

SUMMARY OF BENEFITS

HSA-QUALIFIED INDIVIDUAL PREFERRED CATASTROPHIC PLAN



Asuris
Northwest Health
A Regence Affiliate

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. Services provided by participating or recognized providers do not apply toward the annual out-of-pocket maximum.

<u>Benefits</u>	<u>Preferred Plan Provider</u>	<u>Participating/ Recognized Provider</u>
Annual Deductible 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.	\$2,500 member \$5,000 family	
Lifetime Maximum	\$1,000,000 per member	
Annual Out-of-Pocket Amount 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.	\$5,000 member \$10,000 family	No out-of-pocket maximum
Professional Services Including diagnostic x-ray and laboratory. Coverage includes the services of physicians, osteopaths, naturopaths, and other eligible health care professional providers.	80% (unless specified otherwise)	60%
Hospital Facility (Inpatient & Outpatient) Including diagnostic x-ray and laboratory	80%	60%
Acupuncture 12 visits per calendar year maximum	80%	60%
Ambulance Services** Ground services: \$2,000 per calendar year maximum	80%	80%
Blood Bank**	80%	80%
Home Health and Hospice Home Health – 130 visits per calendar year maximum Hospice – 6 months maximum	80%	80%
Home Medical Equipment \$2,500 per calendar year maximum	80%	60%
Home Phototherapy	80%	80%
Infusion Therapy Growth hormone treatment is limited to \$20,000 per calendar year	80%	60%

(over)

Mammography	80%	60%
Phenylketonuria (PKU) Formulas Not subject to waiting periods	80%	80%
Preventive Care \$300 per calendar year maximum; not subject to deductible	80%	60%
Prostheses and Orthotics	80%	60%
Rehabilitation Inpatient – \$4,000 per calendar year maximum Outpatient – \$2,000 per calendar year maximum	80%	60%
Skilled Nursing Facility 30 days per calendar year maximum	*	80%
Special Equipment and Supplies	80%	80%
Spinal Manipulations 10 visits per calendar year maximum	80%	60%
Transplants \$250,000 lifetime maximum; 12-month waiting period	80%	60%

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

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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.

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. Any balances of charges not covered by this plan will be your, or you and your family's, 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) or its parent company for 12 consecutive months. No benefits will be provided for preexisting conditions 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.