

SUMMARY OF BENEFITS



**PREFERRED
HSA 5000 0711**

MAXIMUM LIFETIME BENEFIT No Overall Lifetime Limit

ANNUAL DEDUCTIBLE

Participating Providers\$5,000 individual / \$10,000 family
 Nonparticipating Providers\$10,000 individual / \$20,000 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 a bullet (•). 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. Only participating provider expense applies to the participating provider deductible and only nonparticipating provider expense applies to the nonparticipating deductible.

OUT-OF-POCKET LIMIT

Participating Providers\$5,000 individual / \$10,000 family
 Nonparticipating Providers\$10,000 individual / \$20,000 family

Once the out-of-pocket limit has been met, this plan will pay 100% of covered charges for the rest of that calendar year. The individual out-of-pocket limit applies only if the employee enrolls without dependents. If the employee and one or more dependents enroll, only the family out-of-pocket maximum applies. Only participating provider expense applies to the participating provider out-of-pocket limit and only nonparticipating provider expense applies to the nonparticipating out-of-pocket limit. Nonparticipating provider charges in excess of the PacificSource fee allowance do not accumulate toward the out-of-pocket limit. Nonparticipating provider charges in excess of the PacificSource allowable fee will continue to be the member's responsibility even after the out-of-pocket limit is met.

SERVICE:	PARTICIPATING PROVIDER/ NETWORK NOT AVAILABLE BENEFIT:	NONPARTICIPATING PROVIDER BENEFIT:
PREVENTIVE CARE		
Well Baby Care	• 100%	100%
Routine Physicals	• 100%	100%
Routine Gynecological Exams	• 100%	100%
Immunizations	• 100%	100%
Routine Colonoscopy, ages 50-75	• 100%	100%
PROFESSIONAL SERVICES		
Office and Home Visits	100%	100%
Office Procedures and Supplies	100%	100%
Urgent Care Center Visits	100%	100%
Surgery	100%	100%
Physical / Occupational / Speech Therapy	100%	100%
HOSPITAL SERVICES		
Inpatient Room and Board	100%	100%
Inpatient Rehabilitative Care	100%	100%
Skilled Nursing Facility Care	100%	100%
OUTPATIENT SERVICES		
Outpatient Surgery/Services	100%	100%
Advanced Imaging	100%	100%
Diagnostic and Therapeutic Radiology and Lab	100%	100%
* Emergency Room Visits	100%	100%
MENTAL HEALTH/CHEMICAL DEPENDENCY SERVICES		
Office Visits	100%	100%
Inpatient Care	100%	100%
Residential Programs	100%	100%
OTHER COVERED SERVICES		
Allergy Injections	100%	100%
Ambulance, Ground and Air	100%	100%
Durable Medical Equipment	100%	100%
Home Health Care	100%	100%

- * **In true medical emergencies, nonparticipating providers are paid at the participating provider level.**
- **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 (see "allowable fee" in the Definitions section) for the geographical area in which the charge is incurred.

This is only a brief summary of benefits. Please refer to the additional information provided for a further explanation of benefits including limitations and exclusions.