ASSURANT®

Look Inside

Assurant Health and Welfare Plan

2017 Summary Plan Description

Main Table of Contents

Getting to Know Your Assurant Benefits 3

Assurant Health and Welfare Plan 4

Assurant Health Plan 14

Prescription Drug Coverage 47

Employee Assistance Program 54

Dental Plan 57

Flexible Spending Accounts 67

Life and Accident Insurance 78

Disability Plan 91

ARAG Group Legal Insurance 104

Tuition Reimbursement Plan 109

Commuter Benefits Program 114

Severance Pay Plan 116

Plan Administration 121

Required Notices 133

Glossary 145

Getting to Know Your Assurant Benefits

Quality, Protection, Value

Your compensation is much more than your paycheck. There also is an enormous value to the benefits Assurant provides. In fact, company-provided benefits are often called the "hidden paycheck." And just as we all decide for ourselves how to spend our cash compensation, we all have different priorities when it comes to our company-provided benefits.

Assurant's range of benefit plans gives you and your family a high level of protection and a high level of flexibility in setting your benefit priorities.

Our health care plan helps you preserve your good health and helps cover the cost of your medical care if you are ill or injured. Other benefit plans ensure that a portion of your income is protected if you're sick or disabled and that your family is protected financially if you die.

Assurant believes we should work together to get the best value for our benefit dollars. The Company currently provides certain core benefits at no cost to you. The Company also shares in the cost of some of the optional benefits available. By working together, we can make the most of our benefits and Assurant also can continue to provide you with benefits that meet the high standards of excellence we set for all of our endeavors.

Defined terms are in italics and their definitions are in found in the Glossary.

Disclaimer

While the Company intends to continue these benefits, it reserves the right to change or terminate them in its sole discretion, at any time. In the event of any discrepancy between the information contained in this SPD and the Plan document, the Plan document will control. If you have questions about the benefits offered by Assurant, contact HR Services at 866.324.6513 or via email at MyHR@assurant.com.

Assurant Health and Welfare Plan

Employee Eligibility 5

Eligible Dependents 5
- Domestic Partner 6

Social Security Number Requirement 7

Proof of Eligibility 7

Electing Coverage and Effective Dates 7
- Initial Eligibility Period 7
- Mid-year Changes 8

Qualified Life Events 9
- Limitations 9
- Effective Date 10

HIPAA Special Enrollments Rights 10

Annual Enrollment 10

Cost of Coverage 11

Tax Information 12
- Non-tax-qualified Dependents 12
- Imputed Income 12

When Coverage Ends 12
- When Your Coverage Ends 12
- When Dependent Coverage Ends 13
- Rescission of Coverage 13

Employee Eligibility

You are eligible to participate in the Assurant Health and Welfare Plan if you are classified by Assurant as:

- An active, full time employee
- An active, part time employee regularly scheduled to work at least 20 hours per week
- A temporary employee who is on Assurant's payroll and is regularly scheduled to work at least 30 hours per week.

You are not eligible to participate if you are:

- An employee of a leasing agency
- An independent contractor
- A seasonal employee working annually in a position of limited duration not to exceed five months or
- An employee who is not on the U.S. payroll.

Assurant's classification of a person as an employee or non-employee is conclusive and binding for purposes for benefit eligibility. If, for any reason, a person is reclassified from a non-employee to an employee, that person will not be retroactively eligible for benefits. Instead, benefit eligibility will begin prospectively from the date the reclassification is made.

◂Page
Page ▸
Main Table of Contents
Chapter Table of Contents
◂◂Back

Eligible Dependents

You can enroll your eligible dependents in the Health and Dental coverage, and Dependent Life Insurance. A person cannot be covered under the Plan as both an employee and a dependent. Further if you and your spouse/domestic partner are both employees, only one of you can cover any eligible children.
Eligible dependents include:

For Health and Dental Coverage:

- Your lawful *spouse* or domestic partner (as defined below):
- Your children, until the last day of the calendar year in which they turn age 26
- Your children who are mentally or physically disabled and totally dependent upon you for support past age 26[1]
- Any child who meets the definition of an eligible dependent and for whom you are required to provide health coverage as the result of a *qualified medical child support order* and
- children (for example grandchildren claimed as dependents on your federal tax return) through the end of the year in which they turn age 26 who:
  - Receive more than half of their support from you and/or your *spouse* or domestic partner
  - Have your home as their principal residence and
  - Are your or your spouse's/domestic partner's legal ward.
- Eligible children include your own and your *spouse's*/domestic partner's biological and adopted children (including children placed for adoption).

For Dependent Life Insurance:

- Your lawful *spouse* or domestic partner and
- Your, your *spouse's*/domestic partner's unmarried children from live birth to age 19, or less than age 24 if a full-time student.
- Children include any biological or adopted children, stepchildren and foster children, each of whom must depend on you or your spouse/domestic partner for support and maintenance. A child will be considered

[1] Certification of disability must be submitted to Anthem no later than 31 days after the date your child reaches age 26 and may be required periodically. You can request a certification form from HR Services at 866.324.6513 or MyHR@assurant.com.

adopted on the date of placement in your home. Children also include any children for whom you or your *spouse*/domestic partner are the legal guardian, who reside with you on a permanent basis and depend on you or your *spouse*/domestic partner for support and maintenance.

Domestic Partner

The definition of a domestic partner varies slightly depending on the benefit plan as outlined below.

	Health and Dental Plans	Dependent Life Insurance	Business Travel Accident Insurance
Affirm that the consent of either domestic partner to the domestic partnership relationship has not been obtained by force, duress, or fraud	✓		
Be each other's sole spousal equivalent and intend to continue the relationship indefinitely	✓	✓	
Not be related by blood or be closer in relation than allowed for marriage under law in your state of residence	✓	✓	✓
Be at least 18 years of age	✓	✓	✓
Be jointly committed to each other's welfare and basic living expenses	✓	✓	
Have dissolved any prior marriages	✓	✓	✓
You and your domestic partner have a committed relationship of mutual caring which has existed for at least six months or meet the requirements and have registered as domestic partners, if the controlling governmental authority provides for such registration		✓	
You and your domestic partner each have power of attorney for each other		✓	
At least six months have elapsed since similar coverage was terminated on a previously insured domestic partner, if any, unless the previous domestic partner has died		✓	
Shares your permanent residence			✓
Has resided with you continuously for at least one year and is expected to reside with you indefinitely			✓
Is not legally married to any other person			✓

Tax treatment of coverage for domestic partners varies by state. Some states follow federal law and tax the value of domestic partner coverage, some exclude this value from wages and others allow you to deduct the value on your state income tax return.

In order to receive special state income tax treatment, you must send a request in writing to HR Services.

◂Page
Page ▸
Main Table of Contents
Chapter Table of Contents
◂◂Back

Social Security Number Requirement

In order to comply with the Medicare Secondary Payer Act and employer reporting of health coverage, Assurant requires that you provide the Social Security number of any dependent you enroll under the Health Plan within 60 days of enrollment. If you enroll a newborn, you will have six months from the date of enrollment to provide the baby's Social Security Number to HR Services.

Proof of Eligibility

Although Assurant does not automatically require that you submit proof of your dependents' eligibility when enrolling, we maintain the right to request such proof at any time and for any reason. If you fail to provide such proof, we determine that you have enrolled someone who does not meet the Plan's eligibility criteria or you fail to notify us of a change in your dependent's eligibility status, you will be:

- Responsible for any claims, expenses, reimbursements or other costs paid during the period of ineligibility and
- Subject to disciplinary action up to and including termination of employment.

Submission of a false claim for benefits (or benefit eligibility) could be a federal crime.

◂Page
Page ▸
Main Table of Contents
Chapter Table of Contents
◂◂Back

Electing Coverage and Effective Dates

Initial Eligibility Period

You have eight calendar days from your hire date or the date you become a benefits-eligible employee to enroll in your Health and Welfare benefits - this is called your initial eligibility period. If you do not enroll during your initial eligibility period, you will be defaulted into the core benefits package outlined below. You will not be able to change your health, dental and flexible spending account elections during the calendar year unless you experience a qualified life event and report it through MyHR within 30 days.

Core Benefits	
Health Plan – You will be enrolled in the Orange Plan option at the Employee-only coverage level.	You will pay the non-discounted rate for this coverage regardless of your use of tobacco products.
Basic Life Insurance (1 x plan pay)	Assurant pays 100 percent of the cost
Basic Accidental Death and Dismemberment Insurance (1 x plan pay)	
Short-Term Disability	
Long-Term Disability	
Business Travel Accident Insurance (5 x plan pay)	
Employee Assistance Program (EAP)	

Generally, the effective date of your Core Benefit coverage is the later of your hire date or the date you become a benefits-eligible employee. Short-Term Disability has a 90-day waiting period.

If you are not actively at work on the day your Basic Life, Basic AD&D and Long-Term Disability insurance would otherwise be effective, insurance will not take effect until you return to active work.

Supplemental Benefits	
Health Plan	Coverage is available for you and your eligible dependents under the Blue and Green Plan and Orange Plan options. You and Assurant share in the cost of your health plan benefits.
Health Savings Account	Assurant contributes to your HSA if you enroll in the Green or Orange Plan options. You can also make contributions.
Dental Plan	Coverage is available for you and your eligible dependents. You and Assurant share in the cost of dental coverage.
Supplemental Life (1 - 5 x plan pay)	You pay the premium
Supplemental AD&D (1 – 5 x plan pay)	You pay the premium
Dependent Life ($10,000 - $100,000)	You pay the premium
Health Care Flexible Spending Account	You contribute to the account
Dependent Day Care Flexible Spending Account	You contribute to the account

◂Page
Page ▸
Main Table of Contents
Chapter Table of Contents
◂◂Back

If you have medical coverage from another source (e.g., *spouse*'s employer), you can waive Health Plan coverage through Assurant. Health and Dental Plan coverage for you and your eligible dependents is effective on the date you elect coverage. The Health Savings Account (HSA) is effective on the first of the month coincident with or following the date your Green or Orange Plan option coverage is effective.

Capping your Basic Life Insurance coverage at $50,000 is effective as of the date you make the election. Supplemental Life, Supplemental AD&D and Dependent Life insurance is effective on the later of:

- The date you make the election and
- The date Assurant Employee Benefits accepts your Proof of Good Health (POGH), if required.

If you are not at active work on the day your Supplemental Life, Supplemental AD&D and Dependent Life insurance would otherwise be effective, insurance will not take effect until you return to active work. Dependent Life Insurance does not take effect until your insurance under this policy becomes effective. If your dependent is in a hospital or similar facility on the day his/her insurance would otherwise take effect, it will not take effect until the day after the dependent leaves the hospital or similar facility. This exception does not apply to a child born while dependent insurance is in effect.

Your participation in the Health Care and/or Dependent Day Care Flexible Spending Account is effective on the first day of the pay period in which your first deduction is withheld from your pay.

If you are hired in December, you may not be eligible to enroll in the FSA until the following plan year.

Mid-year Changes

The Internal Revenue Service (IRS) limits the changes you can make during the year to a benefit plan that is paid for with pre-tax premiums. This means that you can only make changes to your Health, Dental and Flexible Spending Account elections during the year (outside of Annual Enrollment) if you experience a qualified life event or if you qualify for special enrollment rights under the Health Insurance Portability and Accountability Act of 1996.

Qualified Life Events

A qualified life event is a change in your life that changes your need for benefit coverage. The following are examples of qualified life events:

- Change in dependent status, such as:
  - Birth, adoption or placement for adoption
  - Becoming a foster parent/legal guardian
  - Death of a dependent
  - Loss of dependent eligibility due to the attainment of age 26 or a divorce/termination of a domestic partnership
  - Dependent becomes eligible for coverage under the Assurant Plan in his/her own right.

- Significant change in your or your *spouse*'s/domestic partner's/dependent's employment status that affects your or his or her eligibility for coverage, such as:
  - Termination of employment
  - Change in worksite or hours
  - Switch to or from part-time and full-time employment
  - Commencement or return from an unpaid Family and Medical Leave (FML).

- Significant change in coverage under another plan, such as:
  - Eligibility for *Medicare* or Medicaid
  - Loss of eligibility for *Medicare* or Medicaid
  - Exhaustion of COBRA coverage from another employer (does not include termination of COBRA coverage for the failure to pay required premiums)
  - Certain judgments or orders regarding coverage for a dependent child (e.g., a *Qualified Medical Child Support Order (QMCSO)*).

Limitations

- The change you request must be consistent with the qualified life event. This means that the event must affect eligibility for coverage and the requested change must correspond to the event.
- You must submit a completed Life Event Benefits Change Form within 30 calendar days of the event. You can request a change through MyHR.
- You cannot reduce your Health Care FSA contributions to an amount that is less than the amount you've already received in reimbursements.
- You can submit for reimbursements only those expenses incurred while you and/or your dependents are participating in the Plan. For example, if you get married on June 1st and enroll in a FSA on June 15, only the expenses you or your spouse incurs on or after June 15 are eligible for reimbursement.
- If you lose benefit eligibility and then regain it in less than 31 days (e.g., you are rehired) and within the same calendar year, you will step back into your previous elections.
- If you lose benefit eligibility for 31 days or more or you regain eligibility in the following calendar year, you must make new coverage elections.
- If you and/or your dependents are covered under another employer's medical plan, you cannot make changes to your Health Care FSA because of changes to the cost or coverage under the other employer's plan.

The *Plan Administrator* will have final discretion to determine whether the requirements of this section are met.

◂Page
Page ▸
Main Table of Contents
Chapter Table of Contents
◂◂Back

Effective Date

In general, the effective date of coverage added due to a qualified life event is the later of:

- The date of the life event and
- The date you request the change in writing.

Note – the effective date of coverage due to the birth or adoption of a child or placement for adoption is the date of the event. You are still required to enroll the child within 30 calendar days of that event.

If you terminate coverage under the Assurant Plans due to a qualified life event, health and dental coverage will cease at the end of the month in which the qualified life event occurs. Participation in the Health Care and Dependent Day Care Flexible Spending Accounts will terminate at the end of the last pay period for which the last deduction is withheld.

If you want to make a change to your benefit elections due to a qualified life event, contact HR Services at 866.324.6513 or MyHR within 30 days of the event.

Page
Page
Main Table of Contents
Chapter Table of Contents
Back

HIPAA Special Enrollments Rights

If you decline enrollment for yourself or your dependents (including your *spouse*/domestic partner) because you have other health coverage, you may in the future be able to enroll yourself or your dependents in the Assurant Health Plan, if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage. However, you must request enrollment in the Assurant Health Plan within 30 days after you or your dependent's other coverage ends (or after the employer stops its contribution toward the other coverage).

Election changes are typically effective on the date that you submit a completed Life Event Form during the 30-day enrollment change period. In no event will coverage become effective prior to the date of the event.

You and your dependents also may enroll under two additional circumstances:

- You or your dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility or
- You or your dependent becomes eligible for a subsidy (state premium assistance program).

You or your dependent must request Special Enrollment Rights within 60 days of the loss of Medicaid/CHIP or eligibility for a subsidy.

For special enrollment rights for CHIP or Medicaid, you must submit a Life Event Form to enroll in coverage under the Health Plan and/or change your Health Plan election (e.g., from single coverage to family) within 60 days from the date:

- The coverage terminates under the Medicaid or CHIP plan, or
- You and/or your dependent child is determined eligible for state premium assistance.

Call HR Services to request a special enrollment or obtain more information. You can contact the HR Services at 866.324.6513 or MyHR@assurant.com.

Annual Enrollment

Each fall you will have the opportunity to make changes to your benefit elections during Annual Enrollment. You can change Health Plan options (e.g., switch from the Blue Plan option to the Green Plan option) or coverage tier (e.g., move from Family coverage to Employee + *Spouse* coverage). You must make an active election to participate in the Health Plan for the following calendar year; your elections do not carry over from year to year.

If you fail to make a Health Plan election by the deadline, you will be defaulted into the Orange Plan option at the Employee-only coverage level and you will pay the non-discounted premium rate. You will not be able to change your coverage until the next Annual Enrollment period unless you experience a qualified life event and report it through MyHR within 30 days.

You also must make an active election to participate in the Health Care and Dependent Day Care Flexible Spending Accounts and the Health Savings Account (HSA). Your contributions will end at the end of the current year, if you don't elect to participate.

While current Dental, Life and AD&D Insurance elections will continue into the next year unless you make a change, Annual Enrollment is the time to re-evaluate your coverage needs. You can enroll in, change coverage tiers or drop Dental Plan coverage. It's also a great time to review your beneficiary designations to make sure they reflect any changes that occurred during the year.

Any elections you make during Annual Enrollment are effective January 1 of the following year except if you elect to increase Life or Dependent Life Insurance during the Annual Enrollment period, your coverage is effective on the later of:

- January 1 of the following calendar year and
- The date Assurant Employee Benefits, now a member of the Sun Life Financial family, approves your or your *POGH*.

If you are not at actively at work on the day your Basic Life, Supplemental Life and Dependent Life insurance would otherwise increase, the increase will not take effect until you return to active work.

Dependent Life insurance does not take effect until your insurance under this policy becomes effective. If your dependent is in a hospital or similar facility on the day his/her insurance would otherwise increase, it will not take effective until the day after the dependent leaves the hospital or similar facility. This exception does not apply to a child born while dependent insurance is in effect.

You and your dependents will be insured at current levels of coverage until *POGH* is received and approved by Assurant Employee Benefits.

Cost of Coverage

Assurant shares responsibility with you for the cost of your coverage.

Assurant pays the full cost of your Basic Life, Basic Accidental Death and Dismemberment, Business Travel Accident insurance and Long-Term Disability insurance and Short-Term Disability coverage.

You and Assurant share the cost of Health and Dental coverage. For full-time employees working at least 35 hours per week, Assurant currently pays approximately 84 percent of the cost of projected Health Plan coverage and approximately 50 percent of the cost of projected Dental Plan coverage. For part-time employees working between 20 – 34.99 hours per week, the Company pays approximately 75 percent of the contribution made for full-time employees. Your portion of the cost is deducted from your pay on a pre-tax basis. Company contributions are determined by the *Plan Administrator* in its sole discretion.

You are responsible for the cost of Supplemental Life, Dependent Life and Supplemental AD&D Insurance. Premiums are withheld from your pay on an after-tax basis.

Supplemental Life and Supplemental AD&D Insurance are based on *plan pay*. The amount of insurance and the cost may change throughout the year if:

- Your base salary changes
- You change the amount of your coverage and
- You move from one age bracket to another. (Supplemental Life Insurance only)

Page
Page
Main Table of Contents
Chapter Table of Contents
Back

Your *plan pay* also includes your target Short-Term Incentive Plan (STIP) bonus, sales bonuses, commissions, incentives guaranteed under a first year agreement. These amounts will be updated once a year on April 1.

Your cost for benefits, the Company contribution to the Health Reimbursement Account or Health Savings Account and wellness contributions for the current calendar year can be found at MyAssurantBenefits.com.

Tax Information

The Health and Dental Plans, Flexible Spending Accounts and the Health Savings Accounts are pre-tax benefits. This means that the premiums or contributions are deducted from your pay before your federal income and FICA (Social Security and *Medicare*) taxes are calculated. Pre-tax benefit deductions reduce the amount you pay in taxes. This also may mean that your Social Security benefits at retirement, death or disability may be reduced. Whether your Social Security benefit will actually be lower depends on a number of factors, such as your current age, your earnings before participating in the Plans and future pay levels.

◂Page
Page ▸
Main Table of Contents
Chapter Table of Contents
◂◂Back

Non-tax-qualified Dependents

The Internal Revenue Service (IRS) does not allow employees to pay for benefit coverage for their non-tax-qualified dependents (e.g., domestic partners and their dependents) on a pre-tax basis. Therefore, Health and Dental Plan premiums for non-tax-qualified dependents will be withheld from your pay on an after-tax basis. The portion of the premium that represents coverage for you and any tax-qualified dependents will be withheld on a pre-tax basis.

In addition, Assurant's contribution toward the cost of Health and Dental Plan coverage for non-tax-qualified dependents must be included in your taxable income. This amount, also known as imputed income, will be included in your annual gross income for federal tax purposes and shown on your Form W-2.

Imputed Income

The IRS requires that the cost of your Basic Life Insurance in excess of $50,000 be included in your annual gross income. Federal income tax and FICA tax will be deducted. It also is reported on your Form W-2.

Assurant also provides Short and Long-Term Disability coverage at no cost to you. The premiums Assurant pays are added to your taxable income. While there might be a slight reduction in your net pay to cover the applicable taxes on these premiums, any disability benefits you receive will be exempt from federal income and FICA taxes. This greatly enhances the value of your disability benefits.

When Coverage Ends

The following outlines when Health and Dental coverage ends for you and your dependents. You may be able to continue Health and Dental coverage (and your participation in a Health Care Flexible Spending Account) after coverage ends through COBRA.

Please refer to When Coverage Ends under each section to learn when other benefits end.

When Your Coverage Ends

Health and Dental coverage ends on the last day of the month in which the first of the following events occurs:

- Your employment terminates or you retire
- You are no longer in an eligible class (for example, your work schedule changes to less than 20 hours a week)
- You terminate coverage due to a life event
- You fail to make required premium payments on time
- A benefit option is discontinued or is changed to end coverage for a class of employees or
- The Plan is terminated.

If you elect to terminate coverage during the Annual Enrollment period, your coverage will end on Dec. 31 of that same year. In the case of a divestiture of a business or a part of a business, coverage will end on the date the transaction closes.

When Dependent Coverage Ends

Health and Dental coverage for your dependents ends on the earliest of the following:

- The date your coverage ends
- The end of the month in which your spouse/domestic partner no longer meets the definition of an eligible dependent
- The end of the calendar year in which your dependent child no longer meets the definition of an eligible dependent
- The date determined by the *Plan Administrator* if you do not verify that a dependent is eligible in accordance with a dependent audit
- The date a dependent becomes covered as a dependent under another employee's coverage
- The date a dependent becomes eligible for coverage as an employee

Coverage for your dependents will end on Dec. 31 of the calendar year in which you elect to terminate their coverage during the Annual Enrollment period. In the case of a divestiture of a business or a part of a business, coverage will end on the date the transaction closes.

Health coverage for your dependents also will end on Dec. 31 if you fail to re-enroll them during Annual Enrollment. Dental coverage and Dependent Life Insurance will continue for your dependents each year unless you choose to terminate their coverage during Annual Enrollment.

Rescission of Coverage

The Plan may request documentation at any time and cancel your or your dependents' coverage retroactively if it is determined that you or your dependents are involved in fraud or made an intentional misrepresentation of a material fact in seeking coverage for benefits under the Plan. If coverage is canceled retroactively under these circumstances, you will receive a 31-day advance notice of the cancelation and an opportunity to appeal the decision under the Plan's claims and appeal procedures.

The Plan also reserves the right to cancel coverage retroactively in other situations that arise in the normal course of plan operations such as discovery of an error, failure to pay required premiums, failure to notify the Plan of a divorce or failure to provide required eligibility documentation. In these situations, 31-day advance notice and opportunity to appeal are not required.

◂Page
Page ▸
Main Table of Contents
Chapter Table of Contents
◂◂Back

Assurant Health Plan

Health Plan At-a-Glance 17

How the Health Plan Works 18
- Network-based Benefits 18
- How to Find a Provider in the Network 18
- Family Coverage 19
- Annual Deductible 19
- Coinsurance 19
- Annual Out-of-Pocket Maximum 19

Health Reimbursement Account 20

Health Savings Account 21

HRA and HSA: How They Compare 24

Maximum Benefits 24

Pre-certification 25

Medical Services Requiring Pre-certification 25
- Inpatient Admissions 25
- Outpatient Services 26

Medical Specialty Drugs Administered by a Medical Provider 26

AIM Imaging Cost & Quality Programs 27
- High Tech Radiology 27

Sleep Management Program 27
- How to Pre-certify 28
- Series of Services 29

Covered Expenses 29

Preventive Care 30

Covered Services 30
- Inpatient Services (pre-certification required) 30

Outpatient Hospital Services 31
Emergency Services 32
Outpatient Services 32

Special Programs 35
Bariatric Surgery (weight loss surgery) 35
Home Health Care 35
Infertility Services 35
Transplants 36

Limitations and Exclusions 36

Coordination of Benefits 42
Medicare Coverage 42

Claims Payment 43
How to File Claims 43

Programs and Services through Anthem BlueCross BlueShield 43

Castlight Health Cost and Quality Transparency Tool 46

Wellness Program Offerings 46

Assurant Health Plan

Assurant offers you the choice of three Health Plan options- Blue, Green and Orange, administered by Anthem BlueCross BlueShield (Anthem). If you have medical coverage elsewhere (e.g., through a spouse's employer), you can waive Health Plan coverage through Assurant. The Health Plan provides coverage for a wide range of medical expenses with different deductibles, coinsurance and out-of-pocket maximums. The Assurant Health Plan also provides you and your family with free in-network preventive care and free generic preventive prescription drugs.

Coverage for outpatient prescription drugs is administered by CVS Caremark. CVS Caremark is one of the largest providers of pharmacy benefits with more than 68,000 participating retail pharmacies nationwide. Most major drug chains and many small, independent pharmacies are part of the CVS Caremark network. They also provide mail order service for maintenance medications.

Employee Assistance Plan (EAP) services are provided by New Directions Behavioral Health. The EAP is offered to you and your enrolled dependents at no cost to you.

The wellness programs and the EAP are made available to all benefits-eligible employees at no cost. You do not need to enroll in the Assurant Health Plan to take advantage of these benefits.

◂Page
Page▸
Main Table of Contents
Chapter Table of Contents
◂◂Back

Health Plan At-a-Glance

HEALTH PLAN OPTIONS	BLUE	GREEN	ORANGE
What the Plan pays			
In-network preventive care and generic preventive drugs	100%		
Annual Assurant contribution to HRA or HSA (individual/family)[2]	$200/$400 to HRA	$200/$400 to HSA	$200/$400 to HSA
Medical Coverage • In-network services • Out-of-network services	 80% 60%	 80% 60%	 90% 70%
Lifetime Maximum Benefit		Unlimited[3]	
What you pay			
Annual Deductible (individual/family)[2] • In-network services • Out-of-network services	 $850/$1,700[4] $1,350/$2,700[4]	 $1,600/$3,200[4] $2,100/$4,200[4]	 $2,600/$5,200[5] $3,100/$6,200[5]
Medical Coinsurance • In-network services • Out-of-network services	 20% 40%	 20% 40%	 10% 30%
Prescription Drug Coinsurance[6] • Retail prescriptions (30-day supply)[7] • Mail-order prescriptions and maintenance prescriptions from a CVS retail pharmacy (90-day supply)[6]	50% up to $55 per prescription (after deductible) 50% up to $110 per prescription (after deductible)		
Annual Out-of-Pocket Maximum, including deductible (individual/family)[2] • In-network services • Out-of-network services	 $3,350/$6,700[8] $5,850/$11,700	 $4,100/$8,200[9] $6,600/$13,200	 $4,600/$9,200[9] $7,100/$14,200

[2] "Family" includes Employee & Spouse/Domestic Partner, Employee & Child(ren) and Employee & Family.

[3] Certain benefits are limited either on an annual or lifetime basis as outlined in the Maximum Benefits section below.

[4] If you elect Family coverage under the Blue or Green Plan option, there is no individual deductible. This means that the entire Family deductible must be met before benefits begin for any covered family member (except for preventive care benefits and generic preventive prescription drugs). Any combination of you and /or one or more dependents can incur expenses to meet the family deductible.

[5] If you elect Family coverage under the Orange Plan option, each family member has an individual deductible amount equal to the deductible for Employee-only coverage. Once a family member satisfies the individual deductible, the Plan will begin to pay coinsurance for that family member's eligible non-preventive expenses. The family member does not need to wait for the family deductible to be satisfied. Once the family's combined expenses reach the Family deductible, the Plan will begin to pay coinsurance for all covered family members' eligible non-preventive expenses for the remainder of the calendar year.

[6] Caremark periodically reviews their formulary. Certain formulary medications may be excluded from coverage from time to time and impacted members will be notified.

[7] Generic preventive prescriptions are covered at 100 percent. Brand name preventive prescriptions are not subject to the Plan's deductible. All non-preventive prescriptions are subject to the Plan's deductible.

[8] If you elect Family coverage under the Blue Plan option, there is no individual out-of-pocket maximum. This means that the entire Family out-of-pocket maximum must be met before the Plan begins to pay 100 percent for any covered family member (except for preventive care benefits and generic preventive prescription drugs). Any combination of you and /or one or more dependents can incur expenses to meet the family out-of-pocket maximum.

[9] If you elect Family coverage under the Green or Orange Plan option, each family member has an individual out-of-pocket maximum amount equal to the out-of-pocket maximum for Employee-only coverage. Once a family member satisfies the individual out-of-pocket maximum, the Plan will begin to pay 100 percent for that family member's eligible medical expenses. The family member does not need to wait for the family out-of-pocket maximum to be satisfied. Once the family's combined expenses reach the Family out-of-pocket maximum, the Plan will begin to pay 100% for all covered family members' eligible expenses for the remainder of the calendar year.

◂Page
Page ▸
Main Table of Contents
Chapter Table of Contents
◂◂Back

How the Health Plan Works

Network-based Benefits

The Assurant Health Plan uses a network of health care providers and facilities managed by Anthem BlueCross BlueShield. These *network providers* have agreed to provide health care services and supplies at reduced fees. As shown on the chart, Health Plan At-a-Glance, the Plan pays higher benefits for covered medical expenses when you use Anthem *network providers*.

Some services *and supplies such as bariatric surgery (weight loss surgery) may only be covered when you* use a Blue Distinction *Center of Excellence*.

You also can use licensed *providers, hospitals* and *medical facilities* outside Anthem's network. However, your out-of-pocket expenses will generally be higher when you use *out-of-network providers*. If you use an *out-of-network provider*, eligible health care expenses will be reimbursed based on the *maximum allowed amount*.

> The *maximum allowed amount* is the amount the Claims Administrator will reimburse for services and supplies which meet its definition of covered services, as long as such services and supplies are not excluded under the Assurant Health Plan; are *medically necessary*; and are provided in accordance with the Assurant Health Plan. See the Glossary and Claims Payment sections for more information. The *out-of-network provider* can charge you the difference between their bill and the Plan's *maximum allowed amount* plus any *deductible* and/or *coinsurance*. Additionally, you may have to file claims.

All *covered services* must be *medically necessary*, and coverage or certification of services that are not *medically necessary* may be denied.

How to Find a Provider in the Network

There are three ways you can find out if a *provider* or facility is in the Anthem network. You can also find out where they are located and details about their license or training.

- See Anthem's directory of *network providers* at anthem.com, which lists the doctors, *providers*, and facilities that participate in the network.
- Call Customer Service to ask for a list of doctors and *providers* that participate in the network, based on specialty and geographic area.
- Check with your doctor or *provider*.

If you need details about a *provider's* license or training, or help choosing a doctor who is right for you, call the Customer Service number on the back of Your Member Identification Card. TTY/TDD services also are available by dialing 711. A special operator will get in touch with us to help with your needs.

To use the Anthem member website, anthem.com, to determine whether your current physicians participate in Anthem's network or to search for providers in your area that do, click on Find a Doctor on the right side of your screen, then follow these steps:

- On the left side of the screen, select the state in which you would like to search
- Then, select the plan/network. The Anthem Blue Cross and Blue Shield network for Assurant is based upon where you live, not where your doctor is located:
  - If you live in the greater Kansas City service area, scroll down to the Medical (Employer Sponsored) section and choose the Blue Preferred POS (Alternative Network) as the Plan Type.
  - If you live in the state of Georgia, scroll down to the Medical (Employer Sponsored) section and choose the Blue Open Access POS (Alternative Network) as the Plan Type.
  - If you live in the state of Wisconsin, scroll down to the Medical (Employer Sponsored) section and choose the Blue Preferred POS (Alternate Network) as the Plan Type.
  - All other employees will scroll down to the Medical (Employer Sponsored) section and choose National PPO (BlueCard PPO).

Page
Page
Main Table of Contents
Chapter Table of Contents
Back

- Then, click on Select and Continue.
- Next, choose the type of doctor or health professional you want to find
  - You may choose to enter the doctor's name and/or type of specialty (this step is optional)
- Next, enter the city and state or zip code of the area in which you would like to search and how far you are willing to travel
- Then, click on Search.

Family Coverage

Family coverage includes Employee & *Spouse*/Domestic Partner, Employee & Child(ren) and Employee & Family. Your annual *deductible* and *out-of-pocket maximum*, and the Assurant contribution to your HRA or HSA will depend on whether you elect Individual (Employee-only) coverage or Family coverage.

Annual Deductible

The *deductible* is the amount of eligible medical and prescription expenses you must pay on an annual basis before the Plan begins to pay its share of your covered expenses. The annual deductible does not apply to Preventive Care and Preventive Medications.

There are separate in- and out-of-network deductibles for all three Plan options. If you are using providers outside of the Anthem BlueCross BlueShield network, you'll pay more for coverage, and be subject to a higher deductible. Any amount accumulated toward your in-network deductible also will count toward your out-of-network deductible (and vice versa).

If you elect family coverage under the Blue or Green Plan option, there is no individual *deductible*. This means that the entire family deductible must be met before benefits begin for any covered family member (except for preventive care benefits and preventive prescription drugs). Any combination of enrolled family members can incur expenses to meet the family *deductible*.

If you elect family coverage under the Orange Plan option, each family member has an individual *deductible* amount equal to the *deductible* for Employee-only coverage. Once a family member satisfies the individual *deductible*, the Plan will begin to pay a portion of the cost (*coinsurance*) for that member's eligible non-preventive expenses. The family member does not need to wait for the family *deductible* to be satisfied. Once the family's combined deductible expenses reach the family *deductible*, the Plan will begin to pay *coinsurance* for all other covered family members.

Deductibles are not pro-rated for mid-year enrollments into the Plan. If your *deductible* is not satisfied by the end of the calendar year, the amount credited at year-end does not carry over to the next calendar year.

Coinsurance

You pay a certain percentage of the cost of covered services through coinsurance. After your deductible, generally, the Plan pays 80% (for the Blue or Green Plan option) or 90% (for the Orange plan) of the cost of most covered services, and your coinsurance amount is 20% (for the Blue or Green Plan) or 10% (for the Orange Plan option) up until a limit called the out-of-pocket maximum.

Annual Out-of-Pocket Maximum

The *out-of-pocket maximum* is the most you will pay toward covered expenses each calendar year. Once you meet your individual or family out-of-pocket maximum, the Plan pays 100 percent of covered expenses for the remainder of the year. The *out-of-pocket maximum* varies by Health Plan option (Blue, Green and Orange), coverage tier (e.g., Employee only, Employee and *Spouse*) and whether you use in-network or *out-of-network providers*.

If you elect family coverage under the Blue Plan option, there is no individual *out-of-pocket maximum*. This means that the entire Family *out-of-pocket maximum* must be met before the Plan begins to pay 100 percent

◂Page
Page▸
Main Table of Contents
Chapter Table of Contents
◂◂Back

for any covered family member (except for preventive care benefits and generic preventive prescription drugs). Any combination of you and /or one or more dependents can incur expenses to meet the Family *out-of-pocket maximum*.

If you elect family coverage under the Green or Orange Plan option, each family member has an individual out-of-pocket maximum amount equal to the out-of-pocket maximum for Employee-only coverage. Once a family member satisfies the individual out-of-pocket maximum, the Plan will begin to pay 100 percent for that family member's eligible medical expenses. The family member does not need to wait for the Family out-of-pocket maximum to be satisfied. Once the family's combined expenses reach the Family out-of-pocket maximum, the Plan will begin to pay 100% for all covered family members' eligible expenses for the remainder of the calendar year.

Page
Page
Main Table of Contents
Chapter Table of Contents
Back

The following expenses are excluded from your *out-of-pocket maximum*:

- Charges in excess of the *maximum allowed amount*
- Penalties for not obtaining pre-certification
- Charges in excess of Plan limits
- Expenses incurred for *non-covered services*
- Expenses incurred for non-emergency use of the emergency room
- Charges related to the dispense-as-written penalty under the prescription drug benefit and
- Difference between the network pharmacy charge and the out-of-network charge.

Health Reimbursement Account

A Health Reimbursement Account (HRA) is a tax-advantaged benefit that allows you to save on the cost of healthcare. It is an employer-funded medical reimbursement plan. Each year Assurant sets aside a specific dollar amount on a pre-tax basis in an account to help you pay for eligible health care expenses (e.g., deductible, coinsurance). In addition, you can earn wellness contributions to your HRA that will be communicated in 2017. You cannot contribute to the HRA.

If you enroll in the Blue Plan option, Assurant will establish a Health Reimbursement Account (HRA) for you. The Assurant contribution is deposited in your account in the beginning of January. Wellness contributions are deposited as they are earned throughout the year.

Anthem and Caremark will automatically use funds in your HRA to pay for your *deductible* and *coinsurance* expenses until the balance in your HRA is exhausted. Any balance remaining in your account at the end of the year will roll over to the next plan year.

You cannot receive reimbursement through a HRA for any expense that is:

- Not an eligible expense under the Assurant Health Plan
- Incurred before or after you were covered by the Blue Plan option or
- Reimbursable under another health plan.

The maximum amount of reimbursement that you can receive is equal to your HRA balance at the time the request for reimbursement is processed. The balance remaining in your HRA when you terminate is forfeited unless you continue your Health Plan coverage through COBRA. If you are eligible for the Assurant Retiree Medical Program, the balance will be transferred into that Program. Otherwise eligible expenses for domestic partners and their dependents are not eligible for tax-free reimbursement. You will incur imputed income on the entire value of the HRA at the time you enroll a domestic partner or his/her dependents.

Health Savings Account

A Health Savings Account (HSA) is an account that accompanies the Green and Orange Plan options. An HSA allows you to save money on a tax-free basis to help pay for out-of-pocket health care expenses, including retiree health care expenses.

You elect to open this account when you enroll in the Green or Orange Plan option. You own your HSA and it is not part of the Assurant Health Plan. As a convenience to our employees Assurant has arranged to have the annual Company and wellness contributions and your pre-tax HSA payroll deductions, if any, deposited into an HSA maintained by HealthEquity. Assurant's role is limited to passing the contributions to the account. Assurant has no authority or control over the funds deposited in your HSA or any investment options associated with it. Anthem is the HSA custodian.

You also can elect an amount to contribute to your HSA that will be deducted from your paycheck before taxes — that's tax-free savings for health care expenses.

You can use your account to pay eligible health care expenses, such as your *deductible* and *coinsurance* for Health and Dental Plans. If you don't use the money in your account by the end of the year, the balance rolls over to the next year. All HSA contributions are tax-free when you use them for qualified health care expenses.

The money in your HSA always belongs to you. Also, with the HSA you can:

- Choose to save all or part of the money each year for future health care expenses, and
- Take the HSA with you if you leave Assurant (but you will be responsible for all account fees).

If you prefer, you can open a HSA with your own financial institution. The Company contributions (including wellness contributions) will continue to be deposited in the HealthEquity account, but they can be transferred to the alternative HSA. While Assurant pays for the administrative fee for the HealthEquity HSA for active employees, it will not pay administrative fees for these alternate arrangements.

Accessing HSA Funds

If you enroll in the Green or Orange Plan option and are eligible for an HSA, you will receive a debit card from HealthEquity in the mail. To access your HSA funds:

- You can use your debit card to pay for eligible expenses such as prescriptions, deductibles and coinsurance as long as you have funds available in your account.
- Through the HealthEquity member portal you also can pay for your eligible out-of-pocket expenses directly from your online account.

Contributions

Assurant contributes a specified amount to your HSA annually in late January. Refer to Health Plan-At-a-Glance for the current year's contributions. To be eligible for the Company contributions and wellness incentives, you must be actively employed on the date the contributions are made.

If you elect to contribute to your HSA, your contributions are withheld from payroll on a pre-tax basis - before Social Security, federal, and most state and local income taxes are withheld. Your pre-tax contributions reduce the amount you pay in taxes. This also may mean that your Social Security benefits at retirement, death or disability may be reduced. Whether your Social Security benefit will actually be lower depends on a number of factors, such as your current age, your earnings before participating in the Plans and future pay levels.

To be eligible for an HSA, you must meet the following criteria:

- Have a qualified high *deductible* health plan (such as the Green or Orange Plan options)

◂Page
Page▸
Main Table of Contents
Chapter Table of Contents
◂◂Back

- Have no other health coverage except what is permitted as other health coverage by the IRS
- Not be enrolled in Medicare
- Not be claimed as a dependent on someone else's tax return
- Not have access to dollars in a general purpose flexible spending account (FSA) that can pay for any medical expenses before the HSA's required deductible is met, including a spouse's health care FSA. (Limited Purpose FSAs are acceptable other coverage.)

A dependent's coverage under a non-qualifying plan, such as Medicare, does not disqualify you from having an HSA.

If you enroll in the Green or Orange Plan option with an HSA, but are ineligible for an HSA, you must call HR Services at 866.324.6513 within 7 days of your coverage effective date to opt out of the HSA and avoid any adverse tax consequences.

If you are ineligible for an HSA and therefore do not open an account, Assurant's contribution will be deposited in your paycheck as taxable income.

◂Page
Page ▸
Main Table of Contents
Chapter Table of Contents
◂◂Back

Maximum Annual Contribution

The maximum contribution you can make to a HSA is determined each year by the Internal Revenue Service. This limit includes the Company contribution and wellness contributions. There also is a "catch up" contribution if you are age 55 or older[10]. See the latest Health Plan Rates with Health Care Contributions for the current contribution limits.

The maximum contribution varies depending on your tax-filing status and whether your spouse has his/her own HSA. The IRS website provides several examples to help you determine your maximum: http://www.treasury.gov/resource-center/faqs/Taxes/Pages/Health-Savings-Accounts.aspx.

Generally, the maximum annual contribution is prorated if you are not eligible to contribute to the HSA for the full calendar year. However, if you are HSA-eligible on Dec. 1, you can make the full annual contribution provided you remain HSA-eligible and contribute to it in the following calendar year. If you don't meet both conditions, any contributions above the pro-rated amount will be taxable and subject to a six percent excise tax.

Contributions to your HSA will be invested in the interest earning HSA cash account. When your account balance reaches $1,000, additional investment options are available. A full list of available investments can be found on your HealthEquity member portal. Interest rates on the account are variable.

Timing of Contributions

If your enrollment in the Green or Orange Plan is effective after the first day of a month, your HSA is not effective until the first day of the following month. Your pre-tax contributions will begin for the first pay period of that month.

Note: You can start, stop or change your HSA contributions at any time. Your changes will be implemented as soon as administratively feasible after your request. To make changes to your HSA deductions, visit MyHR.

The annual Assurant contribution is deposited in your account in late-January. Wellness contributions are deposited as they are earned throughout the year.

Qualified Medical Expenses

Medical expenses must be incurred while you are participating in the HSA to be considered "qualified".

[10] If you cover a spouse who is age 55 or older, he/she is also eligible to make a catch up contribution.

While IRS Publication 502 provides more detailed information on qualified medical expenses, the following are some examples:

- Deductibles and coinsurance under medical, dental and vision plans
- Prescription drugs and prescribed *over-the-counter* medications
- Prescription eyeglasses, contact lenses and contact lens solution
- Hearing aids and wheelchairs
- Qualified long-term care expenses and insurance premiums for a qualified Long-Term care insurance policy
- COBRA premiums and
- Premiums for health care coverage while you or your eligible dependent is receiving unemployment compensation.

Generally, health insurance premiums are not qualified medical expenses except as noted above. In addition otherwise qualified medical expenses that were paid by insurance companies or other sources are not qualified medical expenses. This is true whether the payments were made directly to you, to the patient, or to the provider of the medical services.

For individuals age 65 or older the following premiums are also qualified expenses:

- Medicare Parts A, B and D
- Medicare HMO (Part C)
- Your share of premiums for employer-sponsored health insurance and
- Employer-sponsored retiree health insurance.

Note: Premiums for Medigap policies are not qualified medical expenses.

You may make tax-free withdrawals to pay for your eligible dependents' qualified medical expenses, even if they are not covered under a high-deductible health plan. For this purpose, children between the ages of 19 through 24 must be *full-time students* when the expense is incurred.

If you cover a dependent under the Health Plan who does not qualify as a tax dependent (such as an adult child, a domestic partner or a domestic partner's child), you cannot use your HSA to pay for his or her expenses. These dependents may set up their own HSA and may contribute up to the maximum amount for family coverage. To set up an account, your dependent can call HealthEquity at 877.997.6123.

Taxes

Amounts withdrawn from an HSA to pay for qualified medical expenses are not taxable. Withdrawals for non-qualified expenses are taxable and, if you are under age 65, are subject to an additional 20 percent excise tax.

After the end of the year, HealthEquity makes available IRS forms to account holders showing total contributions to and distributions (withdrawals) from their HSAs reported in the calendar year. This information also is provided to the Internal Revenue Service. Account holders must file IRS Form 1040 and complete IRS Form 8889 to report HSA contributions and distributions. All contributions to your HSA are reported to the Internal Revenue Service via your IRS Form W-2.

In the event of your death, your HSA balance will be paid to your named beneficiary. If your spouse is your beneficiary, the balance can be transferred tax-free to his/her own HSA. If the balance is paid out to another beneficiary, or is not transferred directly to your spouse's HSA, the payment is taxable.

Note: It is important to keep itemized receipts as back-up for withdrawals from your HSA that were for qualified medical expenses in case your tax return is audited. We recommend that you speak with your

◂Page
Page▸
Main Table of Contents
Chapter Table of Contents
◂◂Back

tax advisor.

Portability

Your HSA belongs to you. If you leave Assurant or retire, you can maintain the account at HealthEquity (at your own cost) or rollover the balance to your own financial institution. For more information on rollovers and transfers, please contact HealthEquity at 877.997.6123.

You can continue to use your HSA funds to pay for qualified medical expenses after you leave Assurant. If you are eligible for and enrolled in a qualified high-deductible health plan, you also can continue to make new contributions to your HSA.

HRA and HSA: How They Compare

You have the choice of three Health Plan options. The Blue Plan is associated with a HRA. The Green and Orange Plans are associated with a HSA. The chart below shows how the HRA and HSA compare.

Maximum Benefits

	HRA	HSA
Employer contributions	Yes	Yes
Employee contributions	No	Yes
Tax-free reimbursements	Yes	Yes
Compatible with a General Purpose Health Care Flexible Spending Account (FSA)	Yes	No; but you can have a Limited Purpose Health Care FSA
Account earns interest	No	Yes
Portability	No	Yes
Use it or lose it	No, unused amounts roll over each year	No, unused amounts roll over each year

Generally, the Assurant Health Plan provides an unlimited lifetime maximum benefit. However, certain benefits are limited either on an annual or lifetime basis as outlined below:

- The annual maximum for chiropractic treatment involving chiropractic care (spinal manipulation) is 15 visits per calendar year
- The annual maximum for outpatient physical, occupational and speech therapy is a combined 90 visits per calendar year. A visit consists of no more than one hour of therapy.
- The annual maximum for private duty nursing benefits is 70 shifts per calendar year. A shift is up to eight hours.
- The annual maximum for skilled nursing is 120 visits per calendar year.
- The annual maximum for home health care is 200 visits per calendar year.
- The annual maximum for hospice is 210 visits per calendar year.
- The lifetime maximum benefit for comprehensive infertility expenses (see Special Programs - Infertility) is $20,000. There is a separate $5,000 lifetime maximum benefit for prescription drug coverage for infertility treatment.

Note: The limits identified above and throughout this section are a combined amount that is the total of all benefits paid under the Health Plan, including in-network and out-of-network benefits and benefits provided under all Health Plan options offered under the Assurant Health and Welfare Benefits Plan.

Page
Page
Main Table of Contents
Chapter Table of Contents
Back

Pre-certification

Pre-certification – the authorization of a specific medical procedure - helps you determine whether the services being recommended are covered under the Assurant Health Plan. Pre-certification promotes the delivery of cost-effective medical care by reviewing the use of procedures and, where appropriate, the setting or place of service in which they are performed. It also allows Anthem to help your *provider* coordinate your transition from an inpatient setting to an outpatient setting (called discharge planning) and to register you for specialized programs or case management when appropriate.

Anthem utilizes its clinical coverage guidelines, such as medical policy and preventive care clinical coverage guidelines, to assist in making medical necessity decisions. Anthem reserves the right to review and update these clinical coverage guidelines periodically.

Pre-certification does not guarantee coverage for or payment of the service or procedure reviewed. For benefits to be paid, on the date you receive service:

- You must be eligible for benefits
- The service or surgery must be a covered benefit under the Plan
- The service cannot be subject to an exclusion under the Plan and
- You must not have exceeded any applicable Plan limits.

Inpatient admissions and certain outpatient procedures and services must be pre-certified by Anthem. While a member of your family, a hospital staff member, or the attending physician can contact Anthem on your behalf, you are responsible for ensuring that the admission or medical services have been pre-certified. If you are admitted to a *hospital* as an emergency admission, the admission must be certified no later than two (2) business days after the admission. Services that are not pre-certified may be denied.

Precertification (or pre-determination) confirms whether a service is covered or not by the Assurant Health Plan and includes a review of medical necessity based on each individual situation. Precertification is based on several pieces of information including: eligibility, procedure code, provider documentation, and diagnosis code. Precertification does not guarantee coverage for reasons such as: Plan rules may change between precertification and service or the billed service isn't coded as expected. You will be notified by letter once a determination has been made.

The following medical services require pre-certification in order for you to receive benefits. To pre-certify, contact Anthem BlueCross BlueShield at 855.285.4212. To avoid denial of services, be sure to call before receiving services or no later than two business days after an emergency admission. Remember that pre-certification is always your responsibility, whether or not the admitting doctor is in the Anthem BlueCross BlueShield network. For services that do not require precertification, you can call for a pre-determination for coverage verification.

Medical Services Requiring Pre-certification

Inpatient Admissions

- All inpatient admissions including acute *inpatient, skilled nursing facility*, long-term acute rehabilitation and obstetrical delivery stays beyond the 48/96 hour federal mandated length of stay minimum (including newborn stays beyond the mother's stay)
- Emergency Admissions (requires Plan notification no later than 2 business days after admission)

Outpatient Services

- Air Ambulance (excludes 911 initiated emergency transport)
- Bariatric surgery (services must be received at a Blue Distinction Center of Excellence)
- Durable Medical Equipment (DME)/Prosthetics in excess of $5,000 (rented or purchased)

◂Page
Page▸
Main Table of Contents
Chapter Table of Contents
◂◂Back

- Home Health Care (includes Home Infusion billed by Home Health Care agency)
- Home Infusion Therapy (billed by home infusion specialist)
- Hospice (inpatient and outpatient)
- Private Duty Nursing
- Visiting Nurses
- Human Organ, Tissue, and Bone Marrow/Stem Cell Transplants
  - Inpatient admissions for all solid organ, tissue, and bone marrow/stem cell transplants (including kidney only transplants)
  - All outpatient services for the following:
  - Stem Cell/Bone Marrow transplant (with or without myeloablative therapy)
  - Donor Leukocyte Infusion

Out of Network Referrals

Out of network services for consideration of payment at the network benefit level (may be authorized, based on network availability and/or *medical necessity*)

Mental Health/Substance Abuse (MHSA)

Pre-certification is required for the following:

- Acute Inpatient Admissions
- Transcranial Magnetic Stimulation (TMS)
- Intensive Outpatient Therapy (IOP)
- Partial Hospitalization (PHP)
- Residential Care

Medical Specialty Drugs Administered by a Medical Provider

Your Plan covers Specialty Drugs that must be administered to you as part of a doctor's visit, home care visit, or at an outpatient Facility when they are Covered Services. This may include Specialty Drugs for infusion therapy, chemotherapy, blood products, certain injectable, and any Drug that must be administered by a Provider. This section applies when a Provider orders the Drug and a medical Provider administers it to you in a medical setting or in your home by a home infusion provider. Specialty drugs which you can administer to yourself (or a caregiver may administer to you) are not covered under the medical benefit.

Specialty Drugs you get from a Retail or Mail Order Pharmacy are also not covered under your medical benefit.

Pre-certification

Pre-certification is required for certain Medically Administered Specialty Drugs to help make sure proper use and guidelines for these drugs are followed. Your Provider will submit clinical information which will be reviewed for decision. We will give the results of our decision to both you and your Provider by letter.

For a list of Medically Administered Specialty Drugs that need pre-certification, please call the phone number on the back of your Identification Card. The pre-certification list is reviewed and updated from time to time. Including a Specialty Drug on the list does not guarantee coverage under your Plan. Your Provider may check with us to verify Specialty Drug coverage, to find out which drugs are covered under this section and if pre-certification is required.

AIM Imaging Cost & Quality Programs

High Tech Radiology

Assurant has selected an innovative imaging cost and quality program for Anthem BlueCross BlueShield *members* through AIM Specialty Health. This program provides you with access to important information

◂Page
Page▸
Main Table of Contents
Chapter Table of Contents
◂◂Back

about imaging services you might need. Before receiving services, you must confirm that AIM has pre-certified your test and is sending you to an approved network facility. Your tests could be delayed if your doctor skips this step.

If you need an MRI or CT scan, it's important to know that costs can vary quite a bit depending on where you receive the service. Sometimes the differences are significant – anywhere from $300 to $3,000 – but a higher price doesn't guarantee higher quality. The Health Plan requires you to pay a portion of this cost (as your deductible and coinsurance) so where you go can make a very big difference to your wallet.

High tech radiology services requiring pre-certification include:

- Computed Tomography (CT/CTA)
- Magnetic Resonance Imaging (MRA/MRA)
- Nuclear Cardiology
- Positron Emission Tomography (PET)
- Stress Echocardiography
- Resting Transthoracic Echocardiography
- Transesophageal Echocardiography

That's where the AIM Imaging Cost & Quality Program comes in – AIM does the research for you and makes it available to help you find the right location for your service. Here's how the program works:

- Your doctor refers you to a radiology *provider* for an MRI or CT scan
- You pre-certify the service by contacting AIM at 1.888.953.6703 and providing them with the name of the procedure, the referring *physician's* contact information, name of the facility the referring *physician* recommends
  - AIM works with your doctor to help make sure that you are receiving the right test – using evidence-based guidelines
  - AIM also reviews the referral to see if there are other high quality *providers* in your area that have a lower price than the one you were referred to
- If AIM finds another *provider* that meets the quality and price criteria, AIM will give you a call to let you know

You have the choice – you can see the radiology provider your doctor suggested OR you can choose to see a provider that AIM tells you about. AIM will even help you schedule an appointment with the new provider.

Sleep Management Program

The Assurant Health Plan includes a sleep management program that helps your doctor make better informed decisions about your treatment. This program also is administered by *AIM Specialty Health*. Please talk to your doctor about getting approval for any sleep testing and therapy equipment and supplies. If you do not contact AIM before receiving services, a claim may not be paid. The phone number for AIM is 888.953.6703. The program includes outpatient and home sleep testing and therapy. If you require sleep testing, depending on your medical condition, you may be asked to complete the sleep study in your home. Home sleep studies provide the added benefit of reflecting your normal sleep pattern while sleeping in the comfort of your own bed versus going to an outpatient facility for the test.

As part of this program, you are required to get pre-certification for:

- Home sleep tests (HST)
- In-lab sleep studies (polysomnography or PSG, a recording of behavior during sleep)
- Titration studies (to determine the exact pressure needed for treatment) and
- Treatment orders for equipment, including positive airway pressure devices (APAP, CPAP, BPAP, ASV), oral devices and related supplies.

◂Page
Page▸
Main Table of Contents
Chapter Table of Contents
◂◂Back

If you need ongoing treatment, AIM will review your care quarterly to assure that medical criteria are met for coverage. Your equipment supplier or your doctor will be required to provide periodic updates to ensure clinical appropriateness. Ongoing claim approval will depend partly on how you comply with the treatment your doctor has ordered.

How to Pre-certify

You are responsible for obtaining required pre-certifications. While a member of your family, a hospital staff member or the attending physician can contact Anthem to request pre-certification on your behalf, you are ultimately responsible for ensuring that the admission or medical services and expenses have been pre-certified. You also are financially responsible for services and/or settings that are not covered under the Plan based on an adverse determination of *medical necessity or experimental/investigative*. You can pre-certify by calling Anthem at 855.285.4212.

When you pre-certify an *inpatient* admission to a facility, Anthem will notify you, your *physician* and the facility about your pre-certified length of stay. If your *physician* recommends that your stay be extended, additional days also need to be certified. You, your *physician*, or the facility will need to call Anthem at 855.285.4212 as soon as reasonably possible, but no later than the final authorized day. Anthem will review and process the request for an extended stay. You and your *physician* will receive a notification of an approval or denial.

If additional information is needed to make a decision, Anthem will notify the requesting *provider*. They will send you written notification of the specific information necessary to complete the review. If Anthem does not receive the information requested or if the information is provided after the deadline specified in the written notification, a decision will be made based upon the information in the Anthem's possession.

Notification of the pre-certification or extended stay decision may be given by Anthem by the following methods:

- Verbal: oral notification given to the requesting *provider* via telephone or via electronic means if agreed to by the *provider*.
- Written: mailed letter or electronic means including email and fax given to, at a minimum, the requesting *provider* and you or your authorized representative.

If pre-certification determines that the admission or services and supplies are not covered expenses, the notification will explain why and how Anthem's decision can be appealed. You or your *provider* may request a review of the pre-certification decision.

◂Page
Page▸
Main Table of Contents
Chapter Table of Contents
◂◂Back

The length of time it takes for Anthem to pre-certify your admission or procedure depends on your situation as outlined in the chart below:

Request Category	Decision and Notification Timeframe Requirements
Prospective Urgent	72 hours from the receipt of request
Prospective Non-urgent	15 calendar days from the receipt of the request
Concurrent/Continued Stay Review when hospitalized at time of request	72 hours from request and prior to expiration of current certification
Other Concurrent/Continued Stay Review Urgent when request is received more than 24 hours before the expiration of the previous authorization	24 hours from the receipt of the request
Concurrent/Continued Stay Review Urgent when request is received less than 24 hours before the expiration of the previous authorization or no previous authorization exists	72 hours from the receipt of the request
Concurrent/Continued Stay Review Non-urgent for ongoing outpatient treatment	15 calendar days from the receipt of the request
Retrospective	30 calendar days from the receipt of the request

Page
Page
Main Table of Contents
Chapter Table of Contents
Back

- Urgent – a request for pre-certification or pre-determination that in the opinion of the treating *provider* or any *physician* with knowledge of your medical condition, could in the absence of such care or treatment, seriously jeopardize your life or health or your ability to regain maximum function or subject you to severe pain that cannot be adequately managed without such care or treatment.
- Prospective – a request for pre-certification or pre-determination that is conducted prior to the service, treatment or admission.
- Concurrent/Continued Stay Review - a request for pre-certification or pre-determination that is conducted during the course of treatment or admission.
- Retrospective - a request for certification that is conducted after the service, treatment or admission has occurred. Post service clinical claims review also is retrospective. Retrospective review does not include a review that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding or adjudication of payment.

Series of Services

When a single charge is made for a series of services, each service will bear a pro-rata share of the expense. Anthem (for health, behavioral health and substance abuse claims) will determine the pro-rata share. Only that pro-rata share of the expense will be considered to have been an expense incurred on the date of such service.

Covered Expenses

For a service, supply or prescription drug to be covered under the Assurant Health Plan, it must:

- Be *medically necessary* as determined by Anthem
- Be obtained while coverage is in effect
- Not exceed the maximums and limitations and
- Be obtained in accordance with all the terms, policies and procedures outlined in this summary.

Preventive Care

This section describes the covered expenses for services and supplies provided when you are well. Early detection of disease can often be the difference between life and death, between being well and being disabled. The Assurant Health Plan encourages you and your family to get the preventive services that are appropriate for your age, gender and other risk factors such as family medical history, by covering the following routine preventive services. If you use a *network provider* or if you don't live within the Anthem network area, these services will be reimbursed at 100 percent and are not subject to the deductible. If you use an *out-of-network provider*, these services will be subject to the deductible and coinsurance.

Following is a list of preventive services that are generally covered at 100 percent. The complete list can be found on MyAssurantBenefits.com. If, as a result of a routine preventive service, a disease or condition is suspected or identified, any further exams and tests for that disease or condition will be considered diagnostic and will be subject to the deductible and coinsurance.

- Services with an "A" or "B" rating from the United States Preventive Services Task Force. Examples of these services are screenings for:
  - Breast cancer
  - Cervical cancer
  - Colorectal cancer
  - High blood pressure
  - Type 2 Diabetes Mellitus
  - Cholesterol
  - Child and Adult Obesity
- Immunizations for children, adolescents, and adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention
- Preventive care and screenings for infants, children and adolescents as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration
- Prostate Cancer Screening - PSA (routine); Includes digital rectal exam and Prostate specific antigen (PSA) test
- Routine eye exams (does not include fittings for glasses or contact lenses). Anthem offers discounts on glasses and contacts. Visit eyewearspecialoffers.com for the details
- Routine hearing exams performed by an otolaryngologist, otologist or an *audiologist*
- Additional preventive care and screenings for women provided for in the guidelines supported by the Health Resources and Services Administration, including the following:
  - Women's contraceptives (Refer to Prescription Drug Coverage for details), sterilization procedures and counseling. Coverage includes contraceptive devices such as diaphragms, intra uterine devices (IUDs) and implants
  - Breastfeeding support, supplies and counseling. Benefits for breast pumps are limited to one pump per pregnancy.
  - Gestational diabetes screening.

If you are receiving services for an existing condition, then the service is not considered preventive.

Covered Services

The following services are subject to the deductible and coinsurance unless otherwise specified in this booklet:

Inpatient Services (pre-certification required)

- Hospital inpatient services
- Birthing Center

Page
Page
Main Table of Contents
Chapter Table of Contents
Back

- Delivery room and newborn nursery services for well-baby care
- *Inpatient* services for behavioral health and substance abuse treatment
- Inpatient Room Charges. Covered charges include semiprivate room and board, general nursing care and intensive or cardiac care. If you stay in a private room, the *Maximum Allowed Amount* is based on the hospital's prevalent semiprivate rate. If you are admitted to a hospital that has only private rooms, the *Maximum Allowed Amount* is based on the hospital's prevalent room rate.
- *Intensive Care Unit*, Cardiac Care Unit, Neonatal *Intensive Care Unit*
- Services and Supplies provided and billed by the hospital while you're an Inpatient, including the use of the operating, recovery and delivery rooms. Laboratory and diagnostic examinations, intravenous solutions, basal metabolism studies, electrocardiograms, electroenecphalograms, x-ray examination and radiation and speech therapy are also covered. Convenience items (such as radios, TV's, record, tape or CD players, telephones, visitors' meals, etc.) will not be covered.
- Medical care. General medical care, consultations, second opinions, intensive care, monitoring and newborn care
- Surgeon
- Assistant surgeon – covered only if surgery is covered
- Acupuncture services are covered only if performed by a physician or licensed acupuncturist as anesthesia in connection with a covered surgical procedure.
- Anesthesiologist
- Pathologist
- Professional therapy services, includes chemotherapy, radiation therapy, dialysis, hemodialysis, infusion therapy, physical therapy, occupational therapy, speech therapy and respiratory therapy. The annual maximum for outpatient physical, occupational and speech therapy is a combined 90 visits per calendar year and a visit consists of no more than one hour of therapy.
- Radiologist
- Bariatric Surgery (weight loss surgery); (pre-certification required). See Special Programs – Bariatric Surgery for additional details.
- Behavioral Health and Substance Abuse. Detoxification and Residential Treatment (pre-certification required)
- Organ Transplant (pre-certification required). See Special Programs – Organ Transplants for additional details
- *Hospice Care* - limited to 210 visits per calendar year, combined In and Out-of-Network (pre-certification required)
- *Skilled Nursing Facility* - limited to 120 visits per calendar year, combined In and Out-of-Network (pre-certification required)

Outpatient Hospital Services

- Institutional/Outpatient Hospital Facility Charges
- Outpatient/Ambulatory Surgery
- Intensive Outpatient Therapy (IOP) and Partial Hospitalization (PHP) for *behavioral health* and substance abuse conditions
- Methadone Treatment Centers (for the treatment of addiction)
- Surgeon
- Anesthesiologist[11]
- Radiologist[11]
- Pathologist[11]

[11] Out-of-network anesthesiologists, pathologists and radiologists may be covered at the in-network *coinsurance* rate, if you use a network hospital. However, you also may be liable for the difference between the maximum allowed amount and the out-of-network provider's charge.

Page
Page
Main Table of Contents
Chapter Table of Contents
Back

- Professional Consultation / Second Opinion and
- Pre-surgical/Pre-admission Testing.

Emergency Services

Emergency room and ambulance services are covered for an emergency medical condition. Covered services include ancillary services routinely available to the emergency department of a hospital.

Network and out-of-network services are reimbursed at the network coinsurance percentage. However, the allowable charge for out-of-network services will be the greatest of:

- The amount negotiated with *network providers* for the emergency services furnished
- The amount of the emergency service calculated using the same method the *Claims Administrator* generally uses to determine payments for out-of-network services but substituting the network cost-costing provision for the out-of-network cost-sharing provisions or
- The amount that would be paid under *Medicare* for the emergency service.

You will be taken to the nearest facility that can give care for your condition.

Benefits also include medically necessary treatment of a sickness or injury by medical professionals from an ambulance service, even if you are not taken to a facility.

Follow up treatment will be subject to the deductible and coinsurance.

Charges for the use of an emergency room for a *non-emergency medical condition* will be reimbursed at 50 percent and the unpaid amount will not apply towards the deductible or out-of-pocket maximum.

Air ambulance benefits only are available when it is not appropriate to use a ground or water ambulance. Air ambulance will not be covered if you are taken to a Hospital that is not an acute care Hospital (such as a Skilled Nursing Facility), or if you are taken to a Physician's office or your home.

Outpatient Services

- Acupuncture - covered only if performed as anesthesia in connection with a covered surgical procedure
- Allergy Testing and Treatment. Serum and allergy shot is not subject to the annual deductible.
- *Behavioral Health* and Substance Abuse Care provided by a psychiatrist, psychologist, licensed clincal social worker (L.C.S.W.),mental health clinical nurse specialist, licensed marriage and family therapist (L.M.F.T.),
  Licensed Professional Counselor (L.P.C.) or any agency licensed by the state to give these services, when they have to be covered by law
- Blood Therapy (processing and storage)
- Cardiac and Pulmonary Rehabilitation
- Chemotherapy
- Chiropractic Care (Spinal Manipulation) - limited to 15 visits per calendar year for spinal manipulation. Other *covered services*, including x-rays, do not apply toward the calendar year maximum if the visit does not include spinal manipulation. The 15 visit annual maximum benefit does not apply to expenses incurred:
  - During a hospital stay
  - For the treatment of scoliosis
  - For fracture care or
  - For surgery. This includes pre- and post-surgical care provided or ordered by the operating *physician*.
- Clinical Trial Benefits - include coverage for services, such as routine patient care costs, given to you as a participant in an *approved clinical trial* if the services are covered services under the Plan.

Page
Page
Main Table of Contents
Chapter Table of Contents
Back

- Contraceptive services and supplies including:
  - Contraceptive devices prescribed by a *physician* provided they have been approved by the U.S. Food and Drug Administration
  - Related outpatient services such as:
  - Consultations
  - Exams
  - Procedures
  - Other medical services and supplies

  Refer to the Covered Expenses under the Prescription Drug Coverage for information on coverage of oral contraceptives.
- Dental and Oral Surgery - services required for the initial repair of an injury to the jaw, sound natural teeth, mouth or face required as a result of an accident and are not excessive in scope, duration or intensity to provide safe, adequate and appropriate treatment without adversely affecting the your condition. Injury as a result of chewing or biting is not considered an accidental injury except where the chewing or biting results from an act of domestic violence or directly from a medical condition. Treatment must be completed within 24 months of the accident.

The Plan also includes benefits for hospital charges and anesthetics provided for dental care if the member meets any of the following conditions:

- The member is under age five;
- The member has a severe disability that requires hospitalization or general anesthesia for dental care; or
- The member has a medical condition that requires hospitalization or general anesthesia for dental care.

- Diagnostic X-rays and labs
- Diagnostic services by a *physician* or specialist *physician*
- Dialysis, Hemodialysis
- Emergency Care and *Ambulance Services* - care received for an *emergency medical condition* will be covered at the network level of benefits. If an *out-of-network provider* is used, however, you are responsible to pay the difference between the *maximum allowed amount* and the amount the *out-of-network provider* charges.
- Eye Care – medical eye care exams and treatment of disease or injury to the eye
- Hearing Care – Audiometric exam/ hearing evaluation tests and Cochlear implants. Hearing devices/hearing aids are covered when hearing loss is due to illness or trauma; they are not covered when the loss is due to age
- Home Health Services – see Home Health Services for details
- Hospice Care Services - limited to 210 visits per calendar year, combined In and Out-of-Network (pre-certification required)
- *Infertility* Services – The Plan includes benefits for the diagnosis and treatment of infertility. Covered Services include diagnostic and exploratory procedures to determine whether a member suffers from *infertility*. This includes surgical procedures to correct any diagnosed disease or condition affecting the reproductive organs. This includes, but is not limited to, endometriosis, collapsed/clogged fallopian tubes or testicular failure.

The lifetime maximum benefit for comprehensive infertility expenses is $20,000 and there is a separate $5,000 lifetime maximum benefit for prescription drug coverage for infertility treatment. Refer to Special Programs - Infertility Services for additional benefits.

- Infusion Therapy
- *Maternity Care* - physician's initial office visit and global care (pre- and post-natal care and delivery); abortion

Page
Page
Main Table of Contents
Chapter Table of Contents
Back

- Medical and Surgical Equipment – charges by a supplier for medical supplies, *durable medical equipment (DME)*, orthotics (foot and shoe) and external prosthetic appliances. The rental of equipment or, In lieu of rental, the initial purchase of DME if Long-Term care is planned and the equipment cannot be rented or is likely to cost less to purchase than to rent. The decision to buy or rent is at Anthem's discretion Diabetic supplies- lancets, syringes, insulin, etc. - are covered under the Prescription Drug Coverage. DME in excess of $5,000 (combined limit for rental or purchase) requires precertification. Note that orthopedic Shoes, therapeutic shoes, foot orthotics, or other devices to support the feet are not covered unless the orthopedic shoe is an integral part of a covered leg brace or to prevent complications of diabetes.
- Nutritional Counseling - only for *members* with diabetes or those diagnosed with an eating disorder
- Obesity Services - Non-surgical services. Also see Bariatric Surgery.
- *Physician* Services - home and office visits; office surgery
- Prescription Injectables/Prescription Drugs Dispensed in a Physician's Office - See the Prescription Drug section of this booklet for information on all other covered prescription drug expenses.
- Preventive Services - see Preventive Services for details.
- Private Duty Nursing - services provided in the home must be pre-certified. The member's condition must require nursing care that requires the education, training and technical skills of a R.N. or L.P.N. and visiting nursing care is not adequate. Benefits are limited to 70 eight-hour shifts per calendar year. Services provided in a *hospital* or health care facility are not covered if care can be provided adequately by the facility's general nursing staff, if it were fully staffed.
- Prosthetic Appliances -Prosthetic devices to improve or correct conditions resulting from accidental injury or illness are covered if *medically necessary* and ordered by a *physician*. Prosthetic devices include: artificial limbs and accessories, artificial eyes, one pair of glasses or contact lenses for eyes used after surgical removal of the lens(es) of the eye(s); arm braces, leg braces (and attached shoes); and external breast prostheses used after breast removal.
- Radiation Therapy
- Reconstructive Surgery – only to the extent Medically Necessary if surgery is needed to:
  - Improve a significant functional impairment of a body part
  - Correct the result of an *accidental injury* provided that surgery occurs no more than 24 months after the original *injury*. For a covered child, the time period for coverage may be extended through age 18
  - Correct the result of an *injury* that occurred during a covered surgical procedure provided the reconstructive surgery occurs no more than 24 months after the original *injury*
- Reconstructive Breast Surgery –following a mastectomy for reconstruction of the breast on which a mastectomy was performed, including an implant and areolar reconstruction. Also covered is surgery on a healthy breast to make it symmetrical with the reconstructed breast and physical therapy to treat complications of mastectomy including lymphedema
- Respiratory Therapy
- Sterilization Services - vasectomy services are covered. Sterilization and contraceptives for women are covered under Preventive Care.
- Therapy Services - physical, speech and occupational therapy are limited to 90 visits (combined) per calendar year. This includes services needed due to *developmental delay*. A visit consists of no more than one hour of therapy. Covered expenses include charges for two therapy visits of no more than one hour in a 24-hour period.
- Transplants – any medically necessary human organ and stem cell/bone marrow transplants and transfusion performed as determined by the Claims Administrator including necessary acquisition procedures, collection and storage including medically necessary myeloablative therapy. Procedures must be performed in a Center of Excellence to be considered a covered expense. See Transplants and Limitations and Exclusions for important information.
- *Urgent Care* - Services received for a sudden, serious, or unexpected illness, Injury or condition. Urgent Care is not considered an emergency. Care is needed right away to relieve pain, find out what is wrong,

Page
Page
Main Table of Contents
Chapter Table of Contents
Back

or treat a health problem that is not life-threatening.
- Vision Therapy

Special Programs

Bariatric Surgery (weight loss surgery)

The Assurant Health Plan covers bariatric surgery if it is pre-certified and performed at a Blue Distinction *Center of Excellence (COE)* facility. If you need to travel to the COE for the surgery, the Plan will cover certain travel expenses for you and a companion when the facility is more than 75 miles away from your home. Travel expenses are limited to $10,000 per episode of care and there is a $50 lodging maximum per day for double occupancy. Call Anthem at 855.285.4212 to pre-certify.

Home Health Care

All *home health care* services must be pre-certified. Limited to 200 visits per calendar year, combined In and Out-of-Network (includes Home Infusion Therapy). Covered services include:

- Visits by a R.N. or L.P.N.
- Visits by a qualified physiotherapist, speech therapist and inhalation therapist certified by the National Board of Respiratory Therapy
- Services provided by a licensed Medical Social Services Worker when *medically necessary* to enable you to understand the emotional, social and environmental factors resulting from or affecting your illness
- Visits by a Home Health Nursing Aide when rendered under the direct supervision of an RN
- Nutritional guidance
- Administration or infusion of prescribed drugs and
- Oxygen and its administration.

Covered services do **not** include:

- Services that are not *medically necessary* or of a non-skilled level of care
- Convalescent or *custodial care* where you have spent a period of time for recovery of an illness or surgery and skilled care is not required or the services being rendered are only for aid in daily living (e.g., feeding, dressing, toileting)
- Dietician services
- Maintenance therapy
- Dialysis treatment
- Food, housing, homemaker services, sitters, home –delivered meals
- Services and supplies that are not included in the *home health care* plan
- Services of a person who ordinarily resides in your home or is a member of your or your *spouse's*/domestic partner's family
- Any services for any period during which you are not under the continuing care of a *physician* and
- Any services or supplies not specifically listed as a covered.

Infertility Services

The Plan *covers certain fertility* services including ovulation induction with menotropins and intrauterine insemination (IUI) when services are performed by a *network provider*. These services must be pre-certified and are subject to a $20,000 lifetime maximum benefit.

Any advanced reproductive technology (ART) procedures or services related to such procedures, including but not limited to artificial insemination, Invitro Fertilization (IVF), Gamete Intrafallopian Transfer (GIFT) and Zygote Intrafallopian Transfer (ZIFT) are not covered expenses under the Plan.

◂Page
Page▸
Main Table of Contents
Chapter Table of Contents
◂◂Back

Reversal of a voluntary sterilization is not covered.

Refer to Limitations and Exclusions for important information.

Transplants

The following organ (solid organ, stem cell, bone marrow and tissue) transplants are covered by the Plan at the In-network level of benefits only if pre-certified and performed at a facility designated by Anthem BlueCross BlueShield as a Blue Distinction Center of Excellence (COE) for the type of transplant being performed. All other facilities are subject to out of network *deductible* and *coinsurance*. Call Anthem at 855.285.4212 to pre-certify the procedure and to locate appropriate COEs.

- Heart
- Lung
- Heart/Lung
- Simultaneous Pancreas/Kidney
- Pancreas
- Liver
- Bone Marrow/Stem Cell

Please note that there are instances where your *provider* requests approval for Human Leukocyte Antigen (HLA) testing, donor searches and/or a collection and storage of stem cells prior to the final determination as to what transplant procedure will be requested. Under these circumstances, the HLA testing and donor search charges are covered as routine diagnostic testing. The collection and storage request will be reviewed for medical necessity and may be approved. However, such an approval for HLA testing, donor search and/or a collection and storage in NOT an approval for the subsequent requested transplant. A separate medical necessity determination will be made for the transplant procedure.

For services rendered in a Blue Distinction facility, the Plan will provide assistance with reasonable and necessary travel expenses as determined by Anthem when you obtain prior approval and are required to travel more than 75 miles from your residence to reach the facility where your *covered transplant procedure* will be performed. The Plan's assistance with travel expenses includes transportation to and from the facility, lodging and meals for the transplant recipient member and one companion for an adult member or two companions for a child patient. You must submit itemized receipts for transportation, meals and lodging expenses in a form satisfactory to Anthem when claims are filed. Anthem will follow Internal Revenue Service (IRS) guidelines in determining what expenses can be paid.

Refer to Limitations and Exclusions for important information.

Limitations and Exclusions

The following services are excluded from or limited by the Assurant Health Plan:

- Expenses incurred before coverage begins or after it ends
- Admissions for non-inpatient services - admission or continued *hospital* or *skilled nursing facility* stay for medical care or diagnostic studies not medically required on an *inpatient* basis.
- Administrative charges - charges for any of the following:
  - Failure to keep a scheduled visit
  - Completion of claim forms or medical records or reports unless otherwise required by law
  - For *physician* or *hospital's* stand-by services
  - For holiday or overtime rates
  - Membership, administrative, or access fees charged by *physicians* or other providers. Examples of administrative fees include, but are not limited to, fees charged for educational brochures or

Page
Page
Main Table of Contents
Chapter Table of Contents
Back

calling a patient to provide their test results and
- Specific medical reports including those not directly related to the treatment of the Member, e.g., employment or insurance physicals, and reports prepared in connection with litigation.

- Allergy Services - specific non-standard allergy services and supplies, including but not limited to, skin titration (Rinkle method), cytotoxicity testing (Bryan's Test), treatment of non-specific candida sensitivity and urine autoinjections
- Alternative Therapies - services or supplies related to alternative or complementary medicine. Services in this category include, but are not limited to holistic medicine, homeopathy, hypnosis, aroma therapy, massage therapy at a salon, Reiki therapy, herbal, vitamin or dietary products or therapies, naturopathy, thermograph, orthomolecular therapy, contact reflex analysis, bioenergial synchronization technique (BEST), iridology (study of the iris), biofeedback, recreational or educational sleep therapy or other forms of self-care or non-medical self-help training and any related diagnostic testing
- Biomicroscopy - including field charting or aniseikonic investigation
- Certain Providers - Service you get from *providers* that are not licensed by law to provide *covered services* as defined in this Booklet. Examples of non-covered providers include, but are not limited to, masseurs or masseuses (massage therapists), and physical therapist technicians
- Christian Science Practitioner
- Comfort and Convenience Items – personal comfort items such as those that are furnished primarily for your personal comfort or convenience, including those services and supplies not directly related to medical care, such as guest's meals and accommodations, barber services, telephone charges, radio and television rentals, homemaker services, travel expenses, and take-home supplies
- Complications of non-covered procedures
- *Cosmetic Surgery*/Cosmetic Services/Beautification Procedures - *cosmetic surgery*, reconstructive surgery, pharmacological services, nutritional regimens or other services for beautification or treatment relating to the consequences of, or as a result of, cosmetic surgery. This exclusion includes, but is not limited to, surgery to correct gynecomastia and breast augmentation procedures and otoplasties. Reduction mammoplasty and services for the correction of asymmetry, except when determined to be medically necessary by the Claims Administrator are not covered.

This exclusion does not apply to surgery to restore function if a body area has been altered by disease, trauma, congenital/developmental anomalies, or previous therapeutic processes. This exclusion does not apply to surgery to correct the results of injuries that caused the impairment, or as a continuation of a staged reconstruction procedure for congenital defects necessary to restore normal bodily functions, including but not limited to, cleft lip and cleft palate.

This exclusion does not apply to breast reconstructive surgery.

Complications directly related to cosmetic services treatment or surgery, as determined by the *Claims Administrator*, are not covered. This exclusion applies even if the original cosmetic services treatment or surgery was performed while the *member* was covered by another carrier or self-funded plan prior to coverage under this Plan. Directly related means that the treatment or surgery occurred as a direct result of the cosmetic services treatment or surgery and would not have taken place in the absence of the cosmetic services treatment or surgery. This exclusion does not apply to conditions including, but not limited to: myocardial infarction; pulmonary embolism; thrombophlebitis; and exacerbation of co-morbid conditions.

- Court-ordered Services - or those required by court order as a condition of parole or probation
- Crime and Incarceration - injuries received while committing a crime as well as care required while incarcerated in a federal, state or local penal institution or required while in custody of federal, state or local law enforcement authorities, unless otherwise required by law or regulation. This exclusion does not apply if your involvement in the crime was solely the result of a medical or mental condition or where you were the victim of a crime, including domestic violence.

◂Page
Page ▸
Main Table of Contents
Chapter Table of Contents
◂◂Back

- *Custodial* Care and Rest Care - custodial care, domiciliary care, rest cures, or travel expenses even if recommended for health reasons by a *physician*. *Inpatient* room and board charges in connection with a *hospital* or *skilled nursing facility* stay primarily for environmental change, *physical therapy* or treatment of chronic pain.
- Daily Room Charges - daily room charges while the Plan is paying for an *intensive care*, cardiac care, or other special care unit.
- Dental Care - dental care and treatment and oral surgery (by *physicians* or *qualified dental professionals*) including dental surgery; dental appliances; dental prostheses such as crowns, bridges, or dentures; implants; orthodontic care; operative restoration of teeth (fillings); dental extractions; endodontic care; apicoectomies; excision of radicular cysts or granuloma; treatment of dental caries, gingivitis, or periodontal disease by gingivectomies or other periodontal surgery; vestibuloplasties; alveoplasties; dental procedures involving teeth and their bone or tissue supporting structures; frenulectomy. Any treatment of teeth, gums or tooth related service except otherwise specified as covered in this Summary Plan Description.
- Educational Services - Educational services for remedial education including evaluation or treatment of learning disabilities, minimal brain dysfunctions, learning disorders, behavioral and cognitive rehabilitation. This includes educational services, treatment or testing and training related to behavioral (conduct) problems, including but not limited to services for conditions related to autistic disease of childhood, hyperkinetic syndromes, including attention deficit disorder and attention deficit hyperactivity disorder, learning disabilities, behavioral problems and mental retardation. Special education, including lessons in sign language to instruct a *member* whose ability to speak has been lost or impaired, to function without that ability is not covered.
- Excessive Expenses - expenses in excess of the Plan's *maximum allowed amount*.
- Employer or Association Medical/Dental Department - received from a dental or medical department maintained by or on behalf of an Employer, mutual benefit association, labor union, trust or similar person or group.
- *Experimental/Investigative* Services - treatments, procedures, equipment, drugs, devices or supplies (hereafter called "services") which are, in the *Claims Administrator's* judgment, experimental/investigative for the diagnosis for which the *member* is being treated. Also, services, treatment or supplies not generally accepted in medical practice for the prevention, diagnosis or treatment of an illness or injury, as determined by the *Claims Administrator*. An *experimental/investigative* service is not made eligible for coverage by the fact that other treatment is considered by a *member's* physician to be ineffective or not as effective as the service or that the service is prescribed as the most likely to prolong life.
- Family Members - services rendered by a *provider* who is a close relative or member of your household. Close relative means wife or husband, parent or grandparent, child, brother or sister, by blood, marriage (including in-laws) or adoption
- Foot Care - foot care only to improve comfort or appearance, routine care of corns, calluses, toe nails (except surgical removal or care rendered as treatment of the diabetic foot or ingrown toenail), flat feet, fallen arches, weak feet, chronic foot strain, or asymptomatic complaints related to the feet. Coverage is available, however, for *medically necessary* foot care required as part of the treatment of diabetes and for *members* with impaired circulation to the lower extremities.
- Free Services - services and supplies for which you have no legal obligation to pay or for which no charge has been made or would be made if you had no health insurance coverage.
- Government Programs - treatment where payment is made by any local, state, or federal government (except Medicaid), or for which payment would be made if the *member* had applied for such benefits. Services that can be provided through a government program for which you as a member of the community are eligible for participation. Such programs include, but are not limited to, school speech and reading programs.
- Halfway House - services provided in a Halfway House.
- Health Spa - expenses incurred at a health spa or similar facility.
- Hearing Aids - hearing aids, hearing devices or examinations for prescribing or fitting them.

◂Page
Page▸
Main Table of Contents
Chapter Table of Contents
◂◂Back

- Ineligible Hospital - any services rendered or supplies provided while you are confined in an ineligible hospital
- Ineligible Provider - any services rendered or supplies provided while you are a patient or receive services at or from an ineligible provider.
- Inpatient Rehabilitation Programs - inpatient rehabilitation in a hospital or hospital-based rehabilitation facility, when the *member* is medically stable and does not require skilled nursing care or the constant availability of a physician or:
  - the treatment is for maintenance therapy
  - the treatment is for congenital learning or neurological disability/disorder
  - the treatment is for communication training, educational training or vocational training or
  - The member has no restorative potential
- International Services - non-emergency treatment of chronic illnesses received outside the United States performed without pre-authorization. See the information on the BlueCard Worldwide program under Programs and Services through Anthem BlueCross BlueShield.
- In-vitro Fertilization and Artificial Insemination.
- Maintenance Care - services which are solely performed to preserve the present level of function or prevent regression of functions for an illness, *injury* or condition which is resolved or stable.
- Marital Counseling - services and treatment related to religious counseling, marital/relationship counseling and sex therapy
- Medicare Benefits – benefits available under *Medicare* or that would have been available if the member had applied for *Medicare*. With respect to end-stage renal disease (ESRD), *Medicare* shall be treated as the primary payor whether or not the member has enrolled *Medicare* Part B. Services provided pursuant to a private contract between the member and a provider, for which reimbursement under the Medicare program is prohibited, as specified in Section 1802 (42 U.S.C. 1395a) of Title XVIII of the Social Security Act.
- Never Events – the Plan will not pay for errors in medical care that are clearly identifiable, preventable and serious in their consequences for patients, which indicate a problem exists in the safety and credibility of a health care facility. The *provider* will be expected to absorb such costs. This exclusion includes, but is not limited to, such errors as operating on the wrong side of the body, operating on the wrong part of the body, using the wrong procedure, or operating on the wrong patient.
- *Non-covered* Services - any item, service, supply or care not specifically listed as a covered service in this Summary Plan Description.
- Non-licensed provider - treatment or services provided by a non-licensed *provider*, or that do not require a license to provide; services that consist of supervision by a provider of a non-licensed person; services performed by a relative of a *member* for which, in the absence of any health benefits coverage, no charge would be made; services provided to the *member* by a local, state, or federal government agency, or by a public school system or school district, except when the plan's benefits must be provided by law; services if the *member* is not required to pay for them or they are provided to the *member* for free.
- Not Medically Necessary Services - Care, supplies, or equipment not medically necessary, as determined by the Claims Administrator, for the treatment of an injury or illness. This includes, but is not limited to, care which does not meet the Claims Administrator's medical policy, clinical coverage guidelines or benefit policy guidelines.
- Nutritional Counseling except for members with diabetes or those diagnosed with an eating disorder
- Obesity Services - Any services or supplies for the treatment of obesity, including but not limited to, weight reduction, medical care or prescription drugs, or dietary control (except as related to covered nutritional counseling). Nutritional supplements; services, supplies and/or nutritional sustenance products (food) related to enteral feeding except when it's the sole means of nutrition. Food supplements. Services for *inpatient* treatment of bulimia, anorexia or other eating disorders which consist of primarily of behavior modification, diet and weight monitoring and education. Any services or supplies that involve weight reduction as the main method of treatment, including medical, psychiatric

Page
Page
Main Table of Contents
Chapter Table of Contents
Back

care, or counseling. Weight loss programs included but are not limited to, commercial weight loss programs (Weight Watcher, Jenny Craig, and LA Weight Loss), nutritional supplements, appetite suppressants, and supplies of a similar nature. This exclusion does not apply to bariatric surgery when approved by the Plan.

- Over the Counter Drug Equivalents - Drugs, devices, products, or supplies with over the counter equivalents and any Drugs, devices, products, or supplies that are therapeutically comparable to an over the counter Drug, device, product, or supply. This exclusion does not apply to over-the-counter products that the Plan must cover as a preventive care benefit under federal law with a prescription.
- Prescription Drugs - Any prescription drugs purchased at a retail or Mail Service Pharmacy are not covered by Anthem BlueCross BlueShield. Prescription benefits are provided through CVS Caremark. See Prescription Drug Coverage section of this Summary Plan Description.
- Private Duty Nursing – For Private Duty Nursing services except when provided through the Home Health Care benefit.
- Private Rooms - Private room, except as specified in Covered Services.
- Research Screenings – For examinations related to research screenings, unless required by law.
- Reversal of Sterilization - Services related to or performed in conjunction with reverse sterilization.
- Routine Examinations - Routine physical examinations, screening procedures, and immunizations necessitated by employment, foreign travel or participation in school athletic programs, recreational camps or retreats or any insurance program which are not called for by known symptoms, illness or *injury* except those which may be specifically listed as Preventive Care.
- Safe Surroundings. Care furnished to provide a safe surrounding, including the charges for providing a surrounding free from exposure that can worsen the disease or *injury*.
- Sclerotherapy. The treatment of varicose veins of the lower extremities including ultrasonic guidance for needle and/or catheter placement and subsequent ultrasound studies to assess the results of ongoing treatment of varicose veins of the lower extremities with sclerotherapy.
- Services Not Specified as Covered. No benefits are available for services that are not specifically described as *covered services* in this Summary Plan Description. This exclusion applies even if your *physician* orders the service.
- Sexual Dysfunction. Medical/surgical services or supplies for treatment of male or female sexual or erectile dysfunctions or inadequacies. This exclusion also includes penile prostheses or implants and vascular or artificial reconstruction, prescription drugs, and all other procedures and equipment developed for or used in the treatment of impotency, and all related diagnostic testing. Refer to Prescription Drug Coverage.
- Sexual Transformation. Surgical care or medical treatment or study related to the modification of sex (transsexualism) and related services, or the reversal thereof.
- Shoes and Orthotics. Shoe inserts, orthotics (except when prescribed by a *physician* for diseases of the foot or systemic diseases that affect the foot such as diabetes when deemed *medically necessary*) and orthopedic shoes (except when an orthopedic shoe is an integral part of a covered leg brace.)
- Smoking Cessation. Programs and treatment of nicotine addiction including gum, patches and prescription drugs to eliminate or reduce dependency on, or addiction to tobacco and tobacco products, unless otherwise required by law, are not covered through Anthem BlueCross BlueShield. Certain Smoking Cessation programs and treatment are provided through the Assurant Wellness Program. Refer to the Preventive Drug List and Wellness Program Offerings.
- Spider Veins. Treatment of telangiectatic dermal veins (spider veins) by any method.
- Supplies or Equipment (including durable medical equipment) Not Medically Necessary. Supplies or equipment not *medically necessary* for the treatment of an *injury* or illness. Non-covered supplies are inclusive of but not limited to:
  - Band-aids, tape, non-sterile gloves, thermometers, heating pads, hot water bottles, home enema equipment, sterile water and bed boards;
  - Household supplies, including but not limited to, deluxe equipment, such as motor-driven chairs or bed, electric stair chairs or elevator chairs;

  - The purchase or rental of exercise cycles, physical fitness, exercise and massage equipment, ultraviolet/tanning equipment;
  - Water purifiers, hypo-allergenic pillows, mattresses, or waterbeds, whirlpool, spa or swimming pools, air purifiers, humidifiers, dehumidifiers;
  - Escalators, elevators, ramps, stair glides, emergency alert equipment, handrails, heat appliances improvements made to a member's house or place of business and adjustments made to vehicles;
  - Air conditioners, humidifiers, dehumidifiers, or purifiers;
  - Rental or purchase of equipment if you are in a facility which provides such equipment;
  - Other items of equipment that the *Claims Administrator* determines do not meet the listed criteria.
- Telecommunication. Advice of consultation given by any form of telecommunication, except as outlined under LiveHealth Online.
- Temporomandibular joint disorder (TMJ) treatment
- Thermograms and thermography.
- Therapy Services. Services for outpatient therapy or rehabilitation other than those specifically listed as covered in this Summary Plan Description. Excluded forms of therapy include, but are not limited to, vestibular rehabilitation, primal therapy, chelation therapy, rolfing, psychodrama, megavitamin therapy, purging, bioenergetic therapy, in-home wrap around treatment, wilderness therapy, and boot camp therapy, salabrasion, chemosurgery and other such skin abrasion procedures associated with the removal of scars, tattoos, actinic changes and/or which are performed as a treatment for acne. Note: tattoos applied to assist in covered medical treatments, such as markers for radiation therapy are covered.
- Transplant Services. The following services and supplies rendered in connection with organ/tissue/bone marrow transplants:
  - Surgical or medical care related to animal organ transplants, animal tissue transplants, (except for porcine heart valves) artificial organ transplants or mechanical organ transplants;
  - Transportation, travel or lodging expenses for more than one non-donor travel companion;
  - Donation related services or supplies, including search, associated with organ acquisition and procurement;
  - Chemotherapy with autologous, allogenic or syngenic hematopoietic stem cells transplant for treatment of any type of cancer not specifically named as covered;
  - Any transplant not specifically listed as covered.
- Transportation provided by other than a state licensed professional *ambulance service*, and *ambulance* services other than for an emergency *medical condition*. Transportation to another area for medical care is also excluded except when medically necessary for you to be moved by ambulance from one hospital to another hospital. Ambulance transportation from the hospital to the home is not covered.
- Travel Costs and Mileage except as authorized by the *Claims Administrator*, on behalf of the Company.
- Trusses, corsets and other support items.
- Vision care services and supplies, including but not limited to eyeglasses, contact lenses and related examinations and services. Analysis of vision or the testing of its acuity except as otherwise indicated under Preventive Care. Service or devices to correct vision or for advice on such service. Orthoptic training is covered. This exclusion does not apply for initial prosthetic lenses or sclera shells following intraocular surgery, or for soft contact lenses due to a medical condition, i.e. diabetes.
- Vision Surgeries. Related to radial keratotomy or keratomileusis or excimer laser photo refractive keratectomy; and surgery, services or supplies for the surgical correction of nearsightedness and/or astigmatism or any other correction of vision due to a refractive problem.
- Vitamins, minerals and food supplement, as well as vitamin injections not determined to be medically necessary in the treatment of a specific illness. Nutritional supplements; services, supplies and/or nutritional sustenance products (food) related to enteral feeding, except when determined to be medically necessary.
- Waived Cost-Shares Out-of-Network - For any service for which you are responsible under the terms of this Plan to pay a copayment, coinsurance or deductible and the copayment, coinsurance or deducible is

◂Page
Page▸
Main Table of Contents
Chapter Table of Contents
◂◂Back

waived by an out-of-network provider.

- Waived Fees - Any portion of a provider's fee or charge which is ordinarily due from a Member but which has been waived. If a provider routinely waives (does not require the Member to pay) an Deductible or Out-of-Pocket amount, the Claims Administrator will calculate the actual Provider fee or charge the fee or charge by the amount waived.
- War/Military Duty. Any disease or *injury* resulting from a war, declared or not, or any military duty or any release of nuclear energy. Charges for services directly related military service provided or avail able from the Veterans' Administration or military facilities also are excluded except as required by law.
- Worker's Compensation. Care for any condition or *injury* recognized or allowed as a compensable loss through any *workers' compensation*, occupational disease or similar law. If workers' compensation benefits are not available to you, then this exclusion does not apply. This exclusion applies if you receive the benefits in whole or in part. This exclusion also applies whether or not you claim the benefits or compensation. It also applies whether or not you recover from any third party.

◂Page
Page ▸
Main Table of Contents
Chapter Table of Contents
◂◂Back

Coordination of Benefits

Some people have coverage under more than one group medical plan. Coordination of benefits provisions determine which plan is the primary carrier – the one that must pay benefits first. The following is a summary of these rules:

- The benefit plan without a coordination of benefits provision will pay benefits before a plan that contains such a provision.
- The plan that covers a person as an employee pays benefits before the plan that covers the person as a dependent. For example, Assurant's Health Plan is the primary carrier for your expenses. Your *spouse's* or domestic partner's plan is primary for his or her expenses.
- The plan of the parent born earlier in the year is the primary carrier for a dependent child. In the case of a divorce or separation, the plan of the parent with custody is the primary plan, unless a court decree names one parent responsible for providing medical coverage.
- The plan that covers a person as an active employee will pay benefits before a plan that covers the per son as a retiree or former employee.
- If the above four rules do not establish a primary plan, then the plan that has covered the person longer is primary.

The Assurant Health Plan always pays secondary to:

- Any motor vehicle policy including "medical payments to others" (MedPay), "personal injury protection" (PIP) and no-fault coverage available to you and
- Any plan or program required by law.

You should review your automobile insurance policy and ensure that uncoordinated medical benefits have been chosen so that the automobile insurance policy is the primary payer.

The Assurant Health Plan is administered under a maintenance of benefits (MOB) payment method. Under MOB, when the Assurant Health Plan is the secondary carrier, the benefit payable under the primary carrier will be deducted from the benefit normally paid by the Plan. You will receive benefits up to but no greater than what you would have received under the Assurant Health Plan if there was no other medical plan.

Medicare Coverage

Generally when an individual is covered under the Assurant Health Plan and *Medicare*, *Medicare* is the primary carrier. However, if you or your enrolled spouse becomes **eligible** for *Medicare* due to age or disability while you are **actively** employed, the Assurant Health Plan will continue to be your primary carrier. In this situation you may want to consider postponing **enrolling** in *Medicare* Parts B and C - which have monthly premiums - until you retire or terminate employment.

If you delayed enrolling in *Medicare* Part B because you had group health coverage as an active employee, you have an eight-month special *Medicare* Part B enrollment period that begins when you retire or terminate employment. If you enroll during the first month of the eight-month period, your *Medicare* Part B coverage will be effective on the first day of that month. If you enroll during any of the remaining seven months, your coverage will be effective the first of the month following the month in which you enroll. There are two important reasons to enroll in *Medicare* on a timely basis:

- Benefits available under the Assurant Health Plan (or the Assurant Early Retirement Medical Plan) assume that you are enrolled in *Medicare* and will be reduced by any *Medicare* benefits that would have been available to you if you had enrolled on a timely basis
- Your *Medicare* Part B premium may be higher if you don't enroll during the special enrollment period.

Page
Page
Main Table of Contents
Chapter Table of Contents
Back

Claims Payment

Participating *providers* have agreed to submit claims directly to the local Blue Cross and/or Blue Shield plan in their area. Therefore if participating network *hospitals, physicians* and ancillary *providers* are used, claims for their services will generally not have to be filed by the *member*. In addition, many out-of-network *hospitals* and *physicians* will also file claims if the information on the BlueCross BlueShield Identification Card is provided to them. If the provider requests a claim form to file a claim, a claim form can be obtained at MyAssurantBenefits.com or by contacting HR Services.

Please note you may be required to complete an authorization form in order to have your claims and other personal information sent to the *Claims Administrator* when you receive care in foreign countries. Failure to submit such authorizations may prevent foreign providers from sending your claims and other personal information to the *Claims Administrator*.

How to File Claims

Under normal conditions, the *Claims Administrator* should receive the proper claim form within twelve [12] months after the service was provided. This section describes when to file a benefits claim and when a *hospital* or *physician* will file the claim for you.

Each person enrolled through the Plan receives an Identification Card. Remember, in order to receive full benefits, you must receive treatment from a *network provider*. When admitted to a network hospital, present your Identification Card. Upon discharge, you will be billed only for those charges not covered by the Plan.

When you receive *covered services* from a network *physician* or other *network provider*, ask him or her to complete a claim form. Payment for covered services will be made directly to the *provider*.

For health care expenses other than those billed by a *network provider*, use a claim form to report your expenses. You may obtain a claim form from MyAssurantBenefits.com or from the *Claims Administrator*. Claims should include your name, Plan and Group numbers exactly as they appear on your Identification Card. Attach all bills to the claim form and file directly with the *Claims Administrator*. Be sure to keep a photocopy of all forms and bills for your records. The address is on the claim form.

Save all bills and statements related to your illness or Injury. Make certain they are itemized to include dates, places and nature of services or supplies.

Programs and Services through Anthem BlueCross BlueShield

Anthem.com

Anthem.com is a great place to start if you have questions about using your health care coverage. It is your online resource for personalized benefits and health information. You simply log on to register. Once you register you can:

- Find *providers* in the Anthem network
- Print a temporary ID card and/or request a permanent one
- Review your covered dependents
- Contact Member Services
- Check explanation of benefits statements for your claims
- Access general sources of health information
- Get discounts on over 50 products and services that help promote better health and well-being.
- Get great discounts on vision care from 1-800 CONTACTS and Premier Lasik Network.

Page
Page
Main Table of Contents
Chapter Table of Contents
Back

BlueCard® Worldwide

Need emergency services when traveling outside the United States? The BlueCard Worldwide program provides coverage through an international network of *hospitals*, doctors and other healthcare *providers*. With this program, you're assured of receiving care from licensed healthcare professionals. The program also assures that at least one staff member at the *hospital* will speak English, or the program will provide translation assistance. Your coverage outside the United States may be different and we recommend you call the Customer Service number on your Identification Card for coverage details before you leave home. To find participating providers, visit bcbs.com and click on "Find a Doctor or Hospital", then "Locate Doctors Worldwide." In order to access the international directory of providers, you will need to enter the first three letters of your Anthem BlueCross BlueShield identification number that is located on the front of your identification card.

ComplexCare

If you are at risk for frequent and high levels of medical care, the ComplexCare program reaches out to you to offer support and assistance in managing your health care needs. ComplexCare empowers you for self-care of your condition(s), while encouraging positive health behavior changes through ongoing interventions. ComplexCare nurses will work with you and your physician(s) to offer:

- Personalized attention, goal planning, health and lifestyle coaching
- Strategies to promote self-management skills and medication adherence
- Resources to answer health-related questions about specific treatments
- Access to other essential health care management programs and
- Coordination of care between multiple *providers* and services.

The program helps you effectively manage your health to improve your health status and quality of life, as well as decreased use of acute medical services.

ConditionCare

ConditionCare programs help maximize your health status, improve health outcomes and control health care expenses associated with the following conditions:

- Asthma (pediatric and adult)
- Diabetes (pediatric and adult)
- Heart failure
- Coronary artery disease and
- Chronic obstructive pulmonary disease.

You'll get 24/7 phone access to a nurse coach who can answer your questions and give you up-to-date information about your condition, a health review and follow-up calls if you need them. You also have access to tips on prevention and lifestyle choices to help you improve your quality of life.

Future Moms

The Future Moms program offers a guided course of care and treatment, leading to overall healthier outcomes for mothers and their newborns. Future Moms helps routine to high-risk expectant mothers focus on early

prenatal interventions, risk assessments and education. The program includes special management emphasis for expectant mothers at highest risk for premature birth or other serious maternal issues. The program consists of nurse coaches, supported by pharmacists, registered dietitians, social workers and medical directors. You'll get:

- 24/7 phone access to a nurse coach who can talk with you about your pregnancy and answer your questions
- Your Pregnancy Week by Week, a book to show you what changes you can expect for you and your baby over the next nine months
- Useful tools to help you, your doctor and your Future Moms nurse coach track your pregnancy and spot possible risks.

Page
Page
Main Table of Contents
Chapter Table of Contents
Back

LiveHealth Online

LiveHealth Online provides certain professional services online 24/7 for generally less money than the average doctor visit or trip to the emergency room. LiveHealth Online connects Assurant Health Plan *members* to board-certified doctors via live two-way video from your personal computer, tablet or mobile device. This service is available to all active employees, regardless of whether you participate in the Assurant Health Plan, However if you are enrolled in the Assurant Health Plan, any costs associated with your online visit will be applied toward your deductible and coinsurance. LiveHealth Online is provided as a convenience. Questions should be addressed to LiveHealth Online directly at 855.603.7985.

Future Moms with Breastfeeding Support on LiveHealth Online will be available starting January 1, 2017. You can have secure and private video chats with a certified lactation consultant, counselor or registered dietitian at no cost when using Future Moms with Breastfeeding Support on LiveHealth Online. These professionals will be able to provide personalized support to help you with breastfeeding techniques, and consult about milk production, baby hunger cues, foods to avoid, postpartum nutrition and more. Sign up for free at livehealthonline.com or on the mobile app.

MyHealth Advantage

MyHealth Advantage is a free service that helps keep you and your bank account healthier. Here's how it works: Anthem reviews your incoming health claims to see if they can save you any money. Anthem can check to see what medications you're taking and alert your doctor if they spot a potential drug interaction. Anthem also keeps track of your routine tests and checkups, reminding you to make these appointments by mailing you MyHealth Notes. MyHealth Notes summarize your recent claims. From time to time, Anthem offers tips to save you money on prescription drugs and other health care supplies.

NurseLine

You may have emergencies or questions for nurses around-the-clock. The NurseLine provides you with accurate health information any time of the day or night. Through one-on-one counseling with experienced nurses, you can make more informed decisions about the most appropriate and cost-effective use of health care services. A staff of experienced nurses is trained to address common health care concerns such as medical triage, education, access to health care, diet, social/family dynamics and mental health issues. The NurseLine is available 24 hours a day, seven days a week at 1.800.700.9184. Specifically, the 24/7 NurseLine features:

- A skilled clinical team – RN-licensed nurses who help *members* assess symptoms, understand medical conditions, ensure *members* receive the right care in the right setting and refer you to programs and tools appropriate to your condition
- Bilingual RNs, language line and hearing impaired services
- Access to the AudioHealth Library, containing hundreds of audiotapes on a wide variety of health topics
- Proactive callbacks within 24 to 48 hours for members referred to 911 emergency services, poison control and pediatric *members* with needs identified as either emergent or urgent and
- Referrals to relevant community resources.

Castlight Health Cost and Quality Transparency Tool

Quality and price for health care can be different depending on where you go and cost isn't necessarily related to the quality of care you can expect to receive. For example, if you need an MRI of the knee in DeKalb County, GA., the cost of a MRI from *network providers* ranges from $561 to $1,656. Unless you already have met your out-of-pocket maximum for the year, you will be paying at least a portion of the cost. Your choice of *providers* has a direct impact on your wallet.

Castlight Health, a confidential and personal health care transparency tool, lets you compare *network providers*, facilities, services and prescription medications based on quality, cost and convenience. Castlight Health, at mycastlight.com/assurant/, is available to employees and their eligible adult dependents enrolled in the Assurant Health Plan. It can help you make smart health care decisions for your family by:

- Comparing *network providers*, medical services and prescription drugs in your area based on the price you'll pay and quality of care other patients have received
- Seeing personalized cost estimates that take into account your Health Plan option and whether you've already met your deductible
- Reviewing step-by-step explanations of past medical spending so you know how much you paid and why and
- Receiving recommendations about ways to find high-quality care and save money.

Wellness Program Offerings

Assurant strives to offer employees sufficient resources to protect what matters most to you - your physical, emotional, social and financial well-being. You can take advantage of most of these wellness programs even if you're not enrolled in the Assurant Health Plan.

Coming Soon! A new well-being program will launch in early 2017. Our new program will provide enhanced resources to help us all be at our best, and ensure we can collectively outperform. Wellness incentives will be available for you to earn at that time.

◂Page
Page▸
Main Table of Contents
Chapter Table of Contents
◂◂Back

Prescription Drug Coverage

How the Prescription Drug Program Works 48
- Network-based Benefits 48
- Dispense as Written 48
- Prior Authorization Requirements 48
- Using a CVS Caremark Participating Retail Pharmacy without Your ID Card 49
- Important Information on Refills 49

Covered Expenses 49
- Preventive Medications 49
- Non-preventive Medications 50

Other Covered Expenses 50

Exclusions and Limitations 51

Programs and Services through CVS Caremark 52

Prescription Drug Coverage

Coverage for outpatient prescription drugs is administered by CVS Caremark. CVS Caremark is one of the largest providers of pharmacy benefits with more than 68,000 participating retail pharmacies nationwide. Most major drug chains and many small, independent pharmacies are part of the CVS Caremark network. They also provide mail order service for maintenance medications through their state-of-the-art facility in Mt. Prospect, Ill.

Most prescriptions drugs that are approved by the U.S. Food and Drug Administration (FDA) and prescribed to treat an illness or injury are covered under the Assurant Health Plan. To obtain information on medications, register on the CVS Caremark website at caremark.com. Click on Learn About Medications, then Drug Reference and Interactions.

The Assurant Health Plan pays benefits only for prescription drug expenses that are *medically necessary*.

◂Page
Page▸
Main Table of Contents
Chapter Table of Contents
◂◂Back

How the Prescription Drug Program Works

The Prescription Drug Program is part of Assurant's Health Plan. It shares a single deductible with your other covered expenses as shown on the Health Plan At-a-Glance chart.

Network-based Benefits

When you get your prescriptions from a network pharmacy, your costs are lower. Go to caremark.com to locate a network CVS Caremark pharmacy near you.

You must present your ID card to the network pharmacy every time you get a prescription filled to be eligible for network benefits. The network pharmacy will calculate your claim online. You will pay any deductible, if applicable and coinsurance directly to the pharmacy. You do not have to complete or submit claim forms. The pharmacy will take care of the claim submissions.

Using an out-of-network pharmacy is likely to cost you more money. You will be responsible for your usual share of the cost (50 percent up to $55 per script) plus the difference between the full retail price of the drug at the non-participating pharmacy and CVS Caremark's discounted price. Not only will you probably pay more when using an out-of-network pharmacy, but you will have to pay for your prescriptions up front, file the claim with CVS Caremark and wait for reimbursement.

Claim forms are available at caremark.com. You will then need to submit a claim form along with a copy of the detailed pharmacy receipt to CVS Caremark to receive reimbursement.

Dispense as Written

To encourage the use of cost-effective FDA-approved *generic* equivalents, Assurant's Health Plan includes "Dispense as Written" guidelines. When a prescribed brand-name drug has an FDA-approved generic equivalent, you will receive the generic equivalent unless your *physician* specifies "Dispense as Written" or "DAW" on the script.

If your *physician* does not specify DAW and you select the brand-name drug, you will pay your share of the cost plus the difference in price between the brand-name drug and the generic drug. You will never pay more than the actual cost of the brand-name drug, but you may pay more than the $55 maximum for retail prescriptions or the $110 maximum for mail order prescriptions.

Prior Authorization Requirements

Certain medications require *prior authorization* to be covered under the Plan. These medications are generally those that may have multiple uses and equally effective alternative therapies. Criteria may need to be assessed for the safety and effectiveness of these medications. You can find the current list of medications

requiring *prior authorization* in the Tools and Resources section of MyAssurantBenefits.com under Medications Requiring *Prior Authorization*.

If prior authorization is required, your pharmacist will notify your doctor that a prior authorization is needed. The doctor can call 800.626.3046 to provide information necessary for a *prior authorization*. Coverage for the prescribed medication will not be available until CVS Caremark has determined that the medication is eligible for coverage.

Using a CVS Caremark Participating Retail Pharmacy without Your ID Card

If you take your prescription to a CVS Caremark participating retail pharmacy and do not present your CVS Caremark ID card at the time of purchase and the pharmacy does not have your card on file, you may be required to pay 100 percent of the prescription price at purchase. Some retail pharmacies will rerun your card, reprocess the transaction and refund the difference between what you paid and the applicable coinsurance. However, you must request this within a specific period of time, usually 7 to 14 days after your purchase. The determination of whether to reprocess your transaction is at the discretion of the pharmacy. Ask your retail pharmacy for its policy.

If the retail pharmacy does not rerun your card, you must submit a claim form along with the original prescription receipt(s) to CVS Caremark. You can request a claim form from CVS Caremark, or you can print a claim form from the CVS Caremark website.

Note: A network pharmacy may refuse to fill a prescription order or refill when in the professional judgment of the pharmacist the prescription should not be filled.

Important Information on Refills

A prescription drug (retail and mail order) will not be refilled until the date when at least 50 percent of the supply could have been used as prescribed, with the exception of erectile dysfunction prescriptions, such as Viagra, Levitra and Cialis. For example, if you have a prescription for a 90-day supply plus two refills, a refill will not be covered until 45 days from the date the previous 90-day supply was filled.

Covered Expenses

Preventive Medications

Preventive drugs can help keep you healthy and prevent serious complications down the road. Regardless of which Health Plan option you elect the deductible does not apply to preventive medications. *Generic* preventive drugs are covered at 100 percent. However, if you take a *brand* preventive medication, you will pay 50 percent of the cost up to a maximum of $55 per prescription for a 30-day supply.
Preventive drugs for the following types of conditions will be covered if prescribed for a preventive purpose and purchased from a pharmacy in the CVS Caremark network:

- Coronary artery disease (e.g., Simvastatin, Zocor)
- Diabetes (e.g., Metformin Hcl, Glucotrol)
- Hypertension (e.g., Lisinopril, Atenolol, Toprol XL, Hydrochlorothiazide)
- Osteoporosis (e.g., Fortical, Fosamax)
- Pre-natal vitamins
- Respiratory disorders (e.g., Singulair)
- Smoking cessation (e.g., Zyban)
- Stroke (e.g., Warfarin, Coumadin, Lovenox)

For a complete list of covered preventive medications, please refer to the Preventive Drug List on MyAssurantBenefits.com.

Page
Page
Main Table of Contents
Chapter Table of Contents
Back

Non-preventive Medications

The cost of non-preventive medications will go toward your Health Plan deductible. After you meet the deductible, you will pay 50 percent of the cost of your prescription drugs up to a maximum of $55 per script, for a 30-day supply or $110 per script for a 90-day supply at mail order or at a CVS retail pharmacy.
Here are some examples of how the Plan pays for non-preventive drugs after your deductible is met:

- Example 1: If a 30-day supply of Synthroid 25 mcg costs $13, you will pay $6.50 (50 percent of $13) and the Plan will pay $6.50.
- Example 2: If a 30-day supply of Nexium 20 mg costs $183, you pay $55 (50 percent of $183, up to $55) and the Plan pays $128.

Note - Even before your deductible is met, you will get the benefit of the discounted rates CVS Caremark negotiates by using participating pharmacies.

If you are enrolled in the Blue Plan option and have enough funds in your Health Reimbursement Account (HRA) to cover your prescription costs, funds automatically will be deducted from your HRA to pay for any prescription claims you incur. If your HRA funds are exhausted, you will need to pay for these expenses out-of-pocket.

Other Covered Expenses

The following prescription drugs, medications and supplies also are covered under the Assurant Health Plan:

- Self-injectable drugs are covered at the network level of benefits only when dispensed through a network retail pharmacy or CVS Caremark's specialty pharmacy network. Go to caremark.com to review the list of self-injectable drugs. The list may be updated from time to time. Each prescription is limited to a maximum 30-day supply.
- Off-Label Use. FDA-approved prescription drugs may be covered when the off-label use of the drug has not been approved by the FDA for that indication. Coverage of off-label use of these drugs may be subject to requirements or limitations.
- Diabetic Supplies. The following diabetic supplies are covered if prescribed by a physician:
  - Diabetic needles and syringes
  - Blood glucose strips, keystone blood test strips, urine testing strips
  - Lancets/lancing devices
- Contraceptives. The following *generic* and single-source *brand* contraceptives and contraceptive devices are covered at 100 percent:
  - Oral contraceptives
  - Diaphragms, one per 365 consecutive-day period
  - Injectable contraceptives
  - Contraceptive patches
  - Contraceptive rings
  - Implantable contraceptives and IUDs are covered when obtained from a *physician*. However, your health care *provider* will purchase it directly from the distributor of the IUD. The distributor of the IUD will bill CVS Caremark directly. Your *physician* will provide insertion and removal of the drugs or device. If you have any questions please call CVS Caremark at 866.587.4799.
- Respiratory Prescription Devises

Note: You will be charged the out-of-network benefit for prescription drugs recently approved by the FDA, but which have not yet been reviewed by CVS Caremark.

A network pharmacy may refuse to fill a prescription order or refill when in the professional judgment of the pharmacist the prescription should not be filled.

◂Page
Page▸
Main Table of Contents
Chapter Table of Contents
◂◂Back

Exclusions and Limitations

Not all prescription drugs are covered, even if prescribed, recommended, or approved by your health care *provider*. Medicines, supplies and expenses that are not covered or have limited coverage include but are not limited to:

- Medicines otherwise covered under the Assurant Health Plan
- Medicines intended solely for cosmetic purposes, such as Latisse and Botox Cosmetic
- Self-care medicines and products (such as hand lotion)
- Any medicine not approved by the FDA to be lawfully marketed for the proposed use
- Any medicine that is not identified in the American Hospital Formulary Service Drug Information [AHFS] and Thomson MicroMedex as effective for the participant's diagnosed condition
- Medicines determined to be experimental or still under clinical investigation by health professionals. These are medications that have not been approved by the Food and Drug Administration (FDA) and are considered experimental and/or still under clinical review.
- *Over-the-counter* medicines, even if the medicine also is available by prescription (e.g., Tagament®, Claritin®, Zantac®, or Monistat®)
- Allergy serums, covered by Anthem
- Nutritional and diet supplements, including any supplements for newborn infants.
- Any medicine provided and entirely consumed at the time and place it is prescribed
- Prescription devices such as elastic bandages and supports, GI-GU ostomy and irrigation supplies; however, respiratory prescription devices are covered
- Vaccines and toxoids are not covered under the CVS Caremark Mail Service Program. However, eligible vaccines and toxoids are covered when the prescriptions are filled at retail pharmacies. See 2017 Preventive Services List in the Appendix for coverage details.
- Any medicine provided while the person is an inpatient or outpatient in any health care facility
- Any drug or medicine considered illegal under the Federal Food, Drug and Cosmetic Act, including, but not limited to, prescription drugs purchased in foreign countries for re-importation into the United States and prescription drugs purchased on the Internet from foreign countries. However, medicines purchased while on vacation in a foreign country due to an emergency medical condition may be covered. Call CVS Caremark if you have questions about coverage under these circumstances.
- Any supply with a National Drug Code (NDC) that is classified as a device, not a medicine except for Intrauterine Devices (IUDs).
- Fertility and *infertility* treatment prescription drug coverage in excess of the $5,000 lifetime maximum
- Any medicine determined by CVS Caremark to be not *medically necessary*
- Glucose monitors, tablets and other nonprescription diabetic supplies; Syringes are covered under the Plan and CVS Caremark provides glucose monitors and lancet devices free of charge. For more information and to see if you qualify, contact the CVS Caremark Diabetic Meter Team at 800.588.4456.
- Vitamins and supplements, except for prenatal vitamins
- Oral hematopoietic mixtures except for folic acid for women age 55 or less
- Oral *over-the-counter* (OTC) aspirin products except for individuals age 45 or older (with a prescription)
- Prescription and OTC (with prescription) iron supplementation products except for children ages 6 months to 12 months
- Prescription oral fluoride supplementation products prescribed by a *physician* except for children ages 5 and younger
- Prescription and OTC (with prescription) folic acid supplementation products, including prenatal vitamins containing folic acid except for women less than 55 years of age.
- Alcohol wipes
- Expenses for administration or injection of any medicine (may be covered by the Anthem BlueCross BlueShield)

◂Page
Page▸
Main Table of Contents
Chapter Table of Contents
◂◂Back

- Any prescription which exceeds the day supply limit per prescription or refill
- Any refill of a medicine exceeding the number of refills specified by the health care *provider*
- Any refill of a medicine more than one year after the latest prescription for the medicine or other than as permitted by the law of the jurisdiction in which the medicine is dispensed
- Medicines that do not meet *prior authorization* requirements, including but not limited to Lupron, growth hormone medications, anabolic medications, androgen medications and acne medications
- Retin A for participants 30 years of age and older
- Any Erectile Dysfunction (ED) medications exceeding 6 doses in a 30-day period or 18 doses per 90-day supply.

Contact CVS Caremark at 866.587.4799 if you have questions about whether a particular medication is covered by the Plan.

Programs and Services through CVS Caremark

Clinical Programs

CVS Caremark uses evidence-based resources from FDA-approved prescribing indications, consensus clinical prescribing guidelines and peer-reviewed studies to develop its clinical programs. These programs are designed to reduce unnecessary prescription drug use and to improve the quality of care and *member safety*. Specifics of these clinical programs are detailed below.

Note - As the *Claims Administrator* of the prescription drug benefit program, CVS Caremark may contact your provider regarding your prescription. This may result in your provider prescribing a different quantity, brand name product or a *generic* equivalent in place of your original prescription. No substitutions will be made by CVS Caremark without either written or verbal approval from your *provider*.

Specialty Guideline Management Program

Specialty drugs are often prescribed for various conditions including, but not limited to the following: asthma, Crohn's disease, cystic fibrosis, multiple sclerosis, oncology, rheumatoid arthritis and transplants. All specialty medications must be dispensed by CVS Caremark specialty pharmacies and will be denied through regular CVS Caremark national retail network pharmacies. CVS specialty pharmacies will work directly with you and your provider whenever a *specialty drug* is prescribed to ensure:

- You are on the right drug that is age-appropriate and effective for you
- The specialty drug is used properly
- Inappropriate utilization is avoided and
- Unsafe or ineffective therapies are discontinued in a timely manner.

In addition to providing the *specialty drugs*, personalized pharmacy care management services are available to you such as:

- Access to an on-call pharmacist 24 hours a day, seven days a week
- Coordination of care with you and your doctor
- Convenient delivery directly to you or your doctor's office

Specialty Preferred Drug Plan Design

Assurant has incorporated a special program feature, preferred *specialty drug* design, to help manage the cost of specialty drugs. This program designates preferred drugs within select therapeutic drug categories. When a non-preferred specialty drug is first prescribed, CVS Caremark will reach out to your prescribing *physician* to suggest switching to the preferred alternative. The preferred alternative offers the same therapeutic benefits at a lower cost.

Page
Page
Main Table of Contents
Chapter Table of Contents
Back

Online Medicine- and Disease-specific Education and Counseling

Disease-specific information is available through Caremark.com/specialty. This online supports includes interactive areas to submit questions to pharmacists and nurses.

Drug Savings Review Program

This program reviews claims to determine if the drugs are being prescribed appropriately for the condition, in the right dose, and to help ensure best treatment practices are being followed. CVS Caremark pharmacists will communicate with the prescribing *physician* if it determines that improvements can be made.

Enhanced Retrospective Review Program

This program reviews prescriptions for therapeutic duplication management, age-appropriate management and related concerns. The prescribing *physician* receives a patient-specific report identifying any clinical issues and suggestions for ways to improve.

◂Page
Page ▸
Main Table of Contents
Chapter Table of Contents
◂◂Back

Employee Assistance Program

Services Provided by New Directions 55

Accessing the EAP 55

Confidentiality 56

Employee Assistance Program (EAP)

Chances are we all will experience a personal problem at some point in our lives. Usually we can handle it ourselves, but sometimes we need help from a professional. The EAP is there when you need it most. Just call 800.624.5544, 24 hours a day, seven days a week.

Whether you have a problem that seems impossible to resolve yourself or you just need help in finding resources such as child or elder care, the EAP can help. When you call, you'll speak with licensed professionals in psychology, clinical social work and counseling.

Page
Page
Main Table of Contents
Chapter Table of Contents
Back

Services Provided by New Directions

EAP services are provided by New Directions. You can reach New Directions at 800.624.5544 or visit their website at ndbh.com. From the home page, under the "EAP Members" section, enter the company login code: Assurant.

The New Directions' website provides information on your EAP benefits along with mental health topics and articles designed to assist you in coping with life's many daily stressors.

Here are just a few of the kinds of issues the EAP may be able to help you with:

- Alcohol or drug abuse
- Child and elder care issues
- Depression
- Domestic violence
- Family issues
- Financial worries
- Legal problems
- Marital problems
- Stress

In addition to the counseling services, legal and financial referrals are available.

- Legal: An initial consultation with a local attorney at no cost. A discount of 25 percent is offered off the hourly rate if you decide to pursue the legal issue.
- Financial: Initial consultation by phone with a financial counselor on issues related to budgeting, taxes, debt consolidation or investing.

Accessing the EAP

You can receive a referral to an EAP counselor by contacting the EAP Call Center or by requesting a session through the website.

When you call, you will speak with a specially trained staff member. He or she will ask you what kind of problem you are having and will then assist you in scheduling an appointment with an EAP counselor. If you are in an immediate crisis when you call, you will be connected to a counselor right away.

The EAP also offers an online tool that will open an EAP session request and allow you to search for a provider. The tool is quick, easy to use and any information provided is kept confidential. After logging in to the EAP Member section, click the "Get Started" button under the Request an EAP session section.

The EAP provides up to six counseling sessions free of charge. If your problem requires longer treatment, your EAP counselor will help you find the best available resource in the community for dealing with your particular

situation. If you or your dependent is enrolled in the Assurant Health Plan, benefits for these services may be available under your coverage. Refer to the Health Plan section for additional information.

Confidentiality

The EAP is a confidential resource. Any contact you have with the EAP will not be revealed to anyone without your permission, except as required by law or as may be permitted by HIPAA for plan administration purposes.

Page
Page
Main Table of Contents
Chapter Table of Contents
Back

Dental Plan

Dental Plan 58

Dental Plan At-a-Glance 59

How the Plan Works 59

Special Provisions 60
- Lifetime of Smiles Program 60
- Missing Teeth Limitation 60
- Predetermination of Benefits 60
- Temporary Treatments 60
- Vision Services Plan (VSP) Discounts 60

Covered Expenses 61
- Preventive and Diagnostic Services 61
- Basic Services 61
- Major Services 62
- Orthodontic Services 63
- Treatment Plan 64
- If Coverage Ends In the Middle of Treatment 64

Exclusions and Limitations 64

Filing a Claim 65

Coordination of Benefits 66

Claim Appeals 66

Dental Plan

Assurant's Dental Plan emphasizes preventive and diagnostic care by covering regular checkups and preventive dentistry at 100 percent with no deductible. Dental care is administered by Assurant Employee Benefits and provided through a dental preferred provider organization – Assurant Dental Network (ADN) – that allows you to stay in the network or go outside of it.

The Plan pays benefits based on the negotiated fee if you use a *network provider* or on the *usual*, *customary* and *reasonable* fee for out-of-network care, as determined by Assurant Employee Benefits. To find a network provider near you, call ADN at 800.735.4226 or visit Online Advantage through Assurant Employee Benefits' website at assurantemployeebenefits.com and click on "For Members".

Services and treatments must be *dentally* or *medically necessary* and performed by a *qualified dental professional*.

Assurant Employee Benefits determines the usual, *customary and reasonable* charge for a covered out-of-network dental service based on the following criteria:

- The usual fee: The fee the qualified dental professional charges the majority of his or her patients for the same service.
- The customary charge: The fee charged for the same service by most other equally qualified professionals in the locality.
- The reasonable fee: The appropriate fee based on the complexity of the service, degree of skill required and any other pertinent factors. The reasonable fee applies if the service or supply is so unusual that Assurant Employee Benefits cannot determine the usual and customary charge for it.

Online Dental Resources

You can review dental and vision benefits, find a participating qualified dental professional and even check your dental claims status through Online Advantage.

Note: Dental ID cards are not mailed to members and are available only from Assurant Employee Benefits' website. You can access and print your ID online via Online Advantage at assurantemployeebenefits.com and click on "For Members". Your member ID card will list only your name, and it serves as the ID card for you and any covered dependents.

◂Page
Page ▸
Main Table of Contents
Chapter Table of Contents
◂◂Back

Dental Plan At-a-Glance

	In-Network	Out-of-Network[12]
Deductibles		
Employee-only	$50	$75
Employee & Family[13]	$100	$150
Coinsurance: The amount you pay after you meet your deductible.		
Preventive/diagnostic services[14]	0%	0%
Basic services (e.g., fillings, extractions, scaling and root planing)	20%	30%
Major services (e.g., dentures, bridges, gold inlays)	50%	60%
Orthodontic services[14]	50%	50%
Maximum Annual Benefit for Preventive/diagnostic, Basic and Major services	$1,500 per person combined in-network/out-of-network	
Maximum Lifetime Benefit for Orthodontia	$1,000 per person combined in-network/out-of-network	
Maximum Lifetime Benefit for Temporomandibular Joint (TMJ) Disease	$1,000 per person combined in-network /out-of-network	

[12] Out-of-network expenses are reimbursed up to the usual, customary and reasonable limits.

[13] Employee & Family coverage includes Employee plus Spouse or Domestic Partner and/or any number of children. Two enrolled family members must each meet an individual deductible in order to meet the family deductible.

[14] Deductible does not apply.

Page
Page
Main Table of Contents
Chapter Table of Contents
Back

How the Plan Works

Deductible

You must meet your annual deductible for covered basic and major services before the Plan begins to cover your costs. Preventive/diagnostic and orthodontic services are covered without having to meet the *deductible*.

The *deductible* for in-network services is $50 for Employee-only coverage and $100 for Family coverage. The *deductible* for out-of-network services is $75 for Employee-only coverage and $150 for Family coverage. Two enrolled family *members* must satisfy their individual *deductibles* before the deductible is satisfied for the whole family. So, if you and your spouse each satisfy the individual deductible of $50, your family deductible is met. But, if you satisfy your individual deductible and two of your dependents accumulate $25 each toward their individual deductibles, your family deductible is not yet met.

Coinsurance

Coinsurance is the percentage of covered expenses you pay once the deductible has been met. For example, basic services from a *network provider* are covered at 80 percent. You are responsible for the remaining 20 percent of expenses once your deductible has been met.

Maximum Benefits

The Plan pays a maximum benefit for all eligible dental expenses of $1,500 a calendar year for each covered *family member*.

There is a lifetime maximum benefit of $1,000 for orthodontic services for each covered *family member*. The benefit is reduced by any payments you or your covered dependents received for orthodontia under a prior Assurant benefits plan.

There is a lifetime maximum benefit of $1,000 for treatment of temporomandibular joint disorder (TMJ) treatment.

Special Provisions

Lifetime of Smiles Program

The Lifetime of Smiles Program covers genetic testing for susceptibility to oral disease, limited to one test per lifetime to eligible individuals over age 18.

The program also covers:

- Localized delivery of anti-microbial agents into diseased cervicular tissue. This is limited to one application per tooth in any 12-month period
- Brush biopsy.

Missing Teeth Limitation

The Plan will not pay benefits to replace a missing tooth/teeth that are missing on or before your or your dependent's coverage is effective under the Plan. If the Plan pays benefits for a natural tooth/teeth that is/are extracted while the Assurant coverage is in effect, it's possible that you may be eligible for benefits for a fixed bridge or removable denture. To determine the benefits, your *dentist* should complete and submit a predetermination of benefits form to the *Claims Administrator* for review.

Predetermination of Benefits

The Plan's predetermination of benefits provision allows you to find out ahead of time how much the plan will pay for a proposed course of dental treatment.

Before starting a course of dental treatment that is expected to cost $300 or more, it is recommended that you submit the charges to Assurant Employee Benefits, the *Claims Administrator*, for a predetermination of benefits. Follow the same procedure and use the same form that you would if you were filing a claim. Assurant Employee Benefits will write to both you and your dentist, letting you know how much the plan will pay if you are covered when the services are performed.

If there is a less expensive alternative treatment to the one your dentist proposes but which produces a professionally satisfactory result, the plan's reimbursement will be based on the cost of the alternative treatment. A predetermination of benefits will let you know whether:

- The services are covered expenses, and
- The charges are within usual, customary and reasonable allowances.

If there is a significant change in the treatment plan, you should request a new estimate.

Temporary Treatments

Temporary treatments are considered an integral part of the final treatment and the fees for these treatments will be combined to determine whether the charges are usual, reasonable and customary by Assurant Employee Benefits.

Vision Services Plan (VSP) Discounts

When you enroll in the Dental Plan, you and your covered dependents also will have access to vision discounts through VSP. VSP includes discounts on eye exams and eyeglasses, prescription sunglasses and other prescription eyewear when prescribed and provided by VSP doctors. There are no claim forms to fill out. You just have to identify yourself as a VSP member and provide the covered member's Social Security number when you make your appointment. For more details or to locate a VSP doctor near you, go to vsp.com, or call VSP at 800.877.7195.

◂Page
Page ▸
Main Table of Contents
Chapter Table of Contents
◂◂Back

Covered Expenses

The following dental treatments are covered when performed by a *qualified dental professional*:

Preventive and Diagnostic Services

- Oral exams – two per calendar year
- Dental prophylaxis – two per calendar year
- Intraoral complete series X-rays, including bitewings and either 10 to 14 periapical X-rays, or panoramic film, limited to one in any 60-month period
- Bitewing X-rays (two or four films) – limited to two times in a calendar year (if performed with 10 to 14 periapical X-rays or panoramic film, they will be considered an intraoral complete series X-ray)
- Intraoral periapical X-rays
- Intraoral occlusal X-rays – limited to once in any six-month period
- Other X-rays – excluding those related to orthodontic procedures or TMJ dysfunction
- Fluoride treatment – two times in a calendar year and limited to dependent children under the age of 16
- Sealants – limited to one time per tooth in any 36-month period and to children under the age of 16 on permanent molars
- Full mouth X-rays – limited to once in any 60-month period
- Space maintainers (including all adjustments made within six months) – limited to children under the age of 19.

You can receive up to four cleanings in 12 months. Regular cleanings are limited to two times in a calendar year and periodontal cleanings are limited to once every three months.

Basic Services

- Limited oral evaluation: Problem focused – covered only if no other treatment (except X-rays) is rendered during visit
- Examination and accession of tissue
- Stainless steel crowns are only covered for children under age 19 and are limited to once in a 36-month period and only on teeth not restorable by an amalgam or composite filling
- Pulpotomy
- Root canal therapy, includes pre-operative, operative and post-operative X-rays, bacteriologic cultures, diagnostic tests, local anesthesia and routine follow-up care (limited to once on the same tooth in any 24-month period)
- Apicoectomy / periradicular surgery (anterior, biscuspid, molar, each additional root), including all pre-operative, operative and postoperative X-rays, bacteriologic cultures, diagnostic tests, local anesthesia and routine follow-up care
- Retrograde filling – per root
- Root amputation – per root
- Hemisection, including any root removal and an allowance for local anesthesia and routine post-operative care; does not include a benefit for root canal therapy
- Periodontal scaling and root planning, limited to once per quadrant in any 24-month period
- Periodontal maintenance, covered one time every three months. Up to four cleanings (a combination of both regular and periodontal cleanings) in any 12-month period with regular cleanings limited to two in a calendar year and periodontal cleanings limited to once every three months
- Simple extraction
- Oral surgery, including an allowance for local anesthesia and routine post-operative care:
  - Surgical extractions (including extraction of wisdom teeth)
  - Alveoloplasty
  - Vestibuloplasty

Page
Page
Main Table of Contents
Chapter Table of Contents
Back

  - Removal of lateral exostosis-maxilla or mandible
  - Frenulectomy (frenectomy or frenotomy)
  - Excision of hyperplastic tissue per arch.
- Tooth re-implantation and/or stabilization of accidentally evulsed or displaced tooth and/or alveolus
- Extraction, erupted tooth or exposed root (elevation and/or forceps removal)
- Biopsy
- Brush biopsy
- Incision and drainage
- Palliative (emergency) treatment of dental pain considered for payment as a separate benefit only if no other treatment is rendered (except X-rays) during the visit
- General anesthesia and intravenous sedation when administered in the dentist's office or outpatient surgical center in conjunction with complex oral surgical services, which are covered only when medically necessary (as determined by Assurant Employee Benefits); benefits will be based on the benefit allowed for the corresponding intravenous sedation
- Consultations, only if not performed on the same day as the operative treatment
- Amalgam replacements limited to 12 months after the placement for children under age 19 and after 36 months for anyone age 19 or over. Multiple restorations on one surface will be considered a single filling; mesial-lingual-buccal (MLB) and distal-lingual-buccal (DLB) restorations will be considered single surface restorations
- Silicate and plastic restorations
- Composite restorations on both anterior and posterior teeth replacements limited to 12 months after the placement for children under age 19 and after 36 months for anyone age 19 or over; mesial-lingual, distal-lingual, mesial-buccal, and distal-buccal restorations on anterior teeth will be considered single surface restorations. Acid etch is not covered as a separate procedure
- Pin retention restorations – covered only in conjunction with amalgam or composite restorations; pins limited to one time per tooth
- Therapeutic drug injections.

Major Services

All major services include an allowance for all temporary restorations and appliances and one-year follow-up care. The following major services are covered if performed by a *qualified dental professional*:

- Inlays, onlays and crowns – covered when the tooth cannot be restored by an amalgam or composite filling and the person is at least age 16
- Porcelain crowns on both anterior and posterior teeth (once every seven years)
- Repairs, adjustments and replacement of inlays, onlays and crowns; repairs and adjustments are limited to once in any 12-month period and to more than 12 months after insertion; replacements are not covered unless seven years have elapsed since the last placement
- Recementing inlays, onlays, crowns and bridges
- Crown build-up, including pins and prefabricated posts
- Post and core, covered only for endodontically treated teeth requiring crowns
- Periodontal surgery, limited to once per quadrant in any 36-month period; limitation applies to gingivectomy, gingival curretage, mucogingival surgery
- Osseous surgery
- Osseous grafts
- Pedicle grafts
- Periodontal appliances (one appliance in any 12-month period)
- Endodontic endosseous implant and endosseous implant
- Replacement of implants – not covered unless seven years have elapsed since the last placement and the existing implant cannot be made serviceable

◂Page
Page ▸
Main Table of Contents
Chapter Table of Contents
◂◂Back

- Full dentures, does not include benefits for personalized dentures or overdentures or associated treatment. The initial placement of full dentures will be considered a covered service if the placement includes the initial replacement of a functioning natural tooth extracted while the person was covered, and the extracted tooth was not an abutment to an existing prosthesis. The plan will not pay for any denture until it is accepted by the patient.
- Partial dentures, including additional clasp and rest; does not include benefits for precision or semi-precision attachments; the initial placement of partial dentures will be considered a covered eligible expense if the placement includes the initial replacement of a functioning natural tooth extracted while the covered person was covered, and the extracted tooth was not an abutment to an existing prosthesis (once every seven years)
- Relining or rebasing dentures, limited to one time in any 36-month period and more than 12 months after the initial insertion of the denture
- Repairs, adjustments and replacement of full dentures and partial dentures; repairs and adjustments are limited to once in any 12-month period and to more than 12 months after insertion. Replacements are not covered unless seven years have elapsed since the last placement and the denture cannot be made serviceable. Partial dentures less than seven years old will be covered if replacement is necessary due to the extraction of an additional functioning natural tooth.
- Tissue conditioning, limited to repairs or adjustment performed more than 12 months after the initial insertion of the denture
- Fixed bridges (including Maryland Bridges), covered for a person who is at least 17 years old; the initial placement of fixed bridges will be considered a covered service if the placement includes the initial replacement of a functioning natural tooth extracted while the person was covered, and the extracted tooth was not an abutment to an existing prosthesis
- Repairs, adjustments and replacement of fixed bridges; repairs and adjustments are limited to once in any 12-month period and to more than 12 months after initial insertion. Replacements are not covered unless seven years have elapsed since the last placement and the bridge cannot be made serviceable. Bridges less than seven years old will be eligible for consideration if replacement is needed due to the extraction of a functioning natural tooth immediately adjacent to the existing bridge. Fixed bridges re placing an extracted portion of a hemisected tooth are not covered.
- Non-surgical temporomandibular joint (TMJ) orthodontia. Treatment for myofascial pain syndrome, muscular, neural, or skeletal disorder, dysfunction or disease of the temporomandibular joint including treatment of the chewing muscles to relieve pain or muscle spasm, TMJ X-rays, and occlusal adjustments; coverage does not include an allowance for appliances for tooth movement or guidance, electronic diagnostic modalities, occlusal analysis, or muscle testing.

Orthodontic Services

Orthodontic Services include the following:

- Initial consultation
- Moldings and impressions, including cephalometric X-rays
- Surgical exposure of an impacted tooth, limited to services performed for orthodontic purposes
- Installation of braces
- Monthly visits and
- Fixed or removable appliances to correct harmful habits.

No payment will be made for orthodontic treatment if the appliances or bands are inserted before coverage is effective. The Plan considers orthodontic treatment to be started on the date the bands or appliances are inserted. Any other orthodontic treatment done the same day is considered to be started and completed the day the treatment is received. Note that space maintainers are covered as a preventive service, not as an orthodontic expense.

Page
Page
Main Table of Contents
Chapter Table of Contents
Back

Benefit payments for orthodontia are made over the full course of treatment, as follows:

- An initial examination fee
- An installation fee
- Monthly or quarterly installments (based on fees for three monthly visits), depending on how services are billed.

Benefits will not be paid for more than three monthly visits at a time, unless submitted after the services have been rendered.

Treatment Plan

Treatment is considered to be started when:

- For a full or partial denture, the date the first impression is taken
- For a fixed bridge, crown, inlay and onlay, the date the teeth are first prepared
- For root canal therapy, on the date the pulp chamber is first opened
- For periodontal surgery, the date the surgery is performed
- For all other treatment, the date treatment is rendered.

Treatment is considered to be completed when:

- For a full or partial denture, the date the final completed appliance is first inserted in the mouth
- For a fixed bridge, crown, inlay and onlay, the date an appliance is cemented in place
- For root canal therapy, the date a canal is permanently filled.

If Coverage Ends In the Middle of Treatment

If you've begun a course of dental treatment and your coverage ends before the treatment is complete, the Plan will pay benefits for completing preventive/ diagnostic, basic and major services for 30 days from the date your coverage ends. If you are in the middle of orthodontic treatment when your coverage ends, the Plan will pay benefits through the quarterly installment that is due as of the day your coverage ends.

Exclusions and Limitations

The following is a list of expenses that are not covered under the Dental Plan:

- Treatments not included in the list of covered expenses and/or services
- Treatments that are not dentally or medically necessary, as determined by Assurant Employee Benefits
- Services that are experimental in nature, as determined by Assurant Employee Benefits
- Services that do not have uniform professional endorsement
- Treatments that were neither started nor completed while the person is covered under this Plan, except as otherwise noted
- Appliances in which the sole or primary purpose relates to:
  - The change or maintenance of vertical dimensions
  - The alteration or restoration of occlusion except for occlusal adjustment in conjunction with periodontal surgery or temporomandibular joint disorder (TMJ)
  - Bite registration
  - Bite analysis
- Replacing a lost or stolen appliance
- Educational procedures, including oral hygiene, plaque control or dietary instructions
- Completing claim forms or missed dental appointments
- Personal supplies or equipment, including WaterPiks, toothbrushes, or floss holders
- Treatment for a jaw fracture
- Services provided by an immediate family member or an employee of the Company; immediate family members include your *spouse*, domestic partner, parents, children, brothers, sisters, anyone who resides in your home, your spouse's or domestic partner's parents, children and siblings

◂Page
Page ▸
Main Table of Contents
Chapter Table of Contents
◂◂Back

- Treatment covered under any other plan sponsored by the Company that provides group hospital, surgical, dental or medical benefits
- *Hospital* or facility charges for a room, supplies or emergency room expenses or routine chest X-rays and medical exams before oral surgery
- Services performed outside the United States except for emergency dental treatment, as determined by the *Claims Administrator*. The maximum benefit payable to any person during a plan year for covered dental expenses related to emergency dental care performed outside the United States is $100.
- Treatments covered under *workers' compensation* or similar laws
- To the extent permitted by law, treatments that are reimbursable by a plan of any governmental agency, including *Medicare*
- Treatments provided primarily for cosmetic purposes, such as teeth whitening or bleaching
- Treatments which may not reasonably be expected to successfully correct the person's dental condition for a period of at least three years, as determined by Assurant Employee Benefits
- Bacteriological studies
- Provisional splinting
- Excision of pericoronal tissues
- Claims received by Assurant Employee Benefits more than one year after expenses were incurred.

◂Page
Page ▸
Main Table of Contents
Chapter Table of Contents
◂◂Back

Filing a Claim

A claim is a request for dental benefits. Eligibility inquiries, general benefit inquiries and requests for a pre-authorization when not required will not be treated as claims for benefits. To file a claim, you must complete an Employee Dental Claim Statement, available at assurantemployeebenefits.com Send the completed forms to:

Assurant Employee Benefits
P.O. Box 2943
Clinton, IA 52733-2943

Include your Social Security number and use a separate form for each family member. Indicate whether you want payment made to you or directly to your dentist.

Expenses submitted to the *Claims Administrator* must identify the treatment performed in terms of the American Dental Association Uniform Code on Dental Procedures and Nomenclature or by narrative description. Assurant Employee Benefits reserves the right to request X-rays, narratives and other diagnostic information, as it deems necessary to determine benefits.

Claims must be received by Assurant Employee Benefits within one year of the date the services are performed. Any claims submitted beyond one year from the date of service are not eligible for reimbursement.

Submitting the Dentist's Bill

You can attach itemized bills or have your dentist complete the *provider's* statement section of the form. Whichever manner you choose, all of the following information must be provided:

- Patient's full name, date of birth and relationship to you
- Dentist's name, address and tax identification number
- Diagnosis
- Date and charge for each service.

Overpayment

If a benefit is paid and it's later shown that a lesser amount should have been paid, the Plan will be entitled to a refund of the excess amount from you or your *provider*.

Coordination of Benefits

The Dental Plan has a coordination of benefits (COB) provision that is designed to prevent duplication of benefits when you or an enrolled dependent is covered for dental benefits under more than one group plan. The following is a summary of these rules:

- A benefit plan without a COB provision will pay benefits before a plan that contains such a provision.
- The plan that covers the person as an employee pays benefits before the plan that covers the person as a dependent. For example, the Assurant Dental Plan is the primary carrier for your expenses. Your spouse's plan is primary for his/her expenses.
- The plan of the parent born earlier in the year is the primary carrier for a dependent child. In the case of a divorce or separation, the plan of the parent with custody is the primary plan, unless a court decree names one parent responsible for providing dental coverage.
- If the above rules do not establish a primary plan, then the plan that has covered the person longer is primary.

If the Assurant Dental Plan pays second, it pays an adjusted benefit that, combined with the benefit payable from the primary plan, equals up to 100 percent of covered dental expenses.

Claim Appeals

If your claim is denied in whole or in part, you can request an appeal. Refer to Claim Appeals for an explanation of the procedures and time frames to file an appeal.

◂Page
Page ▸
Main Table of Contents
Chapter Table of Contents
◂◂Back

Flexible Spending Accounts

How the Plan Works 68

Electing Coverage 69
- Initial Eligibility Period 69
- Mid-year Changes 69
- Annual Enrollment 69

Health Care Flexible Spending Accounts (FSAs) 69
- Eligible Dependents under a Health Care FSA 69
- Your Pre-tax Contributions to a Health Care FSA 70
- General Purpose Health Care FSA 70
- Dual Purpose Expenses 70
- Special Rule for Orthodontic Treatment Benefits 71
- Stockpiling 72
- Exclusions under the General Purpose FSA 72

Limited Purpose Health Care FSA 73
- Eligible Expenses under a Limited Purpose FSA 74
- Special Rules under the Limited Purpose Health Care FSA 74
- Exclusions under the Limited Purpose Health Care FSA 74

Dependent Day Care Flexible Spending Account (FSA) 74
- Your Pre-tax Dependent Day Care FSA Contributions 74
- Eligible Dependents under the Dependent Day Care FSA 75
- Eligible Dependent Day Care Expenses 75
- Exclusions under a Dependent Day Care FSA 76

Filing a Claim 76
- Health Care FSA 76
- Dependent Day Care FSA 76
- When Payments Are Made 77

Appealing a Claim 77

When Participation Ends 77

Forfeitures 77

Flexible Spending Accounts

Assurant provides you with the opportunity to participate in its Health Care and/or Dependent Day Care Flexible Spending Account using pre-tax dollars. Your contributions to these accounts are withheld on a pre-tax basis, meaning FSA contributions are deducted from your salary before your federal and Social Security taxes are determined. Eligible expenses for health care and child/elder care can be reimbursed to you through the account.

There are three types of FSAs:

- The General Purpose Health Care FSA
- The Limited Purpose Health Care FSA
- The Dependent Day Care FSA

Your Health Plan election determines the Health Care FSA for which you are eligible. If you enroll in the Blue Health Plan option, you can elect the General Purpose Health Care FSA. If you enroll in either the Green or Orange Health Plan option, you can elect the Limited Purpose Health Care FSA.

It is important to estimate your FSA contributions carefully. According to Internal Revenue Service (IRS) regulations, any amounts that you contribute but do not use before the end of the calendar year are forfeited. If you want help estimating your eligible expenses, worksheets are available on MyAssurantBenefits.com.

◂Page
Page ▸
Main Table of Contents
Chapter Table of Contents
◂◂Back

How the Plan Works

Your FSA contributions are made on a pre-tax basis, which reduces your taxable income. You do not pay federal income or Social Security taxes on your FSA contributions.

The table below provides estimated tax savings, depending on the percentage of your income you pay in federal income taxes – your tax bracket. Two tax bracket examples are given: 15 percent and 25 percent. Your savings may be higher if you are in a higher tax bracket. State income tax savings, if any, are not included.

Amount you contribute to an FSA	Tax savings if you are in a 15% tax bracket	Tax savings if you are in a 25% tax bracket
$600	$136	$196
$1000	$223	$326
$1,200	$272	$392
$2,400	$544	$784
$5,000	$1,132	$1,632

– Tax savings = federal income tax plus 7.65 percent in Social Security taxes.

– Figures in table are rounded and assume you pay Social Security taxes on your entire income.

This may mean that your Social Security benefits at retirement, death or disability may be reduced.

Check with your tax advisor to determine how your state and local taxes may be affected by your participation in a FSA.

The Internal Revenue Service requires Assurant to report amounts contributed to a Dependent Day Care FSA. These amounts will appear on your Form W-2.

Electing Coverage

Initial Eligibility Period

To participate in the Health Care and/or the Dependent Day Care Flexible Spending Accounts, you must make your election during your initial eight-day eligibility period.

Mid-year Changes

The IRS does not allow you to change your FSA deductions during the year unless you experience a qualified life event. Changes you make due to a life event must be consistent with that life event and reported to HR Services within 30 days of the life event. You can change your elections by calling HR Services at 866.324.6513.

Only eligible expenses incurred while a person is a spouse or eligible dependent under the Health Care or Dependent Care FSA Plan are eligible for reimbursement. For example, if you get married on June 1st, you may increase your contributions to your Health Care FSA, however only the expenses your spouse incurs on or after June 1st are eligible for reimbursement.

You cannot decrease your contribution to a FSA below the amount for which you have already been reimbursed for that year.

See Qualified Life Events for more information.

Annual Enrollment

Annual Enrollment (actual dates each year will be communicated on the intranet) is the time each year when you elect to participate in the FSA for the following year. If you want to participate, you must make an election; elections do not carry over from year-to-year. If elected during Annual Enrollment, your participation is effective January 1 of the following year.

Estimate your expenses carefully before enrolling in a FSA. Here are some important things to consider:

- If you enroll in the Green or Orange Plan option, your only Health Care FSA option is a Limited Purpose Health Care FSA and it can reimburse only eligible dental and vision expenses. (Your HSA that is associated with the Green or Orange Plan option can reimburse eligible medical and prescription drug expenses.)
- If you enroll in the Blue Plan option, your Health Care FSA is a General Purpose Health Care FSA. It can reimburse you for eligible medical, prescription drug, dental and vision expenses that are not paid from another source (e.g., another medical or dental plan). Note: the Blue Plan option comes with a Health Reimbursement Account (HRA), funded by Assurant. Eligible out-of-pocket health care expenses automatically will be reimbursed first from your HRA until its funds are exhausted. If you have eligible out-of-pocket expenses remaining after the HRA reimbursement, they can be submitted to your General Purpose Health Care FSA.
- If you put more money in your FSA than you can claim in expenses, you will forfeit the remaining balance. Use it or lose it.
- You cannot transfer money from one account to the other (e.g., from the Health Care FSA to the Dependent Day Care FSA).
- You cannot carry a balance in your FSA from one year to the next. Use it or lose it.

Health Care Flexible Spending Accounts (FSAs)

Eligible Dependents under a Health Care FSA

You can be reimbursed for your eligible dependent's out-of-pocket health care costs, even if you do not cover him/her under the Assurant Health Plan.

Eligible dependents under a General Purpose or Limited Purpose Health Care FSA are:

◂Page
Page ▸
Main Table of Contents
Chapter Table of Contents
◂◂Back

- Your legal *spouse* (as determined by state law)
- Any other individual who qualifies as your tax dependent. This includes a child of divorced or legally separated parents, regardless of which parent is entitled to claim the dependent exemption, so long as the child lives with one or both of the parents and over half of the child's support is provided by the parents
- Your dependent children required to be covered under a *qualified medical child support order*.

By submitting a request for reimbursement for an expense incurred on behalf of an individual other than your *spouse*, you are certifying that the individual is your eligible dependent.

Expenses for your domestic partner and his or her children are not eligible for reimbursement under the Flexible Spending Accounts.

◂Page
Page ▸
Main Table of Contents
Chapter Table of Contents
◂◂Back

Your Pre-tax Contributions to a Health Care FSA

The minimum annual contribution, regardless of your date of hire, is $600. The maximum annual contribution to a Health Care Flexible Spending Account is $2,550 in 2017.

General Purpose Health Care FSA

A General Purpose Health Care Flexible Spending Account is only available to employees who enroll in Blue Plan option or who waive coverage under the Assurant Health Plan

Eligible Expenses under the General Purpose FSA

Note: Expenses eligible for reimbursement under the Assurant Health Care Flexible Spending Accounts may differ from the IRS publications.

The following expenses are reimbursable under the General Purpose Health Care FSA:

- Deductibles and coinsurance under medical, dental, or vision plans
- Expenses that exceed annual or lifetime limits under medical, dental, or vision plans
- Eyeglasses and contact lenses
- Hearing aids and hearing aid batteries
- Laser eye surgery/intraocular lens implants
- Certain weight-loss programs relating to the diagnosis of clinical obesity (a letter of medical necessity will be required)
- Smoking-cessation programs (e.g., SmokEnders; a letter of medical necessity will be required)
- Acupuncture
- Breast pumps and lactation supplies and
- Over-the-counter medications that are prescribed by your physician and insulin (with or without a prescription).

Dual Purpose Expenses

Certain expenses have both a medical purpose and a general health, personal or cosmetic purpose. These expenses are called "dual purpose" expenses. In order to be reimbursed under the Health Care FSA, claims for a dual purpose expense must be accompanied by a letter of medical necessity from the physician.This letter should state that the dual purpose expense is to treat a specific medical condition that the covered person has. For example, if your doctor recommends you use a treadmill to treat your cardiac condition, the expense may be eligible for reimbursement.

The following is a list of items that are considered dual purpose and that will require you to provide a letter of medical necessity from your doctor:

- Nasal strips
- Nutritionist professional expenses
- Exercise equipment or machines

- Personal trainer fees if used to treat a specific condition
- Propecia (not for male-pattern baldness)
- Retin A (not if purchased for cosmetic purposes even if physician recommended)
- Rubdown/Massage Therapy
- Sunscreen
- Transportation someone other than the person receiving medical care, in connection with a transplant situation
- Treadmill
- Weight-loss programs
- Lodging that is not a hospital or similar institution in connection with an Anthem *Center of Excellence*
- Lodging of a companion in connection with an Anthem *Center of Excellence*

Page
Page
Main Table of Contents
Chapter Table of Contents
Back

Special Rule for Orthodontic Treatment Benefits

IRS regulations prohibit Flexible Spending Accounts from reimbursing expenses before the services are actually performed. This creates a challenge when seeking reimbursement for certain types of expenses, such as orthodontia, where it is common practice for the orthodontist to require payment "up front" for his/her services. If you prepay the bill or a portion of the bill, the Plan only can reimburse you initially for the amount you prepaid up to a maximum of 25 percent of the total cost of treatment. Your remaining reimbursement will be paid out on a monthly basis based on your total cost, your expected insurance and the expected length of treatment.

You should file just one orthodontic claim for the entire plan year, and you are responsible for paying your provider when payments are due. Dates of service will be considered to be the first of the month and reimbursement payments will be generated to you each month automatically. A new claim form must be submitted for each plan year that you elect to participate. Unless the treatment begins in January of the plan year, the payments will be pro-rated for the first year.

When submitting your request for reimbursement, you must submit a completed Orthodontia Form located on MyAssurantBenefits.com.

You also can submit your orthodontia contract from your service *provider* as long as it contains all the required information as requested on the Orthodontia Form. Reimbursement cannot be made without one of these completed documents.

Following are two common examples:

Example 1:

Your orthodontist charges $5,000 for the course of treatment. The Dental Plan has a maximum lifetime orthodontic benefit of $1,000, and you elected to contribute $4,000 to your FSA for the year. You pay the orthodontist a $500 initial payment. The treatment is expected to last about 30 months. The table below shows how the FSA reimbursement would be determined:

Orthodontist's total charge	$5,000
Less benefit available under the Dental Plan	($1,000)
Your responsibility	$4,000
Your prepayment	$500
Estimated length of treatment	30 months
Initial reimbursement from FSA	$500
FSA balance remaining after initial reimbursement	$3,500
FSA monthly reimbursement ($3,500/30)	$116.67

Reimbursement of the $500 initial payment payment would be reimbursed in full, as it is less than 25 percent of the total cost. The remaining reimbursement would be made in monthly installments of $116.67.

Example 2:

Your orthodontist charges $5,000 for the course of treatment. Your Dental Plan has a $1,000 lifetime orthodontic benefit, and you elected to contribute $4,000 to your FSA for the year.. The estimated course of treatment is 30 months. You pay the dentist in full, at the time of the initial treatment.

Orthodontist's total charge	$5,000
Less benefit available under the Dental Plan	$1,000
Your responsibility	$4,000
Your prepayment	$4,000
Estimated length of treatment:	30 months
Initial reimbursement from FSA	$1,000
FSA balance remaining after initial reimbursement	$3,000
FSA monthly reimbursement ($3,000/30):	$100

You would be reimbursed for up to 25 percent of your initial payment, or $1,000. The remaining reimbursement would be made in monthly installments of $100.00.

Stockpiling

Stockpiling, which is the purchasing of large quantities of eligible medical items in effort to exhaust FSA funds, is prohibited by the IRS. In order to prevent stockpiling, Assurant will reimburse only two bottles of any eligible prescribed OTC medication per month. If reimbursement is requested for three or more bottles, you will need to provide a doctor's note indicating the medical necessity for the additional bottles. Remember: Any OTC medications must be prescribed by a physician in order to be eligible for reimbursement.

Exclusions under the General Purpose FSA

In general, you cannot use a General Purpose Health Care FSA to pay for:

- Expenses reimbursable under other benefit or insurance plans including Medicare and Medicaid
- Expenses incurred while a person is not covered under the Health Care FSA
- Expenses incurred during a leave of absence in which you elect to stop contributions to the Health Care FSA or fail to make required contributions
- Non-prescription drugs (e.g., Lamisil, Monistat, Advil, Prilosec, Mucinex and Benedryl), dietary supplements, vitamins and health aids other than those specified in the Covered Expenses section
- Cosmetic procedures (including teeth-whitening)
- Weight-loss programs unless prescribed by a doctor to treat a diagnosis of clinical obesity
- Expenses incurred for long-term care services and
- Anti-baldness drugs for balding due to age.

In addition, the following list of dual purpose items are ineligible for reimbursement under the General Purpose Health Care FSA:

- Air conditioners
- Air purifiers
- Allergy treatment products; household improvements to treat allergies (e.g., air purifiers)
- Automobile modifications
- Behavioral modification – unless covered under the Health Plan
- Birthing classes
- Cayenne pepper
- Chondroitin
- Cold/hot packs

Page
Page
Main Table of Contents
Chapter Table of Contents
Back

- Dancing lessons
- DNA collection and storage
- Dyslexia (language training, school fees) – unless covered by the Health Plan; must be diagnosed by a *physician*
- Ear plugs
- Eggs and embryo storage fees
- Elevator installation expenses
- Fiber supplements
- Fitness programs
- Foods
- Glucosamine
- Herbs
- Holistic or natural healers, dietary substitutes, drugs and medications
- Home improvements (e.g., ramps)
- Inclinators
- Lactation consultant
- Language training (*disabled* or dyslexic child)
- Lead-based paint removal
- Legal fees, general (bears a direct or proximate relationship to the provision of medical care)
- Legal fees in connection with fertility treatments
- Mastectomy-related bras
- Medical conference, admission, transportation, meals
- Orthopedic shoes and inserts
- Rogaine
- Rubbing alcohol
- Schools and education related to a *behavioral health* treatment facility
- Schools and education, special (resources are used to relieve a disability)
- Special foods
- Sperm storage fees (only to the extent necessary for immediate conception)
- St. John's Wort
- Stem cell harvesting and or storage
- Student health fees
- Swimming lessons
- Swimming pool maintenance
- Transportation to and from a medical conference
- Tuition for special needs program (primarily for medical care)
- Umbilical cord freezing and storage.

Page
Page
Main Table of Contents
Chapter Table of Contents
Back

Limited Purpose Health Care FSA

IRS rules allow you to contribute to a Health Savings Account (HSA) if you are covered under a high *deductible* health plan (HDHP) – a health plan with a minimum annual *deductible* in 2017 of $1,300 for individual and $2,600 for family – and you are not covered under any other health plan that is not a HDHP. A General Purpose FSA, that can provide first dollar coverage of health expenses, is not a HDHP. The Green and Orange Plan options are considered high *deductible* health plans. Therefore, if you enroll in either the Green or Orange Plan option that automatically come with a Health Savings Account, you cannot participate in a General Purpose FSA.

That is why we offer a Limited Purpose Health Care FSA to employees who enroll in the Green and Orange Plan options. A Limited Purpose Health Care FSA allows you to fund your out-of-pocket dental, LASIK surgery and vision hardware expenses on a pre-tax basis. You cannot be reimbursed for any medical or prescription expenses from the Limited Purpose Health Care FSA.

Eligible Expenses under a Limited Purpose FSA

Eligible expenses include:

- Deductibles, coinsurance and copays under a dental or vision plan
- Amounts that exceed either the annual or lifetime maximum benefit under a dental or vision plan (e.g., orthodontia)
- Prescription glasses and contact lenses and
- Lasik eye surgery.

Special Rules under the Limited Purpose Health Care FSA

The rules regarding reimbursement of orthodontia expenses and stockpiling outlined under the General Purpose Health Care FSA also apply to the Limited Purpose Health Care FSA.

Exclusions under the Limited Purpose Health Care FSA

Exclusions under the Limited Purpose Health Care FSA include all the exclusions outlined under the General Purpose FSA, plus the following items and services:

- Medical expenses, including deductibles, co-insurance, and co-pays
- Insurance premiums
- Prescription medicines
- *Over-the-counter* medicines and items

◂Page
Page▸
Main Table of Contents
Chapter Table of Contents
◂◂Back

Dependent Day Care Flexible Spending Account (FSA)

You can contribute pre-tax dollars to the Dependent Day Care FSA to help pay for eligible child and elder care services needed so you (and your *spouse*, if married) can work or look for a job. You also can contribute to a Dependent Day Care FSA if your *spouse* is a *full time student* or *disabled* and unable to care for your children.

You can contribute up to $5,000[15] per calendar year if you are:

- Single and file as head of household
- Married and file a joint income tax return or
- Married but your *spouse* maintained a separate residence for the last six months of the calendar year, you file a separate tax return and you furnish more than one-half the cost of maintaining your eligible dependents.

If you and your *spouse* reside together, but file separate federal income tax returns, you can each contribute up to $2,500. The minimum annual contribution, regardless of date of hire, is $650.

If you are married, dependent day care expenses are eligible for reimbursement if the care enables your spouse to work or go to school full-time.

Your Pre-tax Dependent Day Care FSA Contributions

Your contributions are deducted from your pay on a pre-tax basis. The minimum contribution per pay period is $25 (for a total of $650 if you participate for the full year). Generally, the maximum contribution is $192.31 per pay period (for a total of $5,000 if you participate for the full year). However, your maximum depends on a variety of factors including:

- Your tax-filing status
- Whether your *spouse* participates in a dependent care FSA through his/her employer
- Your *spouse*'s income and
- The number of eligible dependents.

[15] Pre-tax contributions for highly compensated employees (HCEs) are limited by IRS regulation. If this impacts you, you will be contacted by HR Services. Estimated maximum for HCEs is available on MyAssurantBenefits.com.

If you are married and file a joint income tax return, your maximum annual contribution is the lesser of your earnings or your *spouse*'s earnings, up to $5,000. If your *spouse* does not work but is either disabled or a *full-time student*, the IRS considers your *spouse*'s income to be:

- $250 a month if you have one eligible dependent and
- $500 a month if you have more than one eligible dependent.

When using this formula to calculate your *spouse*'s earnings, you can only count the months during which your *spouse* is actually attending school or is *disabled*. For example, if your spouse is a *full-time student* for five months and you have one eligible dependent, the IRS considers your *spouse*'s annual earnings to be $1,250 ($250 times five months). So the maximum you can contribute to your Dependent Day Care FSA for the year is $1,250.

The Internal Revenue Service imposes a combined family maximum from all dependent day care FSAs of $5,000 even if both of your and your *spouse*'s employers have such plans.

If your *spouse* loses his or her job and is not actively seeking employment, generally you are not eligible to participate in the Dependent Day Care FSA. In this case, contact HR Services immediately to stop the deductions from your paycheck.

Before you enroll, you also may want to consider whether the federal dependent care tax credit might provide you with a greater tax advantage.

If you are a part-time employee participating in the Dependent Day Care FSA, you will be asked to certify that you are only requesting reimbursement for expenses that enabled you to work.

Eligible Dependents under the Dependent Day Care FSA

Under IRS regulations, eligible dependents for the Dependent Day Care FSA include the following if they reside with you:

- A tax dependent who is under age 13
- Any other tax dependent of yours, such as an elderly parent, who is physically or mentally incapable of self-care and
- A *spouse* who is physically or mentally incapable of self-care.

Note: This definition of a dependent is different from the definitions in other Assurant Benefit Plans including the Health Care FSA.

Eligible Dependent Day Care Expenses

Eligible expenses are those incurred for the care of an eligible dependent if they allow you and your *spouse* to be employed, look for work or attend school on a full-time basis. They must be incurred while the dependent meets the definition of an eligible dependent (See Eligible Dependents under the Dependent Day Care FSA) and you participate in the Dependent Day Care FSA. Eligible expenses under the Assurant Dependent Day Care Flexible Spending Account include:

- Nursery school, pre-school or similar programs below the kindergarten level
- Day care centers for children or dependent adults that provide care for more than six nonresident individuals on a regular basis and comply with all applicable state and local laws (does not include kindergarten tuition)
- Before-school or after-school care for eligible children from kindergarten up to and including age 12
- Summer day camp or other summer programs (but not overnight camp or tutoring programs) used in lieu of regular dependent day care
  - Day camps must be attended by your eligible dependents for at least five consecutive days and during your normal working hours

◂Page
Page▸
Main Table of Contents
Chapter Table of Contents
◂◂Back

- A housekeeper inside your home whose duties include household services related to taking care of an eligible dependent
- Home caregiver such as a governess, au pair or nanny
- Social Security and other taxes you pay on behalf of a provider of care.

Exclusions under a Dependent Day Care FSA

The following expenses are not eligible:

- Dependent day care services provided inside or outside your home by:
  - Your *spouse*
  - The parent of the dependent
  - Your child under age 19 or
  - Anyone who is your dependent for federal income tax purposes.
- Food, clothing and *education expenses* (including expenses for kindergarten)
- Transportation between your home and the place where care is provided, except when it is provided by the facility
- Overnight or sleep away camp
- Medical, prescription and dental expenses
- Expenses incurred before your coverage in the Dependent Day Care FSA began and
- Expenses for which you claim a tax credit.

Page
Page
Main Table of Contents
Chapter Table of Contents
Back

Filing a Claim

All claims must be incurred by December 31 (or earlier if coverage ends earlier) and all claims and supporting documentation must be filed by March 31 of the calendar year following the year the expense was incurred. Claims filed after this deadline will be denied.

IRS regulations do not allow the Plan to issue a reimbursement before the service is actually performed. For example, if you pre-pay child care services or the orthodontist's fee, you should provide a breakdown of the provider's charges on a monthly or quarterly basis.

Claims are processed using an imaging system, so faxing is the preferred method of claim submission. To prevent a delay in processing please fax your claims and supporting documentation to 651.361.4016.[16]

For more information on how to file claims, please contact the Assurant Flexible Spending Department at 866.866.4488, ext. 4600.

Health Care FSA

You can submit a claim for eligible health care expenses and receive reimbursement up to the amount of your annual election, regardless of the amount you have actually contributed at the time you file the claim. For example, you elect to contribute $600 for the year to your Health Care FSA. Each pay period $25 or 1/26th of $600 will deducted from your pay. In February, you have surgery and your out-of-pocket expenses equal $600. You could submit the claim and be reimbursed for the entire $600, even though you only contributed $100 at this point. The Company will continue to deduct $23.08 per pay period for the balance of the calendar year.

Dependent Day Care FSA

Under IRS regulations, you only can be reimbursed for dependent day care expenses up to the amount you've already contributed to your account at the time you submit the claim. If you have an eligible expense of $750 but only have $500 in your account, you only will be reimbursed $500. The remaining $250 will be carried

[16] Claims should only be mailed if you do not have access to a fax. Mail claims to Assurant, Inc., Flexible Spending Department, 6941 Vista Drive, West Des Moines, IA 50266.

forward to the next payment date. Then you will receive another reimbursement up to the new balance available in your account.

If you have a balance in your Dependent Day Care FSA when you leave the Company, you can continue to claim expenses for eligible services received through the end of the year in which you terminate.

The General Purpose Health Care FSA and Limited Purpose Health Care FS A Reimbursement Request form and the Dependent Day Care Flexible Spending Account Reimbursement Request form are available on MyAssurantBenefits.com. Please be sure to sign the Employee Certification section of the form certifying the claim.

Page
Page
Main Table of Contents
Chapter Table of Contents
Back

When Payments Are Made

Your FSA reimbursements will be paid in the same method as your pay (i.e., direct deposit or check). Electronic deposits are made into accounts on the day of payment, after 3:00 p.m. (CT). You can check your annual election amounts, year-to-date contribution, amounts paid out and your balance on the intranet. Click on EPIC>> Benefits Information>> FSA balances.

Appealing a Claim

Refer to Claim Appeals for an explanation of the procedures and the time frames in which to file an appeal.

When Participation Ends

Your participation In the Health Care and/or Dependent Day Care Flexible Spending Account ends on the last day of the pay period in which the first of the following events occur:

- The end of the calendar year, unless you make an election to participate in the Health Care and/or Dependent Day Care FSA for the next plan year
- The date you retire, terminate or die. See COBRA to learn about continuing Health Care FSA participation on an after-tax basis
- The date you take an unpaid personal leave of absence
- The date you stop contributing to your account
- The date your employee status changes to an ineligible status (e.g., your work schedule is reduced to less than 20 hours per week)
- The date you take a leave of absence greater than two weeks (Dependent Day Care FSA only)
- The date the Plan is terminated or amended to exclude from coverage the individual or the class of dependents of which the individual is a member.

Further, your eligible dependent's participation in a FSA ends on the earliest of the following to occur:

- The date your FSA participation ends
- The date that your dependent no longer meets the definition of an eligible dependent
- The date your *spouse* is unemployed and not actively looking for work, unless he/she is a *full-time student* or *disabled*. (Dependent Day Care FSA only) and
- When the remaining amount of your election exceeds your projected earned income for the plan year. (Dependent Day Care FSA only)

Forfeitures

It's very important that you estimate your eligible expenses carefully. If your expenses for the year are less than the amount you contribute to your FSA, you will lose the remainder. Claims and the supporting documentation must be filed by March 31 of the calendar year following the one in which they were incurred or the funds will be forfeited. The IRS does not allow you to transfer funds from one account to another. Forfeitures are used to pay the administrative expenses of the Plan.

Life and Accident Insurance

Life and Accident Benefits At-a-Glance 80

How the Life and Accident Insurance Plans Work 80

Electing Coverage 80
- Initial Enrollment Period 80

Life Insurance 81
- Basic Life Insurance 81
- Supplemental Life Insurance 81
- Dependent Life Insurance 81
- Life Insurance Proof of Good Health (POGH) 82
- Accelerated Life Insurance Benefits 82
- Life Insurance Exclusions 83
- Imputed Income 83

Accidental Death & Dismemberment Insurance (AD&D) 83
- Basic AD&D Insurance 83
- Supplemental AD&D Insurance 84
- Automobile Accident Benefit 84
- Higher Education Benefit 84
- AD&D Exclusions 84

Disability Benefit 85
- Exclusions 85

How Benefits Are Paid 85

When Coverage Ends 86

Conversion to an Individual Policy 86

Business Travel Accident Insurance 86
- Accidental Death and Dismemberment Benefits 87
- Single Accident Limitation 87
- Bereavement and Trauma Counseling Benefit 87
- Coma Benefit 87
- Paralysis Benefit 88
- Rehabilitation Benefit 88
- Seatbelt and Airbag Benefit 88
- Exclusions to Business Travel Accident Insurance 89
- When Business Travel Accident (BTA) Insurance Coverage Ends 89

Naming a Beneficiary 90

Life and Accident Insurance

It's a question no one likes to ask. But how would your family afford to live if you were to die during your earning years? Your family likely depends on your income for security and for the future. Life insurance helps your family if you die and accident insurance helps your family if you experience certain specified injuries. That is why Assurant offers a wide range of coverage for you and your family members.

The fact is life insurance isn't really a benefit for you. It's for those you leave behind. Its purpose is to provide your family and others who depend on you for support with the financial resources they need to go on with their lives.

How much life and accident insurance do you need? That depends on your particular circumstances. If, for example, you have a young, growing family, you'll probably want more life insurance than someone who is unmarried or whose children are grown.

With the Assurant benefit program, you can choose the coverage level that's right for you and your family.

Page
Page
Main Table of Contents
Chapter Table of Contents
Back

Life and Accident Benefits At-a-Glance

Insurance	
Basic Life	1 x *plan pay* (employees who earn more than $50,000 can choose between 1 times plan pay and $50,000) Maximum of $3 million, Basic and Supplemental Life coverage combined (amounts over $1.5 million require Proof of Good Health *(POGH)*
Supplemental Life	1 through 5 x *plan pay* (levels of 3 to 5 times *plan pay* require *POGH*) Maximum of $3 million, Basic and Supplemental Life coverage combined (combined amounts over $1.5 million require *POGH*) Premiums are age-rated and based on tobacco use/non-use
Dependent Life	*Spouse*: $10,000, $25,000, $50,000, $75,000, and $100,000 Amounts over $50,000 require *POGH* Child: $5,000, $12,500, and $25,000 Dependent Life coverage cannot exceed 50% of your combined Basic and Supplemental Life coverage
Basic Accidental Death & Dismemberment (AD&D)	1 x *plan pay* Maximum of $1.5 million (Basic and Supplemental AD&D coverage combined)
Supplemental Accidental Death & Dismemberment	1 through 5 x *plan pay* Maximum $1.5 million (Basic and Supplemental AD&D coverage combined)
Business Travel Accident	5 x *plan pay* Maximum $5 million

How the Life and Accident Insurance Plans Work

Basic Life, Supplemental Life, Basic AD&D, Supplemental AD&D, and Business Travel Accident Insurance are based on *plan pay*. If your *plan pay* changes throughout the year, the amount of insurance and cost can change.

Electing Coverage

Initial Enrollment Period

You automatically are enrolled in Basic Life, Basic AD&D and BTA Insurance on the date you become an eligible employee. To participate in Supplemental Life, Supplemental AD&D and Dependent Life Insurance you must make your election during your initial eight-day enrollment period.

If you are not at active work on the day your Basic and Supplemental Life, Basic and Supplemental AD&D and Dependent Life insurance would otherwise be effective, insurance will not take effect until you return to active work.

Dependent Life Insurance does not take effect until your insurance under this policy becomes effective. If your dependent is in a *hospital* or similar facility on the day his/her insurance would otherwise take effect, it will not take effect until the day after the dependent leaves the *hospital* or similar facility. This exception does not apply to a child born while dependent insurance is in effect.

◂Page
Page ▸
Main Table of Contents
Chapter Table of Contents
◂◂Back

Basic Life Insurance can be reduced from one times *plan pay* to $50,000 at any time. Supplemental Life, Supplemental AD&D and Dependent Life Insurance also can be reduced or cancelled at any time during the year. The reduction or cancellation is effective as of the date you request the change.

Life Insurance

Basic Life Insurance

Basic Life Insurance is provided by Assurant at no cost to you. If your *plan pay* is $50,000 or less, your Basic Life Insurance equals 1 times *plan pay*.

If your *plan pay* is more than $50,000, you can choose Basic Life coverage of 1 times *plan pay* or cap your Basic Life coverage at $50,000. If you choose to cap your Basic Life coverage at $50,000, you will avoid imputed income on the Company contribution on amounts in excess of $50,000, and you also will receive a credit in your semi-monthly pay for the Company's cost of Basic Life coverage in excess of $50,000 that the Company would have paid if you chose not to cap your coverage. This credit is included in your taxable income.

Supplemental Life Insurance

Supplemental Life Insurance benefits are in addition to your Basic Life Insurance benefits. You can purchase Supplemental Life Insurance equal to 1 through 5 times your *plan pay*. The combined maximum amount of Basic and Supplemental Life Insurance coverage is $3 million. *Proof of good health (POGH)* is required for combined coverage over $1.5 million. You can elect up to 2 times *plan pay* without providing *POGH* within 30 days of becoming eligible. Amounts up to 2 times *plan pay* will be effective as of the day you make your election. Amounts greater than 2 times plan pay will not be effective until you submit *POGH*, and the insurer, Assurant Employee Benefits, accepts proof of your good health. *POGH* will also be required if the combined amount of Basic and Supplemental Life Insurance exceeds $1.5 million.

You pay the full cost of Supplemental Life Insurance. Premiums are age-rated and based on whether you use tobacco products. Premiums are deducted from your pay on an after-tax basis.

Dependent Life Insurance

Assurant also gives you the opportunity to purchase life insurance on your eligible dependents. You can choose from the following coverage levels on your *spouse*/domestic partner and/or child provided that the amount of coverage on your life (Basic and Supplemental Life Insurance combined) is at least twice the amount of Dependent Life coverage you elect.

Spouse/Domestic Partner	Eligible Child
$10,000	$5,000
$25,000	$12,500
$50,000	$25,000
$75,000	
$100,000	

POGH is required for spouse/domestic partner Life Insurance coverage greater than $50,000. Amounts up to $50,000 will be effective as of the day you make your election. Amounts greater than $50,000 will not be effective until your *spouse*/domestic partner submits *POGH*, and the insurer, Assurant Employee Benefits, accepts proof of your spouse/domestic partner's good health.

Your dependent's coverage is effective on the latest of the following:

- His/her eligibility date
- The date you elect coverage on your dependent(s) and
- The date Assurant Employee Benefits approves your dependent's POGH, if required.

◂Page
Page▸
Main Table of Contents
Chapter Table of Contents
◂◂Back

You cannot be covered under the Assurant Life Insurance program as an employee and a dependent. If you and your *spouse*/domestic partner or former *spouse*/domestic partner are both employees, you cannot elect dependent coverage on each other and only one of you can cover a dependent child.

Your first child will be covered from birth for the coverage amount you choose as long as the election is made within 30 days of the birth. Subsequent children are automatically covered from birth at the same coverage level and premium.

Life Insurance Proof of Good Health (POGH)

You can change your Basic Life, Supplemental Life and Dependent Life Insurance elections at any time during the year. You must provide *POGH* before an increase in Life Insurance becomes effective. You also can increase your Supplemental AD&D Insurance throughout the year- no *POGH* is required.

You must provide *POGH* if:

- you elect more than 2 times *plan pay* for Supplemental Life Insurance during your initial enrollment period
- you increase your Basic Life Insurance after your initial enrollment period from $50,000 to 1 times *plan pay*
- you request coverage on your *spouse*/domestic partner of $75,000 or $100,000 during your initial enrollment period
- you request Child Life Insurance more than 30 days after the first child is initially eligible
- you increase your Supplemental Life Insurance during the year or during Annual Enrollment
- you increase your *Spouse* or Child Life Insurance during the year or during Annual Enrollment

You have until December 31 to provide *POGH* during Annual Enrollment. Otherwise proof must be submitted to Assurant Employee Benefits within 30 days of your election.

An increase in Life Insurance coverage is effective on the later of:

- The date you elect to increase the coverage and
- The date Assurant Employee Benefits approves your *POGH*, if required.

If you experience a qualified life event, you can add Dependent Life Insurance within 30 days of the life event. Dependent Life insurance on your *spouse*/domestic partner in amounts greater than $50,000 requires *POGH*, however if you do not make the change within 30 days of the life event, you must submit *POGH* regardless of coverage amount.

The *POGH* form is available in EPIC, MyAssurantBenefits.com or from HR Services. The completed form must be submitted to Assurant Employee Benefits within 31 days of your election

You and your dependents will be insured for the level of coverage available without *POGH* until the form is received and approved by Assurant Employee Benefits.

Accelerated Life Insurance Benefits

If Assurant Employee Benefits receives proof that you or your enrolled spouse/domestic partner has a qualifying medical condition and meets certain criteria, the Plan may pay a part of that person's Basic and Supplemental Life Insurance or Dependent Life Insurance as an accelerated benefit. The amount of life insurance will be reduced by the amount of accelerated benefit paid and by any interest charge, if applicable. The purpose is to help pay for medical and living expenses if you become terminally ill. The benefit allows you to receive, under certain circumstances, part of your life insurance coverage before the insured person dies.

The insured person can receive up to 50 percent of his/her life insurance coverage as an accelerated benefit; with the beneficiary's consent, the insured person can receive up to 80 percent as an accelerated benefit. The

◂Page
Page▸
Main Table of Contents
Chapter Table of Contents
◂◂Back

minimum accelerated payment is $5,000; the maximum is $250,000. The maximum benefit for your *spouse* or domestic partner is $50,000. Assurant Employee Benefits will deduct any accelerated benefit payment and the interest on the accelerated benefit payment from the death benefit payable.

You or your covered *spouse* or domestic partner will be considered terminally ill if your doctor determines that you or your *spouse* or domestic partner have a life expectancy of 12 months or less.

The Accelerated Benefit Claim Statement form is available at assurantemployeebenefits.com. Under "For Members" on the top, click "Forms." Scroll down to "Life and A&D" and look for the Accelerated Benefit Claim Statement forms (insured/*spouse* form and a supplement).

◂Page
Page▸
Main Table of Contents
Chapter Table of Contents
◂◂Back

Life Insurance Exclusions

If you take your own life or your covered dependent takes his or her own life within one year of becoming insured, the amount of Supplemental Life Insurance payable will be limited to the amount of premiums paid for the coverage.

If you take your own life or your covered dependent takes his or her own life within one year after you elect to increase the coverage amount, the amount of insurance payable will be limited to the previously elected amount plus the premiums paid for the increased amount of coverage.

Imputed Income

The IRS requires the cost of Basic Life Insurance in excess of $50,000 be included in your annual gross income for federal tax purposes. This is called "imputed income." This cost is based on the Table I rates found in Reg. 1.79-3(d) (2) of the Internal Revenue Code. Imputed income is subject to federal income and FICA (Social Security and *Medicare*) taxes.

If you want to avoid paying taxes on this imputed income, you can cap your Basic Life Insurance coverage at $50,000. Note - if you reduce your Basic Life coverage and want to increase it at a later date, you will have to provide *POGH*.

Currently, only Basic Life Insurance greater than $50,000 is subject to imputed income. If premium rates for Supplemental Life Insurance change, Supplemental Life also may be impacted. Notice of rates subject to imputed income will be included with Annual Enrollment information.

Accidental Death & Dismemberment Insurance (AD&D)

Basic AD&D Insurance

Assurant provides Basic Accidental Death and Dismemberment Insurance (AD&D) Insurance at no cost to you. Your Basic AD&D coverage amount is 1 times your *plan pay*.

If you die in an accident, your Basic AD&D Insurance pays 100 percent of your coverage amount to your beneficiary. If you lose a limb or sight due to an *accidental injury*, benefits are paid to you. The Plan pays the following amounts based on the loss:

Type of Loss	Percentage of Coverage Amount
One hand, one foot, or the sight in one eye	50%
Any two (or more) of the above losses	100%
Thumb and index finger of the same hand	25%

AD&D Insurance will pay for losses that occur within one year of a covered accident. The one-year limit will not apply if you are in a coma or being kept alive by life support at the end of one year. The maximum benefit for all losses you suffer in one accident is 100 percent of your coverage amount.

Supplemental AD&D Insurance

You can purchase Supplemental AD&D Insurance equal to 1 through 5 times your *plan pay*. The combined maximum benefit of your Basic and Supplemental AD&D Insurance is $1.5 million. Supplemental AD&D benefits are paid in addition to Basic AD&D benefits.

Automobile Accident Benefit

If your death is the direct result of an *injury* received in an automobile accident while you are properly wearing an unaltered seatbelt installed by the automobile's manufacturer, Assurant Employee Benefits will pay your beneficiary an additional 20 percent of the amount of your AD&D coverage, up to $100,000. There is a separate $100,000 maximum benefit if you elect Supplemental AD&D.

The insurance will be paid only if death occurs within 365 days after the automobile accident.

The automobile accident benefit will not be paid if the accident occurs when:

- The automobile is being used for racing, stunting, exhibition work, sport or test driving
- You are breaking any traffic laws of the jurisdiction in which the automobile is being operated or
- You are not properly wearing an unaltered seat belt installed by the automobile's manufacturer.

The exclusions listed under the Accidental Death and Dismemberment also apply to the Automobile Accident Benefit.

Higher Education Benefit

If your death is the direct result of an *injury* and an AD&D benefit is payable, Assurant Employee Benefits will pay a higher education benefit of $3,000 per year for up to four consecutive years. This benefit will be payable to each unmarried dependent under the age of 24 who is enrolled full-time at an accredited school at the time of your death or who enrolls within 12 months of your death.

Eligible children include your own and your *spouse*'s or domestic partner's biological and adopted children (including children placed for adoption). "Children" also include any children for whom you are the legal guardian, who reside with you on a permanent basis and depend on you for support and maintenance.

AD&D Exclusions

Basic and Supplemental AD&D Plans do not pay benefits for certain losses, which include losses resulting from:

- War or any act of war, whether declared or undeclared
- Taking part in a riot or insurrection or an act of riot or insurrection
- Service in the armed forces of any country, combination of countries or international organization at war, whether declared or not
- Any physical or mental disease
- Any infection, except a pyogenic infection that occurs from an accidental wound
- An assault or felony you commit
- Suicide or attempted suicide, while sane or insane
- Intentional self-inflicted *injury*, while sane or insane
- The use of any drug, unless you use it as prescribed by a doctor
- Your intoxication, which includes, but is not limited to, operating a motor vehicle while you are intoxicated.

◂Page
Page▸
Main Table of Contents
Chapter Table of Contents
◂◂Back

Disability Benefit

If you stop active work before age 65 due to a disability and remain disabled under the terms of the Plan, the Company will continue to pay for your Basic Life Insurance and Basic AD&D coverage for the first six months of your leave of absence. You also will be given the opportunity to continue your Supplemental Life, Dependent Life and Supplemental AD&D during this period by paying the required premiums in a timely manner. You may be eligible to continue your Basic and Supplemental Life Insurance, Basic and Supplemental AD&D and Dependent Life Insurance beyond the initial six months of your disability if you qualify for the waiver of premium feature under the Plan. Assurant Employee Benefits automatically reviews each case. If you are approved for a waiver of premium for these coverages, effective with the date of approval, you will no longer be required to make premium payments for the contributory coverage. Assurant Employee Benefits will notify you in writing if you are approved for waiver of premium.

Disabled means that you are under the regular care and attendance of a doctor and prevented by injury or physical or mental disease from performing the material duties of any occupation for which education, training or experience qualifies you.

If you are approved for a waiver of your Life Insurance premiums, premiums for AD&D and Dependent Life, as applicable, also will be waived.

If you become disabled before age 60, your Basic Life, Supplemental Life and Dependent Life premiums will be waived until the earliest of the following dates:

- You are no longer disabled under the terms of the Plan
- You begin receiving retirement benefits under the Assurant Pension Plan
- You begin receiving retirement benefits under a *government plan*, as defined by the Plan and
- You attain Social Security *Normal Retirement Age* as stated in the 1983 version of the Social Security Act.

Basic and Supplemental AD&D insurance will continue for up to one year from the date you become disabled.

If you become disabled at or after age 65, you are not eligible for the waiver of premium.

Exclusions

You will not be eligible for the premium waiver if your disability results from:

- Intentionally self-inflicted *injury*, while sane or insane
- War or any act of war, whether declared or not
- Service in the armed forces of any country, combination of countries or international organization at war, whether declared or not and
- Taking part in a riot or insurrection or an act of riot or insurrection.

How Benefits Are Paid

Benefits under $10,000 are paid out in a lump sum directly to the beneficiary.

If the benefit is $10,000 or more, you or your beneficiary may choose to have all or part of the insurance paid in installments. You can request this at any time. Your beneficiary also may request this within 31 days of your death. This option is not available if your beneficiary is an estate, corporation, partnership, association or trustee.

In addition, Survivor Financial Counseling is available to assist you or your beneficiary with financial planning if the life insurance benefit is at least $50,000.

Page
Page
Main Table of Contents
Chapter Table of Contents
Back

When Coverage Ends

Basic Life, Supplemental Life, Basic AD&D and Supplemental AD&D Insurance coverage ends on the earliest of the date:

- The policy(ies) are terminated,
- The policy(ies) are amended to exclude your eligible class,
- You are no longer in an eligible class,
- You retire or terminate employment and
- A premium is not paid.

Dependent coverage ends on the earliest of:

- The date your coverage ends,
- The date the policy terminates or the dependent life insurance coverage terminates,
- The date your *spouse*, domestic partner or child(ren) no longer meet the eligibility requirements or
- The date a premium is not paid.

Conversion to an Individual Policy

If Basic Life, Supplemental Life and/or Dependent Life Insurance terminates, you can apply for any individual policy offered by Assurant Employee Benefits. You must apply and pay the premium within 31 days of the date coverage terminates. The individual policy may be any they offer for conversion. No *POGH* is required. The amount of coverage that can be converted depends on the reason your insurance ended.

If your insurance ends because you are no longer eligible or because of a change in age or other status, you may convert the full amount that ended. However, if your insurance ends as the result of a change in the policy, you may not convert the full amount that ended. If the policy ends or is changed to reduce or end your life insurance and if you have been insured for at least 5 years under the policy, you may convert the lesser of:

- $10,000 and
- The amount of life insurance that ended minus the amount of any group life insurance for which you become eligible within 31 days.

If you die within 31 days after your life insurance ends, Assurant Employee Benefits will pay to your beneficiary the amount you could have converted, whether or not you applied or paid the premium.

You cannot apply for a conversion policy if your life insurance ends because you do not pay your premiums on time.

Basic and Supplemental AD&D Insurance cannot be converted to private policies.

Contact Assurant Employee Benefits at 866.909.6065 to start the conversion process.

Business Travel Accident Insurance

The Business Travel Accident (BTA) Insurance provides financial protection against death and certain physical injuries resulting from a covered accident while you travel on Company business. You are insured for five times plan pay, up to $5 million. Your spouse/domestic partner and all dependent children are insured when they accompany you on a business trip or during travel for relocation at the request of Assurant. Insurance also is provided for Personal Deviations - non-business travel or activities unrelated to Assurant business undertaken while on a business trip. The maximum length of a personal deviation is 14 days.

BTA coverage is insured through a contract with Axis Insurance Company.

◂Page
Page▸
Main Table of Contents
Chapter Table of Contents
◂◂Back

Accidental Death and Dismemberment Benefits

Business Travel Accident benefits depend on the type of covered loss as outlined in the chart below and are a percentage of the insured's principal sum. Your principal sum is 5 times your *plan pay*, up to a maximum of $5 million. The principal sum on your dependents is as follows:

- *Spouse* - $100,000
- Dependent child - $25,000

Type of Loss	Percent of Principal Sum
Life	100%
Two or more hands or feet	100%
Use of two or more hands or feet	100%
Loss of sight of both eyes	100%
Loss of speech and hearing (both ears)	100%
Loss of one hand or foot and sight in one eye	100%
Loss of one hand or foot	50%
Loss of use of one hand or foot	50%
Loss of sight of one eye	50%
Loss of speech	50%
Loss of hearing (in both ears)	50%
Loss of thumb and index of the same hand	25%
Loss of all four fingers of the same hand	25%
Loss of all toes of the same foot	25%

If an insured person sustains more than one covered loss as a result of the same covered accident, Axis will pay the benefit for the covered loss for which the largest benefit is payable.

Single Accident Limitation

The single accident limitation of $25 million applies when more than one covered person is involved in the same accident. If the single accident limitation does not allow you to be paid the amount you would otherwise be eligible for, the amount paid will be the proportion of your loss to the total of all losses, multiplied by the single accident limitation.

Bereavement and Trauma Counseling Benefit

An insured person, immediate family member or Fellow Participant is eligible for bereavement and trauma counseling when required because of an accidental or covered accident under the policy. Counseling must be provided under the care of a *physician* and occur with 365 days of the covered loss.

The benefit is $200 per session for up to 10 sessions or $2,000.

A Fellow Participant is an insured person, other than the insured person who suffered a covered loss, who was present at or participating in the same covered activity and as a result suffered trauma requiring counseling treatment.

Coma Benefit

If an insured person becomes comatose or suffers a covered *injury* that results in a coma (see definition below), the benefit is 1 percent of the principal sum for the first 11 months and the remaining 89 percent in the 12th month. The coma must occur within 30 days of a covered accident.

For purposes of this benefit, "coma" means a profound state of unconsciousness from which the insured person is not likely to be aroused through powerful stimulation. The coma must begin within 30 days of the

Page
Page
Main Table of Contents
Chapter Table of Contents
Back

covered accident, continue for 30 consecutive days and must be diagnosed and treated regularly by a *physician*. Coma does not mean any state of unconsciousness intentionally induced during the course of the treatment of a covered *injury* unless the state of unconsciousness results from the administration of anesthesia in preparation for surgical treatment of injuries sustained in the covered loss.

Paralysis Benefit

Axis will pay the benefits shown in the chart below for that type of paralysis if an insured person suffers a covered loss. The paralysis must occur within 365 days of a covered accident.

Type of Loss	Percentage of Coverage Amount
Quadriplegia	100%
Paraplegia	75%
Hemiplegia	75%
Uniplegia	25%

If the insured person suffers more than one type of paralysis as a result of the same accident, only one amount - the largest - will be paid.

Rehabilitation Benefit

A benefit of 10 percent of the principal sum (100 percent of your BTA coverage amount), up to a maximum benefit of $10,000, is payable when an insured person requires rehabilitation (see definition below) after sustaining a covered loss. The treatment must occur within 365 days of a covered accident.

For purposes of this benefit, "rehabilitation" means medical services, supplies, treatment, *hospital confinement* or part of a *hospital confinement* that satisfies the following conditions:

- Are essential for physical rehabilitation required due to the insured person's covered loss or *injury*
- Meet generally accepted standards of medical practice,
- Are performed under the care, supervision or order of a *physician* and
- Prepare the insured person to return to his/her or any other occupation.

Seatbelt and Airbag Benefit

Axis Insurance Company pays an extra 10 percent of the principal sum, subject to a maximum benefit of $50,000, when an insured person's death results from a covered accident while wearing a seatbelt and operating or riding as a passenger in a private passenger automobile. An additional benefit, 5 percent of the principal sum, is provided if the insured person was also positioned in a seat protected by a properly-functioning and properly deployed Supplemental Restraint System (airbag).

Verification of proper use of the seatbelt at the time of the accident and that the airbag properly inflated upon impact must be a part of an official police report of the accident or be certified, in writing, by the investigating officer and submitted with the claim.

If such certification or police report is not available or it is unclear whether the insured person was wearing a seatbelt or positioned in a seat protected by a properly functioning and properly deployed airbag, Axis will pay a benefit of $1,000 to the beneficiary.

In the case of a child, seatbelt means a child restraint, as required by state law and approved by the National Highway Traffic Safety Administration, properly secured and being used as recommended by its manufacturer for children of like age and weight at the time of the accident.

Supplemental Restraint System means an airbag that inflates upon impact for added protection to the head and chest areas or a child safety device.

◂Page
Page ▸
Main Table of Contents
Chapter Table of Contents
◂◂Back

Exclusions to Business Travel Accident Insurance

BTA benefits will not be paid for any loss which directly or indirectly, in whole or in part, is caused due to or during any of the following circumstances:

- Normal commuting between your home and place of work
- Travel to another location where you are expected to be assigned for more than 365 days
- Any activity not authorized or organized, or not reimbursable, by Assurant
- Participation in any race or speed contest
- Driving any vehicle or private passenger automobile for pay or hire
- Intentionally self-inflicted *injury*, suicide or auto-eroticism or any attempt while sane or insane
- Commission or attempt to commit a felony or an assault
- Declared or undeclared war or act of war or any act of declared or undeclared war unless specifically provided by the policy
- An accident that occurs while on active duty service in the military, naval or air force of any country or international organization. Reserve or National Guard active duty training is not excluded unless it extends beyond 31 days
- Flight in, boarding or alighting from, an aircraft or any craft designed to fly above the Earth's surface:
  - Except as a fare-paying passenger on a regularly scheduled commercial airline
  - Being flown by an insured person or in which the insured person is a member of the crew
  - Being used for:
    - Crop dusting, spraying or seeding, giving and receiving flying instruction, firefighting, sky writing, sky diving or hang-gliding, pipeline or power line inspection, aerial photography or exploration, racing, endurance tests, stunt or acrobatic flying or
    - Any operation that requires a special permit from the FAA even if it is granted (this does not apply if the permit is required only because of the territory flown over or landed on)
  - Designed for flight above or beyond the Earth's atmosphere
  - Including an ultra-light or glider
  - Being used for the purpose of parachuting or skydiving
  - Being used by any military authority, except an aircraft used by the air mobility command or it foreign equivalent
- Travel in any aircraft owned, leased, operated or controlled by Assurant or any of its subsidiaries or affiliates. An aircraft will be deemed to be "controlled" by Assurant if the aircraft may be used as Assurant wished for more than 10 straight days or more than 15 days in any year
- Sickness, disease, bodily or mental infirmity, bacterial or viral infection or medical or surgical treatment thereof (including exposure, whether or not accidental, to viral, bacterial or chemical agents) whether the loss results directly or non-directly from the treatment except for any bacterial infection resulting from an accidental external cut or wound or accidental ingestion of contaminated food and
- Medical or surgical treatment, diagnostic procedure, administration of anesthesia or medical mishap or negligence, including malpractice.

When Business Travel Accident (BTA) Insurance Coverage Ends

BTA ends on the earliest of:

- The date the person is no longer in an eligible class,
- The date the person enters full time active duty in any Armed Forces (active duty does not include Reserve or National Guard duty for training unless it extends beyond 31 days),
- The end of the period for which the last premium is paid,
- The date the BTA policy ends or
- The date the business segment with which the insured person is affiliated ceases to be covered under this policy.

Page
Page
Main Table of Contents
Chapter Table of Contents
Back

Naming a Beneficiary

You can name anyone you choose to be your beneficiary. Your beneficiary will receive benefits from your Basic and Supplemental Life Insurance coverage, plus any death benefits payable from your Basic AD&D, Supplemental AD&D and Business Travel Accident Insurance. You are the beneficiary for Dependent Life Insurance.

Simply log onto EPIC, click on Employee Benefits and then Beneficiary to complete a Life/AD&D Beneficiary Designation form. You can change your beneficiary at any time in EPIC. The beneficiary for Business Travel Accident Insurance is the same as you choose for Life Insurance coverage.

You can choose one or more persons to be your beneficiary. Benefits may be distributed among several people equally or you can divide according to a percentage (e.g., 60 percent to one person and 40 percent to another).

You also can have a primary and contingent beneficiary. A primary beneficiary is the person who is "first in line" to receive benefits. A contingent beneficiary will receive benefits only if your primary beneficiary dies before you do or is otherwise ineligible to receive benefits.

If you don't name a beneficiary or the person you've named is no longer living when you die (or is ineligible to receive benefits), Assurant Employee Benefits will pay the Basic and Supplemental Life Insurance and any death benefits payable under the Basic and Supplemental AD&D policies in the following order:

- Your legal *spouse*
- Your domestic partner
- Your or your domestic partner's children, in equal shares
- Your parents, in equal shares or
- Your estate.

If there is no named beneficiary or surviving beneficiary or if the insured person dies while benefits are payable to him/her, Axis Insurance Company may make direct payment of Business Travel Accident Insurance benefits according to the following hierarchy of beneficiaries:

- *Spouse*
- If no spouse, then child or children
- If no children, then parents
- If no parents, then siblings and
- If no siblings then to the insured person's estate.

If the payee is a minor or is not competent to give a valid release for the payment, the payment will be made to a parent, guardian or other person actually supporting him/her.

Page
Page
Main Table of Contents
Chapter Table of Contents
Back

Disability Plan

How the Plan Works 92

Disability Benefits At-a-Glance 92

Short-Term Disability 93
- Reed Group - Disability Manager 93
- Definition of Disability 94
- Short-Term Disability Schedule Amount and Benefit 94
- Offset Amount 94
- STD Exclusions 94
- When Benefits Begin 95
- When Benefits End 95
- If You Become Disabled Again 95

Long-Term Disability 96
- Definition of Disability 96
- Long-Term Disability Schedule Amount and Benefit 96
- Offset Amount 96
- Other Sources 97
- If You Don't Apply for Offset Amounts or Sources of Income 97
- Lump Sum Benefits 98
- LTD Exclusions 98
- If You Receive a Cost of Living Increase 98
- When Benefits Begin 98
- Duration of Benefits 98
- Alcoholism, Drug Addiction, Chemical Dependency and Mental Illness 99
- When Benefits End 99
- If You Become Disabled Again 100
- Special Features of the Long-Term Disability Plan 100
- Social Security Assistance 102
- Survivor Benefit 102
- How LTD Benefits Are Paid 102
- Filing a Claim 102
- Right of Recovery Provision 103
- Termination of Coverage 103
- Conversion 103

Disability Plan

Assurant's Disability Plan replaces a portion of your earnings if you are unable to work because of an illness, *injury* or pregnancy, providing a level of financial safety that could make a big difference to you and your family.

The Disability Plan has two components:

- Short-Term Disability (STD) coverage and
- Long-Term Disability (LTD) Insurance

Reed Group is the disability manager for STD benefits.
Assurant Employee Benefits is the insurer and disability benefits manager for the Long-Term Disability Insurance.

Page
Page
Main Table of Contents
Chapter Table of Contents
Back

How the Plan Works

Eligibility and Enrollment

You must be employed by Assurant for at least 90 calendar days and be a benefits-eligible employee for Short-Term Disability (STD) coverage to be effective. Your coverage is effective on the 91st day.

Long-Term Disability (LTD) insurance begins on the later of your date of hire or the day you become a benefits-eligible employee.

You are automatically enrolled for STD coverage and LTD insurance when you are eligible. If you are not at active work on the day STD or LTD would otherwise be effective, coverage will not take effect until you return to active work.

Cost of Coverage and Taxes

Short-Term Disability and Long-Term Disability coverage is fully paid by Assurant. However, you pay imputed income on the cost of the coverage. As a result, any Short-Term Disability or Long-Term Disability benefits you receive are not subject to federal income tax or FICA taxes (Social Security and Medicare). You are responsible for paying any state/and or local income taxes that may apply.

Disability Benefits At-a-Glance

	Short-Term Disability	Long-Term Disability
Eligibility Period	90 days	N/A
Qualifying Period	7 consecutive calendar days	6 months
Schedule Amount (Amount of scheduled benefits)		60 percent of plan pay
90 days of service or less	No pay	
91 days – less than 1 year of service	50 percent of your base pay	
1 or more years of service		
• Weeks 2-13	75 percent of your base pay	
• Weeks 13 – 26	60 percent of your base pay	
Maximum Benefit Period	25 weeks	Normal retirement age

Authority

For Short-Term Disability benefits, the Reed Group has discretionary authority to determine eligibility for Short-Term Disability benefits. Determinations made by Reed are conclusive and binding on all parties, unless appealed to and approved by the Benefit Plans Committee. See Claim Appeals for more information.

For Long-Term Disability benefits, Assurant Employee Benefits has discretionary authority to determine eligibility for participation and for benefits and to interpret the terms of the Long-Term Disability Plan. Determinations and interpretations made by Assurant Employee Benefits are conclusive and binding on all parties. See Claim Appeals for more information.

Page
Page
Main Table of Contents
Chapter Table of Contents
Back

Short-Term Disability

Reed Group - Disability Manager

The Short-Term Disability program is managed by the Reed Group. If your disability leave is planned (as in the case of pregnancy or scheduled surgery) and is expected to be longer than 7 consecutive calendar days, you must call Reed at least 14 calendar days before the start of disability, but no later than the first day of absence. If the leave is unplanned, call Reed on your first day of absence. You can reach Reed at 866.829.8859. If you become disabled on a weekend, you can call Reed Group and leave a message; they will return your call on Monday.

If you fail to contact Reed within 14 days of the start of your disability and the disability is approved by Reed, benefits will be payable only from the later of:

- The date you notified Reed or
- The date Reed determines you were first disabled.

Example: Your first day of leave is February 2. You call Reed on February 25. Reed confirms that you were disabled from February 2 through March 13. You only will receive benefits for February 25 through March 13 because you did not call Reed within 14 days of the start of your disability (February 15).

If you do not call Reed within 14 calendar days after the first day of disability, any *banked essential absence days*, Paid Time Off (PTO) and/or Alternate Holidays that you used prior to the date that Reed is called will not be refunded. You will not receive benefits retroactively for any time before you called Reed.

You must also contact HR Services Leave Administration at 866.324.6513 and notify your manager or supervisor to let them know about your absence. You also may request a leave of absence online via Kronos by selecting My Information >> My Actions >> New Leave Request.

If Reed does not approve your leave, no benefits are payable.

When You Call Reed Group

You will be asked some basic questions about yourself, your job, your disability and contact information for your *physician*. You will need to sign a form authorizing your doctor's office to release information about your condition. The form will be included in the disability material that Reed mails to your home. This release must be signed by you and faxed or mailed to Reed as soon as possible. The fax number and mailing address are shown on the medical release form.

You should let your doctor know that he or she will be contacted to certify your disability.

If your *physician* does not provide Reed with medical information that objectively supports your disability, your claim will be pended for 30 days from the date you call Reed Group. If the data to certify your disability is not provided by the end of this period, your claim will be denied. Information on how to appeal Reed Group's decision will be in their denial letter.

Definition of Disability

Generally, you are considered disabled if you are unable to perform the material duties of your regular job with Assurant due to an illness, *injury* or pregnancy, or if you are partially disabled and still working and your disability prevents you from earning more than 80 percent of your *base pay* in your regular job with Assurant.

Reed may require that you be examined by a *physician* or other health care *provider*. If Reed determines that an independent medical examination is needed, they will arrange this at no cost to you. Failure to attend an independent medical examination could result in a loss of benefits.

Note: Even if Assurant has approved your leave of absence, made an accommodation (per ADA rules) or does not allow you to return to work in another position as a result of *injury* or illness, this does not mean that you are "disabled" as defined by the Disability Plan. You should call your local HR Department if you are requesting an accommodation.

Page
Page
Main Table of Contents
Chapter Table of Contents
Back

Short-Term Disability Schedule Amount and Benefit

Your Short-Term Disability benefit is based on your length of service with Assurant and base pay as shown in the Disability Benefits-At-a-Glance chart.

Your STD benefit is equal to the Schedule Amount less any Offset Amount you receive or are eligible to receive.

Offset Amount

If you are eligible for any of the following benefits, the total of all weekly benefits plus the pro-rated amount of any lump sum payments will be subtracted from the Schedule Amount:

- Any salary, wages, partnership or proprietorship draw, commissions or similar pay from any work you do
- Social Security disability benefits, including dependent benefits payable because of your *injury*, sickness or pregnancy,
- Disability benefits from *workers compensation* or a *government plan*, other than Social Security
- Retirement, disability or similar benefits (not including your contributions from a *retirement plan* sponsored by Assurant).

Retirement benefits from a *retirement plan* or a *government plan* will be included only if you choose to receive them.

- Any no-fault motor vehicle coverage, unless:
  - State law or regulation does not allow group disability benefits to be reduced by benefits from no-fault motor vehicle coverage,
  - The no-fault motor vehicle coverage determines its benefits after benefits have been paid under the policy or
  - The benefits are provided under optional coverage.

STD Exclusions

- Any disability that begins before your STD coverage becomes effective and any disability that begins after your coverage is terminated.
- A disability caused by war or any act of war, whether declared or not
- Intentionally self-inflicted *injury*, while sane or insane
- A disability that results from taking part in committing an assault or felony
- A disability resulting from elective cosmetic procedures. The following instances of reconstructive surgery do not count as elective cosmetic procedures:
  - Surgery required because of a previous surgical procedure that was necessary to treat an infection or disease

  - Surgery following a medically necessary mastectomy
  - *Medically necessary* surgery to correct damage caused by an accident or injury
  - Surgery to correct a congenital defect
- Any vague or unidentifiable condition that cannot be described by a standard medical nomenclature diagnosis and for which you are not undergoing tests or receiving treatment
- A disability that begins while you are not at work because of a disciplinary action or administrative suspension.

You cannot receive Short-Term Disability benefits for the same time period you receive Paid Time Off, *banked essential absence days* or alternate holidays.

Page
Page
Main Table of Contents
Chapter Table of Contents
Back

When Benefits Begin

You must be actively at work for at least 90 days before you are eligible for STD benefits. You must be disabled under the terms of the Plan for 7 consecutive calendar days before you can receive STD benefits. This is called your *qualifying period*. If you remain disabled and your disability is approved by Reed, benefits begin on the eighth day. If Reed has not received the information required to approve your disability by the end of the *qualifying period*, your pay will be suspended until it is received and approved by Reed.

If you have *banked essential absence days*, alternate holidays or accrued PTO remaining in the calendar year, you will be required to use them in that order as allowed by law to continue your pay during the *qualifying period*.

If you do not have any paid time available, the *qualifying period* will be unpaid.

When Benefits End

Short-Term Disability benefits end on the earliest of the following dates:

- You reach the Short-Term Disability maximum benefit period
- You are no longer disabled as determined by Reed
- You return to work at your regular, pre-disability schedule
- You die
- It is determined that you are not following an *appropriate medical plan* by the disability *Claims Administrator*
- You refuse to accept a work opportunity with your employer when you are functionally capable of performing such work and
- You do not submit medical evidence of your disability when asked to do so.

If You Become Disabled Again

If you become disabled again, the same disability period will continue and you will not need to satisfy an additional elimination period if:

- You return to active full duty work for less than 30 days and you then become disabled due to the same or related cause or
- You return to active full duty for less than one day and become disabled due to a different cause.

If you return to active work for more than the time shown above and then become disabled again, you will start a new *period of disability*. You will be required to file a new claim and satisfy a new elimination period in order for benefits to begin.

In either of the above situations, you must call Reed Group to let them know that you are disabled again. If you do not call within 14 days, your benefits may be reduced (as outlined above).

Long-Term Disability

Long-Term Disability Insurance is based on plan pay. If your plan pay changes throughout the year, the amount of insurance can change.

Definition of Disability

For the Long-Term Disability Plan, you are considered disabled if you satisfy either the Occupation Test or Earnings Test as determined by Assurant Employee Benefits (the Claims Administrator for Long Term Disability).

Occupation Test - During the 6-month *qualifying period* and the following 24 months, you must be

- Under the regular care and attendance of a doctor and
- Unable to perform at least one of the material duties of your regular occupation due to injury, illness or pregnancy.

After that, you must be unable to perform at least one of the material duties of each gainful occupation for which your education, training, and experience qualifies you.

Earnings Test - You will be considered disabled even if you're actually working if an *injury*, sickness or pregnancy prevents you from earning more than 80 percent of your indexed *plan pay* in any occupation for which your education, training or experience qualifies you.

On each anniversary of the date your disability started, Assurant Employee Benefits will use your *indexed monthly pay* to decide whether you are disabled under this test. If your actual earnings during any month are more than 80 percent of your *indexed monthly pay*, you will not be considered disabled under the Earnings Test during that month. In making this determination salary, wages, partnership or proprietorship draw, commissions, bonuses or similar pay and any other income you receive or are entitled to receive will be included. However, sick pay and Short-Term Disability for periods not at work will not be included. Any lump sum payment will be pro-rated, based on the time over which it accrued or the period for which it was paid.

Assurant Employee Benefits may require you to be examined by a physician periodically (at no cost to you) to confirm your continuing disability.

Long-Term Disability Schedule Amount and Benefit

The Schedule Amount is 60 percent of your monthly *plan pay*, up to $15,000 per month. For each day of a period less than a full month, the Schedule Amount will be 1/30th of this amount.

Your LTD benefit is the lesser of:

- The Schedule Amount minus the Offset Amount (listed below) or
- The *monthly payment limit* minus the sum of the Offset Amount and the Other Sources (listed below).

The minimum monthly benefit is the greater of $100 and 10 percent of your Scheduled Amount, if you normally work at least 30 hours per week before your *period of disability* starts. If your period of disability is less than a full month, the minimum benefit is 1/30th of $100 for each day of disability after the *qualifying period* ends. There is no minimum benefit if you normally work less than 30 hours per week.

Offset Amount

If you are eligible for any of the following benefits or other amounts, the total of all monthly benefits and other amounts plus the pro-rated amount of any lump sum payments will be subtracted from your gross LTD benefit:

- If you are eligible to receive any salary, wages, partnership or proprietorship draw, commissions or similar pay from any work you do, the Plan will not consider such income for the 12 consecutive months starting on the day you become entitled to it, as long as the sum of:

◂Page
Page ▸
Main Table of Contents
Chapter Table of Contents
◂◂Back

- The income described above
- Gross LTD benefit and
- Benefits from any sources described in Other Sources

is not more than 100 percent of your monthly *plan pay*. If the sum is more than 100 percent of your monthly *plan pay*, the Plan will subtract the amount over 100 percent when determining your benefit under this policy.

After you have returned to work and have been eligible to receive salary, wages, partnership or proprietorship draw, commissions or similar pay for 12 consecutive months, the Plan will offset your LTD benefit by 50 percent of any salary, wages, partnership or proprietorship draw, commissions or similar pay you are eligible to receive from any work you do, and by any *family care expense* reimbursement received

- Group disability benefits from any other plan
- Social Security disability benefits, including dependent benefits payable because of your injury, sickness or pregnancy,
- Disability benefits from *a government plan*, other than Social Security
- Any benefits (except medical or death benefits) or any amount received in a settlement or compromise of your rights under any Worker's Compensation Act (or similar law) or the Maritime Doctrine of Maintenance, Wages or Cure,
- Social Security retirement benefits unless your Disability begins after age 65 and you were already receiving such retirement benefits,
- Retirement, disability or similar benefits (not including your contributions) from *a retirement plan* sponsored by Assurant.

Amounts rolled over or transferred into any eligible retirement plan (e.g., Individual Retirement Account (IRA)) unless such amounts are subsequently withdrawn during the Maximum Benefit Period, at which time such amounts will be subtracted retroactively without regard to any other provision of the Plan,

Early retirement benefits from a retirement plan will be included only if:

- You choose to receive them or
- They would not reduce the normal retirement benefit under a *retirement plan* sponsored by Assurant.

- Any amount you receive (including any amount you receive in a settlement or compromise) because of a claim for any of the sources listed above and
- Retirement benefits from a government plan.

Other Sources

- Any amount you receive of a type included in *plan pay* (e.g., salary, commissions)
- Any amount you receive (including any amount you receive in a settlement or compromise) because of a claim for any of the sources listed in Other Sources
- Any group disability insurance contract, except one sponsored by Assurant
- Any no-fault motor vehicle coverage, unless:
  - State law or regulation does not allow group disability benefits to be reduced by benefits from no-fault motor vehicle coverage,
  - The non-fault motor vehicle coverage determines its benefits after benefits have been paid under the policy or
  - The benefits are provided under optional coverage.

If You Don't Apply for Offset Amounts or Sources of Income

If you are eligible for any Offset Amounts or Other Sources or would be if you applied for them on a timely basis, Short-Term Disability or Long-Term Disability benefits will be determined as if you were receiving them.

Page
Page
Main Table of Contents
Chapter Table of Contents
Back

Assurant Employee Benefits will estimate the amount payable from these other sources. It will reduce your LTD benefits by this estimate until Assurant Employee Benefits receives proof that such benefits or other amounts are not payable or are denied. It will continue to offset your LTD benefit by its estimate of your Social Security benefit until it receives a notice of denial of the first level of appeal after an initial denial. (See Social Security Assistance under Special Features of the LTD Plan)

If the actual amount payable from an Offset Amount or Other Sources is different from Assurant Employee Benefits' estimate, it will adjust your LTD benefit. If you were paid a lower benefit than you should have, you will be paid the difference. If you were paid a higher benefit than you should have, you must pay back the difference. Any future LTD benefits that are due, including the minimum benefit, will be applied to the over-payments until it is reimbursed in full.

Page
Page
Main Table of Contents
Chapter Table of Contents
Back

Lump Sum Benefits

If you receive benefits from any source in a lump sum, Assurant Employee Benefits will pro-rate it over the time in which it accrued, based on information from the source of the payment. If it does not receive all the information it needs, it will pro-rate the payment according to its nature and purpose.

LTD Exclusions

The Disability Plan will not pay benefits for any time you are confined to any facility because you were convicted of a crime or public offense. In addition, the Plan will not provide benefits for a disability caused by:

- War or any act of war, whether declared or not
- Intentionally self-inflicted *injury*, while sane or insane
- Taking part in—or the result of taking part in an assault or felony.

The Plan will not pay benefits if:

- Assurant offers you the opportunity to return to limited work while you are disabled
- You are functionally capable of performing the limited work that is offered and
- You do not return to work when and as scheduled.

Benefits will end as of the date you were first scheduled to return to work. Subject to the terms of the LTD policy, benefits will recommence on the earlier of the date you return to such work, if you remain disabled or the date your disability worsens so that you are no longer capable of such work.

If You Receive a Cost of Living Increase

Your LTD benefit will not be reduced further if an Offset Amount or Other Source changes because of a cost-of-living increase.

When Benefits Begin

LTD benefits begin on the later of the completion of the 6-month *qualifying period* and the day after you have exhausted your STD benefits. You must remain disabled as defined by the Plan throughout the *qualifying period*.

Duration of Benefits

After you meet the 6-month *qualifying period* Long-Term Disability benefits may continue until the earlier of:

- The date you are no longer disabled
- The date you reach the maximum benefit period shown in the following chart.

Your age on the date your period of disability starts:	Your maximum benefit period is:
Before 60	The day before retirement age
60 but before 65	The day before retirement age or 36 months of disability, whichever is longer
65 but before 68	24 months of disability
68 but before 70	18 months of disability
70 but before 72	15 months of disability
72 or older	12 months of disability

Page
Page
Main Table of Contents
Chapter Table of Contents
Back

Alcoholism, Drug Addiction, Chemical Dependency and Mental Illness

If you are disabled because of alcoholism, drug addiction, chemical dependency or *mental illness*, your maximum benefit period is 24 months. This is a combined maximum for all periods of disability and for all of these conditions.

Your *period of disability* is considered due to alcoholism, drug addiction, chemical dependency or *mental illness* if:

- You are limited by one or more the stated conditions and
- You do not have other conditions which, in the absence of the stated conditions, would continue to exist, limit your activities and lead Assurant Employee Benefits to conclude that you are disabled.

Benefits may be payable for more than 24 months, but not beyond the Maximum Benefit Period shown in the above chart, if you are hospital confined at the end of the 24-month period and you remain disabled. Benefits will continue for the length of your confinement and for up to 60 days following the end of your hospitalization.

If during this 60-day period, you are hospitalized again for at least 10 consecutive calendar days, benefits will be payable for the length of the second confinement and for up to 60 days following the end of this second hospitalization.

When Benefits End

Your Long-Term Disability benefits end on the earliest of the following dates:

- You are no longer disabled as determined by Assurant Employee Benefits
- You reach the maximum benefit period
- You die
- You are determined to have perpetuated fraud on the Plan
- You fail to comply with an independent medical examination, functional capacity evaluation, vocational assessment or other evaluation as may be required by the *Claims Administrator*
- It is determined you are not following an *appropriate medical plan*
- You fail to fully cooperate with an *appropriate medical plan* or *rehabilitation plan* without good cause
- You refuse to accept a work opportunity with Assurant when you are functionally capable of performing such work
- You do not submit medical evidence of your disability when asked to do so by the *Claims Administrator* or you fail to provide objective medical documentation of a disability (Assurant Employee Benefits can request additional medical documentation of an ongoing disability as often as it deems reasonably necessary).

If You Become Disabled Again

If you become disabled again after you return to active work, the same *period of disability* will continue if:

- You return to active full duty for less than six months and you become disabled due to the same or related cause or
- You return to active duty for less than one day and become disabled due to a different cause.

If your return to active full duty meets either of these conditions, your Long-Term Disability benefits will resume immediately. The maximum benefit period will continue on the day you become disabled again.

If you return to active full duty for more than the time shown above and become disabled again, you will start a new *period of disability*. You will be required to contact Reed Group within 14 days of the start of the new period of disability and will once again be required to satisfy the appropriate qualifying period for benefits to begin. The maximum benefit period will start over.

Page
Page
Main Table of Contents
Chapter Table of Contents
Back

Special Features of the Long-Term Disability Plan

Quality of Care Benefit

You may be eligible for quality of care services while you are disabled. These services will be provided at Assurant Employee Benefit's sole discretion. In providing these services Assurant Employee Benefits will help develop an *appropriate medical plan* for you. As part of the *appropriate medical plan*, it may:

- Arrange any necessary second medical opinions or specialty consultations
- Recommend referrals to therapeutic programs including, but not limited to, physical, occupational and speech therapy, exercise programs, mental health programs, pain clinic programs and other medical rehabilitation programs
- Identify *durable medical equipment* that might improve your ability to function
- Provide published medical materials for you and your doctor and refer you to support groups for people with similar impairments
- Negotiate discounts for your benefit with providers of medical services, equipment or prescription drugs
- Help you identify third parties who may pay for needed therapeutic programs, equipment or services or
- Pay for reasonable costs you incur to participate in an *appropriate medical plan*, in excess of amounts paid or payable by third parties (including any amounts receivable under a medical policy). Assurant Employee Benefits may pay for such costs if you would not otherwise be able to undertake the necessary therapeutic program or receive the services. It will consider, among other things, the likelihood that such programs or services will result in an overall lowering of benefits payable to you under the policy.

If Assurant Employee Benefits finds that an *appropriate medical plan* for your condition has not yet been developed for you, it will develop and endorse such a plan, with input from you and your doctor. If it finds that your doctor has devised an *appropriate medical plan* for you, but you have not followed that plan consistently, it will endorse that plan. In making its decision to endorse a plan, it will rely on the currently published guidelines with respect to your medical condition from *nationally recognized authorities*. If more than one *appropriate medical plan* exists, you and your doctor may choose the one most appropriate for you.

LTD benefits and coverage under the policy will both end, without regard for any other provision of the policy, if:

- There is unreasonable failure on your part to undergo a scheduled examination for a second medical opinion or specialty consultation or
- Once Assurant Employee Benefits has endorsed an *appropriate medical plan* for you, you fail to comply with this plan without good cause. "Good cause" means a medical reason preventing implementation of the plan.

Assurant Employee Benefits will make the final determination of any quality of care services provided, of your eligibility for participation and of any continued benefit payments.

Rehabilitation

The Disability Plan is designed to encourage you to remain working as long as possible and return to work as soon as possible after a disability. Rehabilitation is an important part of the LTD Plan.

Your efforts to be rehabilitated and rejoin the workforce in a gainful way will be supported with an extensive array of benefits. If you participate in an approved rehabilitation plan, your Long-Term Disability benefit will be increased by the lesser of 10 percent of your monthly *plan pay* or $1,000. You also may be eligible for:

- Medical expenses for treatment, *physical therapy* and adaptive equipment in excess of amounts paid under a medical policy or by third parties
- *Education expenses* for training in a new occupation, including tuition, books, computers and other equipment
- *Moving expenses* if, because of school or employment, you must move more than 35 miles
- Accommodation expenses your employer incurs to accommodate your disability, as required by the Americans with Disabilities Act or similar legislation. It also means costs you incur for tools, equipment, furniture, computer software or other items necessary for you to return to work. The amount of the accommodation expense is limited to $3,000 for each *period of disability*
- *Family care expenses* of up to $350 a month for each family member who is under age 13 or who is physically or mentally incapable of caring for themselves so that you can work or be retrained
- Reasonable job placement services for a period of up to 3 months after your disability ends.

If your disability ends while you are participating, with your full cooperation, in your *rehabilitation plan* and you are not able to find gainful employment, Assurant Employee Benefits will

- Pay your LTD benefit, other than rehabilitation benefits, that would have been payable to you if you had remained *disabled* until:
  - 3 months after your disability ends or
  - The date you are able to find gainful work, if earlier and
- Provide or pay for reasonable job placement services for a period of up to 3 months after your disability ends.

Failure to participate with your full cooperation in the *rehabilitation plan*, without good cause, will result in the reduction or the end of your LTD insurance benefits. If benefits end, your LTD insurance coverage under the policy will end. Reduction of benefits will be based on your projected income if you had met the goals of the rehabilitation plan. Benefits will be figured as though you were:

- Actually working in the occupation contemplated in the *rehabilitation plan* and earning the projected income amount.
- If such work at the projected income amount would have resulted in the end of your LTD insurance benefits, your benefits will end as of the expected completion of the *rehabilitation plan*.

Assurant Employee Benefits will make the final determination of any vocational rehabilitation services provided, of your eligibility for participation and any continued benefits payments.

Rehabilitation Plan for Your Spouse

The Long-Term Disability Plan also offers a voluntary *rehabilitation plan* for your *spouse*. You and your *spouse* may ask to participate in a *rehabilitation plan* for your spouse while you are disabled if you are receiving disability benefits from *Social Security* and your spouse's earnings in the six calendar months prior to your disability averaged less than 60 percent of your monthly *plan pay.*

Assurant Employee Benefits has the sole discretion to approve or deny your request. The terms and conditions of the *rehabilitation plan* must be mutually agreed by you, your spouse and Assurant Employee Benefits.

Your *spouse's rehabilitation plan* may include your *spouse's education expense*, reasonable job placement

◂Page
Page▸
Main Table of Contents
Chapter Table of Contents
◂◂Back

expenses and the family's *moving expense*, if any. It also may include family care expense incurred by your *spouse*, necessary in order for him/her to be retrained under the *rehabilitation plan*.

Assurant Employee Benefits will reduce the amount of your LTD benefit by 50 percent of any salary, wages, partnership or proprietorship draw, commissions or similar pay from any work your *spouse* does as a result of participating in his/her *rehabilitation plan*. If your spouse is working when your *spouse's rehabilitation plan* begins, Assurant Employee Benefits will only reduce your LTD benefit by 50 percent of the increase in income that results from your spouse's participation in a *rehabilitation plan*.

Social Security Assistance

If your initial claim for *Social Security* disability benefits is denied, Assurant Employee Benefits can have it reviewed by a *SSA representative* at your request. Alternatively, if Assurant Employee Benefits considers you a good candidate, Assurant Employee Benefits starts this process by giving you a list of *SSA representatives*. If you choose from this list, Assurant Employee Benefits will pay the SSA representative's fee.

Whether you use Assurant Employee Benefit's help or not, it will reimburse you for the fee charged by your *SSA representative* if:

- *Social Security* disability benefits are approved on appeal while you are eligible for LTD benefits under this policy and
- You are no longer eligible to receive LTD benefits under this Plan but become entitled to *Social Security* disability benefits retroactive to a date while you were still eligible for benefits under this policy.

Reimbursement of the fee is limited to the fee approved by the *Social Security* Administration.

Assurant Employee Benefits may reduce any overpayment calculated in your LTD benefit.

Survivor Benefit

If you die while entitled to Long-Term Disability benefits, the Plan will pay a family survivor benefit to your eligible survivors for up to three months following your death. The survivor benefit is equal to your last net monthly benefit.

Your eligible survivors include your *spouse* or domestic partner and your unmarried children or your domestic partner's children under age 21 or, if *full-time students*, under age 25. The plan will not pay family survivor benefits to anyone other than an eligible survivor.

Your *spouse* or your domestic partner will receive the full benefit. If you have no *spouse* or *domestic partner*, your unmarried children under age 21 or 25 (if *full-time students*) will receive equal shares of the monthly benefit.

How LTD Benefits Are Paid

Assurant Employee Benefits pays benefits at the end of each month after it receives the required proof of your disability.

You owe no Federal income and *Social Security* taxes on LTD benefits. Depending on where you live, state and local taxes may be owed on your benefits.

All benefits are payable to you unless medical evidence indicates that a legal guardian should be appointed. In this case, Assurant Employee Benefits will hold further benefits due until such time as a guardian of your estate is appointed; it will pay benefits to the guardian at that time. If any amount remains unpaid when you die, Assurant Employee Benefits will pay your estate.

Filing a Claim

Reed manages the initial six months of all disability leaves of absence. It is your responsibility to contact Reed

◂Page
Page▸
Main Table of Contents
Chapter Table of Contents
◂◂Back

(and HR Services) as soon as it appears that your leave of absence could exceed 7 calendar days. If you are a new employee and not yet eligible for Short-Term Disability benefits, you must still call Reed. While you may not be eligible for STD benefits, you may qualify for Long-Term Disability benefits.

Reed automatically forwards your file to Assurant Employee Benefits - the Long-Term Disability *Claims Administrator* - at least one month before you complete the LTD *qualifying period*. Assurant Employee Benefits reviews your file and requests additional information, if necessary.

Generally, Assurant Employee Benefits makes a decision on your claim within 45 work days after it receives the required proof of your disability. Circumstances beyond Assurant Employee Benefit's control may require an extension of time to process the claim. This extension of time will not exceed 30 additional days unless circumstances beyond Assurant Employee Benefits' control require a second extension. This second extension will not exceed an additional 30 days.

Proof of your disability - satisfactory to Assurant Employee Benefits – must be provided within 90 days after the end of your *qualifying period*. If such proof is received by Assurant Employee Benefits more than 180 days after the end of your *qualifying period*, your Schedule Amount will be reduced by 30 percent.

Continuing proof of disability must be given as often as Assurant Employee Benefits may reasonably require. Such proof must be provided with 60 days of its request.

◂Page
Page▸
Main Table of Contents
Chapter Table of Contents
◂◂Back

Right of Recovery Provision

Assurant has the right to recover any Short-Term Disability benefits that are deemed to be paid incorrectly by either direct payment from you or as an offset of future benefits.

Termination of Coverage

Your eligibility under the Disability Plan automatically ends on the first of the following dates:

- You terminate, retire or die
- The Plan is changed to eliminate coverage for your eligible class
- You cease to be an eligible employee
- You stop active work (See Continuing Coverage During a Leave of Absence)
- The insurance policy ends

If you are disabled on the day your coverage terminates and you remain disabled long enough to satisfy the qualifying period, benefits will be payable under the terms of the Plan.

Conversion

If your LTD insurance ends, you may be able to convert to a private insurance policy, provided you have been insured under this policy for at least a year. You will have 31 days from the date your insurance ends to apply under the conversion policy and pay the first premium. POGH is not required. You can call Assurant Employee Benefits at 866.909.6065 to start the conversion process.

The conversion policy will be one that Assurant Employee Benefits offers for conversion at the time you apply. The premiums will be based on rates for conversion policies at that time. The effective date of coverage will be the day after your insurance under the Assurant Disability Plan ends.

You cannot convert if your LTD insurance ends because:

- The policy ends
- The policy is changed to end your coverage
- You are *disabled*
- You retire from Assurant or an associated company.

STD coverage cannot be converted to a private policy.

ARAG Group Legal Insurance

Enrollment 105

What the Plan Pays 105

Covered Services 105

Services Not Covered 107

Pre-existing Conditions 107

Waiver of Premium 107

Conversion 107

Plan Administrator 108

Enrollment

Enrollment in this plan is for the entire calendar year. If you enroll, your per pay period cost of coverage will be paid on an after-tax basis.

For more information on UltimateAdvisor:

- Visit ARAGLegalCenter.com and type in your Access Code: 11180aiz for detailed information on plan benefits, how to use the plan and FAQs.
- Talk to an ARAG Customer Care Counselor toll-free from 8 a.m. to 8 p.m. ET, Monday through Friday at 800.247.4184.
- E-mail an ARAG Customer Care Counselor at service@ARAGgroup.com.

What the Plan Pays

Under the plan, you may choose to receive services from any attorney. However, In-Office Legal Services benefits are paid differently depending on whether you see a Network Attorney (an attorney who is a member of the plan) or you see a Non-Network Attorney:

- If you see a Network Attorney, the plan pays attorney hourly fees in full for most covered legal matters. In addition, you do not need to file a claim for reimbursement; the Network Attorney does it for you. A complete list of Network Attorneys for your state, the areas of law they practice, their phone number and if they speak a foreign language will be provided to you after you enroll by calling 800.247.4184 or you can visit ARAG's site at ARAGLegalCenter.com and type in your Access Code: 11180aiz.
- Network Attorney Guarantee- If there is not a Network Attorney located within 30 miles of your home, ARAG guarantees you will receive in-network benefits. ARAG will work with you to arrange for you to receive covered legal services through an attorney in your area.
- If you receive services from a Non-Network Attorney, you pay the cost of legal services and then file a claim form along with your attorney's billing statement to ARAG. You will be reimbursed for covered expenses up to the lesser of actual costs or a scheduled amount outlined in the corresponding tables. If you see a Non-Network Attorney, you must notify ARAG within 60 days of consulting a Non-Network Attorney. In addition, your claim for reimbursement must be received by ARAG within 120 days after you incur a legal expense.

Covered Services

The plan generally covers the following services (however, please contact HR Services at 866.324.6513 for a more detailed summary of which services are covered, to what extent and whether there are price differences between a Network Attorney and a Non-Network Attorney):

- Access to free legal articles
- Access to Do-It Yourself Legal Documents
- Identity Theft Services
- Financial Education and Counseling Services
- Telephone Legal Services
- Immigration Services
- Name Change*
- Uncontested Court Adoption*
- Contested Court Adoption*
- Uncontest Guardianship/Conservatorship*

Page
Page
Main Table of Contents
Chapter Table of Contents
Back

- Contested Guardianship/Conservatorship*
- Mental Incompetency or Infirmity Proceedings*
- Small Claims Court*
- Consumer Protection*
- Defense of Consumer Debt*
- Bankruptcy*
- Foreclosure*
- Garnishment*
- Personal Property Protection*
- Purchase of Real Estate*
- Sale of Real Estate*
- Purchase/Sale of Secondary Residence*
- Refinancing of Primary Residence*
- Real Estate Disputes*
- Real Estate Disputes – Secondary Residence*
- Document Preparation and Review*
- Building Codes*
- Zoning and Variances*
- Easement*
- Neighbor Disputes*
- Neighbor Disputes – Secondary Residence*
- Tenant Matters*
- Defense of Civil Damage*
- IRS Audit Protection*
- IRS Collection Defense*
- Social Security/Veterans/Medicare*
- Prenuptial Agreements*
- Protection from Domestic Violence*
- Uncontested Divorce*
- Contested Divorce*
- Child Support Enforcement*
- Post Decree Defense*
- Post Decree Enforcement*
- Post Decree Modification*
- Habeas Corpus*
- Juvenile Court Proceedings*
- Parental Responsibilities*
- Administrative Regulation Protection*
- Minor Traffic Offenses excluding DWI related*
- Driving Privilege Protection excluding DWI related*
- Driving Privilege Restoration excluding DWI related*
- Wills and Durable Powers of Attorney*
- Codicil*
- Irrevocable Trusts*

Page
Page
Main Table of Contents
Chapter Table of Contents
Back

- Revocable Trusts *
- Estate Administration and Estate Closing*

* indicates a cost difference between a Network Attorney (whose services are generally paid-in-full) and a Non-Network Attorney (whose services are reimbursed to you up to a specified amount).

Services Not Covered

The plan does not cover:

- Matters against us, the policyholder or a member against the interests of the named plan member under the same Certificate.
- Legal services arising out of a business interest, investment interests, employment matters, your role as an officer or director of an organization, and patents or copyrights.
- Legal services in class actions, post judgments, punitive damages, malpractice, appeals, small claims court or equivalent court in your state.
- Legal services deemed by us to be frivolous or lacking merit, or in actions where you are the plaintiff and the amount we pay for your legal services exceeds the amount in dispute, or in our reasonable belief you are not actively and reasonably pursuing resolution in your case.

Telephone Legal Access Services include the Exclusions above and

- Matters which in the opinion of the Telephone Legal Access law Firm, may not ethically or appropriately be handled over the telephone.
- Matters which require in your and/or the Telephone Legal Access Law Firm's opinion, your personal presence in an attorney's office or your direct and personal representation by another attorney.
- Matters for which you have already received advice from another attorney.
- Matters outside the jurisdiction of the United States of America.

Pre-existing Conditions

Any legal matter which occurs or is initiated prior to your effective date will be considered excluded and no benefits will apply. ARAG defines initiated at the date when the infraction occurs or a document is filed with the court or when an attorney is hired.

Waiver of Premium

Death Benefit - This waiver of premium will cover the surviving spouse or domestic partner and insured dependents for one year from the date the named insured passed away. After that year, the spouse, domestic partner or insured dependent can roll their membership to the conversion plan.

Military Leave - Should a named insured be called to active duty for a period of more than thirty (30) consecutive days for the purposes of military service or of responding to a declared national emergency, coverage for the spouse and the insured dependents will continue, without the payment of premium, for the length of the named insured's absence and for so long as the named insured remains eligible for benefits through the policyholder.

Conversion

You may continue this insurance when you no longer qualify as an employee or as a member of the group to which this policy is issued. You must notify ARAG within 90 days of this disqualifying event to make arrangements for premium payment. Any questions regarding the ARAG conversion plan, please contact ARAG at 800.247.4184.

◂Page
Page ▸
Main Table of Contents
Chapter Table of Contents
◂◂Back

Plan Administrator

If you have any questions or concerns, please contact the plan administrator at ARAG®, 400 Locust Street, Suite 480, Des Moines, IA, 50309 or at 800.247.4184.

Please note that the ARAG group legal insurance plan is made available to all Assurant U.S. employees as a convenience, and is not endorsed by the Company. The plan agreement is between the employee and ARAG. Assurant's sole function is to coordinate enrollment and payroll deduction processing. Assurant is neither associated with nor responsible for any of the services that may be provided by ARAG, and all issues and concerns related to such services should be communicated to ARAG.

Page
Page
Main Table of Contents
Chapter Table of Contents
Back

Tuition Reimbursement Plan

Tuition Reimbursement Plan At-a-Glance 110

Eligibility 110

Eligible Expenses 111

Taxes 111

How the Plan Works 111
- Before You Register 111
- After Course Completion 111
- Following Course Completion 112

Exclusions 112

When Benefits End 113

Filing a Claim 113

Tuition Reimbursement Plan

You are encouraged to take full advantage of the Educational Assistance Plan (aka the Tuition Reimbursement Plan). The purpose of the program is to help share the cost of continuing your education so that you may gain, maintain or improve your business-related knowledge.

All courses must be part of a business-related degree program. Generally, courses in business administration, accounting, marketing, or other programs that are related to the Company's operations qualify.

Courses must be provided by an accredited college or university. A list of institutions accredited by the U.S. Secretary of Education is available through the U.S. Department of Education Web site.

All courses should be scheduled outside of normal work hours and should not interfere with your work.

Page
Page
Main Table of Contents
Chapter Table of Contents
Back

Tuition Reimbursement Plan At-a-Glance

Plan Feature	
Eligibility Undergraduate Level	Active, regular employees who: • Are regularly scheduled to work at least 20 hours a week • Have completed at least 6 months of service prior to the start of the class • Have good attendance records • Demonstrate job performance of "Performing" or better for the six months prior to the start of the academic term.
Graduate Level	Active full-time, regular employees who: • Have completed at least 12 months of service prior to the start of the academic term • Demonstrate job performance of "Performing" or better for the six months prior to the start of the academic term.
Eligible Expenses	Tuition for business or business-related undergraduate and graduate school programs at an accredited institution.
Reimbursement Amount Undergraduate Level	100 percent of eligible expenses, up to: • $5,250 per calendar year for full-time employees • $3,938 per calendar year for part-time employees.
Graduate Level	100 percent of eligible expenses

Eligibility

All employees must be actively at work to participate in the Tuition Reimbursement Plan. There are other eligibility requirements that vary for the undergraduate and graduate level courses. To be eligible for reimbursement of eligible expenses under an undergraduate degree, you must be an active, regular employee who:

- Is regularly scheduled to work at least 20 hours a week
- Has completed at least six months of service prior to the start of the academic term
- Has a good attendance record and
- Demonstrates job performance of "Performing" or better for six months prior to the start of the academic term and continues performing at that level for the duration of the program.

To be eligible for reimbursement of eligible expenses under a graduate level program, you must be an active, regular employee who:

- Has completed at least 12 months of service prior to the start of the academic term and

- Demonstrates job performance of "Performing" or better for the six months prior to the start of the academic term and continues performing at that level for the duration of the program.

Rehires

If you leave Assurant and are later rehired, your eligibility for the Tuition Reimbursement Plan will be based on the following:

- If you are rehired within 30 days of your termination date, you will be given credit for your prior service with Assurant and
- If you are rehired more than 30 days after your termination date, you must complete at least six months of service from the date of your rehire before becoming eligible.

Eligible Expenses

Eligible expenses include:

- The cost of tuition for business or business-related undergraduate or graduate degree programs at an a*ccredited institution*
- Expenses for proficiency exams for credit, provided the exam is passed and
- Books you purchase to attend a course.

You must receive a grade of "C" or better for reimbursement of undergraduate expenses. Reimbursement for graduate level expenses requires that you receive a grade of "B" or better.

Taxes

Reimbursements for degree programs are not included in your income for federal and Social Security tax purposes.

Reimbursements for graduate degree programs also are not included in your taxable income if the program:

- Is a requirement for your present position or
- Maintains or improves skills needed for your current position.

How the Plan Works

Before You Register

You must obtain approval from your manager, Human Resources and for graduate courses, your business segment's Senior HR Leader to participate in this Plan. Your application also must be reviewed by HR Services before your class start date. Advance approval is obtained by submitting the Assurant Application for Approval to Participate in an Undergraduate or Graduate Program to your supervisor/manager, Human Resources and HR Services. You can access the form(s) on the Corporate Intranet under Human Resources >> Employee Development >> Tuition Reimbursement Program. The HR Services must approve your request before you register for a course. The HR Services can be reached at 866.324.6513 or MyHR@assurant.com.

After Course Completion

To be reimbursed for your eligible educational expenses, you must receive a grade C or better for an undergraduate program and a grade B or better for a graduate program.

After you complete the course requirements, you must complete a Request for Tuition Reimbursement Form. This form is located on the Corporate Intranet under Human Resources >> Employee Development >> Tuition Reimbursement Program. Documentation must be submitted in full and only once per reimbursement request. The HR Services may contact you to request additional documentation if your request for reimbursement is incomplete.

Page
Page
Main Table of Contents
Chapter Table of Contents
Back

Documentation required with the Request for Tuition Reimbursement form includes:

- Proof of payment for tuition, with the detail of the cost per class or per credit hour
- Detailed receipts for books
- Financial assistance, such as grants, scholarships, awards, bonuses, and any pay for work that was deducted from the tuition cost
- Term enrollment and completion dates
- Class grades
- Manager's signature signifying you are performing your job at least at an acceptable level.

Fax the Request for Tuition Reimbursement Form and all required documentation to HR Services at 651.361.4023 within 45 days of course completion.

If your claim and the required documentation for undergraduate courses are not submitted by that year's claim filing deadline (announced by Payroll each December), your reimbursement will be applied against the following year's maximum reimbursement amount ($5,250 for full time employees; $3,938 for part-time employees).

Following Course Completion

You must complete six months and 12 months of employment after you receive reimbursement for undergraduate and graduate level courses, respectively. If you terminate your employment with Assurant before that time for any reason other than reduction in force or a job elimination, you will be required to repay Assurant for any amounts reimbursed to you during that period.

Exclusions

The following expenses are not included under the Tuition Reimbursement Plan:

- The cost of education involving sports, games or hobbies unless such educational expense involves the business of the employer or is required as part of a degree program
- Tools or supplies (other than textbooks) that you may retain after the course has ended
- Fees, meals, lodging and transportation
- Expenses for courses that you do not complete
- Expenses for undergraduate courses that you do not receive a grade of "C" or better; expenses for graduate courses that you do not receive a grade of "B" or better
- Executive MBAs (EMBAs) or Ph.D.'s
- Expenses for courses begun while you are on a leave of absence. If you already are taking a course when your leave begins, you will be eligible for the reimbursement of tuition costs upon successful completion of that course
- Educational expenses that can be reimbursed from other sources, such as scholarships, grants or veterans' benefits.

Individual departments and teams may have need of certification courses and other continuing education types of coursework. These expenses may be covered by your cost center manager but are not covered under the Tuition Reimbursement Plan. Some examples include LOMA and other insurance associations, CPA, CFA, CLE, actuarial certifications, and other professional designations.

In addition, employees, together with management, may elect to pursue a continuing education course in order to meet job requirements. Examples may include business writing courses, financial-related courses and business-related seminars and conferences. These types of courses also may be covered by your cost center manager but are not covered under the Tuition Reimbursement Plan.

◂Page
Page▸
Main Table of Contents
Chapter Table of Contents
◂◂Back

When Benefits End

Your benefits under the Tuition Reimbursement Plan will end on the earliest of the following:

- The date your employment ends.[17]
- The date your employment status changes to an ineligible status (e.g., your work schedule is reduced to less than 20 hours per week.)
- The date you are determined to have perpetuated fraud on the Plan.

If you terminate for any of the reason other than due to a reduction in force or job elimination or within six months and 12 months prior to your termination, respectively must be repaid to Assurant.
Any amount received from the Plan through fraud must be repaid to Assurant.

Filing a Claim

Within 90 days after receipt of proof of claim by HR Services, or within 180 days if special circumstances require an extension, HR Services will notify you in writing if your request for reimbursement is approved or denied. In the event of circumstances requiring more time, written notice will be given to you before the initial 90-day period expires. This notice will explain the circumstances and the date the decision will be furnished.

◂Page
Page▸
Main Table of Contents
Chapter Table of Contents
◂◂Back

[17] If your employment ends due to a reduction in force or job elimination, eligible expenses for courses you are participating in as of your termination date will be paid, provided the expenses meet all other claim requirements and you sign and do not revoke your severance agreement.

Commuter Benefits Program

Eligible Commutation Expenses 115

Limits on Monthly Pre-tax Deductions and Expenses 115

How to Enroll 115

Commuter Benefits Program

Federal tax laws allow employees to save taxes on parking at work and transit or vanpooling expenses incurred to get to work. Employees can save by setting up a pre-tax payroll deduction that reduces taxable income. Qualified expenses are exempt from federal income and FICA (Social Security and Medicare) taxes. Your tax savings will vary, depending on your deduction amount and your tax bracket.

The Commuter Benefit Program is a qualified transportation benefit program authorized by Internal Revenue Code (IRC) Section 132.

Page
Page
Main Table of Contents
Chapter Table of Contents
Back

Eligible Commutation Expenses

Eligible commutation expenses include the following:

- Bus
- Ferry
- Parking at or near work
- Parking at or near public transportation to get to work
- Streetcar
- Subway
- Train and
- Vanpool (seating capacity of 6 or more adults, excluding driver, where 80 percent or more of miles for which vehicle is used is for transporting employees back and forth between work and home during which trip the vehicle is at least 50 percent full).

Limits on Monthly Pre-tax Deductions and Expenses

The following limits are in effect for the 2017 calendar year:

- Parking deduction is limited to $255 per month for 2017.
- Transit passes and vanpooling, whether separate or combined, the deduction is limited to $255 per month for 2017.
- Any monthly costs above these limits cannot be exempt from taxes and cannot be carried over to future months.

Annual limits are set by the Internal Revenue Service.

How to Enroll

If you are a corporate employee working in the New York City office, you can enroll by visiting the WageWorks website at: wageworks.com. New users can register by clicking on the “Register with WageWorks Now” link. Employees outside of New York should contact their HR Representative.

You can enroll, change or terminate your pre-tax deductions at any time on a prospective basis.

Severance Pay Plan

Eligibility 117

How the Plan Works 117

Benefits 117
- Severance Payment 118
- COBRA Offset 118
- Outplacement 118

Offset Amount 118

Special Features 118
- Retiree Medical 118
- Short-Term Incentive Plan 119
- Tuition Reimbursement 119
- Assurant Long-Term Equity Incentive Plan (ALTEIP) 119

Rehires 119

Impact of Severance on Other Benefits 120

Exclusions 120

Severance Pay Plan

The Assurant Severance Pay Plan (Severance Plan) is designed to help ease your transition to a new job in the event of a reduction in force, job elimination, corporate divestiture, corporate reorganization or other qualifying reason as determined by the *Plan Administrator*.

In all cases, severance is granted entirely at the discretion of the *Plan Administrator*. All aspects of the Plan (including eligibility and the amount of benefits) are subject to the interpretation and discretion of the *Plan Administrator*, whose decisions are final and binding.

Page
Page
Main Table of Contents
Chapter Table of Contents
Back

Eligibility

You may be eligible to participate in the Severance Plan if your employment is terminated due to a reduction in workforce, job elimination, corporate divestiture, corporate reorganization or other qualifying reason as determined by the Plan Administrator and you are:

- An active, regular, full time employee of Assurant or
- An active, regular, part time employee who has been regularly scheduled to work at least 20 hours per week for more than 90 consecutive calendar days.

Any other person employed by Assurant who is designated by the *Plan Administrator*, at its sole discretion, as eligible also may participate in the Plan.

Further, you must demonstrate acceptable job performance, stay through the *transition date* given by your manager and sign (and do not revoke) a *severance agreement* to be eligible for Severance Plan benefits. You may choose not to sign the *severance agreement* or you may choose to revoke an already signed *severance agreement*, but doing so will disqualify you from receiving any benefits under the Severance Plan.

How the Plan Works

You will be notified in writing if you are eligible for severance benefits. The notification will include your *severance date*, the benefit amount and a *severance agreement*. You must sign and not rescind the *severance agreement* and return it to your local Human Resources Department before benefits can be paid.

Before you can receive a severance payment, you must meet the following requirements:

- Return all property that belongs to Assurant on or before your *severance date*
- Continue to work in a satisfactory manner during any notice period through your *severance date*
- Cooperate with your manager or supervisor in transitioning all your work, and
- Comply with all the requirements outlined in your *severance agreement*.

Benefits

The Severance Plan has three components:

- Severance payment
- COBRA offset and
- Outplacement.

The severance payment will be made in a lump sum as soon as administratively feasible after your *severance date* but no later than March 15 following the end of the plan year.

Severance Payment

Generally, your severance payment is your weekly base salary multiplied by the number of weeks in your severance period.

For each event, the *Plan Administrator* determines the number of weeks for every completed year of service measured from your hire date. This is called your severance period.

For certain employees, their severance period is based on their position with Assurant regardless of their years of service.

The minimum severance period is one month; the maximum is two years.

Rehire Severance Calculation

If you are a rehired employee, the calculation of your years of service will include prior service period(s) provided you were rehired within five years. Assurant will not give any credit for the gap in employment. If your former service period(s) ended due to a prior reduction in force, job elimination, corporate divestiture, corporate reorganization or other qualifying reason as determined by the *Plan Administrator*, any service included in the calculation of the prior severance payment(s) will not be included in the calculation of this or any subsequent severance payment.

COBRA Offset

The COBRA offset is a lump sum payment of the Company's contribution to your Health and/or Dental coverage plus the 2 percent COBRA administrative fee to help offset any COBRA costs you may incur. The COBRA offset will equal one month of the Company contribution if your severance period is four weeks. The offset will equal two months of the Company contribution if your severance period is more than four weeks.

You must participate in the Assurant Health and/or Dental Plan on the day before your *severance date* to be eligible for the COBRA offset, however you do not need to elect to continue your coverage under COBRA in order to receive this payment.

Outplacement

Outplacement services will be provided by an outside company specializing in these services. The level of outplacement services is based on your position within Assurant. Contact your local HR Representative for the details of this program.

Offset Amount

Payments under the Severance Pay Plan will be reduced by following:

- Applicable federal, state, and local income or employment taxes and any legally enforceable garnishments
- Amounts you may owe to Assurant and
- Amounts paid to you under the Worker Adjustment and Retraining Notification (WARN) Act, or any similar state or local law.

Special Features

Retiree Medical

If you were grandfathered in the Assurant Retiree Medical Program on July 1, 2011, your severance period will be added to your termination date for determining your eligibility and benefits under the Retiree Medical Program.

◂Page
Page▸
Main Table of Contents
Chapter Table of Contents
◂◂Back

Short-Term Incentive Plan

If you are eligible for Short-Term Incentive Plan (STIP) and your *severance date* is Oct. 1 – Dec. 31, you will be eligible for a pro-rated STIP payment in March of the following calendar year. The payment will be based on full year results for the year in which you terminated and the base salary you earned that year.

If you are eligible for Short-Term Incentive Plan (STIP) during the prior year and your severance date is J an. 1 – March 15, you will be eligible for a full STIP payment on March 15 based on the prior year's results and your base salary for the prior year.

You will not be eligible for any STIP payment if your severance date is March 16 - Sept. 30.

Tuition Reimbursement

If you are a participant in the Tuition Reimbursement Plan, you will be eligible for reimbursement of tuition and book expenses for courses begun before your termination according to the term of the Plan. You must submit all required documentation to HR Services within 45 days of the end of your courses(s). In addition, you will not be required to reimburse Assurant for amounts, if any, paid to you prior to your termination date.

Assurant Long-Term Equity Incentive Plan (ALTEIP)

If you are eligible for ALTEIP and you are terminated due to a reduction in force or job elimination, you will be vested in your awards on a pro-rata basis.

Restricted Share Units (RSUs) shares will be issued as soon as administratively feasible after your termination date. Performance Share Units (PSUs) shares will be issued at the end of the three-year performance cycle, based on actual results.

Rehires

If you are rehired by Assurant before the end of your *severance period*, you must repay that portion of your severance payment that represents the period between your rehire date and the end of your *severance period*.

An example

Jane was part of a reduction in force. She terminated on April 15, 2015 and she received a lump sum severance payment. Based on her complete years of service with Assurant, she was eligible for 14 weeks of severance (April 16 – July 22) of severance.

Jane was rehired by Assurant on July 6, 2015 - two weeks and two days before the end of her *severance period*. Therefore, she must repay Assurant the severance she received for the two full weeks between her rehire date (July 6) and the end of her severance period (July 22).

Severance paid:

1st week: April 16 – 22
2nd week: April 22 – 29
3rd week: April 29 – May 6
4th week: May 6 – 13
5th week: May 13 – 20
6th week: May 20 – 27
7th week: May 27 - June 3
8th week: June 3 – 10
9th week: June 10 – 17
10th week: June 17 – 24
11th week: June 24 – July 1
12th week: July 1 – 8

Page
Page
Main Table of Contents
Chapter Table of Contents
Back

13th week: July 8 – 15
14th week: July 15 – 22

Your severance benefits must be returned within 30 calendar days after your *rehire date* or within a period of time determined by the business segment.

If you accept a position that begins after your *severance period*, you will not be required to repay any portion of your severance payment.

Impact of Severance on Other Benefits

Your participation in all other employee benefit plans sponsored by Assurant will end as of your *severance date* unless continued according to the terms of the plan, program or policy (for example, health coverage under COBRA). Any benefits received under the Severance Plan will not be included as eligible compensation under any other benefits.

Exclusions

You will not be eligible for benefits under this Severance Pay Plan if:

- You resign or voluntarily terminate employment, even if you do so in anticipation of an involuntary termination
- You are involuntarily terminated and are offered *substantially similar employment* with Assurant or one of its business units, whether or not you accept the offer
- You are involuntarily terminated in connection with the sale or transfer of any portion of an Assurant business unit and you are offered *reasonably comparable (though not necessarily identical) employment* with the buyer or transferee, whether or not you accept the offer
- You are involuntarily terminated for cause
- You are transferred or reassigned to a position of *substantially similar employment* or
- You are eligible to receive benefits under an individual *severance agreement*, Change of Control Employment Agreement or the Change of Control Severance Plan.

Page
Page
Main Table of Contents
Chapter Table of Contents
Back

Plan Administration

Contact Information 122

Coverage during Leaves of Absence 123

Family and Medical Leaves 123
- Approved Disability Leaves 123
- Short-Term Disability 124
- Long-Term Disability 124
- Family Leave 124
- Qualifying Exigency Leave 124
- Military Caregiver Leave 125
- Military Leave 125

Premium Payments while on a Leave of Absence 125

When You Return to Work from a Leave 125

If You Do Not Return at the End of a Leave 126

Benefits Eligibility Request for Review 126

Claim Appeals 127
- If Your Claim Is Denied 127
- Appeals Procedures 127
- Final Third-Level Appeal 128
- External Review 128
- Other Important Information Regarding Your Appeals 128
- Where to Submit Your Appeal 129
- Special Claims 130
- Limitation on Legal Action 131

Subrogation and Right of Recovery 131
- Specific Requirements and Plan Rights 131
- Participant Duties and Actions 132

Recoupment 132

Grievances 132

Assignment of Benefit Payments 132

Plan Liability 132

Contact Information

The table below shows contact information for the insurance companies and service providers that administer Assurant benefits for the purpose of filing claims and for questions or comments. For general information regarding any of your benefits, contact:

Global HR Services
260 Interstate North Circle
Atlanta, GA 30339-2111
866.324.6513
MyHR@assurant.com

HR Services representatives are available Monday through Friday, 8:30 a.m. – 6:30 p.m. ET.

Plan	Address for Claims	Phone	Web Address
Health (including behavioral health and substance abuse claims)	Anthem BlueCross BlueShield P.O. Box 105187 Atlanta, GA 30348-5187 Account # 003330108	855.285.4212	anthem.com
Anthem 24/7 Nurseline	Not applicable	800.700.9184	anthem.com
Prescription Drug	CVS Caremark Inc. P.O. Box 52196 Phoenix, Arizona 85072-2196 Plan Code – RXBIN# 610029	866.587.4799	caremark.com
LiveHealth Online	Not applicable	855.603.7985	LiveHealthOnline.com (use code "assurant" if not enrolled in the Assurant Health Plan
Castlight	Not applicable	855.819.4717	mycastlight.com/Assurant
Health Savings Account	Not applicable	877.997.6123	myhealthequity.com
COBRA	Assurant, Inc. COBRA Unit P.O. Box 957377 St. Louis, MO 63195-7377	866.324.6513	MyHR@assurant.com
Flexible Spending Accounts	Assurant, Inc. Flexible Spending Dept. 6941 Vista Drive West Des Moines, IA 50266	866.324.6513 Fax: 651.361.4036	MyHR@assurant.com
Employee Assistance Program	New Directions P.O. Box 672 Leawood, KS 66206-0729	800.624.5544 Password: Assurant	ndbh.com
Dental	Assurant Employee Benefits now a member of the Sun Life Financial family P.O. Box 2943 Clinton, IA 52733-2943	800.735.4226	assurantemployeebenefits.com

Page
Page
Main Table of Contents
Chapter Table of Contents
Back

Plan	Address for Claims	Phone	Web Address
Short-Term Disability	The Reed Group P.O. Box 6248 Broomfield, CO 80021	518.283.8298 866.829.8859	
Long-Term Disability	Assurant Employee Benefits now a member of the Sun Life Financial family P. O. Box 419744 Kansas City, MO 64141-6744 Policy # 61,890	800.998.7858	
Basic Life and AD&D, Supplemental Life and AD&D, Depen-dent Life Insurance	Assurant Employee Benefits now a member of the Sun Life Financial family P. O. Box 419876 Kansas City, MO 64141-6744 Policy # G 61,890 Basic Life and Basis AD&D Insurance Policy # 761,890 – Supplemental Life and AD&D, Dependent Life Insurance	816.474.2345 800.733.7879	
Business Travel Accident Insurance	Policy # BTAB 50243-229	888.870.2947	

Page
Page
Main Table of Contents
Chapter Table of Contents
Back

Coverage during Leaves of Absence

With a few exceptions, the continuation of your Health and Welfare benefits during a leave of absence depends on several factors including:

- The type of leave
- The length of the leave and
- Whether you pay the required premium, if any, on a timely basis.

The exceptions are that Business Travel Accident Insurance ends on the day before your leave of absence starts and your participation in the Dependent Day Care Flexible Spending Account (FSA) is suspended if your leave is for more than two weeks. Note – otherwise eligible expenses under the Dependent Day Care FSA that you incur while on leave cannot be reimbursed under the Dependent Day Care FSA.

The Internal Revenue Service considers a significant reduction in your pay to be a qualifying life event. You have the opportunity to terminate coverage while on the leave of absence. Your coverage can be reinstated when you return to work. If you decide to discontinue all or part of your coverage, you must submit a Life Event Form to HR Services within 30 days of your leave start date.

Family and Medical Leaves

Approved Disability Leaves

Assurant will continue to contribute toward the cost of your benefits while you are on an approved disability leave of absence. You can continue your Health, Dental, Health Care FSA, Supplemental Life, Supplemental Accidental Death & Dismemberment and Dependent Life Insurance by paying your portion of the premium on a timely basis.

If you are on a leave of absence for more than two weeks, you will be unable to contribute to a Dependent

Day Care Flexible Spending Account. In addition, any expenses incurred while on the leave cannot be reimbursed under the Plan.

If your disability leave is not approved by The Reed Group or Assurant Employee Benefits and you do not return to work, your benefits will end as outlined in When Benefits End.

Short-Term Disability

If you receive Short-Term Disability (STD) benefits, deductions will continue to be taken from your pay.[18] If your STD benefits are not enough to cover your deductions (garnishments, benefit costs, etc.) or you are not yet eligible for STD, Assurant will bill you for your portion of the premiums.

Long-Term Disability

If you continue to be *disabled* under the terms of the Plan after STD benefits are exhausted, you may be eligible for Long-Term Disability (LTD) benefits. If approved, Assurant Employee Benefits pays LTD benefits at the end of the month. For example, if you are approved for LTD effective January 7, your benefit payment for the period January 7 – January 31 will be made at the end of January.

You also may qualify for waiver of premium for your Basic Life, Supplemental Life, Basic AD&D, Supplemental AD&D and Dependent Group Life Insurance premiums if you are approved for LTD benefits. See the Disability Benefits section under Life Insurance for more information.

Assurant will bill you for your portion of your Health and Dental premiums each semi-monthly period. If you are not approved for waiver of premium as described above, Assurant also will bill you for Supplemental Life, Supplemental Accidental Death & Dismemberment and Dependent Life Insurance premiums.

Your Health and Dental coverage can continue under the Assurant Plan until you terminate employment. You will be offered the opportunity to continue coverage under COBRA if you terminate employment due to disability, Assurant will subsidize the cost of your COBRA coverage. Alternatively, coverage may be available through the Group Insurance Marketplace, but it will not be subsidized.

If you do not qualify for waiver of premium as outlined above, you can convert your Basic, Supplemental and Dependent Life Insurance to private policies upon termination of employment. Basic and Supplemental Accidental Death and Dismemberment Insurance cannot be converted to private policies.

It is important that you stay up-to-date with your premium payments as you transition from Short-Term Disability (benefits are paid semi-monthly through payroll) to Long-Term Disability (Assurant Employee Benefits pays benefits monthly at the end of the month). Your benefit coverage could terminate if premiums are not received on a timely basis. If Health and Dental coverage terminates for failure to pay the premium, you will not be eligible for COBRA.

Family Leave

If you take an approved family leave that meets the requirements of the Family and Medical Leave Act of 1993 (FMLA) or similar state legislation, your benefits can continue for up to 12 weeks, as long as you make timely payments for your share of the contribution. FMLA leave also is a qualified life event, meaning you can terminate your coverage when you start the leave and reinstate it when you return to work.

Qualifying Exigency Leave

If you are approved for a *qualifying exigency leave* that meets the requirements of the Family and Medical Leave Act of 1993 (FMLA) or similar state legislation, your benefits can continue for up to 12 weeks, as long as you make timely payments for your share of the contribution.

[18] STD benefits are payable on a pre-tax basis. Deductions will be withheld on an after-tax basis.

Page
Page
Main Table of Contents
Chapter Table of Contents
Back

Military Caregiver Leave

If you take an approved Military Caregiver Leave, your benefits can continue for up to 26 weeks when the leave is due to care for an injured or ill service member, as long as you make timely payments for your share of the contribution. (Leave to care for an ill service member when combined with other FMLA-qualifying leave may not exceed 26 weeks in a single 12-month period.)

Military Leave

If your leave meets the requirements of *Uniformed Services Employment and Reemployment Rights Act (USERRA)*, your health and welfare benefits will continue as if you remained employed for military service of less than 31 days.

If you take a military leave of more than 30 days, you can continue your benefits provided you continue to make timely payments for your share of the cost. Assurant will continue to contribute toward the cost of your coverage. If you receive a *military pay differential*, deductions may continue to be taken from your pay. If the military pay differential is not enough to cover your deductions (taxes, garnishments, benefit costs, etc.) or you are not eligible for the *military pay differential*, Assurant will bill you for your portion of the premium.

Note: The disability benefit under Basic and Supplemental Life and Dependent Life Insurance, Basic and Supplemental Accidental Death and Dismemberment and Long-Term Disability Insurance and Short-Term Disability coverage have exclusions for a death or disability that results from your service in the military. See AD&D Exclusions; LTD Exclusions; STD Exclusions.

If a military leave extends beyond one year, your benefits under the Assurant Health and Welfare Plan end as described under each of the plans. You can continue Health, Dental and EAP coverage for yourself and your enrolled eligible dependents through COBRA for an additional 18 months. The Company will continue to contribute toward the cost of your coverage as if you were an active employee during this period. Your Basic and Supplemental Life and Dependent Life Insurance can be converted to private policies within 30 days of the date coverage ends. Long-Term Disability also can be converted if you have been covered for at least one year. You cannot convert AD&D insurance or Short-Term Disability.

Premium Payments while on a Leave of Absence

If you terminate coverage during your leave or you do not pay your portion of the premiums within 30 days of the due date, your Health and Dental coverage will terminate retroactive to the last day of the month for which the Company received your last premium payment. Supplemental Life, Supplemental AD&D and Dependent Life Insurance end on last day of the pay period for which you last paid premiums. Health Care FSA coverage will terminate retroactive to the last day of the pay period for which your last contribution was received. Any claims you incur while you are not participating in a plan (including Flexible Spending Accounts) will not be covered and you may be responsible for any associated expenses.

If benefits are terminated because the premiums were not received within 31 days of the due date, they cannot be reinstated more than one time until you return to an active status. Any benefits that may have been paid on your behalf will need to be returned. Any claims you incur while you are not participating in a plan (including Flexible Spending Accounts) will not be covered and you may be responsible for any associated charges. See Subrogation and Right of Recovery for more information.

When You Return to Work from a Leave

Generally, if your leave of absence was for 30 days or less, you will “step back” into the benefits you had prior to the start of your leave, and any missed premiums will be deducted from your pay.

If you go on a leave of absence and miss any Health Care or Dependent Day Care FSA contributions, your annual goal amount will be adjusted so that your deductions per pay period remain the same. For example, if your total contribution for the year was $2,400 and you missed $400 in contributions while on leave, your new

Page
Page
Main Table of Contents
Chapter Table of Contents
Back

annual contribution will be adjusted to $2,000. Note: If you are on a leave of absence for two weeks or longer, you cannot contribute to or receive reimbursements from a Dependent Day Care FSA for any expenses incurred while on leave.

You will need to make new elections upon your return to work if:

- Your unpaid leave is longer than 31 days
- Your leave crosses over into a new calendar year, regardless of the length of the leave
- You cancel your benefits at the start of the leave or
- You do not pay for your portion of your benefit costs.

POGH will be required if you decide to re-enroll in Supplemental Life or Dependent Life Insurance. Contact HR Services at 866.324.6513 or MyHR@assurant.com for information on reinstating your benefits.

If You Do Not Return at the End of a Leave

Your benefits will terminate if you do not return to work after:

- 12 weeks of Family and/or Qualifying Exigency leave under FMLA
- 26 weeks of approved Military Caregiver Leave
- You no longer are considered *disabled* under the terms of the Disability Plan as determined by The Reed Group or Assurant Employee Benefits, as applicable and
- An approved, unpaid leave under the Americans with Disabilities Act or similar, applicable state law.

Your benefits will also terminate if you advise Assurant that you will not be returning to work before the end of your leave. You may be eligible for COBRA coverage.

Health, Dental and EAP coverage ends on the last day of the month that your employment ends. Flexible Spending Account coverage will terminate retroactive to the last day of the pay period for which your last contribution was received. See COBRA for details on how you may be able to continue this coverage after termination.

All other benefits end on the day your employment ends. See Conversion to an Individual Policy and Conversion for information on converting your Life and Disability Insurance.

Benefits Eligibility Request for Review

If you believe that an incorrect decision has been made regarding your eligibility to enroll in, change, terminate, or timely pay your share of any of the Assurant benefits available to you, you may ask the Assurant Benefit Plans Committee, or its delegate, to review the decision.

You have 60 days in which to submit a request for review to the Assurant Benefit Plans Committee. Your appeal must:

- Be in writing
- Provide specific information regarding the basis for your appeal, and
- Include all supporting documentation

Your written request for review must be received no later than 60 days after the date on which your benefits were affected. If you miss a deadline and your benefits are affected or your enrollment is denied, you may submit a request for review that must be received within 60 days after the date on which you benefits were affected. Requests that are received late are not eligible for review.

The Assurant Benefit Plans Committee, or its delegate, will provide you with written notice of its decision within 60 days of the date it receives your appeal. If special circumstances require an extension of time,

◂Page
Page ▸
Main Table of Contents
Chapter Table of Contents
◂◂Back

you'll be notified of the extension within the initial 60-day review period. An extension will provide the Assurant Benefit Plans Committee 60 additional days in which to respond.

If, upon review, the eligibility determination is upheld, you will be provided with an explanation of the reason(s), as well as references to the plan provisions on which the decision is based. The decision of the Assurant Benefit Plans Committee is final and is not subject to further review or appeal. The eligibility review process does not permit you, your beneficiary or authorized representative the opportunity to appear in person before, or meet with the Assurant Benefit Plans Committee, or any of its representatives.

Page
Page
Main Table of Contents
Chapter Table of Contents
Back

Claim Appeals

A claim is any request for a benefit made in accordance with these claim procedures. A request for benefits not made according to these procedures will not be treated as a claim. Questions regarding eligibility and casual inquiries, including requests for prior approval where prior authorization is not required, are not claims. All questions relating to eligibility as well as inquiries regarding payment of required employee contributions are subject to the eligibility review procedures discussed above.

If Your Claim Is Denied

If your claim for benefits is denied, you may have it reviewed in accordance with the following claims review procedures. The procedures will vary depending on the type of benefit claim. In order for your appeal to be considered, it must be submitted in writing, within the prescribed time limit (see following chart). You must include a cover letter, explaining why you think the denial was in error and refer to the specific section(s) in the Health and Welfare Benefit Plan Summary Plan Description and/or other facts that you believe support your appeal. You must also submit all relevant documentation. For example, if your denied claim was for medical treatment, include a copy of the actual bill with the dates of service, fees charged, diagnosis, and a description of services provided. Include all pertinent medical notes from your attending *physician*(s) or *hospital* if you were confined, the explanation of benefits form(s) indicating how the claim was processed and, for second and third level appeals, include a copy of the declination letter(s).

Appeals Procedures

Generally, the following steps describe your appeal procedures for post-service claims:

Step 1: Notice is received from the *Claims Administrator*.

If your claim is denied, you will receive written notice from the *Claims Administrator*. The time frame in which you will receive this notice is described in Special Claims. In addition, the *Claims Administrator* may request an extension of time in which to review your claim for reasons beyond the *Claims Administrator*'s control. If the reason for the extension is that you need to provide additional information, you will be given a certain amount of time in which to obtain the requested information. The time period during which the *Claims Administrator* must make a decision will be suspended until the earlier of the date that you provide the information or the end of the applicable information-gathering period.

Step 2: Review your notice carefully. It will contain:

- The reason(s) for the denial and the plan provisions on which the denial is based.
- A description of any additional information necessary for you to perfect your claim, why the information is necessary, and your time limit for submitting the information.
- A description of the Plan's appeal procedures and the time limits applicable to such procedures, including a statement of your right to bring a civil action following a denial of your appeal.
- A statement indicating whether an internal rule, guideline or protocol was relied upon in making the denial and that a copy of that rule, guideline or protocol will be provided free of charge upon request.
- If the denial is based on a *medical necessity*, *dental necessity*, *experimental /investigative treatment* or a similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination or a statement that such explanation will be provided free of charge upon request.

Step 3: If you disagree with the decision, file a 1st Level Appeal with the *Claims Administrator*.

If you do not agree with the decision of the *Claims Administrator* and you wish to appeal, you must file a written appeal with the *Claims Administrator* within 180 days of receipt of the *Claims Administrator*'s letter referenced in Step 1. You should also submit all information referenced in Step 2 with your appeal (information necessary to perfect your claim and any other information that you believe will support your claim).

Step 4: 1st Level Appeal notice is received from the *Claims Administrator*.

If the claim is again denied, you will be notified by the *Claims Administrator* within the time period described in the chart on the following page.

Step 5: Review your notice carefully.

You should take the same action that you took in Step 2 (review your notice carefully and gather any additional information requested or that you believe will be helpful). The notice will contain the same type of information that is provided in the first notice of denial provided by the *Claims Administrator*.

Step 6: If you still disagree with the *Claims Administrator*'s decision, file a 2nd Level Appeal.

If you still do not agree with the *Claims Administrator*'s decision and you wish to appeal, you must file a written appeal with the *Claims Administrator* at the address listed in your denial notice within 60 days after receiving the 1st Level Appeal denial notice from the *Claims Administrator*. You should gather any additional information that is identified in the notice as necessary to perfect your claim and any other information that you believe will support your claim.

If the *Claims Administrator* denies your 2nd Level Appeal, you will receive notice within the time period described under Special Claims. The notice will contain the same type of information that was referenced in Step 2.

A claim is not deemed to be "filed" for purposes of these claims review procedures until it is filed in accordance with the "Filing a Claim" sections of this Summary Plan Description and it is received by the *Claims Administrator* or, where applicable, the *Benefit Plans Committee*.

Final Third-Level Appeal

Health, Dental and Short-Term Disability benefits allow for a third-level appeal. If the denial of your claim has been upheld after two levels of appeal, you may file a final third-level appeal with the Assurant Benefit Plans Committee (BPC). An appeal to the BPC is voluntary; you are not required to file an appeal with the BPC before bringing suit against the Plan under ERISA.

Your request for a third-level appeal must be made in writing and received by the BPC no more than 60 days from the date you received your second-level appeal decision.

External Review

Once you have exhausted the internal appeal procedures described herein, a separate external appeal opportunity may be available for adverse benefit determinations that relate to certain medical judgments or rescission of coverage. If your medical claim for benefits has been denied and you received a final adverse benefit determination in response to your subsequent appeal, the notification of final adverse benefit determination will provide instructions on how to request an external review. Please contact HR Services if you have questions about the internal claim and appeal procedure standards or external review process.

Other Important Information Regarding Your Appeals

Each level of appeal will be independent from the previous level (i.e., the same person(s) or subordinates of the same person(s) involved in a prior level of appeal will not be involved in the second level appeal) for the Health Plan and Dental Plan.

If a claim involves medical/dental judgment, then the *Claims Administrator* will consult with an independent health care professional who has expertise in the specific area involving medical/dental judgment during the

◂Page
Page ▸
Main Table of Contents
Chapter Table of Contents
◂◂Back

first-level appeal and second-level appeal for the Health Plan and Dental Plan.

On each level of appeal, the claims reviewer will review relevant information that you submit, including new information or information that you did not submit at an earlier stage of the claims process. In addition, you have a right to request documents or other records relevant (as defined by ERISA) to your claim.

If you wish to submit documentation to be considered in reviewing your claim or appeal, you must submit it at the time you file your claim and/or appeal.

You cannot file suit in federal court until you have exhausted these appeals procedures.

Please note that while the steps described apply to claims filed for Health and Dental expenses, the time periods for making a decision will vary depending on the type of benefit. Please refer to the charts below.

Your written appeal must include copies of the initial claim decision, first- and second-level appeal letters and their denials along with any additional documentation that you have supporting your claim for benefits.

Within 60 days of the date the BPC receives your request for a review, the BPC will notify you in writing of its decision or request additional time to reach a decision based on the existence of special circumstances (but no more than 120 days from the day your completed application for appeal is received).

Remember, this third-level appeal is voluntary. You are not required to submit such a request before bringing any legal action or requesting an external review.

◂Page
Page▸
Main Table of Contents
Chapter Table of Contents
◂◂Back

Where to Submit Your Appeal

Appeals should be sent to the following addresses:

Type of Appeal (By Plan)	1st and 2nd Level Appeal	3rd Level Voluntary Appeal
Health Plan (Blue, Green and Orange Plan options)[19]	Anthem BlueCross BlueShield P.O. Box 105187 Atlanta, GA 30348-5187	Assurant Benefit Plans Committee 28 Liberty Street 41st Floor New York, NY 10005
Prescription Drugs under the Health Plan	CVS Caremark Appeals Department MC109 PO Box 52084 Phoenix, AZ 85072-2084	Assurant Benefit Plans Committee 28 Liberty Street 41st Floor New York, NY 10005
Dental Plan	Assurant Employee Benefits P.O. Box 2943 Clinton, IA 52733	Assurant Benefit Plans Committee 28 Liberty Street 41st Floor New York, NY 10005
Short-Term Disability	Reed Group P.O. Box 6248 Broomfield, CO 80021	Assurant Benefit Plans Committee 28 Liberty Street 41st Floor New York, NY 10005
Long-Term Disability	Assurant Employee Benefits P.O. Box 419744 Kansas City, MO 64141-6744	N/A
Basic Life and AD&D, Supplemental Life and AD&D, Dependent Life Insurance	Assurant Employee Benefits P.O. Box 419744 Kansas City, MO 64141-6744	N/A

[19] An external review may be available after the 3rd voluntary appeal if the denial relates to certain medical judgments or a rescission of coverage.

Type of Appeal (By Plan)	1st and 2nd Level Appeal	3rd Level Voluntary Appeal
Business Travel Accident Insurance	AXIS Accident & Health 1 University Square Drive, Suite 200 Princeton, NJ 08540 Attn: Claims Department	N/A
Flexible Spending Accounts	Assurant, Inc. Flexible Spending Dept. 6941 Vista Drive West Des Moines, IA 50266	Assurant Benefit Plans Committee 28 Liberty Street 41st Floor New York, NY 10005
Educational Assistance Plan (aka Tuition Reimbursement)	HR Services 260 Interstate North Circle Atlanta, GA 30339-2111	Assurant Benefit Plans Committee 28 Liberty Street 41st Floor New York, NY 10005
Severance Pay Plan	1st Level Appeal Business Segment Senior HR Executive 2nd level Appeal Assurant Benefit Plans Committee 28 Liberty Street 41st Floor New York, NY 10005	N/A

Page
Page
Main Table of Contents
Chapter Table of Contents
Back

Special Claims

The table below reviews how to appeal special types of group health plan claims.

Type of Claim	Level 1 Appeal	Level 2 Appeal
Urgent care claim: a claim for medical care or treatment where delay could: • Seriously jeopardize your life or health, or your ability to regain maximum function, or • Subject you to severe pain that cannot be adequately managed without the requested care or treatment.	36 hours Review provided by *Claims Administrator* personnel not involved in making the adverse benefit determination.	36 hours Review provided by the *Claims Administrator.*
Pre-service claim: a claim for a benefit that requires the Claims Administrator's approval of the benefit in advance of obtaining medical care.	15 calendar days Review provided by *Claims Administrator* personnel not involved in making the adverse benefit determination.	15 calendar days Review provided by *Claims Administrator.*
Concurrent care claim extension: a request to extend a previously approved course of treatment.	Treated like an urgent care claim or a pre-service claim depending on the circumstances.	Treated like an urgent care claim or a pre-service claim depending on the circumstances.
Post-service claim: a claim for a benefit that is not a pre-service claim.	30 calendar days Review provided by *Claims Administrator* personnel not involved in making the adverse benefit determination.	30 calendar days Review provided by *Claims Administrator.*

You also may choose to have another person (an authorized representative) make the appeal on your behalf by providing written consent to the *Claims Administrator*. However, in case of an *urgent care* claim or a pre-service claim, a *physician* familiar with the case may represent you in the appeal.

For Health Plan claims only: You and/or an authorized representative may attend the second-level appeal hearing and question the representative of Anthem and any other witnesses and present your case. The hearing will be informal. You may bring your physician or other experts to testify. Anthem also has the right to present witnesses.

Limitation on Legal Action

Any legal action to receive benefits must be filed the earlier of:

- One year from the date a determination is made under the particular plan or should have been made in accordance with the Plan's claims review procedures, or
- Two years from the date the service or treatment was provided.

Your failure to file suit within this time limit results in the loss/waiver of your right to sue.

The charts below shows the time limits for you to submit appeals and for the *Claims Administrator* or Benefit Plan Committee to respond.

Subrogation and Right of Recovery

When you or your dependent receive benefits under any of the plans that are related to expenses that are also payable under *workers' compensation*, any statute, any uninsured or underinsured motorist program, any no fault or school insurance program, any other insurance policy or any other plan of benefits, or when related expenses that arise through an act or omission of another person are paid by a third party, whether through legal action, settlement or for any other reason, you or your dependent shall reimburse the Plan for the related benefits received out of any funds or monies you or your dependent recovers from any third party.

Specific Requirements and Plan Rights

Because the Plan is entitled to reimbursement, the Plan shall be fully subrogated to any and all rights, recovery or causes of actions or claims that you or your dependent may have against any third party. This means that the Plan is granted a specific and first right of reimbursement from any payment, amount or recovery from a third party. This right to reimbursement is regardless of the manner in which the recovery is structured or worded, and even if you or your dependent has not been paid or fully reimbursed for all of their damages or expenses.

The Plan's share of the recovery shall not be reduced because the full damages or expenses claimed have not been reimbursed unless the Plan agrees in writing to such reduction. Further, the Plan's right to subrogation or reimbursement will not be affected or reduced by the "make whole" doctrine, the "fund" doctrine, the "common fund" doctrine, comparative/contributory negligence, "collateral source" rule, "attorney's fund" doctrine, regulatory diligence or any other equitable defenses that may affect the Plan's right to subrogation or reimbursement.

The Plan may enforce its subrogation or reimbursement rights by requiring you or your dependent to assert a claim to any of the benefits to which you or your dependent may be entitled. The Plan will not pay attorney's fees or costs associated with the claim or lawsuit without express written authorization from the employer. If the Plan should become aware that you or your dependent has received a third-party payment, amount or recovery and not reported such amount, the Plan, in its sole discretion, may suspend all further benefits payments related to you or any of your dependents until the reimbursable portion is returned to the Plan or offset against amounts that would otherwise be paid to or on behalf of you or your dependents.

◂Page
Page ▸
Main Table of Contents
Chapter Table of Contents
◂◂Back

Participant Duties and Actions

By participating in the Plan, you and your dependents consent and agree that a constructive trust, lien or an equitable lien by agreement in favor of the Plan exists with regard to any settlement or recovery from a third person or party. In accordance with that constructive trust, lien or equitable lien by agreement, you and your dependents agree to cooperate with the Plan in reimbursing it for plan costs and expenses.

Once you or your dependent has any reason to believe that you or they may be entitled to recovery from any third party, you or your dependent must notify the Plan. And, at that time, you and your dependent (and your or their attorney, if applicable) must sign a subrogation/reimbursement agreement that confirms the prior acceptance of the Plan's subrogation rights and the Plan's right to be reimbursed for expenses arising from circumstances that entitle you or your dependent to any payment, amount or recovery from a third party.

If you or your dependent fails or refuses to execute the required subrogation/reimbursement agreement, the Plan may deny payment of any benefits to you and any of your dependents until the agreement is signed. Alternatively, if you or your dependent fails or refuses to execute the required subrogation/reimbursement agreement and the Plan nevertheless pays benefits to or on behalf of you or your dependent, your or your dependent's acceptance of such benefits shall constitute agreement to the Plan's right to subrogation or reimbursement.

You and your dependent consent and agree that you or they shall not assign your or their rights to settlement or recovery against a third person or party to any other party, including their attorneys, without the Plan's consent. As such, the Plan's reimbursement will not be reduced by attorneys' fees and expenses without express written authorization from the employer.

Recoupment

The Plan has the right to recover any mistaken payment, overpayment or any payment that is made to any individual who was not eligible for that payment. The Plan, or its designee, may withhold or offset future benefit payments, sue to recover such amounts, or may use any other lawful remedy to recoup any such amounts.

Grievances

If you are dissatisfied with the service received from Anthem, the quality of care you are receiving or want to file a complaint about a *network provider*, you may file a grievance. To file a grievance, call or write to Anthem Member Services within 30 days of the incident. Include a detailed description of the matter and include copies of any records or documents that you think are relevant to the matter. Anthem will review the information and provide you with a written decision within 30 calendar days of the receipt of the grievance, unless additional information is needed, but cannot be obtained within this time frame. The notice of the decision will specify what you need to do to seek an additional review.

Assignment of Benefit Payments

In general, you cannot voluntarily assign your health care benefit payments under any of the Assurant plans to anyone other than your health care *providers*. This prevents garnishments, attachments and voluntary or involuntary assignments for the benefit of creditors.

Plan Liability

Your Assurant benefits will pay benefits only for expenses incurred while this coverage is in force. Except as described in any extended benefits provision, no benefits are payable for expenses incurred before your coverage has started or after your coverage has ended — even if the expenses were incurred as a result of an accident, *injury* or death that occurred, began or existed while coverage was in force. An expense for a service or supply is incurred on the date the service or supply is furnished.

◂Page
Page▸
Main Table of Contents
Chapter Table of Contents
◂◂Back

Required Notices

Required Notices 134

Consolidated Omnibus Budget Reconciliation Acts (COBRA) 134

What Benefits Does COBRA Cover? 134
- Enrolling in COBRA Coverage 134
- Extended Coverage 135
- Changing COBRA Coverage 136
- When COBRA Coverage Ends 136

Employee Retirement Income Security Act (ERISA) 137
- Plan Information 137
- Your Rights under ERISA 138
- If a Plan is Amended, Modified, Suspended or Terminated 139

Health Insurance and Portability Act (HIPAA) 139
- Notice of Privacy Practices 139
- How We May Use and Disclose PHI Information about You 140
- Your Rights Regarding PHI about You 141
- Complaints 142

Mental Health Parity 142

Newborns' and Mothers' Health Protection Act 143

Patient Protection and Affordable Care Act (PPACA) 143

Women's Health and Cancer Rights Act 144

Required Notices
Consolidated Omnibus Budget Reconciliation Acts (COBRA)

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) gives you and your covered dependents the right to continue health care coverage at group rates if your Assurant coverage ends due to one of the following qualifying events:

- Termination of employment for any reason other than gross misconduct
- Reduction in the number of hours you work
- Death of employee
- Divorce or legal separation
- Dependent child attaining the limiting age (end of calendar year in which he/she turns age 26) and
- Commencement of a bankruptcy proceeding concerning an employer from whose employment the covered employee retired.

Although federal law limits the definition of a qualified beneficiary to include only covered employees, *spouses* (as defined by federal law) and dependents, Assurant allows you to continue coverage for your domestic partner and his/her children as well. Generally, your COBRA premium for the first 18 months of coverage will be 102 percent of the total (both employer and employee) cost of the coverage.

Note: There may be other more cost-effective coverage options for you and your family through the Health Insurance Marketplace, Medicaid or another group health plan (such as a spouse's plan) through what is called a "special enrollment period". You can learn more about these options at http://www.healthcare.gov.

What Benefits Does COBRA Cover?

If you and/or your enrolled dependents lose health coverage as a result of certain qualifying events, COBRA allows you to continue health coverage (including medical, prescription drug, employee assistance program and dental) for up to 36 months. Further, if you have a positive balance in your Health Care Flexible Spending Account at the time your participation ends, you can continue to participate through the end of the calendar year in which your participation in the Assurant Plan ends by making after-tax contributions to the *COBRA Administrator*.

Your coverage under COBRA will be the same benefits as you were eligible to receive as an active employee. If the coverage or premiums change for active employees under the Plan, the same changes will apply to you and/or your enrolled dependents.

A child born, adopted or placed for adoption during your COBRA continuation period is considered a qualifying beneficiary.

Generally if you drop your spouse from coverage during Annual Enrollment, it is not a qualifying event. However, if you later divorce or legally separate, your *spouse* may be entitled to COBRA as of the date of the divorce or legal separation even if it is later than 60 days after the loss of coverage. The termination of the coverage at Annual Enrollment may be deemed by the *Plan Administrator* to be "in anticipation of" the divorce or legal separation. You or your former *spouse* must notify the COBRA Unit within 60 days of the divorce or legal separation to elect COBRA continuation coverage. The COBRA Unit can be reached at 866.866.4488, ext. 4500.

Enrolling in COBRA Coverage

When you terminate employment, your hours are reduced or you pass away, Assurant will send a COBRA Continuation of Coverage Election Notice (COBRA Notice) and a COBRA Coverage Continuation Application (COBRA Application) to your home address.

◂Page
Page▸
Main Table of Contents
Chapter Table of Contents
◂◂Back

If you have a dependent who loses coverage due to a qualifying event, for example due to divorce or a child reaching the maximum age limit, you, your spouse/domestic partner or your former spouse/domestic partner must notify HR Services in writing within 60 days of the qualifying event. Your notification must include your name and Social Security number, the qualifying beneficiary's name, Social Security number, address, the type of event and the date of the qualifying event. When HR Services receives your notification, they will send the COBRA Notice and COBRA Application to the qualifying beneficiary. Failure to notify HR Services in writing within 60 days of the qualifying event could result in a loss of COBRA eligibility. You can reach HR Services at the address below:

HR Services
260 Interstate North Circle NW
Atlanta, GA 30339-2111
866.324.6513
MyHR@assurant.com

You or the qualifying beneficiary will have 60 days from the date of the COBRA Notice or the date the coverage terminated, whichever is later, to elect COBRA. If elected, coverage will be reinstated retroactive to the date your group coverage ended provided the initial premium is paid within 45 days of the date on the invoice. If you do not return your COBRA notice within the time frame outlined above, you will forfeit your rights to COBRA coverage.

You will be required to make all current and past due COBRA payments before your coverage will become effective. Failure to make these payments by the payment due date will result in cancellation of your COBRA coverage. Once canceled, coverage may be reinstated one time. A second cancelation of coverage must be appealed to the Assurant Benefit Plans Committee for possible reinstatement. Payments for continuation coverage must be sent to the address outlined on the continuation application.

Your premium is due by the first of the month for that month of coverage. For example, April's premium is due by April 1. There is a 31-day grace period for all premium payments after the initial payment. If your premium payment is not postmarked by the end of the grace period, your coverage will be terminated retroactive to the last day of the month for which the last premium was paid.

Extended Coverage

COBRA coverage may be extended for up to an additional 11 months if the qualified beneficiary is disabled at any the time during the first 60 days of continuation coverage if the qualifying event is the termination of your employment or reduction in hours. Coverage can continue for up to a total of 29 months (maximum continuation period + disability extension) for the disabled beneficiary and any other qualified beneficiary who became entitled to COBRA as a result of the same qualifying event.

The disabled beneficiary must receive a determination from the Social Security Administration that he or she was disabled as of the qualifying event or within 60 days of the date coverage is lost due to the qualifying event. For example, if you terminate employment on Nov. 17, your coverage under the Assurant plan ends on Nov. 30. The Social Security Administration must determine that the Qualified Beneficiary is disabled as of Nov. 17 or within 60 days of Nov. 30 to be eligible for the extension of coverage.

Further, the disabled beneficiary must notify the COBRA Unit of the Social Security Administration's determination:

- Within 60 days of the Social Security Administration's determination and
- Before the end of the first 18 months of COBRA continuation.

If the Social Security Administration determines that a disabled beneficiary is no longer disabled, he or she must contact the COBRA Unit within 31 days of the determination. Extended COBRA coverage will end as of

◂Page
Page▸
Main Table of Contents
Chapter Table of Contents
◂◂Back

the month that begins more than 31 days after the Social Security Administration's decision, or until coverage would otherwise end, if earlier.

COBRA premiums increase from 102 percent to 150 percent of the total premium for the additional 11 months of extended coverage.

You can get additional information about COBRA coverage from HR Services at 866.324.6513 or MyHR@assurant.com.

Changing COBRA Coverage

You and the qualified beneficiary have the right to change coverage options and coverage levels during Annual Enrollment or if you or the qualified beneficiary experiences a qualified life event. Refer to Qualified Life Events and Special Enrollment Rights or contact the COBRA Unit for more information regarding your enrollment rights. If the addition of a spouse or dependent child will result in a higher contribution, COBRA rates will reflect the higher amount. You can reach the COBRA Unit at 866.8660.4488, ext. 4500.
When COBRA Coverage Ends

When COBRA Coverage Ends

The maximum continuation period under COBRA depends on the qualifying event that caused the loss of coverage under the active employee plan as outlined below:

Qualifying Event	Maximum Continuation Period
Termination of employment for any reason other than gross misconduct	18 months
Retirement	18 months
Reduction in scheduled work hours	18 months
Death of employee	36 months
Divorce or legal separation	36 months
Domestic partner no longer meets eligibility requirements	36 months
Child attains age 26	36 months

COBRA coverage will end earlier if:

- The required payments have not been made on a timely basis
- You or a qualified beneficiary begins coverage under any other group plan, after the date you or the qualifying beneficiary elects COBRA continuation coverage
- You or a qualified beneficiary become entitled to *Medicare*, after the date you or the qualified beneficiary elects COBRA
- Your coverage would be terminated as an active employee for any other reason (e.g., submitting fraudulent claims) or
- The Company terminates the plan.

You or the qualifying beneficiary is obligated to contact the COBRA Unit within 30 days after you or the qualifying beneficiary becomes entitled to Medicare or begins coverage another group health plan. If you fail to contact the COBRA Unit within 30 days and the Plan pays benefits on behalf of you or the qualifying beneficiary, the Plan may recoup any amounts paid in error from you or the qualifying beneficiary.

Page
Page
Main Table of Contents
Chapter Table of Contents
Back

If you or a qualified beneficiary fails to re-enroll for COBRA coverage during Annual Enrollment, you or the qualified beneficiary will be defaulted into the Orange Plan option, at the employee-only tier.

Employee Retirement Income Security Act (ERISA)

Plan Information

Qualifying Event	Maximum Continuation Period
Plan Name:	Assurant Health & Welfare Benefit Plan
Plan Number:	501
Employer ID Number:	39-1126612
Type of Plan:	An employee welfare plan providing self-insured benefits as follows: Health, Prescription Drug, Health Reimbursement Account, Health Savings Account, Dental, Employee Assistance Program (EAP), Short-Term Disability and insured benefits: Life, Accidental Death and Dismemberment, Dependent Life, Long-Term Disability, Business Travel Accident and Long-Term Care.
Type of Administration:	Health, Prescription Drug, Dental, EAP, Health Reimbursement Account and Health Savings Account benefits are administered by Anthem BlueCross BlueShield, CVS Caremark, Assurant Employee Benefits, New Directions Behavioral Health and HealthEquity, respectively. The benefit administrators function as plan service providers, for a fee, and not as insurers. Life, Accidental Death and Dismemberment, Dependent Life Insurance and Long-Term Disability are insured through Assurant Employee Benefits. Business Travel Accident is insured through Axis Insurance Company. Long-Term Care is insured through John Hancock. Flexible Spending Accounts, Educational Assistance Plan and the Severance Pay Plan are administered by Assurant.
Plan Year:	Jan. 1 – Dec. 31
Plan Sponsor:	Assurant, Inc. 28 Liberty Street, 41st Floor New York, NY 10005 212.859.7000
Plan Administrator:	Assurant, Inc. Benefit Plans Committee 28 Liberty Street, 41st Floor New York, NY 10005

The following benefits are provided under the Plan but are not subject to ERISA: Dependent Day Care Flexible Spending Account, Educational Assistance Plan, the Health Savings Account and the Commuter Benefits.

The Assurant Benefit Plans Committee as *Plan Administrator* shall have the exclusive right and discretion to interpret the terms and conditions of the plans, and to decide all matters arising in their administration and operation, including questions of fact and issues pertaining to eligibility for, and the amount of, benefits to be paid by the plans. Any such interpretation or decision shall, subject to the claims procedure described herein, be conclusive and binding on all interested persons, and shall, consistent with the Plans' terms and conditions, be applied in a uniform manner to all similarly situated participants and their covered dependents.

◂Page
Page▸
Main Table of Contents
Chapter Table of Contents
◂◂Back

Your participation in the Assurant Health and Welfare Plan and any of the plans discussed in this document does not guarantee your continued employment at the Company. If you quit, are discharged or laid off, the Plan does not give you a right to any interest in the Plan except as specifically provided for in the plan documents

The *Plan Administrator* is authorized to delegate its administrative duties to one or more individuals or committees within Assurant or its affiliated companies, or to one or more outside administrative service providers. Presently, certain administrative services with regard to the processing of claims and the payment of benefits are provided through contracts with certain service providers. These providers are listed in the Claims and Contacts section.

Page
Page
Main Table of Contents
Chapter Table of Contents
Back

Your Rights under ERISA

Certain benefits offered through the Assurant Benefit Program and described in this booklet are employee welfare benefit plans covered by the Employee Retirement Income Security Act of 1974 (ERISA). If you participate in an ERISA-covered plan, you have certain rights and protections based on ERISA.

ERISA does not require Assurant to provide benefits. But it does set standards for any benefits the Company wishes to offer – and it requires that you be given an opportunity to learn what those benefits are and your rights to them under the law.

ERISA provides that plan participants are entitled to:

Receive Information about Your Plan and Benefits

You may examine, without charge, at the *Plan Administrator*'s office and at other specified locations such as worksites, all documents governing the plan, including insurance contracts and a copy of the latest annual report (Form 5500 series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

You may obtain, upon written request to the *Plan Administrator*, copies of all documents governing the operation of the plans, including insurance contracts and copies of the latest annual report (Form 5500 series) and updated summary plan descriptions. The *Plan Administrator* may make a reasonable charge for the copies.

You may receive a summary of the plans' annual financial report. The *Plan Administrator* is required by law to furnish each participant with a copy of this summary annual report.

Continue Health Coverage

Under COBRA, you may continue health care coverage for yourself, *spouse* or dependents if there is a loss of coverage as a result of a qualifying event. You or your dependents will have to pay for such coverage. You should review this summary plan description for information concerning your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plans. The people who operate your plans, called "fiduciaries," have a duty to do so prudently and in the interest of the plan participants and beneficiaries. No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit from the plan, or from exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit under an ERISA-covered plan is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the plan review and reconsider your claim. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the plan and do not receive them within 30 days, you may file suit in a federal court.

In such a case, the court may require the *Plan Administrator* to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the *Plan Administrator*. If you have a claim for benefits that is denied or ignored in whole or in part, you may file suit in a federal court. In addition, if you disagree with the plan's decision or lack thereof concerning a medical child support order, you may file suit in federal court. If the plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is considered frivolous.

◂Page
Page ▸
Main Table of Contents
Chapter Table of Contents
◂◂Back

Assistance with Your Questions

If you have questions about your plans, you should contact HR Services. If you have any questions about this statement or about your rights under ERISA, or if you need assistance obtaining documents from the Plan Administrator, you should contact the nearest office of the U.S. Department of Labor, Pension and Welfare Benefits Administration listed in your telephone directory, or the Division of Technical Assistance and Inquires, Employee Benefits Security Administration (EBSA), U.S. Department of Labor, 200 Constitution Ave., N.W., Washington, D.C. 20210.

You also may contact the EBSA's toll-free participant assistance number, 866.444.3272, or visit their website at www.dol.gov/ebsa.

If a Plan is Amended, Modified, Suspended or Terminated

Assurant, Inc. reserves the right to suspend, amend, modify, or terminate the plan(s) in any manner at any time, including the right to modify or eliminate any cost-sharing between the Company and participants.

Changes are made by action of the Company's board of directors, or to the extent authorized by resolution of its board of directors, by the Assurant, Inc. Benefit Plans Committee.

The procedure for amendment or modification of the plan, programs, or policies shall consist of the lawful adoption of a written amendment or modification to the plan, programs, or policies by majority vote at a validly held meeting or by unanimous, written consent, followed by the filing of such duly adopted amendment or modification by the Secretary with the official records of the Company. Participants will be notified in due course concerning substantial changes.

Benefits for claims occurring after the effective date of plan modification or termination are payable in accordance with the revised plan documents.

All statements in this book, the official plan documents, and all representations by the Company or its personnel are subject to this right of amendment, modification, suspension, or termination. These rights apply without limitation, even after an individual's circumstances have changed by retirement or otherwise. Plan benefits do not become vested. In the event an Assurant, Inc. plan is terminated, any assets held will be used to provide benefits for employees of Assurant, Inc. or a successor, or they may be used in other ways not prohibited by Internal Revenue Service regulations.

Health Insurance and Portability Act (HIPAA)

The Health Insurance and Portability Act of 1996 (HIPAA) offers a range of rights and protections that you should know. These are outlined in the Notice of Privacy Practices below:

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW PERSONAL HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

IF YOU HAVE ANY QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT HR Services at 866.324.6513.

Effective Date

September 16, 2013

Who Will Follow This Notice

During the course of providing you with health coverage, the Assurant Group Health and Welfare Benefit Plan (the "Assurant Plan") will have access to information about you that is deemed to be "protected health information', or PHI, by the Health Insurance Portability and Accountability Act of 1996, or HIPAA. PHI is defined as any personal information that can identify an individual to a health plan. While we cannot describe every type of information that the Assurant Plan collects, some of the types of PHI include:

- Name and Social Security Number associated with enrollment records,
- Claim information associated with FSA reimbursement requests,
- Claim information associated with a specific appeal for benefits.

This notice describes the uses and disclosure of PHI practices by the Plan and what your rights are under HIPAA.

Our Pledge Regarding PHI

We are required by law to:

- Make sure that PHI that identifies you is kept private
- Provide you with certain rights with respect to your PHI
- Give you this notice of our legal duties and privacy practices with respect to PHI about you and
- Follow the terms of the notice that is currently in effect.

By adoption of this notice, the Assurant Plan confirms that it will comply with the privacy procedures set forth herein. The Assurant Plan may not use or disclose your PHI other than as provided herein or as required by law. All of the carriers or other business associates who are provided your PHI must agree to be bound by the restrictions and conditions concerning your PHI found herein.

How We May Use and Disclose PHI Information about You

This section describes how the Plan uses and discloses PHI. Please note that these are merely examples of the most typical uses and disclosures, and are not intended to show every possible situation that may lead to or require disclosure of your PHI. Other types of disclosures of your PHI that are not categorized in this notice, including uses and discloses of psychotherapy notes, uses and disclosures of PHI for marketing or fundraising purposes, and disclosures that constitute a sale of PHI may only be made by the Plan with your written authorization, which you may revoke at any time by writing the Plan at the address indicated on the authorization.

For Payment (as described in applicable regulations)

We may use and disclose PHI about you to determine eligibility for Plan benefits, to determine employee contribution discounts, to determine benefit responsibility under the Plan, or to coordinate Plan coverage.

For Health Care Operations (as described in applicable regulations). We may use and disclose PHI about you for other Plan operations. These uses and disclosures are necessary to run the Plan. For example, we may use PHI in connection with: underwriting and soliciting bids from potential carriers, premium rating and setting employee contributions, and other activities relating to Plan coverage; submitting claims for stop-loss (or excess loss) coverage, legal services, audit services; business planning and development such as cost management; and business management and general Plan administration activities. In addition, your PHI may occasionally be disclosed to certain non-Assurant personnel (for example, outside legal counsel) in order that they

◂Page
Page▸
Main Table of Contents
Chapter Table of Contents
◂◂Back

may assist with administration of the Plan. The Plan is prohibited from and will not use your PHI that is considered genetic information for underwriting purposes.

Since Assurant is the Plan Sponsor, your PHI will be disclosed to certain employees of Assurant in the below specified areas who perform Plan administration functions, including any employee who receives PHI relating to payment under, health care operations of, or other matter pertaining to the Plan in the ordinary course of business. These individuals are:

- The Your Employee Services Center (HR Services)
- The Human Resources/Benefits Department
- Enterprise Business Services employees associated with the payment of carrier and business associate expenses, direct billing for benefits coverage, collection of premiums for benefits coverage and the administration of health savings accounts, flexible spending accounts and Retiree Reimbursement Plan
- IT work force members who are responsible for the maintenance and development of the IT systems that support the departments indicated above and
- The Assurant, Inc. Benefit Plans Committee.

These individuals may only use your PHI for Plan administration purposes including those described below, provided they do not violate the provisions set forth herein. Any employee of Assurant who violates the rules for handling PHI established herein will be subject to adverse disciplinary action.

Your PHI will not be used by Assurant for any employment-related actions or decisions or in connection with any other benefits or employee benefit plans of Assurant. Assurant must report to the Plan any uses or disclosures of your PHI, that are inconsistent with the provisions set forth herein, when Assurant or its covered employees become aware.

Your Rights Regarding PHI about You

You have the following rights regarding PHI we maintain about you:

Right to Inspect and Copy

You have the right to inspect and copy PHI that may be used to make decisions about your Plan benefits. The enrollment data that we maintain on you is available for viewing through EPIC. To further inspect and copy PHI (PHI that the plan retains on you consists of eligibility and enrollment data) that may be used to make decisions about you, you must submit your request in writing to the Privacy Official at: Assurant Corporate Benefits, Attn: HIPAA Privacy Official, 28 Liberty Street, New York, New York 10005. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request.

We may deny your request to inspect and copy in certain circumstances as required under HIPAA. HIPAA provides several important exceptions to your right to access your PHI. If you are denied access to PHI, you may request that the denial be reviewed.

PHI maintained by your *physician*, or contract carrier is not covered by this notice but regulated by the Privacy Regulations under HIPAA.

Right to Amend

If you feel that PHI we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by the Plan. These requests must be submitted in writing to the Privacy Official. Please be aware that the Plan only maintains eligibility and enrollment data on you which is permitted by law to obtain and utilize for Plan administration. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend the information that:

Page
Page
Main Table of Contents
Chapter Table of Contents
Back

- Is not part of the PHI kept by or for the Plan (remember we only keep the PHI outlined in this notice)
- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment
- Is not part of the information which you would be permitted to inspect and copy or
- Is accurate and complete.

Employer must act on your request for an amendment of your PHI no later than 60 days after receipt of your request.

Page
Page
Main Table of Contents
Chapter Table of Contents
Back

Right to Accounting

You have the right to review a list of disclosures that the Plan made of your PHI (except PHI disclosed as allowed by law covering eligibility and enrollment data, and PHI disclosed to your representative or pursuant to an authorization from you). The Plan has no intention to disclose PHI about you beyond the legal use for eligibility and enrollment data. You must request this accounting in writing, addressed to the Privacy Official.

Right to Request Confidential Communications

You may request that the Plan communicates with you about your medical information in a certain way or at a certain location, provided that you can show that communication in a different manner might endanger you or your well-being. Your request must be in writing and specify why communications in the normal manner would endanger you and what specific manner of communications you are requesting.

Right to Disclosure to Personal Representative

You may request that the Plan disclose your PHI to a named individual who you designate to act on your behalf. Your request must be in writing and must be accompanied by documentation showing that the individual qualifies as your personal representative under law (such as a notarized power of attorney).

Right to be Notified of a Breach

You will be notified by the Plan in the event that your unsecured PHI is compromised.

In order to exercise any of the above discussed rights, please contact Assurant Corporate Benefits, Attn: Privacy Official, 28 Liberty Street, New York, New York 10005.

Changes to This Notice

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for PHI we already have about you as well as any changed information we receive in the future. A copy of this notice will remain posted on the Assurant Intranet Human Resources Benefits Page.

Complaints

If you believe your privacy rights have been violated with respect to the handling of your PHI, you may file a complaint with the Plan or with the Secretary of the Department of Health and Human Services. All complaints associated with the Plan must be in writing to Assurant Corporate Benefits, Attn: HIPAA Privacy Official, 28 Liberty Street, New York, New York 10005.You will not be penalized for a complaint.

Mental Health Parity

The medical benefits under the Plan will provide parity between mental health or substance use disorder benefits and medical/surgical benefits with respect to financial requirements and treatment limitations under group health plans and health insurance coverage offered in connection with the Plan, as required by Code Section 9812 and ERISA Section 712, and the regulations thereunder.

- *Lifetime or Annual Dollar Limits.* The Plan will not impose an aggregate lifetime or annual dollar limit, respectively, on mental health or substance use disorder benefits.

- *Financial Requirement or Treatment Limitations*. The Plan will not apply any financial requirement or treatment limitation (whether quantitative or nonquantitative) to mental health or substance use disorder benefits in any classification (as determined by the *Plan Administrator* in accordance with applicable regulations) that is more restrictive than the predominant financial requirement or treatment limitation of that type applied to substantially all medical/surgical benefits in the same classification.
- *Criteria for medical necessity determinations*. The criteria for making *medical necessity* determinations relative to claims involving mental health or substance use disorder benefits will be made available by the Plan Administrator to any current or potential Participant, beneficiary, or *network provider* upon request.

The manner in which these restrictions apply to the Plan will be determined by the *Plan Administrator* in its sole discretion in light of applicable regulations and other guidance.

◂Page
Page▸
Main Table of Contents
Chapter Table of Contents
◂◂Back

Newborns' and Mothers' Health Protection Act

Under federal law, health insurance issuers generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the issuer may pay for a shorter stay if the attending *provider* (e. g., your *physician*, nurse, midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier. These rights are provided through the Newborns' and Mothers' Health Protection Act of 1996, a federal law.

Also, under federal law, issuers may not set the level of benefits or out-of pocket costs so that any later portion of the 48-hour (or 96-hour) hospital stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

An issuer also may not, under federal law, require that a *physician* or other health care *provider* obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain *providers* or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification. For information on precertification, contact Anthem Member Services at 855.285.4212.

Patient Protection and Affordable Care Act (PPACA)

No Lifetime or Annual Limits. The Plan does not impose a lifetime or annual limit on the dollar value of essential health benefits provided. Essential health benefits are health-related items and services that fall into ten categories, as defined in PPACA §1302 and further determined by the Secretary of Health and Human Services. For purposes of determining whether a benefit or service is an Essential Health Benefit for purposes of permissible annual or lifetime limits and cost sharing limits (see below) under PPACA, the Plan has chosen the State of Utah as its benchmark state.

No Rescission of Coverage. The Plan will not cancel or discontinue medical benefits with a retroactive effect with respect to you or your covered dependents except in the event of fraud, intentional misrepresentation, nonpayment of premiums, etc.

No Pre-Existing Condition Exclusion. The Plan will not impose a pre-existing condition exclusion on medical benefits.

No Cost Sharing on Recommended Preventive Care. The medical benefits under the Plan will not require participant cost-sharing on recommended Preventive Care provided by network providers. Preventive Care services covered in-network at 100% will be reviewed annually and updated prospectively to comply with recommendations of:

- The United States Preventive Care Task Force
- The Advisory Committee on Immunization Practices that have been adopted by the Director of

the Centers for Disease Control and Prevention and

- The Comprehensive Guidelines supported by the Health Resources and Services Administration.

Coverage of Clinical Trials. Medical benefits under the Plan shall not deny participation in an approved clinical trial for which a covered person is a "qualified individual" with respect to the treatment of cancer or another life-threatening disease or condition, or deny (or limit or impose additional conditions on) the coverage of routine patient costs for drugs, devices, medical treatment, or procedures provided or performed in connection with participation in such an approved clinical trial. A covered person participating in such an approved clinical trial will not be discriminated against on the basis of his or her participation in the approved clinical trial. For purposes of this provision, the terms "qualified individual", "life threatening disease or condition", "approved clinical trial" and "routine patient costs" shall have the same meaning as found in Section 2709 of the Public Health Services Act.

Cost Sharing Limits. Medical benefits under the Plan shall comply with the overall cost-sharing limit (i.e., out-of-pocket maximum) mandated by PPACA. For purposes of this provision, cost-sharing includes deductibles, co-insurance, co-pays or similar charges, and any other required expenditure that is a qualified medical expense with respect to essential health benefits covered under the Plan. Cost-sharing shall not include premiums, balance billing amounts for non-network providers or spending for services that are not covered under the Plan. Notwithstanding the foregoing, Assurant reserves the right to maintain bifurcated out-of-pocket maximums as permitted by law.

Patient Protections. To the extent applicable, medical benefits under the Plan shall comply with the patient protections regarding choice of health care professionals and Medical Emergency care services under Public Health Services Act § 2719A.

Women's Health and Cancer Rights Act

For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending *physician* and the patient for all stages of reconstruction of the breast on which the mastectomy was performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; prostheses; and treatment of physical complications of the mastectomy, including lymphedemas. These rights are provided through the Women's Health and Cancer Rights Act of 1998 (WHCRA), a federal law.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under the medical option that the individual has chosen. For more information on WHCRA benefits, contact HR Services.

Glossary

A

Accidental Injury
Bodily injury sustained by a *member* as the result of an unforeseen event and which is the direct cause (independent of disease, bodily infirmity or any other cause) for care which the member receives. Such care must occur while this Plan is in force. It does not include injuries for which benefits are provided under any *workers' compensation*, Employer's liability or similar law.

Ambulance Services
A state-licensed emergency vehicle that carries injured or sick persons to a *Hospital*. Services which offer non-emergency, convalescent or invalid care do not meet this definition.

Appropriate Medical Plan
An appropriate plan to arrive at a more accurate or more supported diagnosis of your medical condition(s) or an appropriate plan of treatment of your medical conditions(s) or both.

Approved Clinical Trial
An approved clinical trial means a phase I, phase II, phase III or phase IV clinical trial that studies the prevention, detection or treatment of cancer or other life-threatening condition. The term life-threatening condition means any disease or condition from which death is likely unless the disease or condition is treated. Benefits are limited to the following trials:

- Federally funded trials approved or funded by one of the following:
  - The National Institutes of Health
  - The Centers for Disease Control and Prevention
  - The Agency for Health Care Research and Quality
  - The Centers for Medicare & Medicaid Services
  - Cooperative group or center of any of the four above entities or the Department of Defense or the Department of Veterans Affairs
  - A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
  - Any of the following if the study or investigation has been reviewed and approved through a system of peer review that the Secretary determines a) to be comparable to the system of peer review of studies and investigation used by the National Institutes of Health and b) assures unbiased review of the highest scientific standards by:
    - The Department of Veterans Affairs
    - The Department of Defense
    - The Department of Energy.
- Studies or investigation done as part of an investigational new drug application reviewed by the Food and Drug Administration
- Studies or investigations done for drug trials which are exempt from the investigation new drug application.

Routine patient care costs include items, services and drugs provided to you in connection with an approved

clinical trial that would otherwise by covered by this Plan.

All other requests for clinical trials services, including requests that are not part of approved clinical trials will be reviewed according to Anthem's clinical coverage guidelines, related policies and procedures.

Audiologist

A person who is:

- Legally qualified in audiology or
- Holds a certificate of Clinical Competence in Audiology from the American Speech and Hearing Association (in the absence of any applicable licensing requirements) and
- Performs the exam at the written direction of a legally qualified otolaryngologist or otologist.

Page
Page
Main Table of Contents
Back

B

Banked Essential Absence Days

Essential Absence Days (EADs) was the term Assurant used for its occasional sick day/absences practice prior to Jan. 1, 2008. Earned but unused EADs, up to a maximum of 30, were "banked" for future use. Employees who had banked EADs on Dec. 31, 2007 can use this time in lieu of PTO in certain situations. See the Employee Handbook on the intranet for more information.

EADs have no cash value and are not paid out upon termination of employment.

Base Pay

Your salary on the day before you become disabled. It does not include bonuses, overtime, benefits, short or Long-Term incentive compensation or any other types of compensation.

For sales employees, *base pay* also includes bonuses, commissions and incentives paid during the calendar year prior to the start of your disability. Sale bonuses, commissions and incentives are updated once per year. If you are a sales person with less than one year of service, *base pay* includes sale bonuses, commissions and incentives guaranteed in a first year agreement.

Behavioral Health Care

Includes services for Mental Health Disorders and Substance Abuse. Behavioral Health and Substance Abuse are conditions that are listed in the current edition of the Diagnostic and Statistical Manual of Mental Health Disorders (DSM) as a mental health or substance abuse condition.

Blue Distinction Bariatric Surgery Providers

• Blue Distinction Center (BDC) Facility: Blue Distinction facilities have met or exceeded national quality standards for care delivery (quality only).
• Blue Distinction Center+ (BDC+) Facility: Blue Distinction+ facilities have met or exceeded national quality standards for care delivery AND have demonstrated that they operate more efficiently (quality and cost).
• Designated Bariatric Surgery Provider: A provider who has achieved designation as a Blue Distinction Center+ or Blue Distinction Center for Bariatric Surgery Procedures

Brand Drug

A single-source *brand* or multi-source *brand* drug as set forth in the Medi-Span Master Drug Database.

Breast Reconstructive Surgery

Covered services are provided following a mastectomy for reconstruction of the breast on which the mastectomy was performed, surgery and reconstruction of the other breast to produce a symmetrical appearance and prostheses and treatment of physical complications, including lymphedemas.

C

Centers of Excellence (COE) Network
A network of health care facilities selected for specific services based on criteria such as experience, outcomes, efficiency, and effectiveness. For example, an organ transplant managed care program wherein *members* access select types of benefits through a specific network of medical centers.

A network of health care professionals contracted with the *Claims Administrator* or one or more of its affiliates, to provide transplant or other designated specialty services.

Page
Page
Main Table of Contents
Back

Claims Administrator
The company Assurant chose to administer its health benefits. Anthem Insurance Companies, Inc. was chosen to administer the Plan. The *Claims Administrator* provides administrative claims payment and medical review services only and does not assume any financial risk or obligation with respect to claims.

COBRA Administrator
The *COBRA Administrator* for the Assurant Health and Welfare Plan is the COBRA Unit of Assurant, Inc.

Coinsurance
If a *member*'s coverage is limited to a certain percentage, for example 80%, then the remaining 20% for which the member is responsible is the *coinsurance amount*. The *coinsurance* may be capped by the *out-of-pocket maximum*.

Cosmetic Surgery
Any non-medically necessary surgery or procedure, the primary purpose of which is to improve or change the appearance of any portion of the body, but which does not restore bodily function, correct a disease state, physical appearance or disfigurement caused by an accident, birth defect, or correct or naturally improve a physiological function. *Cosmetic surgery* includes but is not limited to rhinoplasty, lipectomy, surgery for sagging or extra skin, any augmentation or reduction procedures (e.g., mammoplasty, liposuction, keloids, rhinoplasty and associated surgery) or treatment relating to the consequences or as a result of *cosmetic surgery*.

Covered Services
Medically necessary health care services and supplies that are: (a) defined as *covered services* in the *member's* Plan, (b) not excluded under such Plan, (c) not *experimental/investigative* and (d) provided in accordance with such Plan.

Covered Transplant Procedure
Any *medically necessary* human organ and stem cell/bone marrow transplants and transfusions as determined by the *Claims Administrator* including necessary acquisition procedures, collection and storage, and including *medically necessary* preparatory myeloablative therapy.

Custodial Care
Any type of care, including room and board, that (a) does not require the skills of professional or technical personnel; (b) is not furnished by or under the supervision of such personnel or does not otherwise meet the requirements of post-*hospital skilled nursing facility* care; (c) is a level such that the *member* has reached the maximum level of physical or mental function and is not likely to make further significant improvement. *Custodial care* includes, but is not limited to, any type of care the primary purpose of which is to attend to the *member's* activities of daily living which do not entail or require the continuing attention of trained medical or paramedical personnel. Examples of *custodial care* include, but are not limited to, assistance in walking, getting in and out of bed, bathing, dressing, feeding, using the toilet, changes of dressings of non-infected, post-operative or chronic conditions, preparation of special diets, supervision of medication that can be self-administered by the *member*, general maintenance care of colostomy or ileostomy, routine services to maintain other services which, in the sole determination of the Plan, can be safely and adequately

self-administered or performed by the average non-medical person without the direct supervision of trained medical and paramedical personnel, regardless of who actually provides the service, residential care and adult day care, protective and supportive care including educational services, rest care and convalescent care.

D

Dentist
An individual who is licensed to practice dentistry and is acting within the scope of that license in treating the dental condition.

Detoxification (Detox)
The process whereby an alcohol or drug intoxicated or alcohol or drug dependent person is assisted, in a facility licensed by the appropriate regulatory authority, through the period of time necessary to eliminate, by metabolic or other means, the intoxicating alcohol or drug, alcohol or drug dependent factors or alcohol in combination with drugs as determined by a licensed *physician*, while keeping the physiological risk to the patient to a minimum.

Developmental Delay
The statistical variation, as defined by standardized, validated developmental screening tests, such as the Denver Developmental Screening Test, in reaching age appropriate verbal/growth/motor skill developmental milestones when there is no apparent medical or psychological problem. It alone does not constitute an illness or an *injury*.

Durable Medical Equipment (DME)
Equipment which is (a) made to withstand repeated use; (b) manufactured solely to serve a medical purpose; (c) not merely for comfort or convenience; (d) not normally of use to persons who do not have a disease or injury; (e) ordered by a *physician* (f) related to the *member's* physical disorder.

The *physician* must certify in writing the medical necessity for the equipment. The physician also states the length of time the equipment will be required. The Plan may require proof at any time of the continuing *medical necessity* of any item.

Disabled
Either physically or mentally incapable of self-care. The disabled person must have the same principle residence as you.

E

Education Expenses
In your *rehabilitation plan* the reasonable costs you incur which are required for your education or training to return to work. These costs may include the cost of tuition, books, computers and other equipment. In your *spouse's rehabilitation plan*, education expense means the reasonable costs your *spouse* incurs which are required for your spouse's education or training. These cost may include the cost of tuition, books, computers and other equipment.

Emergency Medical Condition
A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in one of the following conditions:

- Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or

Page
Page
Main Table of Contents
Back

her unborn child) in serious jeopardy
- Serious impairment to bodily functions or
- Serious dysfunction of any bodily organ or part.

Experimental/Investigative

Any drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply used in or directly related to the diagnosis, evaluation, or treatment of a disease, *injury*, illness, or other health condition which the *Claims Administrator* determines to be unproven.

The *Claims Administrator* will deem any drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply to be *experimental/investigative* if the *Claims Administrator*, determines that one or more of the following criteria apply when the service is rendered with respect to the use for which benefits are sought. The drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply:

- Cannot be legally marketed in the United States without the final approval of the Food and Drug Administration (FDA), or other licensing or regulatory agency, and such final approval has not been granted;
- Has been determined by the FDA to be contraindicated for the specific use
- Is subject to review and approval of an Institutional Review Board (IRB) or other body serving a similar function; or
- Is provided pursuant to informed consent documents that describe the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply as *experimental/investigative*, or other wise indicate that the safety, toxicity, or efficacy of the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply is under evaluation.

Any service not deemed *experimental/investigative* based on the criteria above may still be deemed *experimental/investigative* by the *Claims Administrator*. In determining whether a service is *experimental/investigative*, the *Claims Administrator* will consider the information described below and assess whether:

- The scientific evidence is conclusory concerning the effect of the service on health outcomes
- The evidence demonstrates the service improves net health outcomes of the total population for whom the service might be proposed by producing beneficial effects that outweigh any harmful effects
- The evidence demonstrates the service has been shown to be as beneficial for the total population for whom the service might be proposed as any established alternatives and
- The evidence demonstrates the service has been shown to improve the net health outcomes of the total population for whom the service might be proposed under the usual conditions of medical practice outside clinical investigatory settings.

The information considered or evaluated by the *Claims Administrator* to determine whether a dug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply is *experimental/investigative* under the above criteria may include one or more items from the following list which is not all inclusive:

- Published authoritative, peer-reviewed medical or scientific literature, or the absence thereof
- Evaluations of national medical associations, consensus panels, and other technology evaluation bodies
- Documents issued by and/or filed with the FDA or other federal, state or local agency with the authority to approve, regulate, or investigate the use of the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply
- Documents of an Institutional Review Board (IRB) or other similar body performing substantially the same function
- Consent document(s) and/or the written protocol(s) used by the treating physicians, other medical professionals, or facilities or by other treating physicians, other medical professionals or facilities studying substantially the same drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply

Page
Page
Main Table of Contents
Back

- Medical records or
- The opinions of consulting providers and other experts in the field.

The Claims Administrator has the sole authority and discretion to identify and weigh all information and determine all questions pertaining to whether a drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply is experimental/investigative.

F

Page
Page
Main Table of Contents
Back

Family Care Expense

The amount you spend for care of a family member in order for you to be retrained under a *rehabilitation plan*. To qualify:

- Your family member must be under age 13 or be physically or mentally incapable for caring for him or herself
- Your family member must be dependent on you for support and maintenance and
- The person who cares for your family member cannot be a relative.

Not more than $350 per family member per month will be included. A pro-rated amount will apply to any period shorter than a month.

Freestanding Ambulatory Facility

A facility, with a staff of *physicians*, at which surgical procedures are performed on an Outpatient basis—no patients stay overnight. The facility offers continuous service by both *physicians* and registered nurses (R.N.s). It must be licensed by the appropriate agency. A *physician's* office does not qualify as a *freestanding ambulatory facility*.

Full-time Student

An individual who, during five calendar months from January through December, is enrolled as a student for the number of course hours considered to be a full-time course of study at an educational organization. The enrollment for five calendar months need not be consecutive.

G

Generic Drug

A drug that is chemically equivalent to a brand drug and are authorized to be dispensed. Most generic drug names reflect the chemical name of the drug. These drugs are less expensive, yet provide the same therapeutic value. A-rated generics are linked to their corresponding brands. A generic drug shall mean a drug classified by the Medi-Span Master Drug Database with supplements.

Government Plan

The United States Social Security Act, the Railroad Retirement Act, the Canadian Pension Plan, similar plans provided under the laws of other nations and any plan provided under the laws of a state, province or other political subdivision. It also includes any public employee retirement plan or any teachers' employment retirement plan or any plan provided as an alternative to any of the above acts or plans. It does not include any Workers' Compensation Act or similar law or the Maritime Doctrine of Maintenance, Wages or Cure.

H

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

A federal law that protects the privacy and security of your personal health information and prohibits health

plans from discriminating against participants with regard to eligibility or premiums based on a health status-related factor.

Home Health Care
Care, by a licensed program or *provider*, for the treatment of a patient in the patient's home, consisting of required intermittent skilled care, which may include observation, evaluation, teaching and nursing services consistent with the diagnosis, established and approved in writing by the patient's attending *physician*.

Home Health Care Agency
A *provider* who renders care through a program for the treatment of a patient in the patient's home, consisting of required intermittent skilled care, which may include observation, evaluation, teaching and nursing services consistent with the diagnosis, established and approved in writing by the patient's attending *physician*. It must be licensed by the appropriate agency.

Hospice
A provider which provides care for terminally ill patients and their families, either directly or on a consulting basis with the patient's *physician*. It must be licensed by the appropriate agency.

Hospice Care Program
A coordinated, interdisciplinary program designed to meet the special physical, psychological, spiritual and social needs of the terminally ill member and his or her covered family *members*, by providing palliative and supportive medical, nursing and other services through at-home or *inpatient* care. The *hospice* must be licensed by the appropriate agency and must be funded as a *hospice* as defined by those laws. It must provide a program of treatment for at least two unrelated individuals who have been medically diagnosed as having no reasonable prospect of cure for their illnesses.

Hospital
An institution licensed by the appropriate agency, which is primarily engaged in providing diagnostic and therapeutic facilities on an *inpatient* basis for the surgical and medical diagnosis, treatment and care of injured and sick persons by or under the supervision of a staff of *physicians* duly licensed to practice medicine, and which continuously provides 24-hour-a-day nursing services by registered graduate nurses physically present and on duty. "*Hospital*" does not mean other than incidentally:

- An extended care facility; nursing home; place for rest; facility for care of the aged;
- A custodial or domiciliary institution which has as its primary purpose the furnishing of food, shelter, training or non-medical personal services; or
- An institution for exceptional or disabled children.

Hospital Confined and Hospital Confinement
A 24-hours a day stay in a hospital.

I

Ineligible Hospital
A facility that is not a state- recognized medical hospital

Ineligible Provider
A *provider* that does not meet the minimum requirements to become a contracted *provider* with Anthem Blue Cross and Blue Shield.

Infertile or Infertility
The condition of a presumably healthy *member* who is unable to conceive or produce conception after a period of one year of frequent, unprotected heterosexual vaginal intercourse. This does not include

Page
Page
Main Table of Contents
Back

conditions for men when the cause is a vasectomy or orchiectomy or for women when the cause is tubal ligation or hysterectomy.

Injury
Bodily harm from a non-occupational accident.

Inpatient
A *member* who is treated as a registered bed patient in a *hospital* and for whom a room and board charge is made.

Intensive Care Unit
A special unit of a *hospital* that: (1) treats patients with serious illnesses or Injuries; (2) can provide special life-saving methods and equipment; (3) admits patients without regard to prognosis; and (4) provides constant observation of patients by a specially trained nursing staff.

Page
Page
Main Table of Contents
Back

M

Maternity Care
Obstetrical care received both before and after the delivery of a child or children. It also includes care for miscarriage or abortion. It includes regular nursery care for a newborn infant as long as the mother's *hospital* stay is a covered benefit and the newborn infant is an eligible *member* under the Plan.

Maximum Allowed Amount
The maximum allowed amount for this Plan is the maximum amount of reimbursement Anthem will allow for services and supplies that:

- Meet Anthem's definition of *covered services*, to the extent such services and supplies are covered under the Plan and are not excluded
- Are *medically necessary* and
- Are provided in accordance with all applicable preauthorization, utilization management or other requirements set forth in the Plan.

You will be required to pay a portion of the *maximum allowed amount* to the extent you have not met your *deductible* or have *coinsurance*. In addition, when you receive covered services from an *out-of-network provider*, you may be responsible for paying any difference between the *maximum allowed amount* and the *provider's* actual charges. This amount can be significant.

When you receive *covered services* from a *provider*, the *Claims Administrator* will, to the extent applicable, apply claim processing rules to the claim submitted for those covered services. These rules evaluate the claim information and, among other things, determine the accuracy and appropriateness of the procedure and diagnosis codes included in the claim. Applying these rules may affect *Claims Administrator's* determination of the maximum *allowed amount*. The *Claims Administrator's* application of these rules does not mean that the *covered services* you received were not *medically necessary*. It means that the *Claims Administrator* has determined that the claim was submitted inconsistent with procedure coding rules and/or reimbursement policies. For example, your *provider* may have submitted the claim using several procedure codes when there is a single procedure code that includes all of the procedures that were performed. When this occurs, the *maximum allowed amount* will be based on the single procedure code rather than a separate *maximum allowed amount* for each billed code.

Likewise, when multiple procedures are performed on the same day by the same *physician* or other health-care professional, the Plan may reduce the *maximum allowed amounts* for those secondary and subsequent procedures because reimbursement at 100% of the *maximum allowed amount* for those procedures would

represent duplicative payment for components of the primary procedure that may be considered incidental or inclusive.

Medical Necessity or Medically Necessary or Dentally Necessary

An intervention that is or will be provided for the diagnosis, evaluation and treatment of a condition, illness, disease or *injury* and that is determined by the *Claims Administrator* to be:

- Medically appropriate for and consistent with the symptoms and proper diagnosis or treatment of the member's condition, illness, disease or injury;
- Obtained from a *provider*;
- Provided in accordance with applicable medical and/or professional standards;
- Known to be effective, as proven by scientific evidence, in materially improving health outcomes;
- The most appropriate supply, setting or level of service that can safely be provided to the *member* and which cannot be omitted consistent with recognized professional standards of care (which, in the case of hospitalization, also means that safe and adequate care could not be obtained in a less comprehensive setting);
- Cost-effective compared to alternative interventions, including no intervention. Cost effective does not always mean lowest cost. It does mean that as to the diagnosis or treatment of the *member's* illness, *injury* or disease, the service is: (1) not more costly than an alternative service or sequence of services that is medically appropriate, or (2) the service is performed in the least costly setting that is medically appropriate;
- Not *experimental/investigative*
- Not primarily for the convenience of the *member*, the *member's* family or the *provider*
- Not otherwise subject to exclusion under this Summary Plan Description.

The fact that a *provider* may prescribe, order, recommend, or approve care, treatment, services or supplies does not, of itself, make such care, treatment, services or supplies *medically necessary* or a *covered service* and does not guarantee payment.

Medicare

A federal government plan paying certain hospital and medical expenses for those who qualify, primarily those over age 65 or disabled.

Member

Individuals, including you and your eligible dependents, who have satisfied the Plan eligibility requirements, applied for coverage and been enrolled for Plan benefits.

Mental Illness

A mental disorder listed in the current edition of the Diagnostic and Statistical Manual of Mental Disorders, as published by the American Psychiatric Association. A mental illness, as so defined, may be related to or be caused by physical or biological factors, or result in physical symptoms or expressions. For the purposes of this policy, mental illness does not include any mental disorder listed within any of the following categories found in the Diagnostic and Statistical Manual of Mental Disorders, as published by the American Psychiatric Association:

- Mental retardation
- Motor skills disorder
- Pervasive developmental disorders
- Delirium, dementia and amnestic and other cognitive disorders
- Schizophrenia and
- Narcolepsy, obstructive sleep apnea and sleep disorder due to a general medical condition.

Monthly Payment Limit
80% of monthly *plan pay*.

Moving Expenses
The costs you incur to move more than 35 miles so that you can attend school or accept gainful work. In a *spouse's rehabilitation plan*, the costs are those incurred by the family so that the spouse can attend school or accept gainful work.

Multi-source Drug
A drug marketed or sold by two or more manufacturers or labelers. Multi-source medicines refer to products from different manufacturers (including the innovator) that have the same active ingredient at the same strength and in the same dose form and are A-rated to each other.

Page
Page
Main Table of Contents
Back

N

Nationally Recognized Authorities
The American Medical Association (AMA), the AMA Board of Medical Specialties, the American College of Physicians and Surgeons, the Food and Drug Administration, the Centers for Disease Control, the Office of Technology Assessment, the National Institutes of Health, the Health Care Finance Administration, the Agency for Health Care Policy and Research, the Department of Health and Human Services, the National Cancer Institute, the American Psychiatric Association and any additional organization Assurant Employee Benefits chooses that attain similar status.

Network Provider
A *physician*, health professional, *hospital*, *pharmacy*, or other individual, organization and/or facility that has entered into a contract, either directly or indirectly, with the *Claims Administrator* to provide *covered services* to *members* through negotiated reimbursement arrangements. For Georgia, Missouri and Wisconsin residents, only providers in Anthem's Alternate Network are *network providers*.

Network Transplant Provider
A *provider* that has been designated as a *center of excellence* for transplants by the *Claims Administrator* and/or a *provider* selected to participate as a network *transplant provider* by a designee of the *Claims Administrator*. Such *provider* has entered into a *transplant provider* agreement to render *covered transplant procedures* and certain administrative functions to you for the transplant network. A *provider* may be a network *transplant provider* with respect to:

- Certain *covered transplant procedures* or
- All *covered transplant procedures*.

Non-Covered Services
Services that are not benefits specifically provided under the Plan, are excluded by the Plan, are provided by an *ineligible provider*, or are otherwise not eligible to be *covered services*, whether or not they are *medically necessary*.

Normal Retirement Age
Your normal retirement age according to the Social Security Administration (www.ssa.gov).

O

Out-of-Network Provider
A *provider*, including but not limited to, a *hospital, freestanding ambulatory facility, physician, skilled nursing facility, hospice, home health care agency*, other medical practitioner or *provider* of medical services

or supplies, that does not have an agreement or contract with the *Claims Administrator* to provide services to its *members* at the time services are rendered.

Benefit payments and other provisions of this Plan are limited when a *member* uses the services of out-of-network providers. For Georgia, Missouri and Wisconsin residents, only POS providers are network providers.

Out-of-Pocket Maximum
The maximum amount of a Member's Coinsurance payments during a given Plan year. When the Out-of-Pocket Maximum is reached, the level of benefits is increased to 100% of the *maximum allowed amount* for *covered services* for the remainder of the calendar year.

Over-the-counter (OTC)
Drugs for which a doctor's prescription is not required.

P

Physical Therapy
The care of disease or *injury* by such methods as massage, hydrotherapy, heat, or similar care.

Physician
Any licensed Doctor of Medicine (M.D.) legally entitled to practice medicine and perform surgery, any licensed Doctor of Osteopathy (D.O.) legally licensed to perform the duties of a D.O., any licensed Doctor of Podiatric Medicine (D.P.M.) legally entitled to practice podiatry, and any licensed Doctor of Dental Surgery (D.D.S.) legally entitled to perform oral surgery; Optometrists and Clinical Psychologists (PhD) are also physicians when acting within the scope of their licenses, and when rendering services covered under this Plan.

Plan Administrator
The Plan Administrator for the Assurant Health and Welfare Plan is the Assurant, Inc. Benefit Plans Committee.

Period of Disability
The period of time that you are determined to be disabled in accordance with the Short-Term Disability and/or Long-Term Disability Plan.

Plan Pay
Generally, your annual *base pay* plus target short-term incentive (STIP) bonus, if any, in effect as of the last day of active work. For sales people, it includes sales bonuses, commissions and incentives paid during the prior calendar year as well as incentives guaranteed in a first-year agreement. Sales bonuses, commissions, and incentives will be updated once a year on April 1.
Plan pay does not include overtime, long-term incentive compensation or any other form of pay you may be entitled to receive.

Prior Authorization
The process applied to certain drugs and/or therapeutic categories to define and/or limit the conditions under which these drugs will be covered. The drugs and criteria for coverage are defined by the CVS Caremark Pharmacy and Therapeutics Committee.

Proof of Good Health (POGH)
Evidence acceptable to Assurant Employee Benefits of the good health of a person.

Provider
A duly licensed person or facility that provides services within the scope of an applicable license and is a person or facility that the Plan approves. This includes any provider rendering services which are required by

Page
Page
Main Table of Contents
Back

applicable state law to be covered when rendered by such provider. Providers that deliver *covered services* are described throughout this Summary Plan Description. If you have a question if a provider is covered, please call the number on the back of your I.D. card.

Q

Qualified Medical Child Support Order (QMCSO) or Medical Child Support Order (MCSO)

A *QMCSO* creates or recognizes the right of a child who is recognized under the order as having a right to be enrolled under the health benefit plan to receive benefits for which the employee is entitled under the plan; and includes the name and last known address of the employee and each such child, a reasonable description of the type of coverage to be provided by the plan, the period for which coverage must be provided and each plan to which the order applies.

An *MCSO* is any court judgment, decree or order (including a court's approval of a domestic relations settlement agreement) that:

- Provides for child support payment related to health benefits with respect to the child of a *member* or requires health benefit coverage of such child in such plan, and is ordered under state domestic relations law or
- Enforces a state law relating to medical child support payment with respect to a group health plan.

Qualified Dental Professional

Any of the following professionals who are licensed and acting within the scope of their licenses:

- Dentists (D.D.S. or D.M.D.)
- Denturists
- Dental hygienists

Qualified dental professional does not include an immediate family member or an employee of the Assurant. Immediate family members include your spouse, domestic partner, parents, children, brothers, sisters, anyone who resides in your home, your spouse's or domestic partner's parents, children and siblings.

Qualifying Period

The length of time during a *period of disability* that you must be disabled before benefits are payable.

R

Rehabilitation Plan

A written statement, developed by Assurant Employee Benefits which describes:

- The vocational rehabilitation goals for you,
- Assurant Employee Benefit's responsibilities, your responsibilities and the responsibilities of any other parties to the plan and
- The timing of the implementation and expected completion of the plan, to the extent that it can be established, assuming your full cooperation.

The rehabilitation plan will be designed to enable you to return to work in a gainful occupation.

A *spouse*'s rehabilitation plan is a written agreement between you, your spouse and Assurant Employee Benefits in which, at your request, Assurant Employee Benefits agrees to provide, arrange or authorize appropriate vocational or physical rehabilitation services.

Page
Page
Main Table of Contents
Back

Rehire date
The date on which an eligible employee is reemployed by Assurant.

Retail Health Clinic
A facility that provides limited basic medical care services to *members* on a "walk-in" basis. These clinics normally operate in major pharmacies or retail stores. Medical services are typically provided by physician assistants and nurse practitioners. Services are limited to routine care and treatment of common illnesses for adults and children.

Retirement Plan
A formal or informal retirement plan, whether or not under an insurance or annuity contract. It does not include:

- A plan you pay for entirely,
- A qualified profit-sharing plan
- A thrift plan
- An individual retirement account (IRA)
- A tax sheltered annuity (TSA)
- A *government plan* or
- A plan that qualifies under Internal Revenue Service Code 401(k).

S

SSA Representative
Persons or organizations which specialize in assisting people to obtain disability benefits under the United State Social Security Act. If you appoint a SSA representative and they agree you are a good candidate, they will help you pursue your *Social Security* claim.

Semi-private Room
A hospital room that contains two or more beds.

Severance Agreement
An agreement between an eligible employee and an Assurant business unit that includes a waiver of all claims that the eligible employee might have against Assurant, a business unit, the *Plan Administrator*, and any other parties designated in the severance agreement. Signing a severance agreement is a condition for receipt of severance benefits.

Severance Date
The date specified by Assurant as the last day worked by an eligible employee.

Single Source Drug
A drug marketed or sold by only one manufacturer or labeler.

Skilled Nursing Care
Care required, while recovering from an illness or *injury*, which is received in a *skilled nursing facility*. This care requires a level of care or services less than that in a *hospital*, but more than could be given at the patient's home or in a nursing home not certified as a *skilled nursing facility*.

Skilled Nursing Facility
An institution operated alone or with a *hospital* which gives care after a *member* leaves the *hospital* for a condition requiring more care than can be rendered at home. It must be licensed by the appropriate agency and accredited by the Joint Commission on Accreditation of Health Care Organizations or the Bureau of

Hospitals of the American Osteopathic Association, or otherwise determined by the *Claims Administrator* to meet the reasonable standards applied by any of the aforesaid authorities.

Specialist (Specialty Care Physician \ Provider or SCP)

A Specialist is a Doctor who focuses on a specific area of medicine or group of patients to diagnose, manage, prevent, or treat certain types of symptoms and conditions. A non-Physician Specialist is a Provider who has added training in a specific area of health care.

Specialty Drugs

Drugs that meet a minimum of two of the following characteristics:

- Produced through DNA technology or biological processes
- Targets a chronic and complex disease
- Route of administration could be inhaled, infused or injected
- Unique handling, distribution and /or administration requirements

and/or

Must require a customized medical management program that includes medication use review, patient training, coordination of care and adherence management for successful use such that more frequent monitoring and training may be required.

Social Security Plan

The United Sates Social Security Act, the Railroad Retirement Act, the Canadian Pension Plan or any similar plan provided under the laws of any other nation. It also means any public employee retirement plan or teachers' employment retirement plan provided as an alternative to rather than a supplement for such plans.

Spouse

The person to whom you are legally married.

Substantially Similar Employment

A position within Assurant (or buyer/transferee in the case of sale or transfer of any portion of an Assurant business unit) that, in the discretion of the *Plan Administrator*:

- Is of a type for which the eligible employee is, or reasonably can become, qualified by work experience, education and/or training
- Does not require the eligible employee to relocate or to increase his or her commuting distance to his or her principal office or base by more than 35 miles (for positions that are of a telecommuting nature or are essentially mobile, the mileage does not apply)
- Does not entail a significant loss of management responsibility
- Provides a total compensation package (exclusive of non-cash benefits but including base pay plus applicable incentive compensation plans) that, in the aggregate, is not substantially less than the eligible employee earned on his or her last day of employment with a participating entity, and
- Provides, in the aggregate, substantially similar non-cash employee benefits.

The *Plan Administrator* or its designee has the sole authority to determine whether a position is substantially similar employment.

T

Transplant Providers

- Network Transplant Provider - A Provider that has been designated as a "Center of Excellence" for Transplants by the Claims Administrator and/or a provider selected to participate as a Network

Page
Page
Main Table of Contents
Back

Transplant Provider by the Blue Cross and Blue Shield Association. Such provider has entered into a transplant provider agreement to render covered transplant procedures and certain administrative functions to you for the transplant network. A provider may be a Network Transplant Provider with respect to:

- certain Covered Transplant Procedures; or
- all Covered Transplant Procedures.

U

Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA)

A federal law that protects the job rights of individuals who voluntarily or involuntarily leave employment positions to undertake military service or certain types of service in the National Disaster Medical System.

Urgent Care

Services received for a sudden, serious, or unexpected *illness*, injury or condition. *Urgent care* is not considered an *emergency*. *Urgent care* is needed right away to relieve pain, find out what is wrong, or treat a health problem that is not life-threatening.

Usual, Customary and Reasonable (UCR)

The average fee charged by a majority of dental providers in a given geographic area for a particular service. Whenever you use non-network providers, benefits are paid based on UCR rates. You are responsible for paying amounts above UCR. In-network care is always within UCR guidelines.

W

Workers Compensation

A state-based benefit plan that provides medical and income-replacement benefits for work-related illnesses and injuries