Your Guide to PacificSource

SmartHealth Health Plans for Idaho Individuals and Families

PacificSource HEALTH PLANS

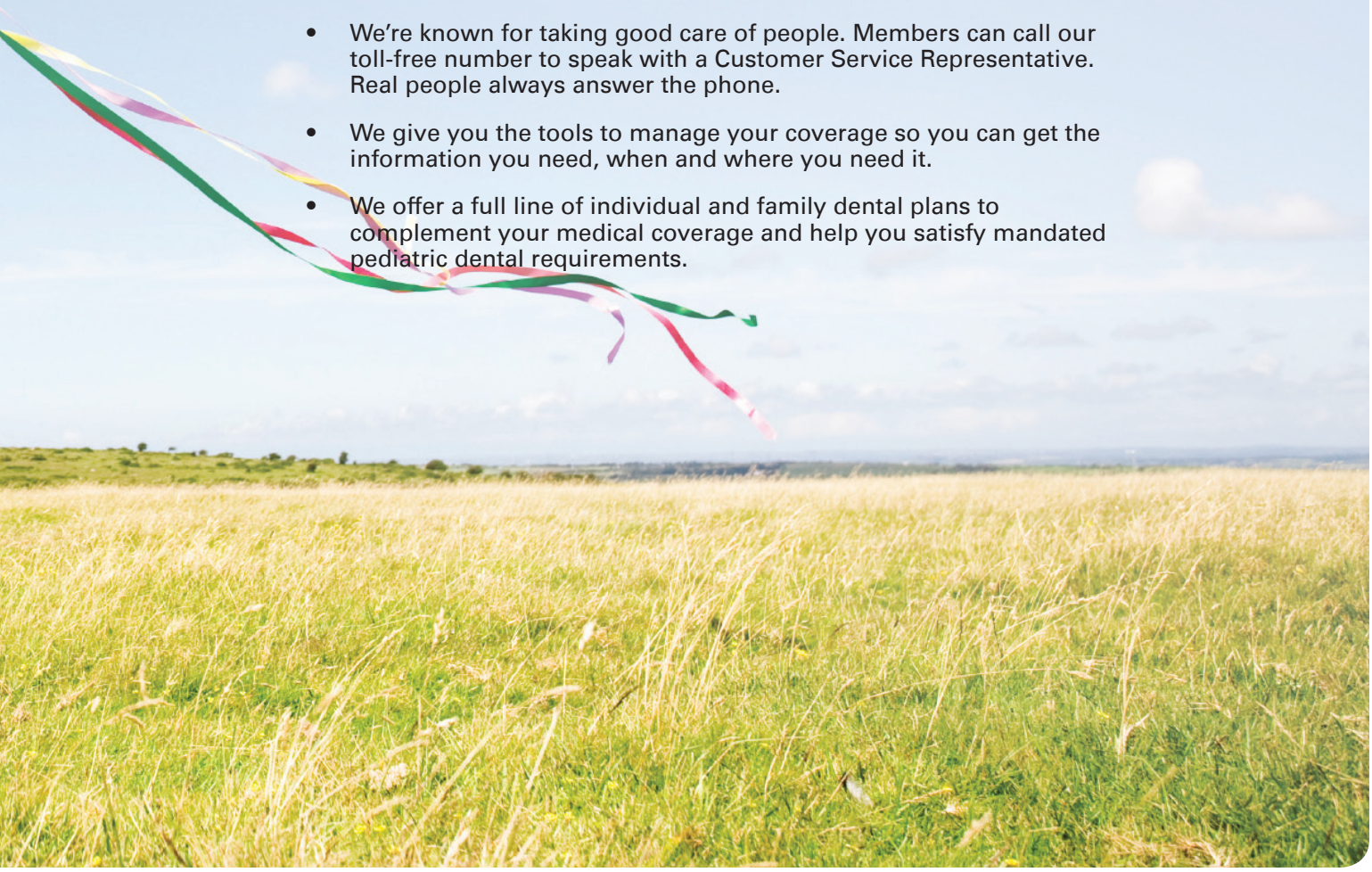
IFPIdahoBrochure_SmartHealth_0115

The Health Insurance You Need From the Company You'll Love to Work With

Having health insurance brings peace of mind. A solid health insurance plan makes it easy to get the preventive care that helps you stay well, and protects you from the high costs of unexpected medical expenses.

At PacificSource, we make health insurance easy, putting you at the center of everything we do.

- Our plans offer a range of premiums and deductibles so you can find the coverage that fits you best.
- We have more than 46,300 providers across our networks to give you the maximum choice of doctors and other healthcare professionals.
- We're known for taking good care of people. Members can call our toll-free number to speak with a Customer Service Representative. Real people always answer the phone.
- We give you the tools to manage your coverage so you can get the information you need, when and where you need it.
- We offer a full line of individual and family dental plans to complement your medical coverage and help you satisfy mandated pediatric dental requirements.



What's Inside

Getting Started

Exceptional value and support

Get More with PacificSource

Wellness and Health Management

These extra services are not insurance, but are included in your medical plan to help you take charge of your health. To learn more, visit PacificSource.com/members.

24-Hour NurseLine

Have a question about your health? Not sure whether you need to see your doctor? Our nurse line gives you 24/7 access to professionals who can answer your health and wellness questions.

Accident Benefit

If you have an unexpected injury from an accident, you'll have a little extra security knowing that within 90 days of the accident, the first $500 of covered services are paid at 100 percent and are not subject to a deductible.

Assist America®

If you experience a medical emergency while 100 or more miles from home or traveling abroad, you can access services provided by Assist America® Global Emergency Services at no cost. With one simple phone call to Assist America, you can access medical care anywhere in the world.

Care Quality Program

Should you need more intensive medical services, we have a Utilization Management Program in place to make sure you receive appropriate, effective, and efficient medical care. Nurses are also available to assist you in ensuring you receive the right care at the right time.

Condition Support Program

Our Condition Support Program offers you education and support if you have asthma, chronic obstructive pulmonary disease (COPD), coronary artery disease, diabetes, or heart failure, or if you have a child with juvenile diabetes.

Gym Membership Discounts

As a PacificSource member, you'll receive discounts from more than 10,000 fitness centers and gyms, including big chains and local favorites.

Pharmacy Coverage

All PacificSource plans feature pharmacy coverage, and wherever possible, generic drugs are substituted in place of name brands to help you save money.

Starting in 2015, we will offer our new Preventive Drug List. This new benefit has been added at no additional cost to our members.

The Preventive Drug List contains more than 90 drugs for $0.

Visit PacificSource.com/drug-list and select Idaho drug lists for more information about drug lists, and preauthorization and step therapy processes.

Health and Wellness Education

You can receive a reimbursement of up to $50 per eligible health and wellness class or series offered by hospitals (up to $150 per member per plan year).

Prenatal Program

Our Prenatal Care Program helps expectant mothers reduce their risk of premature birth. Participants receive educational materials and toll-free telephone access to a nurse consultant.

Tobacco Cessation

Members can access Quit For Life® tobacco cessation services. The program includes one-on-one treatment sessions with a professional Quit Coach to help you quit tobacco use for good.

Weight Management Programs

As a part of your PacificSource medical coverage, you can participate in a **Weight Watchers**® reimbursement program or receive discounts from **Jenny Craig**®.

Online Tools

Online Tools Available at PacificSource.com

InTouch

Through InTouch, our secure website, you can view your claims, status of preauthorizations, accumulated expenses toward your plan's deductible, and more.

You can also access our online health and wellness center through InTouch, which includes personalized wellness information and a variety of helpful, easy-to-use tools, such as a health risk assessment.

To log in or register for InTouch, go to PacificSource.com and access the InTouch login panel on the right side of the page.

myPacificSource Mobile App

Now you can stay "InTouch" with your PacificSource coverage, no matter where you are, with our free app. Use myPacificSource to:

1. Access your ID card, anytime.
2. Access our 24-Hour NurseLine.
3. Find a provider, hospital, or urgent care center.
4. Check your deductible and out-of-pocket totals.

Download our free app from the Android or Apple app stores. For more information, visit PacificSource.com/mobile.

Participating Provider Directory

Take advantage of your plan's participating provider benefits. Find up-to-date participating provider information based on your location, network, or your doctor's name using this online directory.

At PacificSource.com/find-a-provider, you can use our Provider Directory to search for:

- your current doctor;
- doctors accepting new patients;
- specialists; and
- hospitals and facilities.

Our Provider Directory will also help you designate your PCP.

Preauthorization Lists

Certain medical services, surgical procedures, and prescription drugs may require preauthorization, which is the process we use to determine in advance whether or not the service, procedure, or prescription will be reimbursed.

Our preauthorization lists are tools for you and your doctor to determine if the care you need will require preauthorization. As we continually review new technologies and standards of medical practice, these lists are subject to revision. Also keep in mind that your plan may not cover all the items listed. Check your benefit materials or contact our Customer Service Department if you have any questions about your plan benefits.

For a list of medical services that may require preauthorization, visit PacificSource.com/provider/preauthorization.aspx.

Drug Lists

The PacificSource drug lists are guides to help your doctor identify medications that can provide the best clinical results at the lowest cost. As a cost savings for you, generic drugs are substituted in place of name brand drugs wherever possible. Please note that drugs not listed are not automatically covered. Drug lists are updated as new drugs enter the market.

At PacificSource.com/drug-list, you'll find:

- drug list information
- drug list abbreviations and terms
- preauthorization policies
- step therapy policies
- incentive drug list

Some plans only provide coverage for certain drugs on this list. A separate benefit may apply to some drugs, such as specialty drugs.

If you have questions about how your prescription drugs will be covered, please contact a Coverage Advisor at (855) 330-2792 or by email at IdahoIndividual@pacificsource.com.

Know the Lingo

Co-insurance
Co-insurance is your share of the cost of a covered service (in addition to co-pays), calculated as a percentage of the service cost. Co-insurance typically applies once you've met your deductible.

Co-pay
Your co-pay is the amount of money you pay up front right when you have a service, such as a doctor visit.

Deductible
Your deductible is the amount you're responsible to pay before the plan pays for covered services. Some services, such as preventive care, are covered by the plan without you needing to meet the deductible.

Network
A network includes the providers and facilities we have contracted with to provide healthcare services.

Nonparticipating providers, facilities
Nonparticipating providers or facilities are those we have not contracted with for a network. When you see a nonparticipating provider, you will pay more out-of-pocket. Visit PacificSource.com/find-a-provider to find out if your doctor is a participating provider with the network you choose.

Out-of-pocket limit
Your plan's out-of-pocket limit is the most you'll pay for covered services in a calendar year.

Participating providers, facilities
Participating providers or facilities are those that we've contracted with for a particular network. You will pay less out-of-pocket when you receive services from participating providers.

Looking for additional healthcare terms?
Visit our online glossary at PacificSource.com/glossary.

Premium
Your premium is the amount you pay for your health insurance plan. Premiums can be paid monthly, quarterly, or annually.

Preventive care
Preventive care services are routine healthcare services that include screenings, check-ups, and patient counseling to prevent illnesses, disease, or other health problems. When you see a participating provider, these services are not subject to deductible and are covered in full.

Primary care provider (PCP)
A primary care provider, or PCP, is a doctor who you authorize to coordinate all of your healthcare needs, including helping you maintain your health and reach your wellness goals.

Service area
The service area is the geographic location where a plan is available, and where you must live to be eligible to enroll in that plan.

Common Questions

Am I eligible?
You may enroll in a PacificSource individual policy if you are an Idaho resident and you are not covered by Medicare or a group plan. You may also enroll your legal spouse, domestic partner, and dependent children under the age of 26 on your policy. To enroll in a plan, you must be living in a service area where your chosen plan is offered, and you must enroll during the open enrollment period.

When will my plan be effective?
Your policy can become effective on either the 1st or the 15th of the month after we receive your enrollment form and your first month's premium payment.

Can I keep my doctor?
You can keep your doctor, but you may pay more for services if your doctor isn't a participating provider in the SmartHealth network. To get the most value from your plan, you'll want to use participating doctors and hospitals. Check our online directory at PacificSource.com/find-a-provider to make sure your doctor is listed in the network you're considering.

Who may be a PCP?
Several types of providers may have a primary care physician (PCP) designation. Providers who may be PCPs include:

- Doctor of Osteopathic Medicine (DO)
- Medical Doctor (MD)
- Nurse Practitioner (NP)
- Physician Assistant (PA)

PCPs may be providers who specialize in:

- Family practice
- General practice
- Geriatrics
- Internal medicine
- Obstetrics-gynecology
- Pediatrics

To see if a specific provider has a PCP designation for your health plan, visit our Provider Directory at PacificSource.com/find-a-provider.

*"**I love that I can always talk to a person when I call**, and you process your claims very quickly! I've been very happy since switching from our [another insurer] coverage."*

—J.S., PacificSource member

Who can I talk to if I have questions?

Your insurance agent can probably answer most of your questions. If you're not working with an agent, our **Coverage Advisors** are always happy to help. Just email us or give us a call:

- **Email**
  IdahoIndividual@pacificsource.com
- **Call toll-free**
  (855) 330-2792

Do I have to have vision and dental coverage?
Federal law requires vision and dental coverage for children through age 18 be included with all qualified medical health plans. All PacificSource medical plans include pediatric vision coverage. Pediatric or family dental is available as a separate plan. View our full line of dental plans online at PacificSource.com/Idaho-individual-dental-2015.

What is Your Health Idaho?
Your Health Idaho is Idaho's health insurance marketplace. If you meet certain income requirements, you may have access to financial assistance to help you with the cost of your health insurance. To access financial assistance, you'll need to enroll through Your Health Idaho. Contact a PacificSource Coverage Advisor for help choosing a plan, then enroll through YourHealthIdaho.org.

Step by Step

1 Check Network Availability

Make sure SmartHealth is available in the county where you live. If it's not, you'll want to choose a network that is. You can find more information about the SmartHealth network on page 12. For more information about network and plan availability, visit PacificSource.com.

2 Choose a Plan

To choose the right plan for you, there are a few things you'll want to know ahead of time:

- **Budget:** Consider what you can afford on a monthly basis for your premium, and what you can afford for medical care. Plan for out-of-pocket expenses such as deductibles and co-pays.
- **Healthcare and service needs:** Think about the services you used in the past year. If you have an ongoing health issue, you may want a plan with a lower deductible and co-pays.
- **Financial assistance:** You may want visit YourHealthIdaho.org to see if you meet certain income requirements for access to financial assistance to help you with the cost of health insurance.

See "Choosing the Right Plan" on page 15 for help comparing and choosing plans.

3 Enroll in a Plan

Eligible for financial assistance?

Did you learn in step two that you're eligible for financial assistance? If you're eligible, you'll need to enroll through YourHealthIdaho.org.

Not eligible for financial assistance?

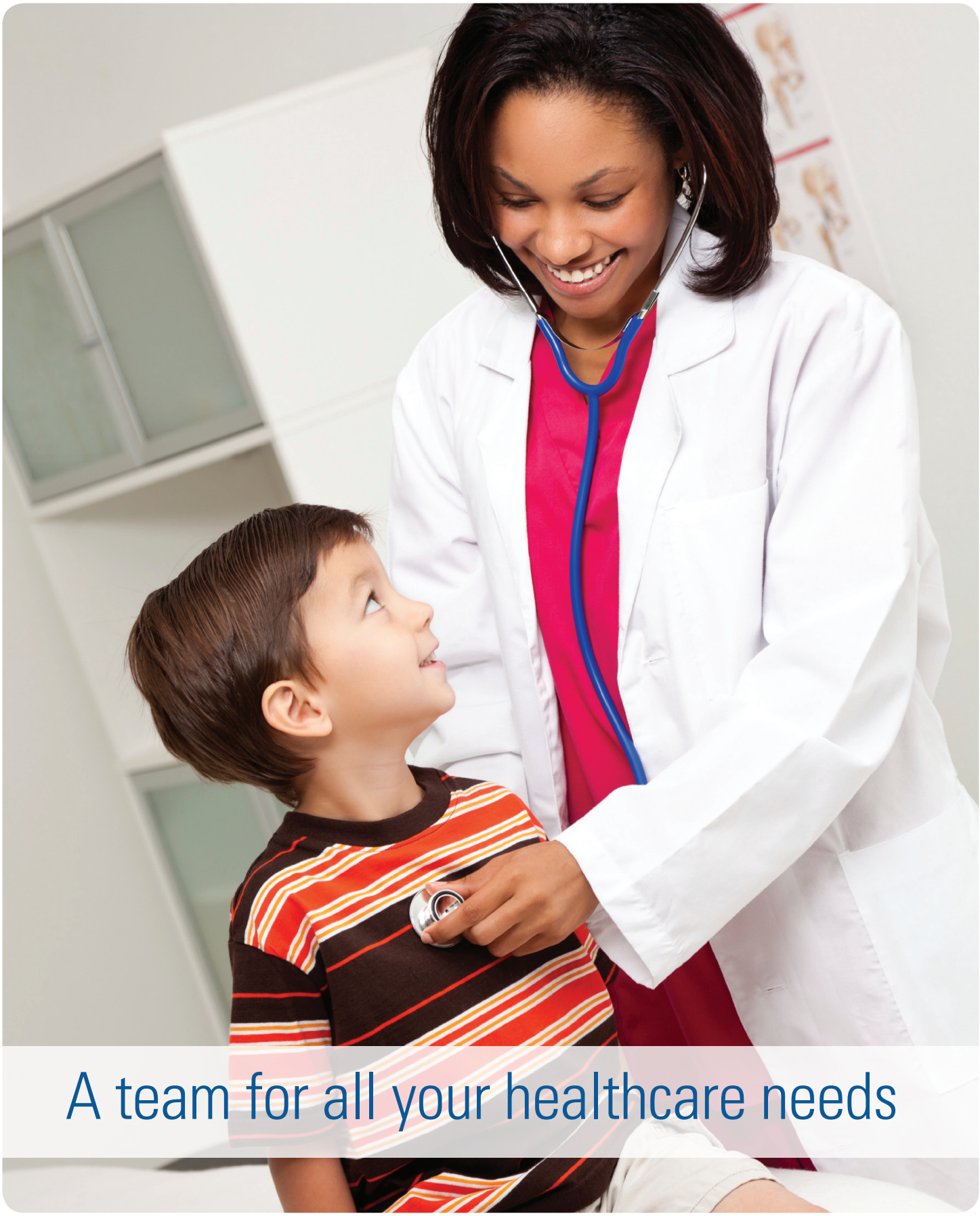
Enroll online directly with PacificSource. Visit PacificSource.com/compare-rates-and-enroll. Follow the on-screen instructions to complete and submit your application.

OR

Complete a paper enrollment form directly with PacificSource.

1. Fill out a printed enrollment form. Ask your agent for a printed form, or contact us.
2. Sign and date the enrollment form. If a spouse, domestic partner, or dependent over the age of 18 is also enrolling for coverage, they must sign and date the application, too.
3. Submit your enrollment form.
    - Email: IdahoIndividual@pacificsource.com
    - Fax: (208) 333-1587
    - Mail:
      PacificSource Health Plans
      Attn: Individual Department
      408 E Parkcenter Boulevard, Suite 100
      Boise, ID 83706

Know Your Network



A team for all your healthcare needs

SmartHealth

Coordinated Care with SmartHealth

When you choose a SmartHealth plan, you'll get a network of providers who work together to help you coordinate all your healthcare needs. You'll receive medical services from providers who are connected to make sure you get the best care possible. Before selecting a plan, make sure SmartHealth is available where you live.

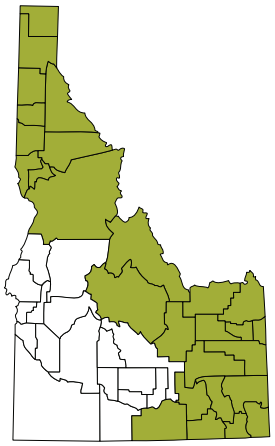
Participating Provider Tiers

SmartHealth plans give you more choices through two tiers of participating providers and benefits. This ensures you receive the highest quality of care, and helps you keep your costs as low as possible.

You'll get the most value out of your SmartHealth plan when you choose a primary care provider (PCP) from tier 1. You'll pay slightly more to see a tier 2 doctor.

To find out if your doctor or facility is tier 1, tier 2, or nonparticipating in the SmartHealth network, visit PacificSource.com/find-a-provider.

Network Availability



Bannock
Bear Lake
Benewah
Bingham
Bonner
Bonneville
Boundary
Butte
Caribou
Cassia
Clark
Clearwater
Custer
Franklin
Fremont
Idaho
Jefferson
Kootenai
Latah
Lemhi
Lewis
Madison
Nez Perce
Oneida
Power
Shoshone
Teton

Travel Networks

If you experience an emergency or need urgent care when traveling outside your plan's network, you have access to providers nationwide. We partner with First Choice Health Network for Washington and Alaska and with the First Health Network® for all other states.

All Our Plans Feature:

- No-cost preventive care
- Choice of top quality primary care providers (PCP selection required)
- No referrals required for specialty care
- Services with co-pays are not subject to deductible
- Value-added extras, such as our 24-Hour NurseLine, weight management program discounts, tobacco cessation support, and more
- Receive the most benefit from your plan when you choose a participating network provider

Choose Your Plan

Plans that fit your lifestyle

SmartHealth Plans

About Our Plans

Navigating plan options and understanding benefits can be challenging. This section gives you more information about our plans and benefits.

Balance vs. Value Plans

Generally speaking, Balance plans offer individuals co-pays on office visits and prescription drugs (see charts starting on page 17), which are not subject to deductible.

Value plans are set up for pairing with a health savings account (HSA; see page 22).

Gold, Silver, and Bronze

Plan names include the words "gold," "silver," or "bronze" to reflect how you and your plan share the costs of care. These categories have nothing to do with the quality or amount of care you get.

Plan Name Numbers

Most of our plans have a number at the end of the plan name. This number represents the individual deductible amount for that plan.

Plans at a Glance

Deductible and out-of-pocket limit amounts shown below are the costs for individuals. Amounts for families are twice the individual amounts. If you receive services from out-of-network providers, your deductible and out-of-pocket limit will be higher than the amounts listed in the chart below.

For nonparticipating deductible and out-of-pocket amounts, view our plan summaries at PacificSource.com.

Plan	Deductible	Out-of-pocket Limit	Co-insurance
Balance Bronze 6600	$6,600	$6,600	0%
Value Bronze 6300	$6,300	$6,300	0%
Value Bronze 3000	$3,000	$6,450	50%
Balance Silver 2500	$2,500	$6,600	30%
Balance Silver 1500	$1,500	$6,600	30%
Value Silver 3600	$3,600	$3,600	0%
Value Silver 3000	$3,000	$3,000	0%
Balance Gold 1000	$1,000	$4,500	20%
Catastrophic>	$6,600	$6,600	0%

> Eligibility requirements apply for Catastrophic coverage.

Choosing the Right Plan

Not sure where to start? Here's a quick quiz to help you determine the right coverage for you:

Read the statements below and rate each statement on a scale of 1 to 3, 1 meaning "No, this isn't true for me," 2 meaning "This sort of describes me, but not exactly," and 3 meaning, "Yes, this describes me." Circle your answers, and then add up your total for which plans might fit you best.

		No	Sort of	Yes
1.	I'm purchasing health insurance for myself **and** family members.	1	2	3
2.	I go to the doctor frequently, beyond annual check-ups.	1	2	3
3.	I need easy access to specialist care.	1	2	3
4.	I have one or more health issues that need managed.	1	2	3
5.	I need a low annual out-of-pocket limit, and I'm not concerned about premium costs.	1	2	3

Total: _____

Add up your total. Choose your plan.

Bare essentials: 5-7 points

You know you need a plan, but you just want the basics. Maybe you don't go to the doctor very often, but you need coverage for an unexpected mishap. Here are some plans that we think would work best for you:

- Balance Bronze 6600
- Value Bronze 6300
- Value Bronze 3000
- Value Silver 3600
- Catastrophic>

Middle of the road: 8-11 points

Great coverage is important to you. You want the lowest out-of-pocket limit you can get, but you don't want to compromise other great benefits to get it. Here are some plans that we think would work best for you:

- Balance Bronze 6600
- Value Bronze 3000
- Value Silver 3600
- Value Silver 3000

Don't hold back: 12-15 points

You might have one or more health issues and you expect to make good use of your health insurance benefits. You need great coverage with co-pays and a lower deductible to help offset the costs. Here are some plans that we think would work best for you:

- Balance Silver 2500
- Balance Silver 1500
- Balance Gold 1000

> Eligibility requirements apply for Catastrophic coverage.

Still not sure?

If you need help choosing the right plan, you can work with an agent, or call one of our Coverage Advisors toll-free at (855) 330-2792, or email IdaholndividualPacificsource.com. Our Coverage Advisors can answer your questions and help you pick a plan that fits your needs.

Choosing the Right Plan

Reading the Plan Benefit Charts

Our plan benefit charts on the following pages will give you a breakdown of key information.

Once you have a couple plans in mind, you'll want to compare the benefits for each plan to make sure you're getting what you need. **The benefit charts on the following pages list your share of costs when you see a participating provider. Calendar year costs and service costs will be higher if you receive medical services from nonparticipating providers.** You'll find our nonparticipating rates listed in our benefit summaries at PacificSource.com.

Here's a quick guide on what you'll see on the following plan benefit charts:

Calendar year costs: These are costs you are responsible for from January 1 through December 31. Understanding what each of these costs means is important to helping you choose a plan. For definitions, see page 8.

Tier 1 (T1) or tier 2 (T2): With two tiers of participating providers, your share of costs may fall into tier 1 or tier 2. To find out if a doctor or facility is tier 1, tier 2, or nonparticipating, go to PacificSource.com/find-a-provider.

	Balance Silver 1500	Value Silver 3600
Calendar Year Costs	**Individual / Family**	**Individual / Family**
Deductible	**T1:** $1,500 / $3,000 **T2:** $1,500 / $3,000	**T1:** $3,600 / $7,200 **T2:** $3,600 / $7,200
Out-of-pocket limit	$6,600 / $13,200	**T1:** $3,600 / $7,200 **T2:** $4,600 / $9,200
Co-insurance	**T1:** 30%; **T2:** 40%	**T1:** 0%; **T2:** 50%
Services		
Office visits	$25 co-pay	Deductible, then 0% or 50%
Specialist office visit	$50 co-pay	Deductible, then 0% or 50%

Two tier out-of-pocket limits: Some SmartHealth plans have two tiers of out-of-pocket limits. The Affordable Care Act (ACA) mandates that out-of-pocket limits may not exceed $6,600 for individuals and $13,200 for families. So even if the two tiers add up to more than $6,600 for individuals or $13,200 for families, you will not pay beyond the mandated limit.

Services: Each plan benefit chart lists common services and your share of the service costs. For a more complete list, view the benefit summaries at PacificSource.com.

Service costs: Costs are shown in the amount you pay. Some services are covered in full, some services have a co-pay, some apply to the deductible, then co-insurance, and some are not covered.

Bronze Plans

This chart lists your share of costs when you see a participating provider; these amounts will be higher if you receive medical services from nonparticipating providers.

	Balance Bronze 6600	Value Bronze 6300	Value Bronze 3000
Calendar Year Costs	**Individual / Family**	**Individual / Family**	**Individual / Family**
Deductible	$6,600 / $13,200	$6,300 / $12,600	**T1:** $3,000 / $6,000 **T2:** $3,000 / $6,000
Out-of-pocket limit	$6,600 / $13,200	$6,300 / $12,600	$6,450 / $12,900
Co-insurance	**T1:** 0%; **T2:** 0%	**T1:** 0%; **T2:** 0%	**T1:** 50%; **T2:** 60%
Services			
Office visits	$25 co-pay >; Deductible, then 0%	Deductible, then 0%	Deductible, then 50% or 60%
Specialist office visit	$50 co-pay >; Deductible, then 0%	Deductible, then 0%	Deductible, then 50% or 60%
Chiropractic manipulation, acupuncture	$25 co-pay >; Deductible, then 0%	Deductible, then 0%	Deductible, then 50% or 60%
Office procedures and supplies	Deductible, then 0%	Deductible, then 0%	Deductible, then 50% or 60%
Urgent care	$25 co-pay >; Deductible, then 0%	Deductible, then 0%	Deductible, then 50% or 60%
Emergency room visits	Deductible, then 0%	Deductible, then 0%	Deductible, then 50% or 60%
Ambulance service	Deductible, then 0%	Deductible, then 0%	Deductible, then 50% or 60%
Hospital services and surgery	Deductible, then 0%	Deductible, then 0%	Deductible, then 50% or 60%
Outpatient services	Deductible, then 0%	Deductible, then 0%	Deductible, then 50% or 60%
Prescription Drugs			
Preventive	Covered in full	Covered in full	Covered in full
Generic	$10 co-pay	Deductible, then 0%	Deductible, then 50%
Preferred brand name	Deductible, then 0%	Deductible, then 0%	Deductible, then 50%
Nonpreferred brand name	Deductible, then 0%	Deductible, then 0%	Deductible, then 50%
Specialty	Deductible, then 0%	Deductible, then 0%	Deductible, then 50%
Other Features			
Preventive care	Covered in full	Covered in full	Covered in full
Pediatric vision	Covered in full	Covered in full	Covered in full
Maternity care	Deductible, then 0%	Deductible, then 0%	Deductible, then 50% or 60%
Accident Benefit	Within 90 days of an accident, the first $500 of covered services is paid at 100% and is not subject to the deductible.		

> First ten visits combined are paid at 100% after co-pay. For additional visits, you will need to meet your deductible before your plan will pay.

Silver Plans

This chart lists your share of costs when you see a participating provider; these amounts will be higher if you receive medical services from nonparticipating providers.

	Balance Silver 2500	Balance Silver 1500
Calendar Year Costs	**Individual / Family**	**Individual / Family**
Deductible	**T1:** $2,500 / $5,000 **T2:** $2,500 / $5,000	**T1:** $1,500 / $3,000 **T2:** $1,500 / $3,000
Out-of-pocket limit	$6,600 / $13,200	$6,600 / $13,200
Co-insurance	**T1:** 30%; **T2:** 40%	**T1:** 30%; **T2:** 40%
Services		
Office visits	$25 co-pay	$25 co-pay
Specialist office visit	$50 co-pay	$50 co-pay
Chiropractic manipulation, acupuncture	$25 co-pay	$25 co-pay
Office procedures and supplies	Deductible, then 30% or 40%	Deductible, then 30% or 40%
Urgent care	$25 co-pay	$25 co-pay
Emergency room visits	$250 co-pay§, plus 30% or 40%	$250 co-pay§, plus 30% or 40%
Ambulance service	Deductible, then 30% or 40%	Deductible, then 30% or 40%
Hospital services and surgery	Deductible, then 30% or 40%	Deductible, then 30% or 40%
Outpatient services	Deductible, then 30% or 40%	Deductible, then 30% or 40%
Prescription Drugs		
Preventive	Covered in full	Covered in full
Generic	$10 co-pay	$10 co-pay
Preferred brand name	$50 co-pay	$50 co-pay
Nonpreferred brand name	Deductible, then 50%	Deductible, then 50%
Specialty	Deductible, then 50%	Deductible, then 50%
Other Features		
Preventive care	Covered in full	Covered in full
Pediatric vision	Covered in full	Covered in full
Maternity care	Deductible, then 30% or 40%	Deductible, then 30% or 40%
Accident benefit	Within 90 days of an accident, the first $500 of covered services is paid at 100% and is not subject to the deductible.	

§ In addition to your co-pay, you will need to meet your deductible before your plan will pay for this service.

Silver Plans

This chart lists your share of costs when you see a participating provider; these amounts will be higher if you receive medical services from nonparticipating providers.

	Value Silver 3600	Value Silver 3000
Calendar Year Costs	**Individual / Family**	**Individual / Family**
Deductible	**T1:** $3,600 / $7,200 **T2:** $3,600 / $7,200	**T1:** $3,000 / $6,000 **T2:** $3,450 / $6,900
Out-of-pocket limit	**T1:** $3,600 / $7,200 **T2:** $4,600 / $9,200	**T1:** $3,000 / $6,000 **T2:** $3,450 / $6,900
Co-insurance	**T1:** 0%; **T2:** 50%	**T1:** 0%; **T2:** 0%
Services		
Office visits	Deductible, then 0% or 50%	Deductible, then 0%
Specialist office visit	Deductible, then 0% or 50%	Deductible, then 0%
Chiropractic manipulation, acupuncture	Deductible, then 0% or 50%	Deductible, then 0%
Office procedures and supplies	Deductible, then 0% or 50%	Deductible, then 0%
Urgent care	Deductible, then 0% or 50%	Deductible, then 0%
Emergency room visits	Deductible, then 0% or 50%	Deductible, then 0%
Ambulance service	Deductible, then 0% or 50%	Deductible, then 0%
Hospital services and surgery	Deductible, then 0% or 50%	Deductible, then 0%
Outpatient services	Deductible, then 0% or 50%	Deductible, then 0%
Prescription Drugs		
Preventive	Covered in full	Covered in full
Generic	Deductible, then 0%	Deductible, then 0%
Preferred brand name	Deductible, then 0%	Deductible, then 0%
Nonpreferred brand name	Deductible, then 0%	Deductible, then 0%
Specialty	Deductible, then 0%	Deductible, then 0%
Other Features		
Preventive care	Covered in full	Covered in full
Pediatric vision	Covered in full	Covered in full
Maternity care	Deductible, then 0% or 50%	Deductible, then 0%
Accident benefit	Within 90 days of an accident, the first $500 of covered services is paid at 100% and is not subject to the deductible.	

Gold Plan

This chart lists your share of costs when you see a participating provider; these amounts will be higher if you receive medical services from nonparticipating providers.

	Balance Gold 1000
Calendar Year Costs	**Individual / Family**
Deductible	**T1:** $1,000 / $2,000 **T2:** $1,000 / $2,000
Out-of-pocket limit	$4,500 / $9,000
Co-insurance	**T1:** 20%; **T2:** 30%
Services	
Office visits	$15 co-pay
Specialist office visit	$50 co-pay
Chiropractic manipulation, acupuncture	$15 co-pay
Office procedures and supplies	Deductible, then 20% or 30%
Urgent care	$15 co-pay
Emergency room visits	$250 co-pay§, plus 20% or 30%
Ambulance service	Deductible, then 20% or 30%
Hospital services and surgery	Deductible, then 20% or 30%
Outpatient services	Deductible, then 20% or 30%
Prescription Drugs	
Preventive	Covered in full
Generic	$10 co-pay
Preferred brand name	$35 co-pay
Nonpreferred brand name	$60 co-pay
Specialty	$250 co-pay
Other Features	
Preventive care	Covered in full
Pediatric vision	Covered in full
Maternity care	Deductible, then 20% or 30%
Accident benefit	Within 90 days of an accident, the first $500 of covered services is paid at 100% and is not subject to the deductible.

§ In addition to your co-pay, you will need to meet your deductible before your plan will pay for this service.

Catastrophic Plan

This chart lists your share of costs when you see a participating provider; these amounts will be higher if you receive medical services from nonparticipating providers.

	Catastrophic
Calendar Year Costs	**Individual**
Deductible	$6,600 / $13,200
Out-of-pocket limit	$6,600 / $13,200
Co-insurance	**T1:** 0%; **T2:** 0%
Services	
Office visits	Deductible, then 0%>
Specialist office visit	Deductible, then 0%
Chiropractic manipulation, acupuncture	Deductible, then 0%
Office procedures and supplies	Deductible, then 0%
Urgent care	Deductible, then 0%
Emergency room visits	Deductible, then 0%
Ambulance service	Deductible, then 0%
Hospital services and surgery	Deductible, then 0%
Outpatient services	Deductible, then 0%
Prescription Drugs	
Preventive	Covered in full
Generic	Deductible, then 0%
Preferred brand name	Deductible, then 0%
Nonpreferred brand name	Deductible, then 0%
Specialty	Deductible, then 0%
Other Features	
Preventive care	Covered in full
Pediatric vision	Deductible, then 0%
Maternity care	Deductible, then 0%
Accident benefit	Within 90 days of an accident, the first $500 of covered services is paid at 100% and is not subject to the deductible.

> First three visits combined are paid at 100%. For additional visits, you will need to meet your deductible before your plan will pay.

Catastrophic Coverage

With Catastrophic coverage, your first three primary care office visits are covered in full. Additional office visits and services will be subject to your deductible and co-insurance.

Do I qualify for the Catastrophic plan?

To qualify, you must be younger than 30 years old, or get a "hardship exemption" because the marketplace determined that you are unable to afford healthcare coverage.

To find out if you're eligible for this plan, visit YourHealthIdaho.org.

Save for Your Health

Health Savings Accounts (HSA)

A health savings account (HSA) is a true bank account into which you deposit money to be used for future healthcare expenses. You can contribute your own money to an HSA and deduct the contributions when you file your income taxes. The money in an HSA earns interest just like a regular bank account if you choose an interest-bearing account.

HSAs have maximum annual contribution limits: $3,350 for individual accounts, and $6,650 for families for 2015.

Why should I consider an HSA?

- **HSAs offer a tax savings benefit.** The money you put into your HSA is tax-free, as is the interest you earn on your savings.
- **It's your money.** The money in your account rolls over, meaning that the money you save can go toward future medical expenses.
- **You choose how to spend it.** If you receive medical services that aren't covered by your plan, you can use your HSA dollars to cover those expenses.

HSA-eligible Plans

High-deductible Health Plan Requirement

You'll need a qualifying high-deductible health plan—also known as an HDHP—to go with your HSA. HDHPs must have a deductible of $1,300 or more for individuals, $2,600 or more for families. Sometimes preventive care is exempt from that deductible.

Here are SmartHealth plans that qualify as an HDHP (HSA-eligible plan):

- Value Bronze 6300
- Value Bronze 3000
- Value Silver 3600
- Value Silver 3000

HSA Highlights

- Anyone can contribute to your HSA.
- You own the account and all the money in it, no matter who contributed.
- Money you deposit is tax deductible, earns tax-free interest, and can build from year to year.
- You can withdraw funds to pay for medical expenses any time without taxes or penalties.
- You can withdraw funds for nonmedical use subject to taxes and an IRS penalty.
- HSAs are regulated by the federal government.

Setting Up Your HSA

Enrolling in an HSA-qualified plan doesn't automatically set up your HSA banking account and your premium doesn't contribute to HSA funds.

To set up your HSA:

1. Enroll in a PacificSource Value plan.
2. Contact your local banking institution to set up your HSA.
3. Deposit money into your HSA banking account.
4. You're done!

If you have questions about HSAs or HSA-eligible plans, contact a health insurance agent or one of our Coverage Advisors at IdahoIndividual@pacificsource.com or toll-free at (855) 330-2792.

Vision and Dental

Pediatric Vision Coverage is Included with Every Plan

We've partnered with VSP, a vision service provider, to provide pediatric vision benefits that meet the Affordable Care Act standards.

VSP offers an Eye Health Management Program that turns routine eyecare into preventive healthcare. With VSP benefits, you're connected to a nationwide network of eyecare providers who share vision exam results with your PCP, giving you more complete, connected healthcare coverage.

For questions about VSP pediatric vision benefits, contact their Member Services Department:

Toll-free: (800) 877-7195
Monday – Friday: 5:00 a.m. to 8:00 p.m. (PST)
Saturday: 7:00 a.m. to 8:00 p.m. (PST)
Sunday: 7:00 a.m. to 7:00 p.m. (PST)

Online email form:
VSP.com/contact-email.html

Don't Forget Dental

Good dental care is an important part of your overall health. Our dental plans are a perfect partner to your medical coverage, giving you peace of mind that you and your family are covered head to toe.

The Pediatric Coverage Requirement

Federal law requires vision and dental coverage for children through age 18 be included with all qualified health plans. All PacificSource plans include pediatric vision coverage. However, pediatric dental is available as separate coverage.

View our Individual and Family Dental Brochure online at PacificSource.com for dental plan options.

What's Not Covered

The following treatments, situations, and conditions are not covered under PacificSource individual and family medical plans. A full explanation of benefits, including limitations and exclusions, will be provided in your policy. You're welcome to contact us if you have questions.

Please note: Full descriptions will be provided in your policy. Only the language of the actual policy is final and binding.

- Abdominoplasty
- Academic skills training
- Any amounts in excess of the allowable fee for a given service or supply
- Aversion therapy
- Biofeedback (other than as specifically noted under the Covered Expenses – Other Covered Services, Supplies, and Treatment section)
- Care and related services designed essentially to assist a person in maintaining activities of daily living
- Charges for phone consultations, missed appointments, get acquainted visits, completion of claim forms, or reports PacificSource needs to process claims
- Charges over the usual, customary, and reasonable fee (UCR) – Any amount in excess of the UCR for a given service or supply
- Charges that are the responsibility of a third party who may have caused the illness, injury, or disease or other insurers covering the incident (such as workers' compensation insurers, automobile insurers, and general liability insurers)
- Chelation therapy
- Computer or electronic equipment for monitoring asthmatic, diabetic, or similar medical conditions or related data
- Cosmetic/reconstructive services and supplies – Except as specified in the Covered Expenses – Other Covered Services, Supplies, and Treatments section of the policy
- Court-ordered sex offender treatment programs
- Court-ordered screening interviews or drug or alcohol treatment programs
- Day care or custodial care – Care and related services designed essentially to assist a person in maintaining activities of daily living
- Dental examinations and treatment
- Drugs and biologicals that can be self-administered (including injectables), other than those provided in a hospital emergency room, or other institutional setting, or as outpatient chemotherapy and dialysis, which are covered
- Drugs or medications not prescribed for inborn errors of metabolism, diabetic insulin, or autism spectrum disorder that can be self-administered (including prescription drugs, injectable drugs, and biologicals), unless given during a visit for outpatient chemotherapy or dialysis or during a medically necessary hospital, emergency room or other institutional stay
- Durable medical equipment available over the counter and/or without a prescription
- Educational or correctional services or sheltered living provided by a school or halfway house, except outpatient services received while temporarily living in a shelter
- Elective abortions, except to save the life of the mother, or if the pregnancy is a result of rape or incest
- Electronic Beam Tomography (EBT)
- Equine/animal therapy
- Equipment commonly used for nonmedical purposes or marketed to the general public
- Equipment used primarily in athletic or recreational activities
- Experimental or investigational
- Eye examinations (routine) members age 19 and older
- Eye glasses/Contact Lenses members age 19 and older
- Eye exercises, therapy, and procedures
- Family planning – Services and supplies for artificial insemination, in vitro fertilization, diagnosis and treatment of infertility, erectile dysfunction, frigidity, or surgery to reverse voluntary sterilization
- Fitness or exercise programs and health or fitness club memberships
- Foot care (routine) – Services and supplies for corns and calluses of the feet, conditions of the toenails other than infection, hypertrophy or hyperplasia of the skin of the feet, and other routine foot care, except in the case of patients being treated for diabetes mellitus
- Genetic (DNA) testing – DNA and other genetic tests, except for those tests identified as medically necessary for the diagnosis and standard treatment of specific diseases

Continued on next page

What's Not Covered

- Growth hormone injections or treatments, except to treat documented growth hormone deficiencies
- Hearing Aids including the fitting, provision or replacement of hearing aids
- Homeopathic medicines or homeopathic supplies
- Hypnotherapy except in the treatment of mental or nervous conditions
- Immunizations when recommended for or in anticipation of exposure through travel or work
- Instructional or educational programs, except diabetes self-management programs unless medically necessary
- Jaw – Procedures, services, and supplies
- Jaw surgery
- Learning disorders
- Maintenance supplies and equipment not unique to medical care
- Marital/partner counseling
- Massage, massage therapy, or neuromuscular re-education, even as part of a physical therapy program
- Mattresses and mattress pads are only covered when medically necessary to heal pressure sores
- Mental health treatments for conditions as listed in the current Diagnostic and Statistical Manual (DSM) of the American Psychiatric Association which, according to the DSM, are not attributable to a mental health disorder or disease
- Modifications to vehicles or structures to prevent, treat, or accommodate a medical condition
- Motion analysis
- Myeloablative high dose chemotherapy, except when the related transplant is specifically covered under the transplantation provisions of this plan
- Narcosynthesis
- Naturopathic treatment and supplies
- Nicotine related disorders
- Obesity or weight control – Surgery or other related services or supplies provided for weight control or obesity (including all categories of obesity), when not medically necessary
- Oral/facial motor therapy for strengthening and coordination of speech-producing musculature and structures
- Orthopedic shoes and shoe modifications
- Orthognathic surgery – Services and supplies to augment or reduce the upper or lower jaw, except as specified under 'Professional Services' in the Covered Expenses section of the policy
- Osteopathic manipulation, except for treatment of disorders of the musculoskeletal system
- Over-the-counter medications or nonprescription drugs
- Panniculectomy
- Paraphilias
- Personal items such as telephones, televisions, and guest meals during a stay at a hospital or other inpatient facility
- Physical or eye examinations required for administrative purposes such as participation in athletics, admission to school, or by an employer
- Private nursing service
- Programs that teach a person to use medical equipment, care for family members, or self-administer drugs or nutrition (except for diabetic education benefit)
- Psychoanalysis or psychotherapy received as part of an educational or training program, regardless of diagnosis or symptoms that may be present
- Recreation therapy – Outpatient
- Rehabilitation
- Replacement costs for worn or damaged durable medical equipment that would otherwise be replaceable without charges under warranty or other agreement
- Scheduled and/or non-emergent medical care outside of the United States
- Screening tests – Services and supplies, including imaging and screening exams performed for the sole purpose of screening and not associated with specific diagnoses and/or signs and symptoms of disease or of abnormalities on prior testing
- Self-help or training programs
- Sensory integration training
- Services for individuals 18 years of age or older with intellectual disabilities which are generally provided by your State Dept. of Health and Welfare for those with Developmental Disabilities
- Services of providers who are not eligible for reimbursement under this plan
- Services or supplies available to you from another source, including those available through a government agency
- Services or supplies for which no charge is made, for which the member is not legally required to pay, or for which a provider or facility is not licensed to provide even though the service or supply may otherwise be eligible. This exclusion

Continued on next page

What's Not Covered

RENEWABILITY OF POLICY – Individual policies shall be renewable with respect to the Insured, at the option of the Policyholder, except in any of the following cases: nonpayment of the required premiums; fraud or intentional misrepresentation of material fact by the Insured or his representatives; the individual's residence changes to one which is outside the established geographic Service Area; if this Policy is made available to the individual through one (1) or more associations, and the membership of the employer in the association ceases; and/ or PacificSource Health Plans elects to nonrenew all of its policies delivered or issued for delivery to individuals in the state of Idaho.

PREEXISTING CONDITION – A Preexisting Condition means the existence of a condition that would have caused an ordinarily prudent person to seek medical advice, diagnosis, care, or treatment within a six (6) month period immediately preceding the Effective Date of coverage; a condition for which medical advice or treatment was recommended or received within a six (6) month period immediately preceding the Effective Date of coverage; or a pregnancy existing on the Effective Date of coverage. The Preexisting Condition exclusion does not apply to any insured members or their dependents under the individual policies contained in this sales literature.

DISCLOSURE OF PREMIUM PRACTICES & GUARANTEES

a) How Premiums Are Set

Your premium is determined by the benefits you selected, your geographic location, and the age of the individuals covered on your policy. Any renewal premium increase is due to changes in age and any increase approved by the Department of Insurance.

b) Premium Guarantee

We guarantee your initial premium until your next renewal date. Your premium may change if you change your benefits at renewal.

includes services provided by the member, or by an immediate family member.

- Services or supplies with no charge or which you are not legally required to pay for. This includes services provided by yourself or an immediate family member.
- Services otherwise available – These include but are not limited to:

  - Services or supplies for which payment could be obtained in whole or in part if the member applied for payment under any city, county, state (except Medicaid), or federal law; and

  - Services or supplies the member could have received in a hospital or program operated by a federal government agency or authority, except otherwise covered expenses for services or supplies furnished to a member by the Veterans' Administration of the United States that are not military service-related.

  This exclusion does not apply to covered services provided through Medicaid or by any hospital owned or operated by the policy's state of issuance or any state-approved community mental health and developmental disability program.
- Services required by state law as a condition of maintaining a valid driver license or commercial driver license
- Services, supplies, and equipment not involved in diagnosis or treatment but provided primarily for the comfort, convenience, intended to alter the physical environment, or education of a patient
- Sexual disorders – Services or supplies for the treatment of sexual dysfunction or inadequacy unless medically necessary to treat a mental health issue and diagnosis
- Sex reassignment
- Sex transformations
- Snoring
- Social skill training
- Speech therapy (unless covered under rehabilitation or habilitative in Professional Service section)
- Support groups
- Surgery to reverse voluntary sterilization
- Temporomandibular joint – related services, or treatment for associated myofascial pain including physical or oromyofacial therapy
- Training or self-help health or instruction
- Transplants – except as expressly provided under the provisions of this plan for covered transplantation expenses

What's Not Covered

- Treatment after insurance ends – Services or supplies a member receives after the member's coverage under this plan ends, except as follows:
  - If the member is pregnant and not eligible for any replacement group coverage within 60 days, this policy's maternity benefits may continue for up to 12 months
  - If the member is totally disabled, coverage may continue for up to 12 months
- Treatment not medically necessary
- Treatment of any illness, injury, or disease resulting from an illegal occupation or attempted felony, or treatment received while in the custody of any law enforcement authority
- Treatment of any work-related illness, injury, or disease, unless you are the owner or partner and are otherwise exempt from, and not covered by, state or federal workers' compensation insurance
- Treatment of intellectual disabilities
- Treatment prior to enrollment
- Unwilling to release information – Charges for services or supplies for which a member is unwilling to release medical or eligibility information necessary to determine the benefits payable under this plan
- Vocational rehabilitation, functional capacity evaluations, work hardening programs, community reintegration services, and driving evaluations and training programs, except as medically necessary in the restoration or improvement of speech following a traumatic brain injury or for a child 17 years or younger diagnosed with a pervasive development disorder
- War-related conditions

Contact us. We'll be happy to answer your questions.
If you have questions about our individual and family health plans, you're always welcome to contact us at (855) 330-2792 or by email at IdahoIndividual@pacificsource.com. A PacificSource Coverage Advisor will be happy to assist you.

PacificSource is an independent, not-for-profit community health plan that values partnership, service excellence, community, and personal relationships. Founded in 1933 in Eugene, Oregon, we deliver healthcare solutions to businesses and individuals throughout the Northwest. PacificSource covers more than 300,000 people with our group, individual, and Medicare health insurance plans. For more information, visit PacificSource.com.

Your privacy is important to us. Learn more about how we protect your personal information by viewing our privacy policy at PacificSource.com/privacy.aspx.

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HEALTH PLANS