

LifeWise Individual HSA PPO Plan

Benefit Plan Summary

Effective July 1, 2006 - June 30, 2007

The deductibles, copays and coinsurance percentages below represent what you pay.

	HSA PPO (HSA QUALIFIED)	
Calendar Year Deductible – Individual¹: (Family is 3x the Individual, except HSA Plans)	\$2,500 individual / \$5,000 family \$3,500 individual / \$7,000 family \$5,000 individual / \$10,000 family	
	Preferred	Non-Preferred
Coinsurance Maximum Per Individual	\$2,500 ded = \$2,500 indiv. ⁶ \$3,500 ded = \$1,500 indiv. ⁶ \$5,000 ded = \$0 indiv. ⁶	\$2,500 ded = \$5,000 indiv. ⁶ \$3,500 ded = \$3,000 indiv. ⁶ \$5,000 ded = \$10,000 indiv. ⁶
Out-of-Pocket Maximum	Deductible + Coinsurance Maximum	
Lifetime Maximum	\$4,000,000	
COVERED SERVICES	Preferred	Non-Preferred
PREVENTIVE CARE / IMMUNIZATIONS		
Routine Physical Exams Well-Baby Care	Coinsurance ³ ; deductible waived	Not covered
Routine Immunizations/Vaccinations	Coinsurance ³ ; deductible waived	Not covered; except for flu shots ²
Women's Routine Mammograms	Coinsurance ³ ; deductible waived	40%
Women's and Men's Annual Health Exams	Coinsurance ³ ; deductible waived	40%
PHYSICIAN PROVIDER SERVICES		
Office Visits	Coinsurance ³	40%
Alternative Care (12 visit PCY limit)	Coinsurance ³ ; (Preferred Providers only)	Not covered
HOSPITAL SERVICES		
Inpatient & Outpatient Surgery Room & Ancillary Charges Physician Services	Coinsurance ³	40%
MATERNITY		
All Pre/Post Office Visits & Doctor Delivery Hospital Charges	Coinsurance ³	40%
EMERGENCY CARE		
Urgent Care	Coinsurance ³	40%
Hospital Emergency Room Ambulance (\$5,000 PCY limit for Air & Ground)	Coinsurance ³	
OTHER FACILITIES & SERVICES		
Lab & X-ray Services Medical Supplies & Devices (\$2,500 PCY limit) Home Health Care (130 visit PCY limit)	Coinsurance ³	40%
Prescription Services (No Mail-Order Program)	Deductible, then coinsurance ³ except generic cardiac preventive drugs covered in full/deductible waived	
Accident Benefit	Paid as any other illness subject to deductible/coinsurance	
SUPPLEMENTAL BENEFIT OPTIONS		
Prescription Drug Buy-Up Option	Not available	
Alcohol Dependency Treatment	This optional benefit is available at an additional cost. It is limited to \$4,500 in any 24 consecutive months.	

Please note that this is only a general outline of the important features of this benefit plan for individuals and families in Oregon. The full terms and conditions of these plans are provided in the policy at the time of purchase.

PCY = Per Calendar Year

¹ Family Deductible for Plus, Preferred and Value plans = 3x the Individual. Family Deductible for HSA plans is 2x the Individual deductible and applies when an individual and a spouse or one (1) or more dependents are enrolled. Therefore, prior to benefits being paid, the entire family deductible must be met.

² Deductible waived.

³ \$5,000 deductible has a 0% coinsurance.
\$2,500 or \$3,500 deductible has a 20% coinsurance.

⁶ Family coinsurance maximum is 2x the Individual.