

**ANH Infinity - \$3,000**  
**SUMMARY OF BENEFITS**  
**PlanPPO (100)/80/80/50/25**



Infinity \$3,000 has the following unique features: 1) The first \$500 per calendar year for outpatient diagnostic x-ray and laboratory services will not be subject to the annual deductible and will be provided as specified below; 2) Outpatient diagnostic x-ray and laboratory exceeding the first \$500 per calendar year, and all other professional services not billed as an office visit will be subject to the annual deductible and will be provided as specified below; and 3) Preventive care benefits are also included, are unlimited, and are not subject to deductible. All other benefits of this plan will be provided at the percentage of the allowed amount as specified below after the deductible has been met. All benefits must be medically necessary and are subject to any copays and coinsurance unless otherwise specified. When you have reached the annual out-of-pocket coinsurance maximum for Preferred Plan or out-of-area provider services only, this plan will provide benefits at 100% of the allowed amount for Preferred Plan or out-of-area provider services for the remainder of the calendar year, unless otherwise specified.

<b>Benefits</b>	<b>Preferred Plan Provider</b>	<b>Participating/ Recognized Provider</b>
<b>Professional Services</b> Not subject to deductible - Unlimited visits in the office, home, or outpatient hospital per year after office-visit copay and first \$500/year for outpatient x-ray and lab	100%	50%
Subject to deductible - Outpatient x-ray and lab above the first \$500/year; and all other professional services not billed as an office visit (i.e., x-ray, laboratory, medical procedures)	80%	50%
<b>Hospital Facility**</b> Inpatient and outpatient including diagnostic x-ray and laboratory \$150 copay per emergency room visit (waived if admitted)	80%	50%
<b>Acupuncture</b> 12 visits per calendar year maximum; subject to the deductible	80%	50%
<b>Ambulance Services*</b>	80%	80%
<b>Blood Bank*</b>	80%	80%
<b>Chemical Dependency</b> \$14,500 every two calendar year maximum	80%	50%
<b>Growth Hormone</b> \$25,000 per calendar year maximum	80%	50%
<b>Home Health and Hospice</b> Home health - 130 visits per calendar year maximum Hospice - 6 month benefit maximum; 14 day inpatient maximum	80%	80%
<b>Home Medical Equipment, Prostheses and Orthotics</b>	80%	50%
<b>Home Phototherapy</b>	80%	80%
<b>Hospitalization for Dental Services</b> \$1,000 per calendar year maximum No benefits provided for charges from a dentist	80%	50%
<b>Mammography</b>	same as any condition	
<b>Maternity</b> (provided for the subscriber or spouse)	80%	50%
<b>Mental Disorders</b> Inpatient - 8 days per calendar year Outpatient - 12 visits per calendar year	80%	50%
<b>Neurodevelopmental Therapy</b> (for children age 6 and under) \$1,500 per calendar year maximum	80%	50%

<b>Occupational Injury</b> (provided for the subscriber only)	same as any condition	
<b>\$250,000 lifetime maximum</b>		
<b>Phenylketonuria (PKU) Formulas</b>	80%	80%
<b>Prostate Cancer Screening</b>	same as any condition	
<b>Rehabilitation</b>		
Inpatient - \$15,000 per condition	80%	50%
Outpatient - \$1,000 per calendar year maximum	80%	50%
<b>Repair of Teeth*</b>	80%	80%
\$1,000 per occurrence		
<b>Skilled Nursing Facility</b>	80%	80%
30 days per calendar year maximum		
<b>Smoking Cessation</b>	75%	75%
\$500 lifetime maximum		
<b>Special Equipment and Supplies</b>	80%	80%
<b>Spinal Manipulations</b>	80%	50%
12 spinal manipulations per calendar year; not subject to the deductible		
<b>Temporomandibular Joint Disorder (TMJ)</b>	80%	50%
\$1,000 per calendar year maximum; \$5,000 per lifetime maximum		
<b>Transplants</b>	80%	
\$250,000 lifetime maximum; \$50,000 per transplant donor organ procurement maximum; \$2,500 per transplant travel and lodging maximum		

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

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

**Lifetime Maximum:** \$2,000,000

**Annual Deductible:** \$3,000 per individual / \$9,000 per family.

**Annual Out-of-Pocket Coinsurance Amount:** The total amount of coinsurance you 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, unless otherwise specified. The annual deductible, copays, neurodevelopmental therapy, outpatient rehabilitation, repair of teeth, smoking cessation, and most services provided by participating or recognized providers do not apply to the out-of-pocket coinsurance amount. \$5,000 per individual / \$15,000 per family.

**Copay:** There is a \$25 per-visit copay for each office call/home visit billed as such by a provider in the office, home, or hospital outpatient department (waived for surgery, for radiation and chemotherapy, for spinal manipulations, or if you are directly admitted to the hospital as an inpatient). Copays do not apply toward the deductible or to the out-of-pocket coinsurance amount.

**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 benefits for smoking cessation will be provided at the level specified. Any balances of charges not covered by this plan will be your 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) 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. 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](http://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.**