

**SUMMARY OF
BENEFITS**



**SmartHealth™ for Business
HSA 75+3000 ID0711**

MAXIMUM LIFETIME BENEFIT No Overall Lifetime Limit

ANNUAL BENEFIT MAXIMUM \$2,000,000

ANNUAL DEDUCTIBLE \$3,000 individual / \$6,000 per family

The deductible is an amount of covered medical expenses the member pays each calendar year before the plan's benefits begin. The individual deductible applies only if the employee enrolls without dependents. If the employee and one or more dependents enroll, only the family deductible applies.

CALENDAR YEAR COINSURANCE EXPENSE MAXIMUM \$2,000 individual / \$4,000 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. The individual Coinsurance Expense Maximum applies only if the employee enrolls without dependents. If the employee and one or more dependents enroll, only the family Coinsurance Expense Maximum applies.

SERVICE:	PARTICIPATING PROVIDER/ NETWORK NOT AVAILABLE BENEFIT:	NONPARTICIPATING PROVIDER BENEFIT:
PREVENTIVE CARE		
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%
PROFESSIONAL SERVICES		
Office and Home Visits	75%	50%
Office Procedures and Supplies	75%	50%
Specialist Office and Home Visits	75%	50%
Urgent Care Center Visits	75%	50%
Surgery	75%	50%
Outpatient Rehabilitation Therapy	75%	50%
HOSPITAL SERVICES		
Inpatient Room and Board	75%	50%
Inpatient Rehabilitative Care	75%	50%
Skilled Nursing Facility Care	75%	50%
OUTPATIENT SERVICES		
Outpatient Surgery	75%	50%
Diagnostic and Therapeutic Radiology and Lab, and Advanced Imaging	75%	50%
Emergency Room Visits (copay waived if admitted)	\$100 copay per visit, then 75%	50%
MENTAL HEALTH/CHEMICAL DEPENDENCY SERVICES		
Office Visits	Not covered	Not covered
Inpatient Care	Not covered	Not covered
OTHER COVERED SERVICES		
Allergy Injections	75%	50%
Ambulance	75%	50%
Durable Medical Equipment	75%	50%
Hospice	75%	50%
Home Health Care	75%	50%
Transplants	75%	10%
Temporomandibular Joint Disorders	75%	50%

* Not subject to 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.