

SUMMARY OF BENEFITS INDIVIDUAL ASURIS HSA HEALTHPLAN



For medically necessary services rendered by a Preferred Plan, participating, or recognized provider in the service area, the benefits of this plan will be provided at the percentage of the allowed amount as specified below after the deductible has been met. Unless specified otherwise, all benefits are subject to the annual deductible in addition to any coinsurance. When you, or you and your family, have reached the annual out-of-pocket maximum for Preferred Plan or out-of-area provider services only, this plan will provide benefits at 100% of the allowed amount for the remainder of the calendar year for the services of Preferred Plan or out-of-area provider services only. Any balances of charges not covered by this plan will be your, or you and your family's, responsibility to pay. Most services provided by participating or recognized providers do not apply toward the annual out-of-pocket maximum.

<u>Benefits</u>	<u>Preferred Plan Provider</u>	<u>Participating/ Recognized Provider</u>
Annual Deductible Family deductible applies when the subscriber and one or more dependents are enrolled. Prior to benefits being paid for any family member, the entire family deductible must be met.	\$2,500 per member/\$5,000 per family or \$3,500 per member/\$7,000 per family	
Lifetime Maximum	\$2,000,000 per member	
Annual Out-of-Pocket Amount The total amount of coinsurance and deductible amount you, or you and your family, are responsible to pay during a calendar year for covered services, after which the plan will provide benefits at 100% of the allowed amount for the remainder of that calendar year for the services of Preferred Plan or out-of-area providers only, unless otherwise specified. Most services provided by participating or recognized providers do not apply toward the annual out-of-pocket maximum. Any balances of charges not covered by this plan will be your, or you and your family's, responsibility to pay. The family out-of-pocket amount applies when the subscriber and one or more dependents are enrolled. Prior to benefits being paid for any family member at 100%, the entire family out-of-pocket maximum must be met.	\$5,000 per member \$10,000 per family	No out-of-pocket maximum
Professional Services Including diagnostic x-ray and laboratory. Coverage includes the services of physicians, osteopaths, naturopaths, and other eligible health care professional providers.	80% (unless specified otherwise)	60%
Hospital Facility (Inpatient and Outpatient)** Including diagnostic x-ray and laboratory	80%	60%
Acupuncture 12 visits per calendar year maximum	80%	60%
Ambulance Services* Ground services: \$2,000 per calendar year maximum	80%	80%
Blood Bank*	80%	80%
Home Health and Hospice Home Health – 130 visits per calendar year maximum Hospice – 6 months maximum	80%	80%
Home Medical Equipment \$2,500 per calendar year maximum	80%	60%
Home Phototherapy	80%	80%
Infusion Therapy Growth hormone treatment is limited to \$20,000 per calendar year	80%	60%

(over)

Mammography Routine mammograms not subject to deductible	80%	60%
Mental Disorders Inpatient – 8 days per calendar year Outpatient – 12 visits per calendar year	80%	60%
Occupational Injury (provided for subscriber only)	80%	60%
Phenylketonuria (PKU) Formulas Not subject to waiting periods	80%	80%
Preventive Care (not subject to deductible)	80%	60%
Prostate Cancer Screening Routine prostate cancer screenings not subject to deductible	80%	60%
Prostheses and Orthotics	80%	60%
Rehabilitation Inpatient – \$4,000 per calendar year maximum Outpatient – \$2,000 per calendar year maximum	80%	60%
Skilled Nursing Facility 30 days per calendar year maximum	80%	80%
Special Equipment and Supplies	80%	80%
Spinal Manipulations 10 manipulations per calendar year maximum	80%	60%
Transplants \$250,000 lifetime maximum; 12-month waiting period	80%	60%

*At this time, these services are provided only by recognized providers.

**Services and supplies required to treat a medical emergency will be provided at the Preferred Plan payment level of benefits.

Cost Containment Provisions: All hospital and skilled nursing facility admissions must be medically necessary. When outside the service area, preadmission approval should be obtained to ensure that full plan benefits will be provided.

Emergency Care: In the event of a medical emergency inside the service area, benefits will be provided at the level specified for a Preferred Plan provider. Benefits for recognized providers will be based on the recognized provider's actual charge for the service. Outside the service area, benefits will be provided at the level specified below.

Care Outside the Service Area: Benefits will be provided at 80% of the allowed amount for care received from an out-of-area provider. Any balances of charges not covered by this plan will be your, or you and your family's, responsibility.

Waiting Periods: No benefits are provided for treatment relating to a transplant until you have been covered under this or a prior plan with the Company (Asuris Northwest Health) for 12 consecutive months. No benefits will be provided for preexisting conditions until you have been covered under this plan for nine consecutive months, unless you were continuously covered for at least nine months under the immediately preceding creditable plan.

This is a brief summary of benefits; it is not a certificate of coverage. For full coverage provisions, including a description of waiting periods, limitations, and exclusions, refer to your plan contract. myAsuris.com is designed to advise you on health care and lifestyle options, navigate you through the health care system, and reward you who make healthy choices. Go to www.myAsuris.com and view claims; get fitness and nutrition tips; learn about medical conditions, medications and formulary information; search for doctors; and research cost and care options.