SUMMARY OF BENEFITS
ASURIS CLARITY℠ 70
(A PREFERRED PLAN)

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 otherwise specified, all benefits are subject to the annual deductible in addition to any copays and coinsurance.

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 the remainder of the calendar year for the services of Preferred Plan or out-of-area providers, unless otherwise specified. Any balances of charges not covered by this plan will be your responsibility to pay.

The annual deductible, copays, prescription drugs, outpatient rehabilitation, vision hardware, and most services provided by participating or recognized providers do not apply to the annual out-of-pocket coinsurance amount.

Benefits	Preferred Plan Provider	Participating/Recognized Provider
Annual Deductible Copays, prescription drugs, preventive care, and the routine eye exam do not count toward the deductible. Family deductible is met when three or more covered family members reach the equivalent of three individual deductible amounts in a calendar year	$1,000 per individual/$3,000 per family or $3,000 per individual/$9,000 per family	
Lifetime maximum	$2,000,000 per individual	
Annual Out-of-Pocket Coinsurance Amount Family out-of-pocket coinsurance amount is met when three or more covered family members reach the equivalent of three individual out-of-pocket coinsurance amounts in a calendar year	$5,000 per person $15,000 per family	No out-of-pocket maximum
Professional Services	(unless specified otherwise)	
Visits in the office, home, and outpatient hospital; not subject to deductible	100% after $30 per-visit copay	100% after $40 per-visit copay
Outpatient diagnostic x-ray and laboratory services, and other professional services; subject to deductible Coverage includes the services of physicians, osteopaths, naturopaths, and other eligible health care professional providers	70%	50%
Hospital Facility (Inpatient and Outpatient)**** Including diagnostic x-ray and laboratory $100 copay per emergency room visit (waived if admitted)	70%	50%
Acupuncture 12 visits per calendar year maximum	70%	50%
Ambulance Services** Ground services: $2,000 per calendar year maximum	70%	70%
Blood Bank**	70%	70%
Home Health and Hospice Home Health – 130 visits per calendar year maximum Hospice – 6 months maximum	70%	70%
Home Medical Equipment $2,500 per calendar year maximum	70%	50%
Home Phototherapy	70%	70%
Infusion Therapy Growth hormone treatment is limited to $25,000 per calendar year	70%	50%
Mammography Routine mammograms not subject to deductible	70%	50%
Maternity	70%	50%

(over)

Benefit		
Occupational Injury (provided for subscriber only)	same as any condition	
Phenylketonuria (PKU) Formulas Not subject to waiting periods	70%	70%
Prescription Drugs $3,000 per calendar year maximum; not subject to deductible***		
Generic Formulary	100% after $10 Retail copay / 100% after $20 Mail Order copay	
Brand-Name Formulary	70%	
Non-Formulary	50%	
Preventive Care $200 per calendar year maximum; not subject to deductible Routine exams, immunizations, well child care, and routine cancer screenings	70%	50%
Prostheses and Orthotics	70%	50%
Rehabilitation Inpatient – $4,000 per calendar year maximum Outpatient – $2,000 per calendar year maximum	70%	50%
Skilled Nursing Facility 30 days per calendar year maximum	*	70%
Special Equipment and Supplies	70%	70%
Spinal Manipulations 10 manipulations per calendar year maximum	70%	50%
Transplants $250,000 lifetime maximum; $50,000 per transplant donor organ procurement maximum; $2,500 per transplant travel and lodging maximum; 12-month waiting period	70%	50%
Vision Care (not subject to deductible)		
One routine eye exam per calendar year	100% after $30 copay	100% after $40 copay
Vision hardware: $200 per calendar year maximum	*	100%

*At this time, this service is provided only by participating or recognized providers.
**At this time, these services are provided only by recognized providers.
***Prescriptions obtained from non-participating pharmacies will not be covered except outside the service area or for cases of medical emergency.
****Services and supplies required to treat a medical emergency, inside the service area, 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.

Copay: There is a 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.

Care Outside the Service Area: All care received outside the service area, whether or not a medical emergency, will be covered at 70% of the allowed amount, except benefits for prescription drugs and vision hardware will be provided at the levels specified. Any balances of charges not covered by this plan will be your 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, including maternity, 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. 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 and complete the Suggestion Box form located on the Contact Us page.