



ASSURANT  
Health®

Assurant. On your terms.®

## Real Choices® II

Medical Insurance Plans  
for Small Employer Groups



# Assurant Health

An Assurant Health medical insurance plan provides more than just protection – it provides peace of mind. That peace of mind comes from knowing you’ve chosen a health insurance carrier with the commitment and financial resources to be there when you or your employees need them.

The Assurant Health companies<sup>1</sup> are rated A- (Excellent) for financial strength and ability to meet policyowner obligations by the highly respected insurance industry analyst, A.M. Best Company.<sup>2</sup>

## Flexible

The Assurant Health Real Choices portfolio offers small business owners **an array of choices** – including many benefits typically reserved for big businesses. This flexibility enables you to construct the ideal plan for your group.

## Affordable

Flexibility and affordability go hand in hand. You can have the coverage you want at an economical price because you **choose and pay for the benefits that are most important** to your group.

## Responsive

When you choose an Assurant Health plan, you can rely on receiving **prompt, accurate claims payment and quick, courteous customer service.**

Whether you prefer the convenience of online service or the personal touch of a knowledgeable person, you and your employees will receive top-notch service.

Discover how *easy* it is to build your plan and how comfortable it is to be insured by a highly reputable company that understands your needs.

<sup>1</sup> Assurant Health is the brand name for products underwritten and issued by Time Insurance Company and John Alden Life Insurance Company.

<sup>2</sup> 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 2009.

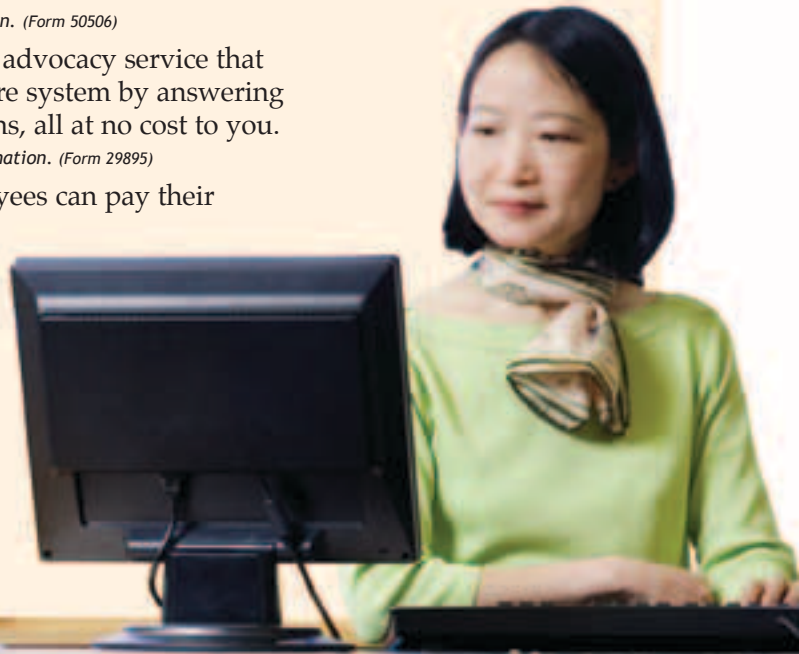
# Real Choices® II

## Medical Insurance Plans that Maximize Your Choices

Real Choices II plans are designed for employers seeking design flexibility to create an *affordable plan based on the needs of the group*.

### Real Choices II Highlights:

- Preventive care services recommended by the United States Preventive Task Force are covered. Many services such as routine physical exams, mammograms and immunizations are covered at 100%.
- Choice of six prescription drug options, including a \$0 copay option for generics.
- Choice of three different office visit copay options which each include a choice of four copay amounts plus a \$50 copay for visits to urgent care facilities.
- Copay option for emergency room visits. *(Availability varies by state)*
- First-dollar benefit option for lab/x-ray services and accidents.
- Dental, Life and Short Term Disability coverages to enhance your employee benefit package.  
*Refer to the Ancillary Brochure for additional information. (Form 50506)*
- Access to Patient Care, an independent advocacy service that helps employees navigate the health care system by answering questions and working through concerns, all at no cost to you.  
*Refer to the Patient Care Pamphlet for additional information. (Form 29895)*
- A tax-favored program in which employees can pay their portion of health insurance premiums with pretax dollars, reducing their taxable income and your payroll taxes.  
*Refer to the Premium Only Plan Brochure for additional information. (Form 50514)*
- The ability to cover employees at branch locations and offer multiple plans and networks to accommodate different employee needs.
- Online administrative capabilities.



# Terms

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## PAYMENT RELATED

**Benefit Percentage** is the portion of covered expenses the 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 to pay in a calendar year. The plan pays 100% of covered expenses after this limit is reached, except for copays. The family coinsurance out-of-pocket maximum is two times the individual maximum.

**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 plan pays benefits. The family deductible is two times the individual deductible.

**Family Deductible Accumulation** refers to the method for applying covered expenses to satisfy the family deductible. The plans provide a choice between an Individual/Family Deductible and One Deductible.

- **Individual/Family Deductible** is an accumulation method for a family deductible where expenses for all covered family members are applied to the family deductible. If a covered family member incurs expenses exceeding the single deductible amount, additional expenses for the individual are paid according to the group's plan. This is the most commonly used accumulation method in the industry.
- **One Deductible** is the accumulation method for a family deductible in which covered expenses for all covered family members are combined to satisfy the total deductible. The entire deductible must be satisfied before benefits are paid for any family member.

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

**Maximum Allowable Amount** is the most the plan pays for services performed by providers. The negotiated rate is the maximum allowable amount paid to participating (network) providers. For nonparticipating (out-of-network) providers, the plan offers a choice for determining the maximum allowable amount.

- **Scheduled Network Option (SCH)** – This option uses the network fee schedule. It costs less than the UCR option but requires the covered person to pay more in out-of-pocket expenses for going out of the network.
- **Usual, Customary and Reasonable (UCR)** – This option uses charges by area providers to determine the maximum allowable amount. A covered person has less out-of-pocket expenses when going out of the network.

With either method, a covered person using a nonparticipating provider is responsible for any amount in excess of the maximum.

**Out-of-Network Charge** is an additional amount paid by a covered person who receives treatment from a nonparticipating provider (a provider that is not in the network).

- The out-of-network deductible is two times the network deductible, with a minimum of \$1,000.
- The out-of-network coinsurance amount is typically an additional 20% of charges.
- The out-of-network, coinsurance out-of-pocket maximum is two times the 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.
- Out-of-network charges are applied to the network deductible and network coinsurance out-of-pocket maximum as well as the out-of-network deductible and coinsurance maximum.
- Charges are subject to the maximum allowable amount.

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## MEDICAL SERVICE RELATED

**Emergency Care** covers treatment, services or supplies for an illness or injury that develops suddenly and unexpectedly, which if not treated immediately would place the covered person's life in jeopardy or cause serious bodily impairment.

**Health Care Practitioner** is a person licensed to treat an illness or injury and includes the services of doctors, surgeons, assistant surgeons, anesthesiologists, physician assistants and nurses.

**Medically Necessary Care** includes treatments, services or supplies which 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.

**Office Visit** is a meeting with a healthcare practitioner that takes place in an office, an acute medical facility's outpatient department or a free-standing facility for evaluation, diagnosis and management of an illness or injury, or preventive services.

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

**Primary Care Provider** is a general caregiver, commonly a physician who is a general or family practitioner, internist, pediatrician, obstetrician or gynecologist.

**Rx Preferred Pricing Card** provides a discounted rate for many outpatient prescriptions at network pharmacies. The Rx Preferred Pricing Card is not insurance.

**Urgent Care** covers 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.

**Plan Design\*** Unless otherwise noted, all deductibles, out-of-pocket expenses and benefit amounts are applied per person and are reset each January 1. Plans do not have a lifetime maximum.

<b>Deductible:</b> Individual Family Family Deductible Accumulation	(You Pay)	\$500, \$1,000, \$1,500, \$2,000, \$2,500, \$3,500, \$5,000, \$7,500 or \$10,000 \$1,000, \$2,000, \$3,000, \$4,000, \$5,000, \$7,000, \$10,000, \$15,000 or \$20,000 Individual/Family Deductible or One Deductible
<b>Benefit Percentage</b>	(Plan Pays)	100%, 80%, 70% or 50%
<b>Coinsurance Percentage</b>	(You Pay)	0%, 20%, 30% or 50%
<b>Coinsurance Out-Of-Pocket Maximum</b>	(You Pay)	\$0, \$1,000, \$1,500, \$2,000, \$2,500, \$3,500, \$5,000 or \$10,000
<b>Office Visit (OV) Copay</b>  Primary Care Provider (PCP)	(You Pay)	Copays: PCP – \$20, \$25, \$35, \$50 Specialist – \$50 <ul style="list-style-type: none"> <li>• Copay applies to unlimited visits to network PCPs and specialists, or</li> <li>• Copay applies to unlimited visits to network PCPs only, or</li> <li>• 4-visit copay limit per person, per year to network PCP or Specialist</li> </ul>

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

<b>Outpatient Hospital/Surgical Center Care, Outpatient Physical Medicine, Physician Services, Durable Medical Equipment</b>	Covered
<b>Prescription Drugs</b> (Generic/Preferred Brand/Nonpreferred Brand) <i>Contraceptive products (self-administered) are covered. Mail order prescriptions are available. Save 10% on your 3 copays for a 3-month supply. A Preferred Pricing Card is included with plans that don't have a prescription copay.</i>	<ul style="list-style-type: none"> <li>• \$0/\$50/\$75 copays with a \$500 brand name deductible, or</li> <li>• \$15/\$35/\$55 copays with a \$250 brand name deductible, or</li> <li>• \$15/\$35/\$55 copays, or • \$15/\$45/\$60 copays, or</li> <li>• \$20/\$50/\$75 copays, or</li> <li>• Deductible/Coinsurance, or • Preferred Pricing Card only</li> </ul>
<b>Office Visits</b>	Covered If OV Copay selected, subject to copay – copay limits apply
<b>Emergency Room</b> <i>Nonemergency use of the ER is subject to a 30% penalty.</i>	Covered If OV Copay selected, option to add \$500 ER copay <i>Plan pays 100% after \$500 copay. Option is available at an additional cost.</i>
<b>Urgent Care Services</b>	Covered If OV Copay selected, subject to \$50 copay, then covered at 100%
<b>Diagnostic Imaging and Laboratory Services</b>	<ul style="list-style-type: none"> <li>• \$200 first-dollar benefit, or</li> <li>• Deductible/Coinsurance</li> </ul>
<b>Professional Ground and Air Ambulance</b>	Covered
<b>Allergy Shots</b>	Covered If OV Copay selected, covered at 100%
<b>Home Health Care</b>	30-visit benefit
<b>Family Planning Services</b> <i>Covers contraceptive products and drugs – oral contraceptives covered under Rx Drugs.</i>	Covered If OV Copay selected, subject to copay – copay limits apply
<b>Behavioral Health and Substance Abuse</b> <i>Inpatient benefits listed below.</i>	Deductible and 50% coinsurance <i>Coinsurance does not apply to out-of-pocket maximum.</i>

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

<b>Hospital and Physician Services</b> <i>Hospital services include semi-private room, board, intensive care and miscellaneous services and supplies.</i>	Covered
<b>Inpatient Rehabilitation Facility</b>	90-day benefit
<b>Subacute Rehabilitation and Nursing Facilities</b>	90-day benefit
<b>Hospice Care Services</b>	Covered at 100% (no deductible)
<b>Transplants</b> (Refer to page 5 for additional information.)	Covered
<b>Behavioral Health and Substance Abuse</b>	21-day benefit

**Optional Features** Optional features are available at an additional cost.

<b>Maternity Care Services</b> <i>Includes prenatal, delivery, well-newborn and postpartum care.</i>	<ul style="list-style-type: none"> <li>• Deductible/Coinsurance, or</li> <li>• Separate \$7,500 maternity deductible, then 100%</li> </ul>
<b>Accident Medical Expense (AME)</b>	\$500 or \$1,000 first-dollar benefit per occurrence

\* Not all plan payment combinations are available. The amount of benefits depends upon the plan design selected and the premium will vary with the amount of benefits. Plans may vary by state. Please refer to the State Variation for state-specific differences.

# 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. The following choices are available:

0 days 30 days 60 days 90 days 180 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 plan pays a greater percentage of the charge, the covered person is responsible for any remaining balance.

## Emergency Care Benefit

PPO plans pay for emergency treatment at the network benefit level whether treatment is received from a participating or nonparticipating provider.

## 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 at designated providers. In addition, \$10,000 is available for travel expenses for the covered person and a companion.

If services are performed at a network, nondesignated transplant provider, there is a \$100,000 lifetime benefit maximum per organ.

If services are performed at a nonparticipating, nondesignated transplant provider, in addition to the \$100,000 organ maximum, charges are subject to the out-of-network coinsurance percentage.

Donor expenses are limited to a maximum of \$10,000.

## Utilization Review

When inpatient treatment or outpatient surgery is needed, the covered person is responsible for calling Assurant Health to receive authorization. The toll-free telephone number appears on the insurance ID card. If authorization is not received, a penalty of 30% of the charge to a maximum of \$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 six-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 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.

## Takeover Provision

If Real Choices is replacing an existing group major medical plan which has been in force for 12 months, those employees covered by the prior plan receive base plan deductible credit and pre-existing conditions limitation credit.

## 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

## Real Choices does not provide benefits for:

- Treatment not listed in the Covered Medical Services section of the policy
- Treatment of a pre-existing condition, until continuously insured for 12 months for ages 19 and older
- An illness or injury caused by acts of war, felony, attempted suicide or influence of an illegal substance
- 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
- Dental care not related to a dental injury (unless a dental plan is purchased)
- Maternity and routine nursery charges unless maternity coverage is chosen or covered under the Complications of Pregnancy provision
- Custodial care, private nursing, telemedicine or phone consultations
- Diagnosis and treatment of infertility, sex transformation, surrogate pregnancy, sterilization reversal
- Cosmetic services, experimental treatment, complications of an excluded service
- Umbilical cord storage, genetic testing, counseling and services, prophylactic treatment
- Charges in excess of the lifetime maximum of \$50,000 for durable medical equipment
- 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 (unless recommended by the United States Preventive Services Task Force and authorized by a health care provider), drugs obtained from sources outside the United States, the difference in cost between a generic and brand name drug when the generic is available

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This brochure provides summary information. Please refer to the State Variation for state-specific differences. Please refer to the insurance policy for a complete listing of benefits, exclusions and terms of coverage.

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

**Assurant Health**  
501 W. Michigan  
Milwaukee, WI 53203

### *About Assurant Health*

Assurant is a premier provider of specialized insurance products and related services in North America and select worldwide markets. The four key businesses — Assurant Solutions, Assurant Specialty Property, Assurant Health, and Assurant Employee Benefits — partner with clients who are leaders in their industries and have built leadership positions in a number of specialty insurance market segments in the U.S. and select worldwide markets. The Assurant business units provide debt protection administration; credit-related insurance; warranties and service contracts; pre-funded funeral insurance; creditor-placed homeowners insurance; manufactured housing homeowners insurance; individual health and small employer group health insurance; group dental insurance; group disability insurance; and group life insurance.

Assurant, a Fortune 500 company and a member of the S&P 500, is traded on the New York Stock Exchange under the symbol AIZ. Assurant has more than \$26 billion in assets and \$8 billion in annual revenue. Assurant has approximately 14,500 employees worldwide and is headquartered in New York's financial district. [www.assurant.com](http://www.assurant.com).