Asuris HSA Healthplan 2.0SM

$2,500/5,000 Single/Family Deductible
80%/60%/60% Coinsurance

ASURIS NORTHWEST HEALTH

Sample Summary Inc
Effective Date: January 1, 2012

Benefit Summary	
Annual Maximum Benefit	$2,000,000
Deductible per calendar year	$2,500 single coverage $5,000 family coverage
Out-of-Pocket maximum per calendar year	$5,000 single coverage $10,000 family coverage
After the Out-of-Pocket maximum 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 the deductible** is satisfied. Your deductible applies for all services unless otherwise specified.
- A member who is enrolled on single coverage satisfies the single coverage deductible by incurring covered services during the calendar year for which the allowed amounts total and meet the single coverage deductible.
- The family coverage deductible is satisfied when some or all covered family members' allowed amounts for covered services for that calendar year total and meet the family coverage deductible amount.
- Once you have satisfied any applicable deductible, 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).
- Members can meet the out-of-pocket maximum for a calendar year by payments of deductible and coinsurance for all categories as specified.
- The family out-of-pocket maximum for a calendar year is satisfied when some or all family members' deductible and coinsurance for that calendar year total and meet the family out-of-pocket maximum amount.

Important Information Regarding Preventive Care: Benefits will be covered under the preventive care benefit if services 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). In the event any of these bodies adopts a new or revised recommendation, this plan has up to one year before coverage of the related services must be available and effective under this benefit. For a list of services covered under this benefit, please visit **www.myAsuris.com**. 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 select 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 and/or coinsurance for covered services. You can find a list of providers at our Website or by calling Customer Service.
- **Category 2**. You select to see a participating provider and your out-of-pocket expenses will generally be higher than if you select 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 and/or coinsurance for covered services.
- **Category 3**. You select 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 and/or coinsurance.** This is sometimes referred to as balance billing.

Covered Medical Services (Per Member)	*Member Responsibility Category 1*	*Member Responsibility Category 2*	*Member Responsibility Category 3*
Professional Services ▪ Office visits for illness or injury ▪ Laboratory, radiology and diagnostic procedures ▪ Surgery, inpatient visits and therapeutic injections	20%	40%	40%
Preventive Care ▪ Preventive care services include routine well-baby care, routine physical examinations, routine immunizations and routine health screenings ▪ Provider counseling for tobacco use cessation ▪ Immunizations for adults and children	0% (deductible waived)	0% (deductible waived)	40% (deductible waived)
Acupuncture ▪ 12 visit limit per calendar year	20%	40%	40%
Ambulance Services	20%	20%	20%
Blood Bank	20%	20%	20%
Chemical Dependency Services	20%	40%	40%
Durable Medical Equipment	20%	40%	40%
Emergency Room (Including Professional Charges)	20%	20%	20%
Genetic Testing	20%	40%	40%
Home Health Care ▪ 130 visit limit per calendar year	20%	40%	40%
Hospice Care ▪ 14 respite care day limit per member lifetime	20%	40%	40%
Hospital Care ▪ Inpatient, Outpatient and Ambulatory Service Facility	20%	40%	40%
Maternity Care	20%	40%	40%
Mental Health Services	20%	40%	40%
Neurodevelopmental Therapy ▪ Covered for children age 6 and under ▪ Inpatient: No limit ▪ Outpatient: 25 visit limit per calendar year	20%	40%	40%
Nutritional Counseling ▪ 3 visit limit per member lifetime	20%	40%	40%
Orthotic Devices	20%	40%	40%
Prosthetic Devices	20%	40%	40%
Rehabilitation Services ▪ Inpatient: 30 day limit per calendar year ▪ Outpatient: 25 visit limit per calendar year	20%	40%	40%
Skilled Nursing Facility (SNF) Care ▪ 60 inpatient day limit per calendar year	20%	40%	40%
Spinal Manipulation ▪ 10 spinal manipulations per calendar year	20%	40%	40%
Temporomandibular Joint (TMJ) Disorders	20%	40%	40%
Transplants ▪ 6 month waiting period (you may receive credit from your prior medical coverage)	20%	40%	40%

Prescription Medications	
A nationwide network of Participating Pharmacies is available to you. Pharmacies that participate in this network submit claims electronically. You can find a list of Participating Pharmacies at our Website, **www.myAsuris.com**.	
Deductible per calendar year	Calculated together with your medical deductible
Out-of-Pocket maximum per calendar year	Calculated together with your medical out-of-pocket maximum
Important note: You are not responsible for any applicable deductible and/or coinsurance when you fill prescriptions at a Participating Pharmacy, for specific strengths or quantities of medications that are specifically designated as preventive medications (including, but not limited to, aspirin, fluoride, iron and generic medications for tobacco use cessation) or for immunizations. The applicable deductible and/or coinsurance will apply when you fill these preventive medications and immunizations at a Nonparticipating Pharmacy. Once enrolled, you can find a list of such medications at **www.myAsuris.com**.	

Covered Prescription Medication Services (Per Member)	*Member Responsibility*
Prescription Medications From a Pharmacy or Mail-Order Supplier ▪ Generic or brand-name medications (90-day supply for each prescription) ▪ Injectable medications (30-day supply each injectable medication)	20%

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 for: 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	
Exclusion Period for Preexisting Conditions	9 months (you may receive credit from your prior medical coverage)
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 6-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.

Medical Exclusions
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 except as provided under the prescription medication benefits section of the contract.
Hearing Care: We do not cover 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. Non-covered treatment includes, but is not limited to, all assisted reproductive technologies (for example, in vitro fertilization, artificial insemination, embryo transfer or other artificial means of conception) 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.
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 No-Fault Coverage
Non-Direct Patient Care including appointments scheduled and not kept, charges for preparing or duplicating medical reports and chart notes, 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 a temporomandibular joint disorder, 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 medications 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.
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 except as specifically provided under the preventive care and immunizations benefit of the contract, we do not cover treatment of tobacco addiction and supportive items for addiction to tobacco, tobacco products or nicotine substitutes.
Travel and Transportation Expenses other than covered ambulance services.
Vision Care: Routine eye exam and vision hardware. 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.

Prescription Medication Exclusions
Biological Sera, Blood or Blood Plasma
Cosmetic Purposes: Prescription medications used for cosmetic purposes including, removal, inhibition or stimulation of hair growth, retardation of aging or repair of sun-damaged skin.
Devices or Appliances (coverage for devices and appliances may otherwise be provided under the medical benefit).
Foreign Prescription Medications except those associated with an emergency medical condition while you are traveling outside the United States, or those you purchase while residing outside the United States.
Growth Hormones unless we preauthorize them.
Inhibition and/or Suppression of Sleepiness: Prescription medications used to inhibit and/or suppress drowsiness, sleepiness, tiredness or exhaustion, unless we preauthorize them.
Insulin Pumps and Pump Administration Supplies (coverage for insulin pumps and supplies is provided under the medical benefit).
Medications We Don't Consider Self-Administrable (coverage for these medications may otherwise be provided under the medical benefit).
Nonprescription Medications: Medications that by law do not require a prescription order.
Onychomycosis: Prescription medications for the treatment of onychomycosis (nail fungus), unless we preauthorize them.
Prescription Medications Dispensed in a Facility: Prescription medications dispensed to you while you are a patient in a hospital, skilled nursing facility, nursing home or other health care institution.
Prescription Medications Dispensed in Connection with Participation in a Clinical Trial
Prescription Medications For Treatment of Infertility
Prescription Medications Not Dispensed by a Pharmacy Pursuant to a Prescription Order
Prescription Medications Not within a Provider's License: Prescription medications prescribed by providers who are not licensed to prescribe medications (or that particular medication) or who have a restricted professional practice license.
Prescription Medications With No FDA Proven Therapeutic Indication
Prescription Medications Without Examination: Prescriptions made by a provider without recent and relevant in-person examination of the patient, whether the prescription order is provided by mail, telephone, internet or some other means.
Professional Charges for Administration of Any Medication

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**. Please refer to your benefits booklet for a complete list of benefits, the limitations and exclusions that apply, and a definition of medical necessity.

ASURIS NORTHWEST HEALTH

Contact Customer Service at 1 (877) 508-7361

Or write to us at 528 E. Spokane Falls Blvd., Suite 301, Spokane, WA 99202

www.asuris.com