

**SUMMARY OF BENEFITS**  
**HSA Qualified**  
**PREFERRED PLAN**  
**80/80/60**



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.

<b>Benefits</b>	<b>Preferred Plan Provider</b>	<b>Participating/Recognized Provider</b>
<b>Professional Services</b> Including diagnostic x-ray and laboratory	80%	60%
	(unless otherwise specified)	
<b>Hospital Facility (Inpatient &amp; Outpatient)</b> Including diagnostic x-ray and laboratory	80%	60%
<b>Acupuncture</b> 12 visits per calendar year maximum	80%	60%
<b>Ambulance Services**</b>	80%	80%
<b>Blood Bank**</b>	80%	80%
<b>Chemical Dependency</b> \$14,000 every two calendar year maximum	80%	60%
<b>Growth Hormone</b> \$20,000 per calendar year maximum	80%	60%
<b>Home Health and Hospice</b> Home health - 130 visits per calendar year maximum Hospice - 6 month maximum	80%	80%
<b>Home Medical Equipment, Prostheses and Orthotics</b>	80%	60%
<b>Home Phototherapy</b>	80%	80%
<b>Hospitalization for Dental Services</b> \$1,000 per calendar year maximum No benefits provided for charges of a dentist	80%	60%
<b>Maternity</b> (provided for the subscriber or spouse) Inpatient - 8 days per calendar year Outpatient - 12 visits per calendar year	same as any other condition	
<b>Neurodevelopmental Therapy</b> (for children age 6 and under) \$1,500 per calendar year maximum	80%	60%
<b>Occupational Injury</b> (provided for the subscriber only) \$250,000 lifetime maximum	80%	60%
<b>Phenylketonuria (PKU) Formulas</b>	80%	80%

<b>Prescription Drugs</b> Services provided only by participating providers	Asuris Northwest Health Reimburses Member	
	80%	80%
<b>Preventive Care</b> \$300 per calendar year maximum; not subject to deductible	80%	60%
<b>Rehabilitation</b> Inpatient - \$15,000 per condition Outpatient - \$1,000 per calendar year maximum	80%	60%
<b>Repair of Teeth**</b> \$1,000 per occurrence	80%	80%
<b>Skilled Nursing Facility</b> 30 days per calendar year maximum	*	80%
<b>Special Equipment and Supplies</b>	80%	80%
<b>Spinal Manipulations</b> 12 spinal manipulation limit per calendar year	80%	60%
<b>Temporomandibular Joint Disorders (TMJ)</b> \$1,000 per calendar year maximum; \$5,000 lifetime maximum	80%	60%
<b>Transplants</b> \$250,000 lifetime maximum	80%	60%

\* At this time, this service is provided only by participating and recognized providers.

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

**Lifetime Maximum:** \$2,000,000/ \$20,000 annual reinstatement.

**Annual Deductible:** Individual \$1,500/ Family \$3,000. 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.

**Annual Out-of-Pocket Amount:** \$5,000 Member/\$10,000 Family. 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 percent 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. 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.

**Emergency Care in the Service Area:** In the event of a medical emergency, treatment by a participating or recognized provider will be provided for a 24-hour period or for such additional time as is reasonably required to come under the care of a Preferred Plan provider. Emergency 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.

**Care Outside the Service Area:** All care received outside the service area, whether or not a medical emergency, will be covered at 80% of the allowed amount, except outpatient mental disorder care will be provided at the level specified. Any balances of charges not covered by this plan will be your, or you and your family's, responsibility.

**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.

**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) or its parent company for six consecutive months. There is a preexisting condition waiting period that must be met prior to benefits being available. Refer to your benefits brochure for details regarding this waiting period. Maternity benefits and PKU benefits are not subject to the waiting periods of this 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 benefits brochure and the contract on file with your group. Your feedback is important to us. If you have suggestions about the benefits covered under this plan, you may contact us at 1-888-344-5587 or visit our Web site at [www.asuris.com](http://www.asuris.com) and complete the Suggestion Box form located on the Contact Us page.**