

**SUMMARY OF  
BENEFITS**



**SmartHealth™ for Business**  
**1000+30-45/2500 ID0711**

**MAXIMUM LIFETIME BENEFIT** .....No Overall Lifetime Limit

**ANNUAL BENEFIT MAXIMUM** .....\$2,000,000

**ANNUAL DEDUCTIBLE** .....\$1,000 per person / \$2,000 per family

The deductible is an amount of covered medical expenses the member pays each calendar year before the plan's benefits begin. The deductible applies to all services and supplies except those marked with an asterisk (\*).

**CALENDAR YEAR COINSURANCE EXPENSE MAXIMUM** ..... \$2,500 per person or per family

Once the deductible and coinsurance expense maximum have been met, this plan will pay 100% of covered charges for the rest of that calendar year. Benefits paid in full, deductible, copayments, and charges in excess of the PacificSource fee allowance do not accumulate toward the coinsurance expense maximum. Copayments and nonparticipating provider charges in excess of the PacificSource allowable fee will continue to be the member's responsibility even after the coinsurance expense maximum is met.

<b>SERVICE:</b>	<b>PARTICIPATING PROVIDER/ NETWORK NOT AVAILABLE BENEFIT:</b>	<b>NONPARTICIPATING PROVIDER BENEFIT:</b>
<b>PREVENTIVE CARE</b>		
Well Baby Care	100%*	50%
Routine Physicals	100%*	50%
Routine Gynecological Exams	100%*	50%
Routine Mammograms	100%*	50%*
Immunizations	100%*	50%
Routine Colonoscopy	100%*	50%
<b>PROFESSIONAL SERVICES</b>		
Office and Home Visits	100% after \$30 copay*	50%
Office Procedures and Supplies	75%	50%
Specialist Office and Home Visits	100% after \$45 copay*	50%
Urgent Care Center Visits	100% after \$30 copay*	50%
Surgery	75%	50%
Outpatient Rehabilitation Therapy	75%	50%
<b>HOSPITAL SERVICES</b>		
Inpatient Room and Board	75%	50%
Inpatient Rehabilitative Care	75%	50%
Skilled Nursing Facility Care	75%	50%
<b>OUTPATIENT SERVICES</b>		
Outpatient Surgery	75%	50%
Diagnostic and Therapeutic Radiology and Lab, and Advanced Imaging	100% of first \$500*; 75%	50%
Emergency Room Visits (copay waived if admitted)	\$100 copayment per visit, 75%	\$100 copayment per visit, 75%
<b>MENTAL HEALTH/CHEMICAL DEPENDENCY SERVICES</b>		
Office Visits	Not covered	Not covered
Inpatient Care	Not covered	Not covered
<b>OTHER COVERED SERVICES</b>		
Allergy Injections	75%	50%
Ambulance	75%	75%
Durable Medical Equipment	75%	50%
Hospice	75%	50%
Home Health Care	75%	50%
Transplants	75%	10%
Temporomandibular Joint Disorders	75%	50%

*\*Not subject to annual deductible.*

Payment to providers is based on the prevailing or contracted PacificSource fee allowance for covered services. Although participating providers accept the fee allowance as payment in full, nonparticipating providers may not. Services of nonparticipating providers could result in out-of-pocket expense in addition to the percentage indicated. Network Not Available payment is allowed when PacificSource has not contracted with providers in the geographical area of the member's residence or work for a specific service or supply. Payment to providers for Network Not Available is based on the usual, customary, and reasonable charge for the geographical area in which the charge is incurred. For more information, refer to the Payment to Providers section in the proposal or member benefit handbook.