

## Asuris HSA Healthplan 2.0<sup>SM</sup> Benefit Summary



The new Asuris HSA Healthplan 2.0 is a simple way to pay for life's medical expenses. It's a comprehensive health plan and a tax-free savings account all rolled into one. You get broad medical coverage, support and guidance from an HSA specialist plus rewards for healthy living.

|  |   |
|--|---|
| <b>Lifetime Maximum Benefit</b>  | <b>\$2,000,000</b>  |
| <b>Calendar Year Deductible</b><br>Applies to all covered expenses except where noted  | Deductible: <b>\$3,000</b> for single coverage, <b>\$5,000</b> or <b>\$7,000</b> for family coverage.<br>Benefits begin for one family member when the single deductible is met. When the family deductible is met, benefits begin for the entire family. |
| <b>Calendar Year Out-of-Pocket Maximum</b><br>Out-of-pocket maximum amount per calendar year, including deductible, applies to all covered expenses.<br>When the out-of-pocket maximum is reached, this plan provides benefits at 100% of the allowed amount for the remainder of the calendar year. | Individual out-of-pocket maximum: <b>\$5,000</b><br>Family out-of-pocket maximum: <b>\$10,000</b>   |

| <b>Covered Services</b>   | <b>Category 1<br/>(Preferred)</b>   | <b>Category 2<br/>(Participating)</b> | <b>Category 3<br/>(Non-contracted)<br/>(Member may be responsible for any provider costs above the Category 3 allowed amount)</b> |
|---|---|---------------------------------------|---|
|   | Benefits will be provided at the percentage of the allowed amount as specified below, applied after deductible is met and until out of pocket maximum is reached. |                                       |   |
| <b>Professional Services</b><br>Office and inpatient services and supplies                            |   |                                       |   |
| <b>Hospital Services/Ambulatory Surgical Center</b><br>Inpatient and outpatient services and supplies |   |                                       |   |
| <b>Maternity</b> (Subscriber and spouse)  | <b>80%</b>  | <b>60%</b>                            | <b>60%</b>  |
| <b>Preventive Care</b><br>No benefit limits<br>Not subject to deductible                              |   |                                       |   |
| <b>Immunizations</b> - Adult and childhood<br>No benefit limit<br>Not subject to deductible           |   |                                       |   |

| Covered Services  | Category 1<br>(Preferred) | Category 2<br>(Participating) | Category 3<br>(Non-contracted)<br>(Member may be responsible for any provider costs above the Category 3 allowed amount) |
|---|---------------------------|-------------------------------|--|
| Benefits will be provided at the percentage of the allowed amount as specified below, applied after deductible is met and until out of pocket maximum is reached.                                     |                           |                               |  |
| <b>Emergency Room Services</b>  | 80%                       | 80%                           | 80%  |
| <b>Ambulance Services</b><br>Air and ground ambulance to nearest facility   |                           |                               |  |
| <b>Genetic Testing</b><br>\$5,000 per lifetime maximum benefit (this limit does not apply to prenatal testing)  | 80%                       | 60%                           | 60%  |
| <b>Nutritional Counseling</b><br>Three visits per lifetime (this limit does not apply to diabetic counseling)   |                           |                               |  |
| <b>Durable Medical Equipment</b><br>\$7,500 per calendar year maximum benefit (this limit does not apply to insulin pumps/supplies and lifesaving equipment such as oxygen and ventilators)           |                           |                               |  |
| <b>Orthotics</b><br>\$500 per calendar year maximum benefit (this limit does not apply to diabetic orthotics)   |                           |                               |  |
| <b>Prostheses</b><br>\$20,000 per calendar year maximum benefit (this limit does not apply to surgically implanted or external breast prostheses)   |                           |                               |  |
| <b>Prescription Medication Coverage</b><br>Retail or Mail Order: Up to 90 day supply for covered prescription medications (Up to 30 day supply for covered self-administrable injectable medications) |                           |                               |  |
| <b>Rehabilitation Services</b><br>Inpatient: \$25,000 per calendar year maximum benefit<br>Outpatient: \$1,500 per calendar year maximum benefit  | 80%                       | 60%                           | 60%  |

| Covered Services  | Category 1<br>(Preferred) | Category 2<br>(Participating) | Category 3<br>(Non-contracted)<br>(Member may be responsible for any provider costs above the Category 3 allowed amount) |
|---|---------------------------|-------------------------------|--|
| Benefits will be provided at the percentage of the allowed amount as specified below, applied after deductible is met and until out of pocket maximum is reached.                                   |                           |                               |  |
| <b>Neurodevelopmental Therapy</b><br>For children age 6 and under<br>Inpatient and outpatient combined: \$1,500 per calendar year maximum benefit   |                           |                               |  |
| <b>Acupuncture</b><br>12 visits per calendar year   |                           |                               |  |
| <b>Spinal Manipulations</b><br>10 spinal manipulations per calendar year  |                           |                               |  |
| <b>Chemical Dependency</b><br>(Groups of 2-50): \$14,500 combined inpatient/outpatient maximum benefit every 2 calendar years<br>(Groups of 51+): No benefit maximums                               |                           |                               |  |
| <b>Home Health</b><br>130 visits per calendar year  |                           |                               |  |
| <b>Hospice</b><br>Respite care limited to 14 days inpatient/outpatient per lifetime   | 80%                       | 60%                           | 60%  |
| <b>Mental Health</b><br>(Groups of 2-50):<br>Inpatient: 8 days per calendar year<br>Outpatient: 12 visits per calendar year<br>(Groups of 51+): No benefit limits for inpatient/outpatient services |                           |                               |  |
| <b>Skilled Nursing Facility</b><br>60 inpatient days per calendar year  |                           |                               |  |
| <b>Temporomandibular Joint Disorders (TMJ) Treatment</b><br>\$1,000 per calendar year maximum benefit   |                           |                               |  |
| <b>Transplants</b><br>Services and supplies to \$250,000 lifetime maximum benefit<br>\$50,000 donor expense maximum benefit per transplant<br>6-month waiting period                                |                           |                               |  |

| Covered Services  | Optional Benefits Available<br>(Optional benefits that are not elected are excluded from coverage) |                               |  |
|---|--|-------------------------------|--|
|   | Category 1<br>(Preferred)  | Category 2<br>(Participating) | Category 3<br>(Non-contracted)<br>(Member may be responsible for any provider costs above the Category 3 allowed amount) |
| <b>Spinal Manipulations</b><br>Option with no benefit maximum   | 80%  | 60%                           | 60%  |
| <b>Vision</b><br>One routine eye exam per calendar year<br>Hardware limited to \$150 per calendar year maximum benefit<br>Not subject to deductible | 100%   |                               |  |

| Optional Program Available   |
|--|
| <p>Employee Assistance Program (EAP)</p> <p>No cost to the member for:</p> <p>Up to four face-to-face sessions per incident to manage stress or work-life balance situations</p> <p>Legal and financial assistance</p> <p>24/7 crisis line</p> |

| Additional Information          |   |
|---------------------------------|---|
| <b>Waiting Periods</b>          | No benefits are provided for treatment relating to a transplant until the member has been covered under this or a prior Asuris plan with the same group for six consecutive months. There is a waiting period that must be met prior to benefits being available for pre-existing conditions: groups with 2-50 eligible employees have a nine-month pre-existing condition waiting period and groups with 51 or more eligible employees have a three-month pre-existing condition waiting period. Members may receive credit from prior medical coverage.   |
| <b>Outside the Service Area</b> | Through arrangements with our affiliates in Washington, Oregon, Idaho and Utah, members can access all levels of providers and payment in those states as if in the home service area. Outside those four states, members have the security of knowing they can access providers across the country. Through the Asuris Preferred Network, members receive Category 1 coverage with thousands of providers nationwide, discounted services, balanced-billing protection, and nationwide provider search capability. When you're an Asuris Northwest Health member, you take your benefits with you. |

### General Medical Exclusions

Coverage is not provided for any of the following, including direct complications or consequences that arise from:

- **Cosmetic/Reconstructive Services and Supplies** except for reconstruction for functional injury and disease, to treat a congenital anomaly, and for breast reconstruction following a medically necessary mastectomy to the extent required by law
- **Counseling** in the absence of illness
- **Custodial Care:** Non-skilled care and helping with activities of daily living
- **Dental Examinations and Treatments**
- **Fees, Taxes, Interest:** Charges for shipping and handling, postage, interest, or finance charges that a provider might bill
- **Government Programs:** Benefits that are covered, or would be covered in the absence of this plan, by any federal, state or governmental program
- **Infertility** except to the extent covered services are required to diagnose such condition
- **Investigational Services:** Treatment or procedures (health interventions) and services, supplies and accommodations provided in connection with investigational treatments or procedures
- **Medications without a Prescription Order**
- **Military Service Related Conditions:** The treatment of any condition caused by or arising out of a member's active participation in a war or insurrection or conditions incurred in or aggravated during a performance in the Uniformed Services
- **Motor Vehicle Coverage and Other Insurance Liability**
- **Non-Direct Patient Care** including appointments scheduled and not kept, charges for preparing medical reports, itemized bills or claim forms, and visits or consultations that are not in person, including telephone consultations and email exchanges
- **Obesity or Weight Reduction/Control:** Medical treatment, medication, surgical treatment (including reversals), programs, or supplies that are intended to result in or relate to weight reduction, regardless of diagnosis
- **Orthognathic Surgery** except for congenital conditions, temporomandibular joint disorder, injury, and sleep apnea

### General Medical Exclusions

Coverage is not provided for any of the following, including direct complications or consequences that arise from:

- **Personal Comfort Items:** Items that are primarily for comfort, convenience, cosmetics, environmental control, or education
- **Physical Exercise Programs and Equipment** including hot tubs or membership fees at spas, health clubs, or other facilities; applies even if the program, equipment, or membership is recommended by the member's provider
- **Private Duty Nursing** including ongoing shift care in the home
- **Riot, Rebellion and Illegal Acts:** Services and supplies for treatment of an illness, injury or condition caused by a member's voluntary participation in a riot, armed invasion or aggression, insurrection or rebellion, sustained by a member while committing an illegal act or felony
- **Routine Foot Care** including treatment of corns and calluses and trimming of nails
- **Routine Hearing Care:** Routine hearing examinations, programs, or treatment for hearing loss including hearing aids (externally worn or surgically implanted) and the surgery and services necessary to implant them, except for cochlear implants
- **Self-Help, Self-Care, Training, or Instructional Programs** including childbirth classes, diet and weight monitoring services and instruction programs, including those to learn how to stop smoking and programs that teach a person how to use durable medical equipment or how to care for a family member
  
- **Services and Supplies Provided by a Member of Your Family**
- **Services and Supplies That Are Not Medically Necessary**
- **Services to Alter Refractive Character of the Eye**
- **Sexual Reassignment Treatment and Surgery:** Treatment, surgery, or counseling services for sexual reassignment
- **Sexual Dysfunction:** Regardless of cause, except for counseling provided by covered, licensed mental health practitioners
- **Third-Party Liability:** Services and supplies for treatment of illness or injury for which a third party is or may be responsible
- **Tobacco Addiction Treatment**
- **Travel and Transportation Expenses** other than covered ambulance services
- **Work-Related Conditions** except for subscribers who are owners, partners, or corporate officers and are exempt from state or federal workers' compensation law

**This is a brief summary of benefits; it is not a certificate of coverage. All benefits must be medically necessary. For full coverage provisions, refer to the contract.**