



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.

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Asuris HSA – Comprehensive Plan

Age Band Category	Single		Family	
	\$1,500 Deductible		\$3,000 Deductible	
	Non-Smoker	Smoker	Non-Smoker	Smoker
0-29	124	137	97	108
30-34	152	172	119	137
35-39	180	218	141	172
40-44	230	264	183	210
45-49	264	304	210	245
50-54	304	349	245	279
55-59	364	421	289	333
60 +	426	505	335	402
First Child	N/A	N/A	93	93
2 or more Children	N/A	N/A	185	185

Rates Effective August 2008

**SUMMARY OF BENEFITS
INDIVIDUAL
ASURIS HSA HEALTHPLAN
COMPREHENSIVE
PRESCRIPTION DRUGS**



Getting Your Prescription Filled: Prescription drugs and other covered items must be furnished by a participating pharmacy or a participating mail order supplier. There are more than 1,200 participating pharmacies in our Washington State network from which to choose. A list of these participating pharmacies, along with a list of participating out-of-state pharmacies is available on our Web site at www.asuris.com.

- Present your identification card at a participating pharmacy and pay the full amount of the covered prescription. The Company will reimburse you 50% of the allowed amount for the covered prescription.
- Prescription drugs furnished by a participating pharmacy will be limited to a 34-day supply, except as otherwise specified.

Using Mail Order Service:

- Send an order form and the prescription along with the full amount of the covered prescription to the address listed on the mail order service form. The Company will reimburse you 50% of the allowed amount for the covered prescription.
- Prescription drugs furnished by mail order will be limited to a 90-day supply per purchase, except that certain drugs, including but not limited to antidepressants, narcotics, and other select medications may be limited to a lesser supply as indicated on your prescription or as required by the Company.
- Drugs requiring continuous refrigeration may not be available through mail order service.

Prescription drugs (including oral contraceptives) and other covered items will be provided as described below after you have paid the full amount of the covered prescription. **Benefits will be subject to any applicable waiting periods, limitations, and exclusions, except that prescription drugs benefits will not be subject to the coordination of benefits provisions or to any stoploss described in this plan.**

FORMULARY	A formulary is a list of selected generic and brand-name preferred drugs, which is established, reviewed, and updated routinely by the Company. All drugs are reviewed and selected for inclusion in the Company’s formulary by an outside committee of providers, including physicians and pharmacists. Drugs are selected based on published scientific evidence and support proper use and cost-effective medication decisions. If clinical data show several drugs are equally effective, the committee usually chooses the most cost-effective ones. For convenience, the list is available on our Web site at www.asuris.com .
BENEFIT MAXIMUM	Benefits for prescription drugs will be provided to a maximum of \$2,000 per member per calendar year.
COINSURANCE	You will be responsible for paying the coinsurance percentage specified below for each covered prescription or refill.
	Participating Pharmacies and Participating Mail Order Service.....50% of the allowed amount

Covered Items: Prescription drugs, which are included in the Company’s current drug formulary, will be covered when medically necessary for the treatment of an illness, injury, or disability covered under this plan, subject to all provisions described below. Providers may request coverage of drugs not included in the current drug formulary by calling the Company. Other items covered under this benefit and requiring a prescription include:

- Legend vitamins for prenatal care.
- Diabetic supplies, including insulin and insulin syringes.
- Oral contraceptive drugs will be provided for a single copay per prepackaged monthly cycle. A maximum of three prepackaged monthly cycles may be purchased at one time for one copay per monthly cycle.

Limitations: Benefits for prescription drugs and other covered items will be limited as follows:

- Prescription drugs must be included in the current drug formulary of approved medications established by the Company.
- Prescription drugs must be prescribed by a provider covered under the plan who is acting within the scope of his or her license.
- Prescription drugs related to transplants are covered under this Prescription Drugs Benefit; however, claims for such drugs will be applied to and are subject to the Transplants Benefit maximum of the plan.
- Certain drugs may be limited to a lesser supply as indicated on your prescription or as determined by the Company. Participating pharmacies have been provided with a list of those drugs and our Web site formulary also provides this information.
- Any drug purchased outside the United States must have an equivalent to a prescription drug approved by the FDA to be a covered benefit under this plan, and must be either:
 - Associated with a medical emergency while you are traveling. When submitting a claim for reimbursement, you will be responsible for notifying the Company that the prescription was required for a medical emergency; or
 - When you are residing outside the United States. When submitting a claim for reimbursement, you will be responsible for notifying the Company that your residence is outside the United States. The medication needs to be purchased in the country in which you are residing, except for a medical emergency.
- The Company may require you to obtain all prescriptions from a single participating pharmacy when reasonably necessary.

Exclusions: The following items are not covered under this Prescription Drugs Benefit due to contract exclusions or, as noted, covered under another benefit of the plan:

- Any items limited or excluded by the medical plan, except where specifically provided.
- Appetite suppressants and drugs for weight loss.
- Drugs or medications used for cosmetic purposes.
- Drugs dispensed by a non-participating pharmacy, except when specifically provided for cases of emergency or outside the service area.
- Inside the United States, any prescription drug that has not been approved by the FDA, including compounded products with active ingredient(s) that have not been approved by the FDA.
- Any drugs or items obtained from a participating pharmacy when you fail to present the identification card.
- Over-the-counter medications (OTC) and any prescription medication with the same active ingredients and in the same strength as an over-the-counter product.
- Replacement prescriptions resulting from loss, theft, or breakage.
- Any drugs or items in excess of the specific limits described above.

This is a brief description of the prescription drugs benefit for the Individual Asuris HSA Healthplan Comprehensive plan; it is not a certificate of coverage. A complete statement of benefits, including waiting periods, limitations, and exclusions is listed in the plan contract or is available through Customer Service. 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.

SUMMARY OF BENEFITS INDIVIDUAL ASURIS HSA HEALTHPLAN COMPREHENSIVE



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. Most 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.	\$1,500 per member/\$3,000 per family	
Lifetime Maximum	\$2,000,000 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% 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. Most 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 per member \$10,000 per 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 and 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%

Mammography Routine mammograms not subject to deductible	80%	60%
Maternity	80%	60%
Mental Disorders Inpatient – 8 days per calendar year Outpatient – 12 visits per calendar year	80%	60%
Newborn Care	80%	60%
Occupational Injury (provided for the subscriber only)	80%	60%
Phenylketonuria (PKU) Formulas Not subject to waiting periods	80%	80%
Prescription Drugs \$2,000 per calendar year maximum; closed formulary	*	50%
Preventive Care (not subject to deductible)	80%	60%
Prostate Cancer Screening Routine prostate cancer screenings 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%	80%
Special Equipment and Supplies	80%	80%
Spinal Manipulations 10 manipulations 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 providers.

**At this time, these services are provided only by recognized providers.

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) 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. 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.



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 HSA HealthPlan

Age Band Category	Single		Family	
	\$2,500 Deductible		\$5,000 Deductible	
	Non-Smoker	Smoker	Non-Smoker	Smoker
0-29	87	95	68	77
30-34	106	120	84	95
35-39	126	153	99	120
40-44	161	185	127	147
45-49	185	213	147	172
50-54	213	245	172	196
55-59	256	295	203	234
60 +	299	355	236	282
First Child	N/A	N/A	66	66
2 or more Children	N/A	N/A	131	131

Age Band Category	Single		Family	
	\$3,500 Deductible		\$7,000 Deductible	
	Non-Smoker	Smoker	Non-Smoker	Smoker
0-29	79	87	62	70
30-34	97	110	77	87
35-39	115	139	91	110
40-44	146	168	117	133
45-49	168	194	133	157
50-54	194	223	157	178
55-59	232	269	185	213
60 +	272	323	214	257
First Child	N/A	N/A	60	60
2 or more Children	N/A	N/A	119	119

Rates Effective August 2008



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Lifetime Maximum	\$2,000,000 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% 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. Most 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 per member \$10,000 per family	No out-of-pocket maximum
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(over)

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