SmartHealth

Healthcare Coverage for Health-minded Individuals and Families

Healthcare coverage designed for health-minded people like you.

We know you and your family value good health. That's why SmartHealth has built-in preventive benefits, along with coverage for prescription drugs and lab work.

Our goal is to make your health insurance coverage easy to understand and convenient to use. That's why the deductibles for the SmartHealth family plan are combined—one deductible for the entire family.

PacificSource Extras Add Even More Value to Your Coverage

Take advantage of these member programs, available to you at no additional cost.

These value-added programs and services are not insurance, but are offered in addition to your medical plan to help you take charge of your health.

Online Tools at PacificSource.com

InTouch for Members lets you track your benefits online. The PacificSource Provider Directory helps you find up-to-date information about local participating providers.

Health and Wellness Programs*

Better your health and manage existing conditions with the help of our health and wellness programs. Our "extras" include tobacco cessation, prenatal care, and reimbursement for hospital-based wellness classes.* We also offer programs to help you manage existing conditions such as diabetes, high blood pressure, and other chronic diseases. Through InTouch for Members, you can also access information and manage your health online using Health Manager.

Global Emergency Services

Travel worry free with global emergency services from Assist America®. If you experience a medical emergency when traveling 100 or more miles from home or in a foreign country, Assist America offers a wide range of services to help you.

** Visit our website for more details: PacificSource.com.*

SmartHealth—because you manage your health so well.

1. **I work hard to remain healthy. What does SmartHealth offer me?**

   We know you value good health, so SmartHealth has preventive benefits built right in. You won't need to use your deductible.

2. **What happens if I do get sick and need to see the doctor?**

   No problem. The SmartHealth plan provides four in-network doctor visits each year for a simple $30 co-pay. If you need to see the doctor more often, your deductible applies and co-insurance will help pay the bill.

3. **Suppose my child gets hurt—how will SmartHealth cover x-rays or lab work?**

   SmartHealth covers up to the first $500. If the cost goes over $500, your deductible applies and co-insurance begins.

4. **And if someone ends up in the hospital?**

   You're covered. The maximum out-of-pocket expense would be the co-insurance plus deductible.

5. **How do I get the most value out of my coverage?**

   Use participating providers (providers who participate in our provider network) to get the most value out of your coverage.

SmartHealth
Plan Options and Coverage Highlights

SmartHealth is designed to deliver value and protection to individuals and families who take responsibility for their own health.

Chose from coverage plans that feature:

- Office visits and diagnostic benefits before deductible
- Prescription drug benefits
- A simple family deductible
- Statewide network of credentialed physicians, hospitals, and other healthcare providers

	Preferred Provider Organization (PPO)				Health Savings Account (HSA)	
Your Costs (each calendar year)	**PPO Individual**	**PPO Individual or Family**	**PPO Individual**	**PPO Individual or Family**	**HSA Individual**	**HSA Family**
Deductible Options	$2,000	$4,000[1]	$5,000	$7,000[1]	$3,000	$6,000[1]
Co-insurance (percent of cost the **member** is responsible for after the deductible is met)	Participating[3] provider: 25% Non-participating provider: 50%				Participating[3] provider: 25% Non-participating provider: 50%	
Out-of-Pocket Limit (deductible plus co-insurance)	$5,000 plus your deductible				$2,000 plus your deductible	$4,000 plus your deductible
Annual Maximum Benefit	$2,000,000				$2,000,000	
Lifetime Maximum Benefit	No lifetime maximum				No lifetime maximum	
Accident Benefit	Subject to deductible				Pays 100% of first $500 if treatment occurs within 90 days of accident , then deductible and coinsurance apply	
	Participating Provider[3] Plan Benefits (each calendar year)					
Preventive Care (routine physicals and gynecological exams)	100% (not subject to your deductible)				100% (not subject to your deductible)	
Office Visits (illness and injury)	4 visits at $30 co-pay, then your deductible and co-insurance apply.				Deductible and co-insurance	
Immunizations	100% (not subject to your deductible)				100% (not subject to your deductible)	
Diagnostic Lab, X-ray	$0 co-pay up to $500 maximum (After $500 the cost is applied to your deductible)				Deductible and co-insurance	
Maternity[2]	Separate $7,500 deductible				No coverage	
Hospital & In Office Procedures	Deductible and co-insurance				Deductible and co-insurance	
Prescription Drugs	Generic drugs: $10 co-pay Brand name drugs: Separate $1,000 deductible, then 50% co-insurance				**After medical deductible is met:** Generic drugs: $10 co-pay Brand name drugs: 50% co-insurance	

[1] Eligible expenses for all family members are used to meet the combined family deductible.
[2] Involuntary complications of pregnancy will be covered under major medical benefits.
[3] Participating provider is a provider who participates in our network (check our provider directory for a list of participating doctors and hospitals).

Questions?

Visit us online at PacificSource.com, call your insurance agent, or contact a PacificSource Individual Service Representative at 208.333.1559 or toll-free at 855.333.1559, or by email at idahoindividual@pacificsource.com. We look forward to helping you.

SMART questions to ask:

What is a waiting period?

Can I be declined for coverage?

Will my premium go up next year?

Do I have coverage when I travel?

Is SmartHealth different from a limited benefit plan?

PacificSource
HEALTH PLANS

PacificSource.com

PacificSource is based in Eugene, Oregon, with regional offices throughout Oregon, Idaho, and Montana. Founded in 1933, we put our decades of experience to work providing our members with affordable coverage and the best possible service. We provide healthcare coverage for more then 290,000 people through our group and individual health insurance plans.

DETERMINATION OF ELIGIBILITY - You are eligible to apply for individual coverage with PacificSource Health Plans if you are an Idaho resident or dependent of an Idaho resident who also resides in Idaho, are not eligible for coverage under a group health plan, and are under the age of 65 years at the time of application. You are ineligible if you currently are eligible for Medicare or Medicaid or any successor program.

AVAILABILITY - As a condition of offering individual health benefit plans in Idaho, PacificSource Health Plans actively offers health benefit plans including mandated plans under the Idaho High Risk Pool.

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.

WAITING PERIODS - Benefits for Preexisting Conditions shall only be provided for services twelve (12) months or more after the Insured's Effective Date under the Policy. This waiting period shall not apply to Newborn Children, including adopted Newborn Children, who shall be covered from the moment of birth, or to adopted children or children in the process of adoption who have been placed with the Policyholder. PacificSource Health Plans shall waive any time period applicable to a Preexisting Condition exclusion or limitation period for the period of time an individual was previously covered by Qualifying Previous Coverage, provided that the Qualifying Previous Coverage was continuous to a date not more than sixty-three (63) days prior to the Effective Date of coverage under this Policy.

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 insured members or their dependents under the age of 19. A Preexisting Condition exclusion or limitation shall not apply to an individual with qualifying previous coverage. Qualifying previous coverage means health benefits or coverage provided under any of the following:

- Group health benefit plan;
- Health insurance coverage without regard to whether the coverage is offered in the group market, the individual market, or otherwise;
- Part A or Part B of Title XVII of the Social Security Act (Medicare);
- Title XIX of the Social Security Act (Medicaid);
- Chapter 55 of Title 10, United States Code (medical and dental care for members and certain family members of the uniformed services and their dependents). For purposed of 55 Title 10, United States Code, "uniformed services" means the armed forces, the Commissioned Corps of the National Oceanic and Atmospheric Administration, and the Public Health Service;
- A medical care program of the Indian Health Services or of a tribal organization;
- A state health benefits risk pool;
- A public health plan, which for purposes of this act, means a plan established or maintained by a state, a foreign country, the U.S. government, or other political subdivision of a state, the U.S. government or foreign country that provides health insurance coverage to individuals enrolled in the plan;
- A health benefit plan under section 5(e) of the Peace Corps Act (22 U.S.C. 2504(e)); or
- A State Children's Health Insurance Program (CHIP), under Title XXI of the Social Security Act, whether it is a stand-alone separate program, a CHIP Medicaid expansion program, or a combination program, and whether it is provided through a group health plan, health insurance, or any other mechanism.

DISCLOSURE OF PREMIUM PRACTICES & GUARANTEES -

a) How Premiums Are Set

Your premium is determined by two factors—case characteristics and health status. The case characteristics of your policy include the benefits you selected, your geographic location, and the age and gender of the individuals covered on your policy. These case characteristics determine your index rate, which is the same for all individuals with the same case characteristics. The index rate is then adjusted for the health status of the individuals covered on your policy. Health status may cause the premiums to be set anywhere from 50 percent above to 50 percent below the index rate. In addition to an index rate change, no more than a 15 percent premium increase will be given each year due to changes in health status. The remaining portion of any premium increase is due to changes in case characteristics or general medical trends.

b) Premium Guarantee

We guarantee your initial premium for 12 months for the benefits selected. Your premium may change if you change your benefits. Any new premium applies from the date benefit changes begin. An exception to the premium guarantee may be made if any state or federal law unexpectedly increases our administrative costs or claims liability. Each policy is subject to a premium adjustment at its renewal.

EXCLUSIONS - Benefits shall not be provided in any of the following circumstances or for any of the following conditions under the terms of the Policy:

1. Elective abortions, except to preserve the life of the female Insured upon whom the abortion is performed.
2. Any services provided to an Insured who leaves a Physician's office, Facility or Hospital against the medical advice of the treating Physician.
3. Any procedure or treatment designed to alter physical characteristics of the Insured from the Insured's biologically determined sex to those of another sex.
4. Alternative Therapies.
5. Cosmetic and/or reconstructive services or supplies, including services and supplies related to a previous cosmetic procedure or complications of a previous cosmetic procedure, except as follows: (a) related to breast reconstruction following a mastectomy to the extent required by law; (b) due to a trauma, infection, or other

disease of the involved part; or (c) due to congenital disease or anomaly of a covered dependent child.

6. No benefits are provided for the treatment of injuries sustained while committing a felony, voluntarily taking part in a riot, or while engaging in an illegal act or occupation.
7. Custodial Care.
8. General anesthesia, conscious sedation, and nitrous oxide, for extraction of teeth or other dental procedures, whether inpatient or at an outpatient facility or provider office.
9. Exercise equipment, ice units, electronic controlled thermal units, hygienic and household equipment and fixtures. Brace(s) that are prescribed to an Insured for the purpose of other than necessary daily living activities; exercise cycles, air purifiers, central or unit air conditioners, water purifiers, nonallergenic pillows, mattresses or waterbeds; and any supplies or equipment that do not meet the definition of DME.
10. Experimental and/or Investigational Drugs and procedures.
11. Any and all services, including prescriptions for pharmaceuticals, ordered or furnished by a Provider who is an Immediate Family Member.
12. The reversal of an elective sterilization procedure; any contraceptive products available without a prescription.
13. Routine foot care, including, but not limited to, trimming of corns, calluses and nails, except those services related to systemic conditions.
14. Genetic testing and counseling for nonpregnant Insureds for purposes other than pregnancy planning.
15. Any and all diagnoses and treatment of hearing impairment or difficulty, including routine hearing examinations; hearing aids.
16. Any and all diagnosis and treatment(s) of infertility or for the inability to conceive are excluded. Ultrasounds or other similar techniques designed to determine if pregnancy has occurred while being diagnosed or treated for infertility or the inability to conceive, are also excluded.
17. No Maternity benefits are provided under the HSA Policy, except for involuntary complications of pregnancy, which shall be treated as any other illness.
18. Maternity Care Services for Dependent children.
19. Over the counter Medical Supplies, consumable or disposable supplies, including but not limited to elastic stockings, ace bandages, gauze, ice units, alcohol swabs or dressings.
20. Care of military service-connected conditions for which the Insured is legally entitled to services and for which Facilities are reasonably accessible to the Insured. This includes illness or injury that developed while in the military service.
21. Telephone/email/internet consultations; records copying; late payments, interest or taxes on professional services; for completion of a claim form; or for personal mileage, transportation, food, or lodging expenses or for mileage, transportation or lodging expenses billed by a Physician or other Provider.
22. Charges made to an Insured by a Provider for missed or canceled appointments.
23. Dietary substances, nutritional substances, or supplements.
24. Certain Orthotics are not covered appliances, including, but not limited to: shoe lifts, arch supports and corrective shoes.
25. Services for pain management.
26. Personal comfort or convenience items, including, but not limited to: guest meals and accommodations, telephone charges, travel expenses, take-home supplies, ice units, barber or beauty services, radio, television or videos of procedures, and private rooms unless the private room is Medically Necessary.
27. Physical, psychiatric, or psychological examinations or testing, and vaccinations, immunizations, treatments, or testing for purposes of: (a) obtaining or maintaining employment; or, (b) premarital, and pre- and post-adoptive purposes; or, (c) obtaining or maintaining insurance; or, (d) otherwise relating to employment or insurance; or, (e) obtaining or maintaining a license of any type; or, (f) relating to any judicial or administrative proceeding; or, (f) medical research.
28. Private duty nursing and private rooms except when approved by PacificSource Health Plans. Private duty nursing does not include nonskilled care or custodial care. Respite care is not covered.
29. Intentionally self-inflicted injuries are excluded.
30. Any services rendered prior to the Insured's Effective Date are not covered services under this Policy.
31. Allergy testing methods deemed unacceptable by the American Academy of Allergy, Asthma & Immunology, including applied kinesiology, cytotoxicity testing, urine autoinjection, skin titration (Rinkel Method), provocative and neutralization testing, or sublingual provocation.
32. Speech Therapy for a developmental and cognitive condition(s) is not a covered benefit.
33. Services required as a result of suicide or attempted suicide, whether intentional or unintentional.
34. No benefits are provided for "take home" drugs provided to a patient at the end of a hospital or facility stay.
35. Transportation of an Insured to or from any location for treatment or consultation.
36. Vision Care Services except initial testing in the PCP's office. Exclusions include eyeglasses, contact lenses (except following cataract surgery or congenital absence), eye exercise, radial keratotomy and other refractive eye surgery including, but not limited to myopic keratomileusis and other surgical procedures of the refractive-keratoplasty type, the purpose of which is to cure or reduce myopia or astigmatism.
37. Illness or Injury as a result of participation in war, insurrection, or riot.
38. Medical and Surgical procedures for the treatment of weight loss/control, that are intended to result in weight reduction, or for reversal, revision or complications of surgery for weight loss/control. This exclusion shall not apply to medical conditions caused by obesity.
39. No benefit is provided for treatment of any injury or illness that arises out of, or as the result of, any work for wage or profit, and subsequent Worker's Compensation claims.
40. Scheduled and/or nonemergent medical care outside the United States is not covered.

Smart**Health Plans**

Smart Healthcare Coverage for Individuals and Families

PacificSource HEALTH PLANS

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