ASSURANT Health

Assurant® Catastrophic Plans
Washington

Choice, Coverage, and Value

Protecting yourself and your family is a priority and health insurance is an essential part of your financial plan. Choose your optimum blend of broad coverage and great value.

Lifetime benefit maximum options — $3 million or $6 million

You choose the amount of protection you want.

Initial rate guarantee

Your premium rate is locked in for the first 12 months. Have the convenience of knowing what you'll pay in premium for an entire year.

Worldwide coverage, 24 hours a day

Whether you're near or far from home — you're covered.

No referrals necessary to see a specialist

You don't have to jump through hoops when you need a specialist's care — simply make an appointment.

Accident Medical Expense benefit

We pay 100% of the first $2,000 of accident-related expenses per accident — regardless of your deductible.

Built-In Features

Your plan covers the following services – subject to deductible and coinsurance, unless otherwise noted.

Office Visit Copays

Your copay is your only cost for an eligible network office visit, including allergy shots.

Pay just $35 per visit for your first four visits. Additional visits are also covered, subject to deductible and coinsurance.

Preventive Services

Covered immediately at 100%, preventive services include immunizations, Pap tests, PSA screening, lipid profile tests, barium enemas, and tuberculosis tests — with no annual dollar limit.

Mammograms

Mammograms are covered, even if you haven't yet met your plan deductible. You pay your coinsurance, and the plan pays the rest.

Maternity

Your plan gives you access to network discounts on doctor and hospital bills.

Charges from a routine pregnancy that exceed the plan's separate $20,000 deductible are paid at 100% — even if you haven't yet met the plan deductible.

Complications of Pregnancy

Includes emergency Caesarean section and any sickness associated with a pregnancy except hyperemesis gravidarum.

Diagnostic Imaging and Laboratory Services

Includes x-rays, ultrasounds, CAT scans, MRIs, lab tests, and interpretation.

Additional Coverage for Accidental Injuries

Accident Medical Expense coverage is included with your Assurant Catastrophic Plan. This coverage pays the first $2,000 of expenses related to each accident — even if you haven't yet met your plan deductible.

Outpatient Hospital, Surgical Center, and Urgent Care Facilities

Includes the services of the facility and supplies.

Ground and Air Ambulance

You get coverage for emergency air or ground ambulance to the nearest facility equipped to provide appropriate care — not just the closest.

Emergency Room

Includes the services of the facility and supplies. Benefits for covered emergency services are always paid at the higher network benefit percentage — even if you are out of network.

Health Care Practitioner Services

Includes doctors, surgeons, assistant surgeons, anesthesiologists, physician assistants, and nurses.

Outpatient Physical Medicine

Includes physical, speech, and occupational therapies, cardiac and pulmonary rehabilitation, treatment of developmental delay, massage therapy, acupuncture, and chiropractic services.

Inpatient Hospital

Includes the services of the facility such as semi-private room and board, intensive care, and supplies.

Transplants

After a 12-month waiting period, includes:

- Kidney, cornea, and skin transplants covered as any other service.
- Transplants such as bone marrow, heart, liver, and lung covered up to $250,000 when performed through a network provider. When performed at a designated transplant provider, transplants are covered up to $500,000.
- Up to an additional $10,000 toward travel expenses when a designated transplant provider is selected.

Assurant® Catastrophic Plan — Network Benefits

Plan Design

Unless otherwise noted, all deductibles, maximums, and benefit amounts are applied per person and are reset each January 1.

Deductible *Amount you pay toward covered expenses before the plan pays benefits*	$2,000, $3,000, $5,000, or $10,000 *(Family deductible maximum is two times the deductible and is met collectively by two or more people.)*
Benefit Percentage *Percentage of covered expenses the plan pays after the deductible*	75% or 50%
Coinsurance *Percentage of covered expenses you pay after the deductible*	25% or 50%
Total Out-Of-Pocket Maximum *(includes deductible)* *After this maximum is met, the plan pays 100% of covered expenses*	$4,500 to $22,000 depending on coinsurance *(Family total out-of-pocket maximum is two times the total out-of-pocket maximum and is met collectively by two or more people.)*
Office Visit Copay *You pay your copay and the plan pays 100% of the remaining cost of an eligible network office visit including examination, consultation, evaluation, development of a treatment plan, and allergy shots*	$35 copay Copay applies to each of four network office visits per person Additional visits are covered, subject to the deductible and coinsurance
Lifetime Benefit Maximum *The total maximum amount the plan pays per person*	$3 million or $6 million

Outpatient Benefits

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

Preventive Services	Covered — not subject to deductible or coinsurance
Mammograms	Covered — subject to coinsurance, deductible waived
Diagnostic Imaging and Laboratory Services	Covered
Outpatient Hospital, Surgical Center, or Urgent Care Facility	Covered
Professional Ground and Air Ambulance	Covered
Emergency Room	Access fee: $75 copay, then subject to deductible and coinsurance — $75 copay waived if admitted to the hospital
Health Care Practitioner Services	Covered
Outpatient Physical Medicine	Rehabilitation: 20 visits Chiropractic: 10 visits Acupuncture: 10 visits
Home Health Care	Up to 130 visits

Inpatient Benefits

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

Inpatient Hospital	Covered
Inpatient Rehabilitation Facility	Up to 10 days
Subacute Rehabilitation and Skilled Nursing Facilities	Up to 45 days

Optional Coverage

Dental-Vision Discount Plan Saves You Money at the Dentist and the Eye Doctor.

You'll get discounts on services from a nationwide network of dental and eyewear providers. You'll save 15 – 50% on dental services and 10 – 60% on eyewear.

Actual costs and savings may vary by provider and geographic area. This optional coverage is available at an additional cost. Discount programs are not insurance. Additional provisions may apply.

Other Covered Services

- Behavioral Health
- Complications of Pregnancy
- Dental Injuries
- Diabetic Services
- Hospice Care
- Reconstructive Surgery

The amount of benefits depends upon the plan design components selected, and the premium varies with the amount of benefits. Plan design components are not available in all combinations. Plan design above reflects in-network benefits. Out-of-network provisions may apply. See page 5 for details.

Plan Provisions

Office Visit Copay

With this benefit, a copay is your only cost for an eligible network office visit. Any associated imaging and laboratory services, such as x-rays and blood tests, are covered subject to deductible and coinsurance, but are not eligible for benefits under the office visit copay.

Immunizations administered during an office visit are covered under the preventive services benefit.

Other services that are subject to deductible and coinsurance, but not eligible for benefits under the office visit copay, are: office visits with non-participating providers, surgical procedures, and allergy tests.

Maternity Benefit

While a routine pregnancy typically does not exceed the plan's $20,000 deductible, if such charges occur, they are paid at 100%. The biggest value of this benefit is that you qualify for network discounts on doctor and hospital bills.

The maternity deductible is separate from the plan deductible. Once the maternity deductible is met, the plan pays for covered maternity services (whether or not the plan deductible has been satisfied).

Medically Necessary Care

Treatment must be medically necessary to be covered. Medically necessary services or supplies must be:

- Appropriate and consistent with the diagnosis.
- Commonly accepted as proper treatment.
- Reasonably expected to result in improvement of the condition.
- Provided in the least intensive setting without affecting the quality of medical care provided.

Maximum Allowable Amount

The maximum allowable amount is the most the 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.

Network Services

When you use network providers, covered charges are eligible for discounts and never exceed the maximum allowable amount.

Out-of-Network Services

Emergencies: Covered services are always paid at the network benefit percentage—even if you are out of network—subject to the maximum allowable amount.

Non-emergencies: Covered services are subject to the out-of-network deductible, the maximum allowable amount provision, the out-of-network coinsurance, and the increased out-of-network coinsurance out-of-pocket maximum. See chart below.

ASSURANT CATASTROPHIC PLANS OUT-OF-NETWORK COSTS	
OUT-OF-NETWORK DEDUCTIBLE	
Individual	Family
2x in-network deductible	2x individual out-of-network deductible met collectively by 2 or more people
OUT-OF-NETWORK TOTAL OUT-OF-POCKET MAXIMUM	
Individual	Family
$9,000 – $30,000 depending on coinsurance	2x individual out-of-network total out-of-pocket maximum met collectively by 2 or more people

Utilization Review

Authorization is required before inpatient treatment and certain types of outpatient procedures. Unauthorized services will result in a penalty. Unauthorized transplants are not covered.

Benefit Waiting Periods on Certain Treatment

Benefits for certain types of treatment are payable after the benefit waiting period listed here:

- Durable and personal medical equipment ($500 lifetime benefit) — six months.
- Face and jaw dysfunction services ($500 lifetime maximum) — six months.
- Surgical treatment of bunions, hemorrhoids, inguinal hernia, varicose veins — six months.
- Surgical treatment of tonsils/adenoids — six months.
- Transplants — 12 months.

Pre-Existing Conditions

A pre-existing condition is a sickness, pregnancy or injury, and related complications for which, during the six-month period immediately prior to the effective date of your health insurance coverage:

- You sought, received or were recommended medical advice, consultation, diagnosis, care, or treatment.
- Prescription drugs were prescribed.
- Symptoms were produced, or diagnosis was possible.

No benefits are paid for charges incurred due to a pre-existing condition until you have been continuously insured under the plan for nine months. After the nine-month period, benefits are paid for a pre-existing condition.

Get Added Protection with a Prescription Drug Plan

Taking care of your family and yourself is a smart way to ensure a high quality of life. That includes the medications your family needs to stay healthy.

An outpatient prescription drug plan puts you in control against rising prescription costs. It's real insurance — more than a discount card — that you can add to your Assurant® Catastrophic Plan or purchase separately.

- Thousands of covered brand-name and generic medications
- Just $15 for generic prescriptions
- Broad selection of retail pharmacies nationwide
- Mail-order services available

You'll save two ways: First, as an Assurant Health customer, you're eligible for discounts on prescriptions. Then, the plan will pay for a portion of covered prescriptions up to the Prescription Annual Maximum.

Prescription at a Discount

Your drug card also provides discounts on many "lifestyle" prescription drugs not covered (e.g. Zyban® for smoking cessation), so you should be sure to use your card every time you fill a prescription.

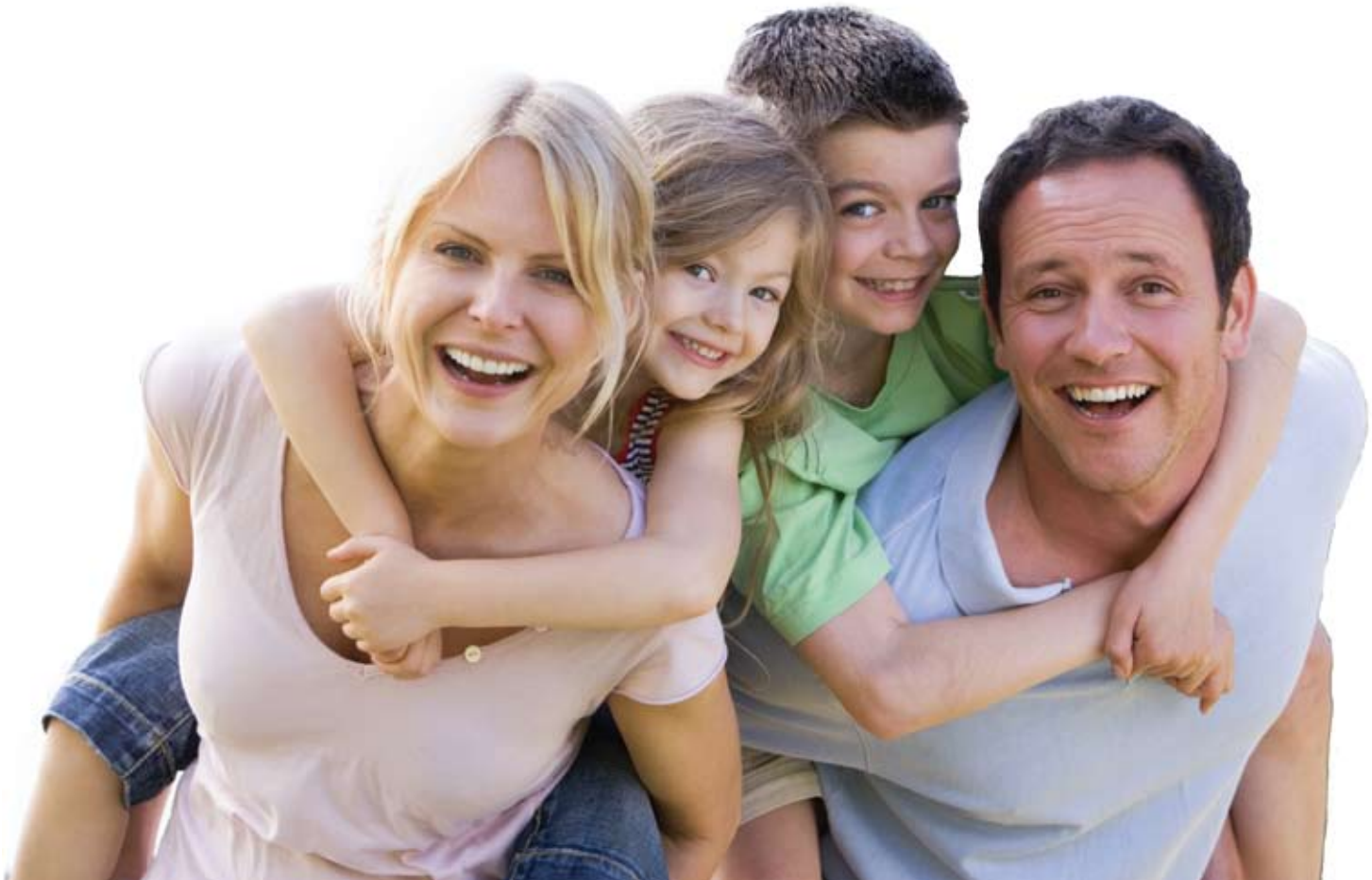
Even if the benefit maximum is reached, you can still receive discounts on covered prescriptions.

Mail-Order Service

A convenient network mail order service providing home delivery of prescription medications is available. Up to a 90-day supply of selected maintenance medications may be purchased for two copays plus applicable coinsurances.

Out-of-Network

If you purchase a covered generic or brand prescription outside of the pharmacy network, you can still receive benefits. You'll need to pay for the prescription and submit a claim to the pharmacy network administrator. Benefits are considered based upon the contracted rate for the cost of the drug at a network pharmacy.



Select your Plan

For up to $500 of benefits per year, per covered person, choose the ***Assurant® Basic 500*** plan.

For more extensive protection, choose the ***Assurant® Select 5000*** plan. It pays up to $5,000 per year, per person for brand-name prescriptions with no limit on generic prescriptions.

These plans can also be purchased separately from a health plan. See the chart below for details.

	Assurant® Basic 500	*Assurant® Select 5000*
Retail Pharmacy		
Generic		
Copay	$15	$15
Coinsurance	Covered 100%	Covered 100%
Brand name		
Copay	$25	$25
Coinsurance	50%	25%
Mail-Order Pharmacy		
Generic		
Copay	$30	$30
Coinsurance	Covered 100%	Covered 100%
Brand name		
Copay	$50	$50
Coinsurance	50%	25%
Prescription Annual Maximum		
	$500 per year, per person	Brand—$5,000 per year, per person Generic—Unlimited

Outpatient prescription drug plans are separate contracts.
These plans are subject to underwriting. You may not qualify for the benefit level selected.

Exclusions Summary

MEDICAL PLANS

No benefits are provided for the following:

- Charges incurred due to a pre-existing condition until you have been continuously insured for nine months.
- Sickness or injury caused by war, participation in a felony, attempted suicide, or a hazardous activity for which compensation is received.
- Routine hearing care, routine vision care, vision therapy, surgery to correct vision, routine foot care, or foot orthotics.
- Cosmetic services including chemical peels, plastic surgery, and medications.
- Charges by a health care practitioner or medical provider who is an immediate family member. Immediate family members are you, your spouse, your children, brothers, sisters, parents, their spouses, and anyone with whom legal guardianship has been established.
- Custodial care.
- Charges reimbursable by Medicare, Workers' Compensation, or automobile insurance carriers.
- Growth hormone stimulation treatment to promote or delay growth.
- Routine dental care.
- Services provided through a school system.
- Diagnosis and treatment of infertility.
- Pregnancy, maternity, and other expenses related to surrogate pregnancy.
- Storage of umbilical cord stem cells or other blood components in the absence of sickness or injury.
- Genetic testing, counseling and services.
- Charges for sex transformation, treatment of sexual dysfunction or inadequacy, or to restore or enhance sexual performance or desire.
- Over-the-counter products.
- Outpatient prescription drugs.
- Treatment of "quality of life" or "lifestyle" concerns, including, but not limited to: smoking cessation, obesity, hair loss, or cognitive enhancement.
- Cranial orthotic devices, except following cranial surgery.
- Experimental or investigational services.
- Charges in excess of the lifetime maximum or any other benefit maximum.
- Charges for non-medical items.
- Charges related to health care practitioner assisted suicide.
- Treatment of substance abuse, including related prescription drugs.

OUTPATIENT PRESCRIPTION DRUG PLAN

No benefits are provided for the following:

- Charges for any amount in excess of any calendar year maximum benefit.
- Charges for any supplies, or drugs to treat, impact, or influence controlling the covered person's weight; or charges related to obesity.
- Charges for supplies or drugs used for growth hormone therapy, including growth hormone medication and its derivatives or other drugs.
- Charges for supplies or drugs 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.
- Charges for infertility diagnosis and treatment for males or females including, but not limited to, drugs and medications regardless of intended use.
- Charges for drugs that have not been fully approved by the FDA for marketing in the United States.
- Charges for any over-the-counter products or medications.
- Charges for prescription products, drugs, or medications in the following categories, whether or not prescribed by a health care practitioner:
  - Dietary or nutritional substances or dietary supplements
  - Nutraceuticals
  - Tube feeding formulas and infant formulas
  - Medical foods

- 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.
- 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.
- Charges for any drug used for cosmetic services; drugs used to treat onychomycosis (nail fungus); botulinum toxin and its derivatives.
- 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.
- 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.
- 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.
- Charges for drugs used to treat, impact, or influence: 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).
- Charges for drugs used for inpatient or outpatient treatment of behavioral health or substance abuse.
- Drug charges incurred outside of the United States; charges for drugs obtained from pharmacy provider sources outside the United States, except for covered charges that are received for an emergency medical condition.
- 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.

This coverage is renewable and will not cancel or terminate except for the following reasons: nonpayment of premium; fraud or material misrepresentation; all policies with the same form number are non-renewed in your state; you move to a state where we do not provide medical insurance coverage; you move outside of the sevice area if you have a PPO plan; or a covered dependent no longer qualifies as a dependent.