



Rates are based on the age of each applicant.

To qualify for the non-smoker rate, you must not have smoked cigarettes, cigars, pipes or used chewing tobacco, smokeless tobacco or any other form of tobacco or illegal drug substances within the past 12 months.

Families with one child pay only the one child rate. Families with two or more children pay the two or more children rate.

Asuris Clarity 70

Age Band Category	\$1,000 Deductible		\$3,000 Deductible	
	Non-Smoker	Smoker	Non-Smoker	Smoker
0-24	149	173	97	113
25-29	172	197	112	128
30-34	200	230	131	151
35-39	236	271	153	177
40-44	279	325	183	212
45-49	339	391	223	256
50-54	402	462	260	303
55-59	472	544	309	356
60 +	557	648	360	423
First Child	139	139	92	92
2 or More Children	263	263	173	173

Asuris Clarity 50

Age Band Category	\$2,500 Deductible		\$5,000 Deductible	
	Non-Smoker	Smoker	Non-Smoker	Smoker
0-24	54	62	40	47
25-29	60	70	45	53
30-34	71	80	53	61
35-39	84	95	61	72
40-44	99	114	74	85
45-49	120	138	91	104
50-54	143	164	106	124
55-59	168	193	126	145
60 +	198	229	148	173
First Child	48	48	37	37
2 or More Children	93	93	70	70

Rates Effective August 1, 2008

SUMMARY OF BENEFITS
ASURIS CLARITYSM 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 Visits in the office, home, and outpatient hospital; not subject to deductible 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	(unless specified otherwise)	
	100% after \$30 per-visit copay	100% after \$40 per-visit copay
	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%
Mental Disorders Inpatient – 8 days per calendar year Outpatient – 12 visits per calendar year	70%	50%
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	70%	50%
\$200 per calendar year maximum; not subject to deductible		
Routine exams, immunizations, well child care, and routine cancer screenings including preventive surgeries (routine colorectal cancer screenings not subject to maximum)		
Prostate Cancer Screening	70%	50%
Routine prostate cancer screenings not subject to deductible		
Prostheses and Orthotics	70%	50%
Rehabilitation	70%	50%
Inpatient – \$4,000 per calendar year maximum		
Outpatient – \$2,000 per calendar year maximum		
Skilled Nursing Facility	70%	70%
30 days per calendar year maximum		
Special Equipment and Supplies	70%	70%
Spinal Manipulations	70%	50%
10 manipulations per calendar year maximum		
Transplants	70%	50%
\$250,000 lifetime maximum; \$50,000 per transplant donor organ procurement maximum; \$2,500 per transplant travel and lodging maximum; 12-month waiting period		
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.

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***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: Benefits will be provided at 70% of the allowed amount for care received from an out-of-area provider. 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. 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 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.

SUMMARY OF EXCLUSIONS

INDIVIDUAL PLANS



Exclusions and Limitations to Coverage: The noncovered services and supplies under our standard medical plans include, but are not limited to:

- Acupuncture for smoking cessation.
- Addiction to or abuse of drugs, alcohol, or any other chemical substance, whether legal or illegal, except for injuries sustained as a consequence of being intoxicated or under the influence of narcotics.
- Benefits covered by government programs.
- Charges for services or supplies that are above the allowed amount, except as required by law for emergencies.
- Charges that in the absence of the contract there would be no obligation to pay.
- Cosmetic surgery and supplies (including drugs) and the treatment of any direct or indirect complications of such surgery, except: 1) when related to an illness or injury; 2) for congenital anomalies; 3) for reconstructive breast surgery following mastectomies to the extent required under federal and state law as follows: a) reconstruction of the diseased breast; b) reconstruction of the nondiseased breast to produce a symmetrical appearance; and c) prostheses and physical complications of all stages of a mastectomy, including lymphedemas.
- Custodial care.
- Dentistry, dental x-rays, or hospitalization for dentistry.
- Dyslexia treatment.
- Hospitalization for conditions for which the member is not usually hospitalized, such as common colds, minor cuts or bruises, removal of small tumors and similar minor conditions.
- Injuries sustained while practicing for or competing in a professional or semiprofessional athletics contest.
- Investigational services or supplies.
- In-vitro fertilization, artificial insemination, embryo transfer, or other artificial means of conception, including any expenses for fertility drugs.
- Marital counseling; family counseling, except for Mental Disorders.
- Maternity/complications of pregnancy (*excluded on PPO Catastrophic, HSA-Qualified Preferred Catastrophic, Asuris HSA Healthplan, and Asuris ClaritySM 50 plans only*).
- Neurodevelopmental therapy.
- Occupational injury or disease (*excluded on PPO Comprehensive, PPO Catastrophic, and HSA-Qualified Preferred Catastrophic plans only*).
- Over-the-counter contraceptive supplies and devices.
- Physical or psychiatric exams to obtain or continue employment, licensure, legal proceedings, insurance, school admission, sports activities, or for purposes of medical research.
- Prescription drugs, except as provided to an inpatient (*excluded on PPO Catastrophic, HSA-Qualified Preferred Catastrophic, Asuris HSA Healthplan, and Asuris Clarity 50 plans only*).
- Preventive care, except for routine mammography, prostate, and colorectal cancer screening services (*excluded on PPO Catastrophic and Asuris Clarity 50 plans only*).
- Private duty nursing or hourly nursing charges.
- Routine hearing exams, hearing aids.
- Routine newborn care (*excluded on PPO Catastrophic, HSA-Qualified Preferred Catastrophic, Asuris HSA Healthplan, and Asuris Clarity 50 plans only*).
- Services and supplies for which benefits are or would have been payable to a member eligible and enrolled under Medicare, regardless of whether the member actually enrolled.
- Services or supplies covered by auto insurance, personal injury protection insurance, homeowner insurance, or commercial premises coverage.
- Services or supplies not medically necessary* for illness, injury, or physical disability.
- Services provided by a family member (spouse, parent, or child).
- Smoking cessation (*excluded on HSA-Qualified Preferred Catastrophic, Asuris HSA Healthplan, Asuris HSA Healthplan Comprehensive, and Asuris Clarity plans only*).
- Sterilization.
- Surgery (including reversals), treatment, programs, or supplies that are intended to result in weight reduction, regardless of diagnosis.
- Surgery or treatment for sexual dysfunction/impotence or transsexualism.
- Treatment and any appliances used in connection with malocclusions, jaw abnormalities, Temporomandibular Joint Disorders, and myofascial pain syndrome.
- Treatment of any condition caused by or resulting from active participation in the armed forces in a war or insurrection.
- Treatment of any 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.
- Vision exams and hardware (*excluded on PPO Catastrophic, HSA-Qualified Preferred Catastrophic, Asuris HSA Healthplan, Asuris HSA Healthplan Comprehensive, and Asuris Clarity 50 plans only*).
- Visits or consultations that are not in person, including but not limited to any telephone, Internet, or other electronic communication (except tele-medicine in remote locations, as approved by the Company), whether initiated by the member or the member's provider.
- Visual analysis, therapy, training, or orthoptics.

***Medically Necessary:** Health care services or supplies that a physician or other health care provider exercising prudent clinical judgment, would provide to you for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms and that are: In accordance with generally accepted standards of medical practice; clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for your illness, injury or disease; and not primarily for the convenience of you, or your physician or other health care provider, and not more costly than an alternative service or sequence of services, or supply at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your illness, injury or disease. For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations and the views of the physicians practicing in relevant clinical areas and other relevant factors.

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