BrightIdea

Well-Balanced Healthcare Coverage for Individuals and Families

BrightIdea and BrightPath: A Partnership that Works for You

PacificSource has partnered with BrightPath Health Network in Idaho. BrightPath shares our commitment to helping employers, providers, and patients reform healthcare at the community level. BrightPath brings healthcare providers to the table to help control costs, promote health initiatives, and reinvest in local communities.

You're free to use doctors or hospitals that aren't in the BrightPath network, but you will save money by using one of the more than 3,000 BrightPath providers throughout Idaho. Participating providers are reimbursed at a higher percentage than nonparticipating providers. Participating providers accept benefits paid under the policy as full payment, and will not bill you for the balance (other than for deductibles, coinsurance, or copayments).

For specific provider information, please refer to the BrightPath Participating Provider Directory at PacificSource.com.

PacificSource Extras Add 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 BrightPath 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 Web site, PacificSource.com, for more details.*

Commonly Asked Questions and Answers

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

   We know you value good health, so BrightIdea has preventive benefits built right in. You pay only a small copay for routine physicals and gynecological exams.

2. **What is an accident benefit?**

   BrightIdea's unique accident benefit will pay 100 percent of the first $500 (or $1,000, depending on the plan you choose) of your medical expenses if treatment occurs within 90 days of an accident. This coverage is not subject to your annual deductible.

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

   To get the most value out of your BrightIdea coverage, use providers who participate in the BrightPath network. You'll save on out-of-pocket expenses.

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

   You're covered! Benefits vary depending on the plan you choose. With our Preferred plan, you may visit the doctor as often as needed and pay only a $25 copay; your deductible won't apply. With our Value plan, you can visit the doctor up to four times annually for only a $25 copay plus 40 percent coinsurance; after your fourth visit, your deductible and coinsurance apply. Health Savings Account (HSA) plans are subject your deductible.

BrightIdea
Plan Options and Coverage Highlights

	BrightPath Preferred Provider Organization (PPO)		Health Savings Account (HSA)	
Your Costs (each calendar year)	**Preferred**	**Value**	**HSA $1,500 and $3,000**	**HSA $5,000**
Annual Deductible and Participating Provider Out-of-Pocket (individual/family) *Deductible applies to out-of-pocket limit.*	*Deductible* / *Out-of-Pocket Limit* $2,500/$5,000 / $8,000/$16,000 $5,000/$10,000 / $9,000/$18,000 $7,500/$15,000 / $10,000/$20,000	*Deductible* / *Out-of-Pocket Limit* $2,500/$5,000 / $10,000/$20,000 $5,000/$10,000 / $10,000/$20,000 $7,500/$15,000 / $10,000/$20,000 $10,000/$20,000 / $12,500/$25,000	*Deductible* / *Out-of-Pocket Limit* $1,500/$3,000 / $5,000/$10,000 $3,000/$6,000 / $5,800/$11,600	*Deductible* / *Out-of-Pocket Limit* $5,000/$10,000 / $5,000/$10,000
Coinsurance (percent of cost you're responsible for after the deductible is met)	Preferred[1] provider: 30% Nonpreferred provider: 50%	Preferred[1] provider: 40% Nonpreferred provider: 50%	Preferred[1] provider: 20% Nonpreferred provider: 50%	Preferred[1] provider: 100% covered Nonpreferred provider: 50%
Lifetime Maximum Benefit	$1,000,000		$1,000,000	
Accident Benefit	Pays 100% of first $1,000 if treatment occurs within 90 days of accident[2], then deductible and coinsurance apply	Pays 100% of first $500 if treatment occurs within 90 days of accident[2], then deductible and coinsurance apply	Pays 100% of first $500 if treatment occurs within 90 days of accident[2], then deductible and coinsurance apply	
	Preferred Provider[1] Plan Benefits (each calendar year)			
Preventive Care (routine physicals and gynecological exams)	$25 copay, then 100% covered up to a combined $500 maximum[2]	$25 copay, then 100% covered up to a combined $300 maximum[2]	$30 copay, then 100% covered up to a combined $500 maximum	100% covered up to a combined $500 maximum
Office Visits	$25 copay, then 100% covered[2]	First 4 visits: $25 copay, then 40% coinsurance[2] After 4th visit: deductible and coinsurance apply	Deductible then 20% coinsurance	Deductible then 100% covered
Immunizations	100% covered[2]		100% covered[2]	Deductible then 100% covered
Diagnostic Lab, X-ray	Deductible and coinsurance apply		Deductible and coinsurance apply	
Maternity[3]	Separate $5,000 deductible applies		Not covered	
Hospital & In Office Procedures	Deductible and coinsurance apply		Deductible and coinsurance apply	
Chiropractic Manipulation	$25 copay, then 100% covered[2]	Not covered	Deductible and coinsurance	Deductible then 100% covered
Vision	Eye exam: $25 copay, then 100% covered Hardware: $100 per calendar year[2]	Not covered	Not covered	Not covered
Prescription Drugs	Generic drugs: $10 copay Preferred brand name drugs: 50% coinsurance up to $2,500 max benefit[2]	Generic drugs: $15 copay Preferred brand name drugs: 50% coinsurance up to $1,500 max. benefit[2]	Deductible applies, then: Generic drugs: 50% coinsurance Preferred brand name drugs: 50% coinsurance up to $2,000 max. benefit	Deductible applies, then: Generic drugs: 100% covered Preferred brand name drugs: 100% covered up to $2,000 max. benefit

[1] A preferred provider is a provider who participates in our network. (Check our provider directory for a list of participating doctors and hospitals.)
[2] Not subject to the annual deductible.
[3] Involuntary complications of pregnancy will be covered under major medical benefits.

EXCLUDED SERVICES
This policy does not pay benefits for the following:

Admission prior to coverage.

Cardiac rehabilitation Phase III.

Charges over the allowable fee.

Chiropractic manipulations (BrightPath Value plan only).

Cosmetic/reconstructive services and supplies–except for congenital anomalies.

Criminal conduct–illness or injury in which a contributing cause was the member's commission of or attempt to commit a felony.

Custodial care.

Dental examinations and treatment.

Drugs and medications that are not administered while an inpatient in the hospital, or not ordered by a physician or other licensed provider prescribing within the scope of his or her license, or not dispensed by a licensed pharmacist, or is primarily used for the treatment of mental health, regardless of diagnosis.

Elective abortions, except to preserve the life of the member upon whom the abortion is performed.

Equipment commonly used for nonmedical purposes, marketed to the general public and available without a prescription, intended to alter the physical environment, or used primarily in athletic or recreational activities.

Experimental or Investigational Services.

Eye exam, glasses or refraction (BrightIdea Value and HSA plans only).

Family planning – except for the purpose for diagnosing possible infertility.

Foot care (routine).

Foot orthotics, including related charges for evaluation and casting.

Hearing aids and supplies.

Immunizations except those specified in the Covered Expenses Preventive Care section.

Infertility – except for the purpose for diagnosing possible infertility.

Maternity benefits are not provided for dependent children.

Mental health – except for the initial diagnostic exam by an eligible mental health provider, PacificSource will not pay benefits for services and supplies from a mental health or other healthcare provider for the following diagnoses and/or diagnostic categories as listed in the fourth edition of The Diagnostic and Statistical Manual of Mental Disorders (DSM-IV): mental retardation, learning disorders, motor skills disorders, communication disorders, pervasive developmental disorders, disruptive behavior disorders, factitious disorders, sexual and gender identity disorders, impulse control disorders, paraphilias except for pedophilia, relational problems, caffeine-related disorders, nicotine-related disorders, and the category of "additional conditions that may be a focus of clinical attention." This exclusion applies to developmental delays and disorders, learning disorders, sensory integration disorders, and conduct disorders whether or not associated with either attention deficit/hyperactivity disorder or adjustment reactions. **Drugs primarily used in the treatment of mental health are also excluded.**

Naturopathic/homeopathic/massage therapist – service provided by a naturopathic or homeopathic practitioner or massage therapist.

Obesity or weight control – surgery or other related services or supplies provided for weight control or obesity (including all categories of obesity). However, the direct medically necessary treatment of medical conditions that are caused or complicated by obesity are covered.

Preexisting conditions – except as provided specifically in this policy.

Private duty nursing.

Providers not specified as eligible for reimbursement according to the provisions of this policy.

Rehabilitation – functional capacity evaluations, work hardening programs, vocational rehabilitation, community reintegration services, and driving evaluations and training programs.

Routine services and supplies – services, supplies, and equipment not involved in diagnosis or treatment but provided primarily for the comfort, convenience, cosmetic purpose, environmental control, or education of a patient or for the processing of records or claims.

Screening examinations and 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, except as medically necessary in the treatment or diagnosis of a condition or to the extent covered under the policy's preventive care benefits.

Services or supplies for which no charge is made or which the member is not legally required to pay.

Sexual disorders.

Sex reassignment.

Third party liability, motor vehicle liability, motor vehicle insurance coverage, workers' compensation.

Training or self-help programs.

Treatment after insurance ends.

Treatment not medically necessary.

Treatment prior to enrollment.

Treatment while incarcerated.

Unwilling to release information – charges for services or supplies for which a member is unwilling to release medical information necessary to determine eligibility for payment.

War-related conditions – the treatment of any condition caused by war or act of war (whether declared or undeclared); participation in a riot or insurrection; or service in the armed forces or units auxiliary to it.

Workers' Compensation, Medicare, CHAMPUS – charges for which benefits are provided by Workers' Compensation, Medicare, or CHAMPUS.

Bright**Idea Plans**

Well-Balanced Healthcare for Individuals and Families

PacificSource HEALTH PLANS

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Questions?

Visit us online at PacificSource.com, call your insurance agent, or contact a PacificSource Individual Service Representative at 208.333.1559 or by e-mail at individual@pacificsource.com. We look forward to helping you.

PacificSource HEALTH PLANS

PacificSource.com

PacificSource is based in Eugene, Oregon, with regional offices in Portland, Bend, and Medford, Oregon, as well as Boise, Coeur d'Alene, and Idaho Falls, Idaho. Founded in 1933, we provide medical and dental benefits to more than 5,500 Northwest employers and cover more than 182,000 people with 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, do not receive health insurance subject to the regulation of the Small Employer Health Insurance Availability Act, 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. 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 purposes 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 a 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.