

# SUMMARY OF BENEFITS PREFERRED PLAN 100/80/60/15



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. The deductible must be met for all services except as specified below.

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. Refer to your benefits brochure for your specific deductible and out-of-pocket coinsurance amount. Any balances of charges not covered by this plan will be your responsibility to pay. Coinsurance amounts on Preferred Plan or out-of-area provider services apply toward the out-of-pocket coinsurance maximum, unless specified otherwise in the summary below.

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 toward the out-of-pocket coinsurance amount.

Benefits	Preferred Plan Provider	Participating/ Recognized Provider
<b>Professional Services</b> \$15 per-office visit copay for office, home, and outpatient hospital visits; Office, home, and hospital outpatient department visits are not subject to deductible when subject to copay; outpatient diagnostic x-ray and laboratory services are not subject to deductible	100% (unless otherwise specified)	60%
<b>Hospital Facility***</b> Inpatient and outpatient including diagnostic x-ray and laboratory \$75 copay per emergency room visit (waived if admitted)	80%	60%
<b>Acupuncture</b> 12 visits per calendar year maximum	100%	60%
<b>Ambulance Services**</b>	80%	80%
<b>Blood Bank**</b>	80%	80%
<b>Chemical Dependency</b>	100%	60%
<b>Colorectal Cancer Screening</b>	100% professional 80% facility	60%
<b>Growth Hormone</b> \$25,000 per calendar year maximum	100%	60%
<b>Home Health and Hospice</b> Home health - 130 visits per calendar year maximum Hospice - 6 month maximum	100%	100%
<b>Home Medical Equipment, Prosthesis and Orthotics</b>	80%	60%
<b>Home Phototherapy</b>	100%	100%
<b>Hospitalization for Dental Services</b> \$1,000 per calendar year maximum No benefits provided for charges of a dentist	100% professional 80% facility	60%
<b>Mammography</b>	100% professional 80% facility	60%
<b>Maternity</b> (provided for the subscriber or spouse)	same as any other condition	
<b>Mental Disorders</b>	100% professional 80% facility	60%
<b>Neurodevelopmental Therapy</b> (for children age 6 and under) \$1,500 per calendar year maximum	80%	60%

<b>Occupational Injury</b> (provided for the subscriber only) \$250,000 lifetime maximum	same as any other condition	
<b>Phenylketonuria (PKU) Formulas</b>	100%	100%
<b>Prostate Cancer Screening</b>	100% professional 80% facility	60%
<b>Rehabilitation</b>		
Inpatient - \$30,000 per condition	100% professional 80% facility	60%
Outpatient - \$1,500 per calendar year maximum	80%	60%
<b>Repair of Teeth**</b> \$1,000 per occurrence	80%	80%
<b>Skilled Nursing Facility</b> 90 days per calendar year maximum	80%	80%
<b>Smoking Cessation</b> \$500 lifetime maximum	75%	75%
<b>Special Equipment and Supplies</b>	80%	80%
<b>Spinal Manipulations</b> 10 spinal manipulations per calendar year	100%	60%
<b>Temporomandibular Joint Disorder (TMJ)</b> \$1,000 per calendar year maximum; \$5,000 per lifetime maximum	same as any other condition	
<b>Transplants</b> \$250,000 lifetime maximum; \$50,000 per transplant donor organ procurement maximum; \$2,500 per transplant travel and lodging maximum	100% professional 80% facility	60%

\*\* 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:** Refer to your benefits brochure for your specific deductible amount. The deductible is waived for professional services billed as office visits in the office, home, or hospital outpatient department and for outpatient diagnostic laboratory and x-ray. Services provided by professionals that are not subject to the per-visit copay are subject to the annual deductible.

**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 maximum annual out-of-pocket coinsurance amount per family is three times the individual out-of-pocket coinsurance amount. Refer to your benefits brochure for your specific annual out-of-pocket amount.

**Copay:** There is a \$15 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.**