracing our roots back to 1892, Assurant Health has a history of business experience, financial stability and health-insurance expertise you won't find anywhere else.
 - Assurant Health companies are rated A- (Excellent) for financial strength and ability to meet policyowner obligations by the highly respected insurance industry analyst, A.M. Best Company.¹
 - We offer health insurance solutions to individuals and small businesses across the U.S.
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¹ A.M. Best is a rating organization that evaluates insurers' financial strength. The rating represents the organization's opinion of Time Insurance Company's and John Alden Life Insurance Company's ability to meet their ongoing obligations to policyholders. Source: A.M. Best Ratings and Analysis, November 2010.

Self-Funded Health Plans

Assurant Health makes it easy to establish a health benefit plan—*you get all the advantages of self-funding and none of the hassles.*

Assurant Self-Funded Highlights:

- **We help you build your health benefit plan** by selecting from many plan design options—just like for traditional health insurance.
- **Your maximum cost for the year is determined up front and guaranteed**, subject to enrollment and benefit changes, **and it's typically lower than the cost of a comparable fully-insured plan.**
- If claims ever become larger than expected, **insurance protection for your business—employer stop-loss insurance—takes care of these expenses.** Your costs for the year are not increased.
- **Our trusted, established, third-party plan administrator manages all the details of your self-funded plan**—providing customer service and plan accounting and also paying claims from your claims fund.

Unlike other types of health plans, *our self-funded plans give you money back* if your group's actual benefit expenses for the year are less than expected. You decide whether to apply the savings to your monthly bill or take a refund.

Our health plans are designed for employers determined to *take control of health care costs without compromising the quality of benefits* their employees receive.

Health Benefit Highlights:

- **First-dollar** preventive care benefits
- Diagnostic x-ray and laboratory services **paid at 100%**
- **Copays** for prescription drugs, office visits to network doctors and urgent care facilities
- **No referrals** necessary to see a specialist
- Optional Health Savings Accounts (HSAs) and Health Reimbursement Arrangements (HRAs)—health care savings programs with **tax advantages**
- Lets you **cover employees across the U.S.** with multiple plan designs and provider networks to accommodate different employee needs

Assurant Health and its legal entities are not engaged in rendering tax or legal advice. If tax or legal advice is required, seek the services of a qualified professional.

An **Assurant Self-Funded Health Plan** combines a self-funded employee health benefit plan with plan administration and employer stop-loss coverage, all of which are regulated by federal law. The employer stop-loss coverage is an insurance product that is also regulated by the state in which the coverage is issued. Employer stop-loss insurance for Assurant Self-Funded Health Plans is underwritten and issued by Time Insurance Company and John Alden Life Insurance Company.

How We Make Self-Funding Work for You

Our complete self-funding package means *you're free to focus on your business.*

You simply pay a monthly bill, which includes the amount needed to fund expected claims as well as your stop-loss insurance premium and plan administration fee. We take it from there:

- The plan administrator pays claims from your claims fund
- Your stop-loss insurance takes care of larger-than-expected claims
- Any unused funds accrue and can either be applied to your monthly bill or refunded to you

Employer Stop-Loss Insurance

- An **aggregate stop-loss benefit** protects against high, unexpected claims incurred by your group as a whole. If total claims reach a pre-determined limit, your stop-loss insurance takes care of additional claims for the rest of the year.

This benefit also provides monthly advances to your claims fund if the claims paid exceed the current balance in your claims fund.

- You're also protected against high claims incurred by an individual group member. A **specific stop-loss benefit** takes care of a member's additional claims for the rest of the year once that individual's claims exceed a pre-determined limit, which you select.

Choose from these specific stop-loss options:

\$10,000, \$15,000, \$20,000 or \$25,000*
per person each year

* Not all options are available in all states.

Plan Administration

Easy to Work With — Easy to Trust

Our third-party administrator has:

- Easy-to-use online services that allow you to access plan information
- Easy-to-understand monthly reports that keep you on top of your plan's performance
- More than 25 years of experience in benefit management and administration services
- An administrative performance guarantee

One Point of Contact

Customer service is available when you need:

- Answers to health benefit plan questions
- Help finding doctors and hospitals in your network(s)
- Claims status (also available online)
- Answers to plan cost and billing questions
- Changes to your plan
- COBRA and HIPAA administration and compliance
- ID cards and summary plan descriptions

Self-funding offers great advantages for many small groups, but it's not appropriate for all. We will work with you now and in the future to help you determine if self-funding is the right choice for your group.

Health Benefit Plan

Plan Design¹

Deductible	(You Pay)
Benefit Percentage	(Plan Pays)
Coinsurance Out-Of-Pocket Maximum	(You Pay)

Self-Funded (Plan Types — PPO Copay, PPO Copay HRA, PPO HSA)

- **PPO Copay:** \$500, \$1,000, \$1,500, \$2,000, \$2,500, \$3,500 or \$5,000
- **PPO Copay HRA:** \$1,500, \$2,000, \$2,500, \$3,500 or \$5,000
- **PPO HSA:** \$1,500, \$2,000, \$2,500, \$3,500 or \$5,000

Family deductible maximum is two times the selected deductible

100%, 90%, 70% or 50%

\$0, \$1,000, \$1,500, \$2,000, \$2,500, \$3,500, \$5,000 or \$10,000

Family coinsurance out-of-pocket maximum is two times the selected amount

Outpatient Benefits Benefits are subject to selected deductible and coinsurance unless otherwise noted.

Office Visit Copay ² (Primary Care Copay/Specialist Copay)
Preventive Care Services
Prescription Drugs (Generic Copay/Preferred Brand Copay/Non-preferred Brand Copay) ²
Urgent Care Services ²
Diagnostic X-Ray and Laboratory Services ³
Emergency Room ²
Home Health Care
Behavioral Health and Substance Abuse
Outpatient Hospital/Surgical Center, Physician Services, Outpatient Physical Medicine ⁴ , MRI, EKG, Colonoscopy, Maternity Care, Ambulance, Chemotherapy, Dialysis, Durable Medical Equipment and most other covered services

- \$20/\$35, \$35/\$50 or \$40/\$60 – no deductible or coinsurance

Covered at 100% for services rendered by network providers. Preventive services are those recommended by the United States Preventive Services Task Force (USPSTF) and include: routine physicals, mammograms, well-child exams and immunizations.

	Option 1	Option 2	Option 3
Retail Pharmacy	\$15/\$45/\$60	\$20/\$50/\$75	\$15 (generic only)
Mail Order (three-month supply)	\$45/\$135/\$180	\$60/\$150/\$225	\$45 (generic only)
Deductible and Coinsurance Option	None or \$300 for brand	None	None

\$50 copay, no deductible or coinsurance²

Paid at 100%, no deductible or coinsurance³

\$100 access fee, then deductible and coinsurance
Nonemergency use of an emergency room is subject to a 30% benefit penalty

50-visit benefit

Covered, subject to selected deductible and 50% coinsurance
Coinsurance does not apply to the out-of-pocket maximum

Covered

Inpatient Benefits Benefits are subject to selected deductible and coinsurance unless otherwise noted.

Hospital and Physician Services
Acute and Subacute Rehabilitation Facilities
Skilled Nursing Facility
Hospice Care Services
Transplants
Behavioral Health and Substance Abuse

Covered

31-day combined benefit

31-day benefit

- Paid at 100%, no deductible or coinsurance for PPO and HRA plans
- Subject to deductible, then covered at 100% for HSA plans

- Covered at a designated provider
- \$100,000 lifetime benefit maximum per organ at a nondesignated provider

30-day benefit, subject to selected deductible and 50% coinsurance
Coinsurance does not apply to the out-of-pocket maximum

Benefits and options may vary by state. The amount of benefits depends upon the plan selected and the premium will vary with the amount of benefits.

¹ Not all plan payment combinations are available.

² HSA plans do not have copays or access fees — all covered expenses are subject to deductible and coinsurance.

³ MRI, CT scan, PET scan, ultrasound, EKG, chemotherapy, radiation therapy and dialysis are subject to deductible and coinsurance.

⁴ Subject to the applicable copay when performed during a Primary Care Provider or Specialist office visit, otherwise subject to deductible and coinsurance.

Important Provisions

Employment Waiting Period

The employment waiting or affiliation period is the number of consecutive days an employee must be working before he/she is eligible to be covered. Coverage begins on the first day of the following month.

The following choices are available:

0, 30, 60, 90, 180 or 365 days

Affiliated Provider Benefit

Assurant Health has PPO arrangements with local and national provider networks, so you have convenience and choice. However, many times physicians and other health care providers such as radiologists, anesthesiologists, pathologists and emergency room personnel are affiliated with participating hospitals and clinics but are not members of the network. If care is received at a network facility from those nonparticipating providers, covered charges will be paid at the network benefit level. Though the health benefit plan pays a greater percentage of the charge, the covered person is responsible for any remaining balance.

Emergency Care Benefit

The health benefit plan pays for emergency treatment at the network benefit level whether treatment is received from a participating or nonparticipating provider.

Utilization Review

When inpatient treatment is needed, the covered person is responsible for calling Assurant Health to receive authorization. The toll-free telephone number appears on the ID card. If authorization is not received, a penalty of 15% of the charge up to \$1,000 could be applied. No benefits are paid for transplants which are not authorized. Authorization is not a guarantee of coverage.

Pre-Existing Condition

A pre-existing condition is a physical or mental condition, regardless of the cause, for which medical advice, diagnosis, care or treatment was recommended or received within the 6-month period ending on the enrollment date. Benefits are not paid for charges incurred due to a pre-existing condition until a covered person is continuously insured under the health benefit plan for 12 months, 18 months for late enrollees. **This exclusion period can be reduced or eliminated if the covered person had prior creditable coverage. Those under age 19 are covered for pre-existing conditions.**

Deductible Credit

When coverage first begins, credit is given for any portion of a calendar-year deductible satisfied under the prior plan during the same calendar year. However, no credit is given for past policy-year deductibles.

Continuity of Coverage

The pre-existing conditions limitation is reduced by the amount of time a person was covered under prior creditable coverage, provided there was no more than a 63-day gap between coverages (excluding any employment waiting/affiliation period).

EXCLUSIONS SUMMARY

- Treatment not listed in the summary plan description
- Treatment of a pre-existing condition, until continuously insured for 12 months for ages 19 and older
- Services by a medical provider who is an immediate family member or who resides with a covered person
- Treatment reimbursable by Medicare, Workers' Compensation, automobile carriers or expenses for which other coverage is available
- Routine hearing care, routine vision care, vision therapy, surgery to correct vision, routine foot care or foot orthotics
- Custodial care, private nursing, telemedicine or phone consultations
- Charges in excess of the \$50,000 lifetime maximum for Durable Medical Equipment
- Diagnosis and treatment of infertility, sex transformation, surrogate pregnancy, sterilization reversal
- Cosmetic services, experimental treatment, complications of an excluded service
- Genetic testing, counseling and services except those recommended by the USPSTF
- Treatment of varicose veins
- Treatment of "lifestyle" concerns including but not limited to hair loss, restoration or promotion of sexual function, cognitive enhancement and educational testing or training
- Over-the-counter drugs (except those recommended by the USPSTF and authorized by health care provider), drugs not approved by the FDA, drugs obtained from sources outside the United States, the difference in cost between a generic and brand name drug when the generic is available

Terms

BENEFIT PAYMENT RELATED

Benefit Percentage is the portion of covered expenses the health benefit plan pays after the deductible.

Coinsurance is the portion of covered expenses a covered person pays after the deductible.

Coinsurance Out-of-Pocket Maximum is the total amount of coinsurance a covered person is responsible for paying in a year. The health benefit plan pays 100% of covered expenses after this limit is reached, except for copays.

Copay is a fixed fee paid by a covered person each time for certain visits, services or benefits.

Deductible is the amount a covered person pays toward covered expenses before the health benefit plan pays benefits.

Family Deductible is two times the individual deductible. All network and out-of-network covered expenses for all covered family members accrue toward the satisfaction of the family deductible. Once the family deductible is satisfied, any remaining network covered expenses for the year will be paid by the health benefit plan at the selected benefit percentage. However, any remaining out-of-network covered expenses for the year will continue to accrue toward the satisfaction of the out-of-network family deductible. For a **Common Family Deductible**, either one or more covered family members must satisfy the family deductible before benefits are paid for any covered family member.

First-Dollar describes benefits paid by the health benefit plan that are not subject to the deductible, coinsurance or a copay.

Maximum Allowable Amount is the most the health benefit plan pays for services performed by providers. The negotiated rate is the maximum allowable amount paid to participating (network) providers.

Unlike some plans, the health benefit plan also covers services performed by nonparticipating (out-of-network) providers. The maximum allowable amount for these services is based on **usual, customary and reasonable (UCR)**, which uses charges by area providers to determine the maximum allowable amount. A covered person using a nonparticipating provider is responsible for any amount in excess of the maximum allowable amount.

Out-of-Network Charge is an additional amount paid by a covered person who receives treatment from a nonparticipating provider.

- The out-of-network deductible is two times the network deductible
- The out-of-network family deductible is two times the out-of-network deductible
- The out-of-network coinsurance out-of-pocket maximum is two times the network coinsurance out-of-pocket maximum
- The out-of-network family coinsurance out-of-pocket maximum is two times the out-of-network coinsurance out-of-pocket maximum
- Copays for office and facility visits are not accepted at nonparticipating providers. Those charges are subject to the out-of-network deductible and out-of-network coinsurance

MEDICAL SERVICE RELATED

Emergency Care includes treatment, services or supplies for an illness or injury of such a nature that failure to get immediate medical attention or treatment could place the covered person's life in jeopardy or cause serious harm to the person's bodily functions.

Hospital Services include a hospital's semi-private room, board, intensive care and miscellaneous services and supplies for illnesses, injuries, maternity and well-newborn care.

Health Care Practitioner is a person licensed by the state or other geographic area in which covered services are rendered to treat the kind of illness or injury for which a claim is made. Included are doctors, surgeons, assistant surgeons, anesthesiologists, physician assistants and nurses.

Office Visit is a face-to-face meeting between a covered person and a health care practitioner that takes place in the health care practitioner's office for evaluation, diagnosis and management of an illness or injury or preventive services.

Outpatient Physical Medicine Services include physical, speech and occupational therapies, chiropractic care, cardiac and pulmonary rehabilitation and treatment for developmental delay.

Primary Care Provider is a health care practitioner who is: 1) a general or family practitioner, internist, pediatrician, obstetrician or gynecologist, or 2) designated by the network manager as a primary care provider.

United States Preventive Services Task Force (USPSTF) is a Congressionally-mandated, but independent, panel of primary care providers who are experts in medicine and prevention (e.g., family physicians, internists, nurses) responsible for reviewing preventive services and developing recommendations.

Urgent Care includes treatment or services for an illness or injury that develops suddenly or unexpectedly outside of a health care practitioner's normal business hours that requires immediate treatment, but is not of sufficient severity to be considered emergency treatment.



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For more information, or to apply for coverage,
contact your insurance agent.

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About Assurant Health

Assurant Health is the brand name for products underwritten and issued by Time Insurance Company (est. 1892), John Alden Life Insurance Company (est. 1961) and Union Security Insurance Company (est. 1910) ("Assurant Health").

Together, these three underwriting companies provide health insurance coverage for people nationwide. Each underwriting company is financially responsible for its own insurance products. Primary products include individual, small employer group and short-term limited-duration health insurance products, as well as non-insurance products and consumer-choice products such as Health Savings Accounts and Health Reimbursement Arrangements.

Assurant Health is headquartered in Milwaukee, Wisconsin, with operations offices in Minnesota, Idaho and Florida, as well as sales offices across the country. The Assurant Health Web site is www.assuranthealth.com.

Assurant Health is part of Assurant, a premier provider of specialized insurance products and related services in North America and select worldwide markets. www.assurant.com.

This brochure provides summary information. Please refer to the summary plan description for a complete listing of employee health benefits, exclusions and terms of coverage. Please refer to the stop-loss policy for a complete listing of employer stop-loss benefits, exclusions and terms of coverage. In the event that there are discrepancies with the information in this brochure, the terms and conditions of coverage documents will govern.

Not for use in Colorado, Massachusetts or Washington.

Stop-Loss Policy Forms: 27426, 27427, 28844 and 28845
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