

*Progressive 0*

\$25 Copay

\$0 Deductible

90%/50%/50% Coinsurance

Plan Year October 2010 – September 2011



*This coverage is a “non-grandfathered health plan” under the Patient Protection and Affordable Care Act (PPACA).*

**Benefit Summary**

Annual maximum benefit	\$2,000,000
Deductible per calendar year	\$0 Per Member
Maximum coinsurance per calendar year	\$2,500 Per Member \$5,000 Per Family (2 times the member amount)
After the maximum coinsurance is met, the plan pays	100% for the remainder of the calendar year except where noted

**Understanding Your Benefits**

- We will begin to pay benefits for covered services in any calendar year only after your deductible is satisfied. Your deductible applies for all services unless otherwise specified. Copayments do not count toward the deductible.
- Once you have satisfied any applicable deductible and any applicable copayment, we pay a percentage of the allowed amount for covered services. When our payment is less than 100%, you pay the remaining percentage. This is your **Coinsurance** (Member Responsibility).

You can meet the maximum coinsurance by payments of coinsurance for all categories. Any amounts you pay for non-covered services, deductible, copayments or amounts in excess of the allowed amount do not apply toward the maximum coinsurance.

**Important Information Regarding Preventive Care:** Benefits will be covered under the preventive care benefit if services or supplies are in accordance with age limits and frequency guidelines according to, and as recommended by, the United States Preventive Services Task Force (USPSTF), the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (CDC) or Health Resources and Services Administration (HRSA). Covered services that do not meet this criteria will be covered the same as any other illness or injury.

**You Select Your Provider and Control Your Out-of-Pocket Expenses**

- **Category 1.** You choose to see a preferred provider and save the most in your out-of-pocket expenses. Choosing this category means you will not be billed for balances beyond any deductible, copayment, and/or coinsurance for covered services. You can find a list of providers at our Website or by calling Customer Service.
- **Category 2.** You choose to see a participating provider and your out-of-pocket expenses will generally be higher than if you choose Category 1 because we may negotiate larger discounts with preferred providers that will result in lower out-of-pocket amounts for you. Choosing this category means you will not be billed for balances beyond any deductible, copayment, and/or coinsurance for covered services.
- **Category 3.** You choose to see a provider that does not have a participating contract with us and your out-of-pocket expenses will generally be higher than Category 1. **Also, choosing this category means you may be billed for balances beyond any deductible, copayment, and/or coinsurance.** This is sometimes referred to as balance billing.

<b>Covered Medical Services (Per Member)</b>	<b>Member Responsibility Category 1</b>	<b>Member Responsibility Category 2</b>	<b>Member Responsibility Category 3</b>
<b>Office Visits</b> ▪ For illness or injury	\$25 copay per visit (deductible waived)	\$25 copay per visit (deductible waived)	50%
<b>Other Professional Services</b> ▪ Surgery, inpatient visits and therapeutic injections ▪ Laboratory, radiology and diagnostic procedures	10%	50%	50%
<b>Preventive Care</b> ▪ Routine visits for preventive care including well-baby care, screenings for women and routine physical exams ▪ Routine radiology and laboratory services including mammography and prostate screening ▪ Routine procedures including routine colonoscopies ▪ Immunizations for adults and children	0% (deductible waived)	0% (deductible waived)	0% (deductible waived)
<b>Acupuncture</b> ▪ 12 visit limit per calendar year	10%	50%	50%
<b>Ambulance Services</b>	10%	10%	10%
<b>Blood Bank</b>	10%	10%	10%
<b>Chemical Dependency Services</b>	10%	50%	50%
<b>Dental Hospitalization</b>	10%	50%	50%
<b>Durable Medical Equipment</b>	10%	50%	50%
<b>Emergency Room (Including Professional Charges)</b> ▪ Copay waived if admitted directly to a hospital or facility on an inpatient basis	10% after \$200 copay	10% after \$200 copay	10% after \$200 copay
<b>Genetic Testing</b>	10%	50%	50%
<b>Home Health Care</b> ▪ 130 visit limit per calendar year	10%	50%	50%
<b>Hospice Care</b> ▪ 14 respite care day limit per member lifetime	10%	50%	50%
<b>Hospital Care</b> ▪ Inpatient, Outpatient and Ambulatory Service Facility	10%	50%	50X%
<b>Maternity Care</b>	10%	50%	50%
<b>Mental Health Services</b>	10%	50%	50%
<b>Neurodevelopmental Therapy</b> ▪ Covered for children age 6 and under ▪ Inpatient: Unlimited ▪ Outpatient: 25 visits per calendar year	10%	50%	50%
<b>Nutritional Counseling</b> ▪ 3 visit limit per member lifetime	10%	50%	50%
<b>Orthotic Devices</b>	10%	50%	50%
<b>Prosthetic Devices</b>	10%	50%	50%
<b>Rehabilitation Services</b> ▪ Inpatient: 30 days per calendar year ▪ Outpatient: 25 visits per calendar year	10%	50%	50%
<b>Skilled Nursing Facility (SNF) Care</b> ▪ 30 inpatient day limit per calendar year	10%	50%	50%
<b>Spinal Manipulation</b> ▪ 12 spinal manipulations per calendar year	10% (deductible waived)	50% (deductible waived)	50% (deductible waived)

<b>Covered Medical Services (Per Member)</b>	<b>Member Responsibility Category 1</b>	<b>Member Responsibility Category 2</b>	<b>Member Responsibility Category 3</b>
<b>Transplants</b> <ul style="list-style-type: none"> <li>▪ 6 month waiting period (you may receive credit from your prior medical coverage)</li> </ul>	10%	50%	50%

## *General Exclusions*

We will not provide benefits for any of the following conditions, treatments, services, supplies or accommodations, including any direct complications or consequences that arise from them. However, these exclusions will not apply with regard to an otherwise covered service: 1) an injury, if the injury results from an act of domestic violence or a medical condition (including physical and mental) and regardless of whether such condition was diagnosed before the injury; or 2) a preventive service as specified under the preventive care benefit.

### **Preexisting Condition Exclusion**

<b>Exclusion Period for Preexisting Conditions</b>	3 months (you may receive credit from your prior medical coverage)
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**Important note:** By preexisting condition, we mean a physical or mental condition, regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was recommended or received within the 3-month period before the enrollment date. If you enrolled during your initial period of eligibility, enrollment date means your effective date of coverage or, if earlier, the first day of any waiting period for coverage applied to you. If you enrolled during a special enrollment, the enrollment date is the effective date of coverage. Pregnancy and phenylketonuria (PKU) are not considered preexisting conditions. Genetic information will not be considered a preexisting condition in the absence of a diagnosis related to such information. In addition, exclusion periods for preexisting conditions are not imposed on a member who is enrolled prior to reaching 19 years of age.

### **Medical Exclusions**

**Condition Caused By Active Participation in a War or Insurrection:** The treatment of any condition caused by or arising out of a member's active participation in a war or insurrection.

**Condition Incurred in or Aggravated During Performances in the Uniformed Services:** The treatment of any member's condition that the Secretary of Veterans Affairs determines to have been incurred in, or aggravated during, performance of service in the uniformed services of the United States.

**Cosmetic/Reconstructive Services and Supplies** except to treat a congenital anomaly, to restore a physical bodily function lost as result of injury or illness or related to 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 Services** provided to prevent, diagnose or treat diseases or conditions of the teeth and adjacent supporting soft tissues, including treatment that restores the function of teeth.

**Expenses Before Coverage Begins or After Coverage Ends:** Services and supplies incurred before your effective date under the contract or after your termination under the contract, except as may be provided under the other continuation options of the contract.

**Fees, Taxes, Interest:** Charges for shipping and handling, postage, interest or finance charges that a provider might bill.

**Foot Care (Routine):** Routine foot care including treatment of corns and calluses and trimming of nails, except when indicated for diabetic patients.

**Government Programs:** Benefits that are covered, or would be covered in the absence of this plan, by any federal, state or governmental program.

**Growth Hormone Therapy** (coverage for these services may be provided under the prescription medication benefit)

**Hearing Care:** Routine hearing examinations, programs or treatment for hearing loss, including, but not limited to, hearing aids (externally worn or surgically implanted) and the surgery and services necessary to implant them. This exclusion does not apply to cochlear implants.

**Infertility:** Treatment of infertility, except to the extent covered services are required to diagnose such condition, including all assisted reproductive technologies and fertility drugs and medications.

**Investigational Services:** Investigational treatment or procedures (health interventions) and services, supplies and accommodations provided in connection with investigational treatments or procedures.

### **Medical Exclusions**

**Mental Health Treatment For Certain Conditions** including diagnostic codes 302 through 302.9 found in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders for all ages. Additionally, we will not cover any "V code" diagnoses except the following when medically necessary: parent-child relational problems for children five years of age or younger, neglect or abuse of a child for children five years of age or younger and bereavement for children five years of age or younger

**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 or psychological conditions.

**Orthognathic Surgery:** By orthognathic surgery, we mean surgery to manipulate facial bones, including the jaw, in patients with facial bone abnormalities resulting from abnormal development to restore the proper anatomic and functional relationship of the facial bones. This exclusion does not apply to orthognathic surgery due to injury, sleep apnea or congenital anomaly.

**Over the Counter Contraceptives** including supplies and oral contraceptives (coverage for these services may be provided under the prescription medication benefit).

**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 such 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.

**Reversals of Sterilizations** including services and supplies related to reversals of sterilization.

**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 or sustained by a member arising directly from an act deemed illegal by an officer or a court of law.

**Self-Help, Self-Care, Training or Instructional Programs** including diet and weight monitoring services, childbirth-related classes including infant care and breast feeding classes, 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**

**Sexual Dysfunction:** Services and supplies including medications for or in connection with sexual dysfunction regardless of cause, except for counseling services provided by covered, licensed mental health practitioners when mental health services are covered benefits under the contract.

**Sexual Reassignment Treatment and Surgery:** Treatment, surgery or counseling services for sexual reassignment.

**Temporomandibular Joint (TMJ) Disorder Treatment:** Services and supplies provided for temporomandibular joint (TMJ) disorder treatment.

**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** including supportive items for addiction to tobacco, tobacco products or nicotine substitutes.

**Travel and Transportation Expenses** other than covered ambulance services.

**Vision Care:** Visual therapy, training and eye exercises, vision orthoptics, surgical procedures to correct refractive errors/astigmatism, reversal or revisions of surgical procedures which alter the refractive character of the eye.

**Work-Related Conditions:** Expenses for services and supplies incurred as a result of any work-related injury or illness, including any claims that are resolved related to a disputed claim settlement. The only exception is if an enrolled employee is exempt from state or federal workers' compensation law.

**Please note:** This benefit summary provides a brief description of your health care plan benefits, limitations and exclusions under your health care plan and is not a guarantee of payment. Once enrolled, you can view your benefits booklet online at our Website, [www.myAsuris.com](http://www.myAsuris.com). Please refer to your benefits booklet for a complete list of benefits, the limitations and exclusions that apply, and a definition of medical necessity.



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