Health Insurance Plans

for Individuals from

Blue Cross of Idaho

Choose coverage that fits.

Blue Cross of Idaho

Form No. 3-1021 (03-14)

Policy Form Numbers:
18-061-01/14 18-066-01/14 18-072-01/14 18-075-01/14 3-420-05/11
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18-065-01/14 18-071-01/14 18-074-01/14 18-078-01/14

Blue Cross of Idaho

BLUE CROSS OF IDAHO HEALTH INSURANCE PLANS

We offer a variety of health insurance plans with the coverage you need at a price you can afford. Whether you buy directly from us, or through the Idaho Health Insurance Exchange, you will find affordable coverage for you and your family from Blue Cross of Idaho.

We offer four levels of plans based on the amount of coverage they provide. These levels, known as metal levels, are Bronze, Silver, Gold, and Platinum and vary by the monthly premium cost and the percent of expected costs covered.

The metal level ranking system makes it easy to compare plans in the same category or across categories. This allows you to make apples-to-apples comparisons among plans, see your expected costs more easily and get the coverage you need. It is important to know that all metal levels have the same essential health benefits, such as emergency room services, maternity and newborn care, annual doctor visits, and medical screenings.

As a general rule of thumb, you can choose to pay a higher monthly premium, so that when you need medical care, you pay less. Or you can choose a lower monthly premium so that when you need medical care, you pay more. You can choose the level of coverage that best meets your health needs and budget.

You can learn more about our products and the metal levels at ***bcidaho.com***.

Blue Cross of Idaho Metallic Plans

BRONZE	SILVER	GOLD	PLATINUM
Bronze Choice	Silver Choice	Gold Choice	Platinum Connect *Supported by the Saint Alphonsus Health Alliance Network in southwestern Idaho only.*
Bronze Connect	Silver Connect	Gold Connect	
Bronze HSA Saver	Silver Choice *no deductible*		
	Silver Connect *no deductible*		

Individual Medical Plans

Minimum benefit plans

We also offer a pair of high-deductible, low payment plans available to people under the age of 30, or to people who qualify through the Exchange on a hardship exemption. These "catastrophic" plans provide coverage for the essential health benefits but only after a member has met the deductible levels in out-of-pocket expenses. If you are under the age of 30, or if you meet certain criteria through the Exchange, these plans may be a good choice for you. Members on the catastrophic plans are not eligible for the monthly premium tax credit or cost sharing subsidy available through the Idaho Health Insurance Exchange at ***Yourhealthidaho.org***.

- ***Covered Choice:*** Combines our largest provider network with a high-deductible, lower-premium plan design.
- ***Covered Connect:*** The same benefit design as our ***Covered Choice*** plan at a slightly lowered price. Supported by ***ConnectedCare*** networks in southwestern and eastern Idaho only.

Short Term PPO plan

If you need coverage for a short time, our ***Short Term PPO*** offers a limited benefit plan for temporary coverage. Our short-term plans are only available directly from Blue Cross of Idaho and are not subject to the rules set forth by the ACA, including the pre-existing condition coverage requirement. For information about our Short Term PPO plan, please call your local Blue Cross of Idaho office or insurance agent.

Dental Insurance

Good oral health is an important part of your overall health. Our flexible and affordable dental plans include varying degrees of coverage so you can select a dental plan that best fits your health and financial needs. Whatever plan you're looking for, we've got you covered. You can choose a plan directly from Blue Cross of Idaho or through the Idaho Health Insurance Exchange at ***Yourhealthidaho.org***.

It's important to know that federal law requires dependents under age 19 to have dental insurance with their medical insurance. We offer dental products that provide the coverage you need and meet all ACA requirements. Dental insurance must be included in your coverage if you or a dependent are under the age of 19.

A note about provider networks

Blue Cross of Idaho offers the largest PPO network in the state, with every acute care hospital and 96 percent of all Idaho physicians in Idaho.

Our managed care products are supported by ***ConnectedCare*** networks in southwestern and eastern Idaho. You can identify these products by their ***Connect*** name.

ConnectedCare networks provide coordinated care through primary care and specialty physicians. This gives you the option to choose a plan that offers coordinated care with a lower monthly premium. ***ConnectedCare*** is supported by the Saint Alphonsus Health Alliance Network in southwestern Idaho and the Portneuf Quality Alliance in eastern Idaho. ***ConnectedCare*** is designed to improve the quality of care and control costs by coordinating services through a primary care physician. Members must select a PCP to serve as their care coordinator who acts as a central point for their care. Our Platinum Connect plan is only available through the Saint Alphonsus Health Alliance Network in southwestern Idaho. To see if your physician is in our networks, go to ***bcidaho.com/members*** and select ***Find a Provider***.

Blue Cross of Idaho

Benefit grid outlines coverage for in-network and out-of-network services. This is not a comprehensive list of benefits. You can find a comprehensive list of services in the member contract.

METAL LEVEL	BRONZE			
Plans	BRONZE HSA SAVER			
	In-Network *(Individual)*	**Out-of-Network** *(Individual)*	**In-Network** *(Family)*	**Out-of-Network** *(Family)*
Deductible	Individual – $5,000	Individual – $5,000	Family – $10,000	Family – $10,000
Annual Out-of-Pocket Maximum Costs *Includes deductible*	Individual – $6,350	Individual – $8,350	Family – $12,700	Family – $16,700
	The individual deductible applies ONLY to an individual plan with one insured member. If more than one member is insured on an individual HSA plan, the family deductible applies and each family member contributes towards the family deductible. Benefits for all family members begin after meeting the family deductible.		The claims of all family members accumulate toward the same family deductible and out-of-pocket maximum. Benefits for all family members begin after the family deductible is met.	
Coinsurance	**You pay nothing.** (Services may be subject to deductible.)	**You pay 30%** (Services may be subject to deductible.)	**You pay nothing.** (Services may be subject to deductible.)	**You pay 30%** (Services may be subject to deductible.)
	WHAT YOU'LL PAY UP TO YOUR ANNUAL OUT-OF-POCKET MAXIMUM			
Preventive Care Services	**You pay nothing** for covered preventive care services.	**You pay costs** up to your deductible and then 30%.	**You pay nothing** for covered preventive care services.	**You pay costs** up to your deductible and then 30%.
Doctor's Office Visit	**You pay costs** up to your deductible and then you pay nothing.	**You pay costs** up to your deductible and then 30%.	**You pay costs** up to your deductible and then you pay nothing.	**You pay costs** up to your deductible and then 30%.
Prescription Drugs *Costs for prescription drugs count toward the member's out-of-pocket maximum*	**You pay nothing** for covered generic and brand-name preventive drugs. **You pay costs** up to your deductible and then **$10 copayment** for non-preventive generic drugs, or **50%** for non-preventive brand-name drugs.			
Immunizations	**You pay nothing** for covered immunizations.	**You pay nothing** for covered immunizations.	**You pay nothing** for covered immunizations.	**You pay nothing** for covered immunizations.
Inpatient Hospital Services	**You pay costs** up to your deductible and then you pay nothing.	**You pay costs** up to your deductible and then 30%.	**You pay costs** up to your deductible and then you pay nothing.	**You pay costs** up to your deductible and then 30%.
Emergency Room Visit	**You pay costs** up to your deductible and $150 copayment.	**You pay costs** up to your deductible, 30% and $150 copayment.[1]	**You pay costs** up to your deductible and $150 copayment.	**You pay costs** up to your deductible, 30% and $150 copayment.[1]
Maternity	**You pay costs** up to your deductible and then you pay nothing.	**You pay costs** up to your deductible and then 30%.	**You pay costs** up to your deductible and then you pay nothing.	**You pay costs** up to your deductible and then 30%.
Outpatient Mental Health Services	**You pay costs** up to your deductible and then you pay nothing.	**You pay costs** up to your deductible and then 30%.	**You pay costs** up to your deductible and then you pay nothing.	**You pay costs** up to your deductible and then 30%.
Physician, Surgical & Medical Services	**You pay costs** up to your deductible and then you pay nothing.	**You pay costs** up to your deductible and then 30%.	**You pay costs** up to your deductible and then you pay nothing.	**You pay costs** up to your deductible and then 30%.
Diabetes Education Services	**You pay costs** up to your deductible and $30 copayment.	**You pay costs** up to your deductible and then 30%.	**You pay costs** up to your deductible and $30 copayment.	**You pay costs** up to your deductible and then 30%.
Chiropractic Care	**You pay costs** up to your deductible and then you pay nothing.	**You pay costs** up to your deductible and then 50%.	**You pay costs** up to your deductible and then you pay nothing.	**You pay costs** up to your deductible and then 50%.
	Up to a combined total of 18 visits per member, per benefit period.			
Outpatient Rehabilitation Services *Physical Therapy (PT) Occupational Therapy (OT) Speech Therapy (ST)*	**You pay costs** up to your deductible and then you pay nothing.	**You pay costs** up to your deductible and then 30%.	**You pay costs** up to your deductible and then you pay nothing.	**You pay costs** up to your deductible and then 30%.
	Limited to a combined total of 20 visits per member, per benefit period.			
Diagnostic X-Ray and Lab Services	**You pay costs** up to your deductible and then you pay nothing.	**You pay costs** up to your deductible and then 30%.	**You pay costs** up to your deductible and then you pay nothing.	**You pay costs** up to your deductible and then 30%.

[1]*For treatment of emergency medical conditions as defined in the policy, Blue Cross of Idaho will provide in-network benefits for covered services.*

Provider networks in southwest and southeast Idaho support the Bronze, Silver, Gold Connect plans and members must visit doctors or hospitals within a specific service area and receive referrals to see specialists from a Primary Care Provider (PCP). See Connect description on Page 3.

METAL LEVEL	BRONZE			
Plans	BRONZE CHOICE		BRONZE CONNECT* *Please note: at this time the ConnectedCare network is only available in southwestern and eastern Idaho.*	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Deductible	Individual – $6,350 Family – $12,700	Individual – $6,350 Family – $12,700	Individual – $6,350 Family – $12,700	Individual – $6,350 Family – $12,700
Annual Out-of-Pocket Maximum Costs *Includes deductible*	Individual – $6,350 Family – $12,700	Individual – $8,350 Family – $16,700	Individual – $6,350 Family – $12,700	Individual – $10,000 Family – $20,000
Coinsurance	**You pay nothing.** (Services may be subject to deductible.)	**You pay 30%** (Services may be subject to deductible.)	**You pay nothing.** (Services may be subject to deductible.)	**You pay 30%** (Services may be subject to deductible.)
	WHAT YOU'LL PAY UP TO YOUR ANNUAL OUT-OF-POCKET MAXIMUM			
Preventive Care Services	**You pay nothing** for covered preventive care services.	**You pay costs** up to your deductible and then 30%.	**You pay nothing** for covered preventive care services.	**You pay costs** up to your deductible and then 30%.
Doctor's Office Visit	**You pay $30 copayment** (up to 4 non-preventive office visits, then you pay costs up to your deductible.)	**You pay costs** up to your deductible and then 30%.	**You pay $30 copayment** (up to 5 PCP office visits, then you pay costs up to your deductible.) **You pay costs** up to your deductible for non-PCP visits with referral.	**You pay costs** up to your deductible and then 30%.
Prescription Drugs *Costs for prescription drugs count toward the member's out-of-pocket maximum*	**You pay costs** up to your deductible and then nothing.		**You pay costs** up to your deductible and then nothing.	
Immunizations	**You pay nothing** for covered immunizations.	**You pay nothing** for covered immunizations.	**You pay nothing** for covered immunizations.	**You pay nothing** for covered immunizations.
Inpatient Hospital Services	**You pay costs** up to your deductible and then nothing.	**You pay costs** up to your deductible and then 30%.	**You pay costs** up to your deductible and then nothing.	**You pay costs** up to your deductible and then 30%.
Emergency Room Visit	**You pay costs** up to your deductible and then nothing.	**You pay costs** up to your deductible and then 30%. [1]	**You pay costs** up to your deductible and then nothing.	**You pay costs** up to your deductible and then 30%.[1]
Maternity	**You pay costs** up to your deductible and then nothing.	**You pay costs** up to your deductible and then 30%.	**You pay costs** up to your deductible and then nothing.	**You pay costs** up to your deductible and then 30%.
Outpatient Mental Health Services	**You pay $30 copayment** for outpatient psychotherapy services. For facility and other professional services, you pay costs up to deductible.	**You pay costs** up to your deductible and then 30%.	**You pay $30 copayment** for outpatient psychotherapy services. For facility and other professional services, you pay costs up to deductible.	**You pay costs** up to your deductible and then 30%.
Physician, Surgical & Medical Services	**You pay costs** up to your deductible and then nothing.	**You pay costs** up to your deductible and then 30%.	**You pay costs** up to your deductible and then nothing.	**You pay costs** up to your deductible and then 30%.
Diabetes Education Services	**You pay $30 copayment.**	**You pay costs** up to your deductible and then 30%.	**You pay $30 copayment.**	**You pay costs** up to your deductible and then 30%.
Chiropractic Care	**You pay costs** up to your deductible and then nothing.	**You pay costs** up to your deductible and then 50%.	**You pay costs** up to your deductible and then nothing.	**You pay costs** up to your deductible and then 50%.
	Up to a combined total of 18 visits per member, per benefit period.		Up to a combined total of 18 visits per member, per benefit period.	
Outpatient Rehabilitation Services *Physical Therapy (PT) Occupational Therapy (OT) Speech Therapy (ST)*	**You pay costs** up to your deductible and then nothing.	**You pay costs** up to your deductible and then 30%.	**You pay costs** up to your deductible and then nothing.	**You pay costs** up to your deductible and then 30%.
	Limited to a combined total of 20 visits per member, per benefit period.		Limited to a combined total of 20 visits per member, per benefit period.	
Diagnostic X-Ray and Lab Services	**You pay costs** up to your deductible and then nothing.	**You pay costs** up to your deductible and then 30%.	**You pay costs** up to your deductible and then nothing.	**You pay costs** up to your deductible and then 30%.

**Our Connect plans are supported by the Saint Alphonsus Health Alliance Network in southwestern Idaho and the Portneuf Quality Alliance Network in eastern Idaho. When you choose managed care through ConnectedCare networks, you must choose a primary care physician from these networks to serve as your care coordinator. You must obtain a referral from your PCP to see a specialist.*

[1]For treatment of emergency medical conditions as defined in the policy, Blue Cross of Idaho will provide in-network benefits for covered services.

Blue Cross of Idaho

Provider networks in southwest and southeast Idaho support the Bronze, Silver, Gold Connect plans and members must visit doctors or hospitals within a specific service area and receive referrals to see specialists from a Primary Care Provider (PCP). See Connect description on Page 3.

METAL LEVEL	SILVER			
Plans	SILVER CHOICE		SILVER CONNECT* *Please note: at this time the ConnectedCare network is only available in southwestern and eastern Idaho.*	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Deductible	Individual – $4,000 Family – $8,000	Individual – $4,000 Family – $8,000	Individual – $4,000 Family – $8,000	Individual – $4,000 Family – $8,000
Annual Out-of-Pocket Maximum Costs *Includes deductible*	Individual – $6,350 Family – $12,700	Individual – $8,350 Family – $16,700	Individual – $6,350 Family – $12,700	Individual – $10,000 Family – $20,000
Coinsurance	**You pay 30%** of the cost of your care. (Services may be subject to your deductible.)	**You pay 50%** of the cost of your care. (Services may be subject to your deductible.)	**You pay 30%** of the cost of your care. (Services may be subject to your deductible.)	**You pay 50%** of the cost of your care. (Services may be subject to your deductible.)
	WHAT YOU'LL PAY UP TO YOUR ANNUAL OUT-OF-POCKET MAXIMUM			
Preventive Care Services	**You pay nothing** for covered preventive care services.	**You pay costs** up to your deductible and then 50%.	**You pay nothing** for covered preventive care services.	**You pay costs** up to your deductible and then 50%.
Doctor's Office Visit	**You pay $10 copayment** (up to 4 non-preventive office visits, then you pay costs up to your deductible and 30%.)	**You pay costs** up to your deductible and then 50%.	**You pay $10 copayment** (up to 5 PCP office visits, then you pay costs up to your deductible and 30%.) **You pay costs** up to your deductible and 30% for non-PCP visits with referral.	**You pay costs** up to your deductible and then 50%.
Prescription Drugs *Costs for prescription drugs count toward the member's out-of-pocket maximum*	**You pay $10 copayment** for generic drugs.		**You pay $10 copayment** for generic drugs.	
	You pay costs up to a separate $2,350 deductible per person for brand-name and specialty drugs per person and then: **$30** for preferred brand-name, **$50** for non-preferred brand-name, **$100** for specialty drugs.		**You pay costs** up to a separate $2,350 deductible per person for brand-name and specialty drugs per person and then: **$30** for preferred brand-name, **$50** for non-preferred brand-name, **$100** for specialty drugs.	
Immunizations	**You pay nothing** for covered immunizations.	**You pay nothing** for covered immunizations.	**You pay nothing** for covered immunizations.	**You pay nothing** for covered immunizations.
Inpatient Hospital Services	**You pay costs** up to your deductible and then 30%.	**You pay costs** up to your deductible and then 50%.	**You pay costs** up to your deductible and then 30%.	**You pay costs** up to your deductible and then 50%.
Emergency Room Visit	**You pay costs** up to your deductible, 30% and **$150 copayment**.	**You pay costs** up to your deductible, 50% and **$150 copayment**.[1]	**You pay costs** up to your deductible, 30% and **$150 copayment**.	**You pay costs** up to your deductible, 50% and **$150 copayment**.[1]
Maternity	**You pay costs** up to your deductible and then 30%.	**You pay costs** up to your deductible and then 50%.	**You pay costs** up to your deductible and then 30%.	**You pay costs** up to your deductible and then 50%.
Outpatient Mental Health Services	**You pay $10 copayment** for outpatient psychotherapy services. For facility and other professional services, you pay costs up to deductible and 30%.	**You pay costs** up to your deductible and then 50%.	**You pay $10 copayment** for outpatient psychotherapy services. For facility and other professional services, you pay costs up to deductible and 30%.	**You pay costs** up to your deductible and then 50%.
Physician, Surgical & Medical Services	**You pay costs** up to your deductible and then 30%.	**You pay costs** up to your deductible and then 50%.	**You pay costs** up to your deductible and then 30%.	**You pay costs** up to your deductible and then 50%.
Diabetes Education Services	**You pay $10 copayment** per visit.	**You pay costs** up to your deductible and then 50%.	**You pay $10 copayment** per visit.	**You pay costs** up to your deductible and then 50%.
Chiropractic Care	**You pay costs** up to your deductible and then 30%.	**You pay costs** up to your deductible and then 50%.	**You pay costs** up to your deductible and then 30%.	**You pay costs** up to your deductible and then 50%.
	Up to a combined total of 18 visits per member, per benefit period.		Up to a combined total of 18 visits per member, per benefit period.	
Outpatient Rehab Services *Physical Therapy (PT) Occupational Therapy (OT) Speech Therapy (ST)*	**You pay costs** up to your deductible and then 30%.	**You pay costs** up to your deductible and then 50%.	**You pay costs** up to your deductible and then 30%.	**You pay costs** up to your deductible and then 50%.
	Limited to a combined total of 20 visits per member, per benefit period.		Limited to a combined total of 20 visits per member, per benefit period.	
Diagnostic X-Ray and Lab Services	**You pay costs** up to your deductible and then 30%.	**You pay costs** up to your deductible and then 50%.	**You pay costs** up to your deductible and then 30%.	**You pay costs** up to your deductible and then 50%.

**Our Connect plans are supported by the Saint Alphonsus Health Alliance Network in southwestern Idaho and the Portneuf Quality Alliance Network in eastern Idaho. When you choose managed care through ConnectedCare networks, you must choose a primary care physician from these networks to serve as your care coordinator. You must obtain a referral from your PCP to see a specialist.*

[1]For treatment of emergency medical conditions as defined in the policy, Blue Cross of Idaho will provide in-network benefits for covered services.

Provider networks in southwest and southeast Idaho support the Bronze, Silver, Gold Connect plans and members must visit doctors or hospitals within a specific service area and receive referrals to see specialists from a Primary Care Provider (PCP). See Connect description on Page 3.

METAL LEVEL	SILVER			
Plans	SILVER CHOICE NO DEDUCTIBLE		SILVER CONNECT NO DEDUCTIBLE* *Please note: at this time the ConnectedCare network is only available in southwestern and eastern Idaho.*	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Deductible	Individual – $0 Family – $0	Individual – $1,000 Family – $2,000	Individual – $0 Family – $0	Individual – $1,000 Family – $2,000
Annual Out-of-Pocket Maximum Costs *Includes deductible*	Individual – $6,350 Family – $12,700	Individual – $8,350 Family – $16,700	Individual – $6,350 Family – $12,700	Individual – $10,000 Family – $20,000
Coinsurance	**You pay 50%** of the cost of your care.	**You pay 75%** of the cost of your care. (Services may be subject to your deductible.)	**You pay 50%** of the cost of your care.	**You pay 75%** of the cost of your care. (Services may be subject to your deductible.)
	WHAT YOU'LL PAY UP TO YOUR ANNUAL OUT-OF-POCKET MAXIMUM			
Preventive Care Services	**You pay nothing** for covered preventive care services.	**You pay costs** up to your deductible and then 75%.	**You pay nothing** for covered preventive care services.	**You pay costs** up to your deductible and then 75%.
Doctor's Office Visit	**You pay 50%**.	**You pay costs** up to your deductible and then 75%.	**You pay 50%** for PCP visits and non-PCP visits with a referral.	**You pay costs** up to your deductible and then 75%.
Prescription Drugs *Costs for prescription drugs count toward the member's out-of-pocket maximum*	**You pay 50%** of the cost of your prescription.		**You pay 50%** of the cost of your prescription.	
Immunizations	**You pay nothing** for covered immunizations.	**You pay nothing** for covered immunizations.	**You pay nothing** for covered immunizations.	**You pay nothing** for covered immunizations.
Inpatient Hospital Services	**You pay 50%**.	**You pay costs** up to your deductible and then 75%.	**You pay 50%.**	**You pay costs** up to your deductible and then 75%.
Emergency Room Visit	**You pay $150 copayment** and then 50%.	**You pay costs** up to your deductible, 75% and **$150 copayment**. [1]	**You pay $150 copayment** and then 50%.	**You pay costs** up to your deductible, 75% and **$150 copayment**. [1]
Maternity	**You pay 50%.**	**You pay costs** up to your deductible and then 75%.	**You pay 50%.**	**You pay costs** up to your deductible and then 75%.
Outpatient Mental Health Services	**You pay 50%.**	**You pay costs** up to your deductible and then 75%.	**You pay 50%.**	**You pay costs** up to your deductible and then 75%.
Physician, Surgical & Medical Services	**You pay 50%**.	**You pay costs** up to your deductible and then 75%.	**You pay 50%**.	**You pay costs** up to your deductible and then 75%.
Diabetes Education Services	**You pay 50%**.	**You pay costs** up to your deductible and then 75%.	**You pay 50%**.	**You pay costs** up to your deductible and then 75%.
Chiropractic Care	**You pay 50%**.	**You pay costs** up to your deductible and then 75%.	**You pay 50%**.	**You pay costs** up to your deductible and then 75%.
	Up to a combined total of 18 visits per member, per benefit period.		Up to a combined total of 18 visits per member, per benefit period.	
Outpatient Rehab Services *Physical Therapy (PT) Occupational Therapy (OT) Speech Therapy (ST)*	**You pay 50%**.	**You pay costs** up to your deductible and then 75%.	**You pay 50%**.	**You pay costs** up to your deductible and then 75%.
	Limited to a combined total of 20 visits per member, per benefit period.		Limited to a combined total of 20 visits per member, per benefit period.	
Diagnostic X-Ray and Lab Services	**You pay 50%.**	**You pay costs** up to your deductible and then 75%.	**You pay 50%.**	**You pay costs** up to your deductible and then 75%.

**Our Connect plans are supported by the Saint Alphonsus Health Alliance Network in southwestern Idaho and the Portneuf Quality Alliance Network in eastern Idaho. When you choose managed care through ConnectedCare networks, you must choose a primary care physician from these networks to serve as your care coordinator. You must obtain a referral from your PCP to see a specialist.*

[1] *For treatment of emergency medical conditions as defined in the policy, Blue Cross of Idaho will provide in-network benefits for covered services.*

Blue Cross of Idaho

Provider networks in southwest and southeast Idaho support the Bronze, Silver, Gold Connect plans and members must visit doctors or hospitals within a specific service area and receive referrals to see specialists from a Primary Care Provider (PCP). See Connect description on Page 3.

METAL LEVEL	GOLD			
Plans	GOLD CHOICE		GOLD CONNECT* *Please note: at this time the ConnectedCare network is only available in southwestern and eastern Idaho.*	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Deductible	Individual – $1,000 Family – $2,000	Individual – $1,000 Family – $2,000	Individual – $1,000 Family – $2,000	Individual – $1,000 Family – $2,000
Annual Out-of-Pocket Maximum Costs *Includes deductible*	Individual – $6,350 Family – $12,700	Individual – $8,350 Family – $16,700	Individual – $6,350 Family – $12,700	Individual – $10,000 Family – $20,000
Coinsurance	**You pay 15%** of the cost of your care. (Services may be subject to deductible.)	**You pay 50%** of the cost of your care. (Services may be subject to deductible.)	**You pay 15%** of the cost of your care. (Services may be subject to deductible.)	**You pay 50%** of the cost of your care. (Services may be subject to deductible.)
	WHAT YOU'LL PAY UP TO YOUR ANNUAL OUT-OF-POCKET MAXIMUM			
Preventive Care Services	**You pay nothing** for covered preventive care visits.	**You pay costs** up to your deductible and then 50%.	**You pay nothing** for covered preventive care visits.	**You pay costs** up to your deductible and then 50%.
Doctor's Office Visit	**You pay $10 copayment** (up to 4 office visits, then you pay costs up to your deductible and coinsurance.)	**You pay costs** up to your deductible and then 50%.	**You pay $10 PCP copayment** and **$40 non-PCP** copayment with a referral (up to 5 office visits, then you pay costs up to your deductible and coinsurance.)	**You pay costs** up to your deductible and then 50%.
Prescription Drugs *Costs for prescription drugs count toward the member's out-of-pocket maximum*	**You pay $10 copayment** for generic prescription drugs.		**You pay $10 copayment** for generic prescription drugs.	
	You pay costs up to your deductible for brand-name and specialty drugs and then: **$30** for preferred brand-name, **$50** for non-preferred brand-name, **$100** for specialty drugs.		**You pay costs** up to your deductible for brand-name and specialty drugs and then: **$30** for preferred brand-name, **$50** for non-preferred brand-name, **$100** for specialty drugs.	
Immunizations	**You pay nothing** for covered immunizations.	**You pay nothing** for covered immunizations.	**You pay nothing** for covered immunizations.	**You pay nothing** for covered immunizations.
Inpatient Hospital Services	**You pay costs** up to your deductible and then 15%.	**You pay costs** up to your deductible and then 50%.	**You pay costs** up to your deductible and then 15%.	**You pay costs** up to your deductible and then 50%.
Emergency Room Visit	**You pay costs** up to your deductible, 15% and **$150 copayment**.	**You pay costs** up to your deductible, 50% and **$150 copayment**.[1]	**You pay costs** up to your deductible, 15% and **$150 copayment**.	**You pay costs** up to your deductible, 50% and **$150 copayment**.[1]
Maternity	**You pay costs** up to your deductible and then 15%.	**You pay costs** up to your deductible and then 50%.	**You pay costs** up to your deductible and then 15%.	**You pay costs** up to your deductible and then 50%.
Outpatient Mental Health Services	**You pay $10 copayment** for outpatient psychotherapy services. For facility and other professional services, you pay costs up to deductible and then 15%.	**You pay costs** up to your deductible and then 50%.	**You pay $10 copayment** for outpatient psychotherapy services. For facility and other professional services, you pay costs up to deductible and then 15%.	**You pay costs** up to your deductible and then 50%.
Physician, Surgical & Medical Services	**You pay costs** up to your deductible and then 15%.	**You pay costs** up to your deductible and then 50%.	**You pay costs** up to your deductible and then 15%.	**You pay costs** up to your deductible and then 50%.
Diabetes Education Services	**You pay $10 copayment** per visit.	**You pay costs** up to your deductible and then 50%.	**You pay $10 copayment** per visit.	**You pay costs** up to your deductible and then 50%.
Chiropractic Care	**You pay costs** up to your deductible and then 15%.	**You pay costs** up to your deductible and then 50%.	**You pay costs** up to your deductible and then 15%.	**You pay costs** up to your deductible and then 50%.
	Up to a combined total of 18 visits per member, per benefit period.		Up to a combined total of 18 visits per member, per benefit period.	
Outpatient Rehab Services *Physical Therapy (PT) Occupational Therapy (OT) Speech Therapy (ST)*	**You pay costs** up to your deductible and then 15%.	**You pay costs** up to your deductible and then 50%.	**You pay costs** up to your deductible and then 15%.	**You pay costs** up to your deductible and then 50%.
	Limited to a combined total of 20 visits per member, per benefit period		Limited to a combined total of 20 visits per member, per benefit period	
Diagnostic X-Ray and Lab Services	**You pay costs** up to your deductible and then 15%.	**You pay costs** up to your deductible and then 50%.	**You pay costs** up to your deductible and then 15%.	**You pay costs** up to your deductible and then 50%.

**Our Connect plans are supported by the Saint Alphonsus Health Alliance Network in southwestern Idaho and the Portneuf Quality Alliance Network in eastern Idaho. When you choose managed care through ConnectedCare networks, you must choose a primary care physician from these networks to serve as your care coordinator. You must obtain a referral from your PCP to see a specialist.*

[1]For treatment of emergency medical conditions as defined in the policy, Blue Cross of Idaho will provide in-network benefits for covered services.

Visit ***bcidaho.com/SBC*** for a Summary of Benefits and Coverage.

METAL LEVEL	PLATINUM	
Plans	**PLATINUM CONNECT*** *Please note: at this time the ConnectedCare network is only available in southwestern and eastern Idaho.*	
	In-Network	**Out-of-Network**
Deductible	Individual – $550 Family – $1,100	Individual – $550 Family – $1,100
Annual Out-of-Pocket Maximum Costs *Includes deductible*	Individual – $6,350 Family – $12,700	Individual – $10,000 Family – $20,000
Coinsurance	**You pay nothing.** (Services may be subject to deductible.)	**You pay 50%** of the cost of your care. (Services may be subject to deductible.)
	WHAT YOU'LL PAY UP TO YOUR ANNUAL OUT-OF-POCKET MAXIMUM	
Preventive Care Services	**You pay nothing** for covered preventive care visits.	**You pay costs** up to your deductible and then 50%.
Doctor's Office Visit	**You pay $10 PCP copayment** and **$40 non-PCP** copayment with a referral (up to 5 office visits, then costs up to your deductible.)	**You pay costs** up to your deductible and then 50%.
Prescription Drugs *Costs for prescription drugs count toward the member's out-of-pocket maximum*	**You pay $10 copayment** for generic prescription drugs.	
	You pay $30 copayment for preferred brand-name, **$50 copayment** for non-preferred brand-name, **$100 copayment** for specialty drugs.	
Immunizations	**You pay nothing** for covered immunizations.	**You pay nothing** for covered immunizations.
Inpatient Hospital Services	**You pay costs** up to your deductible and then nothing.	**You pay costs** up to your deductible and then 50%.
Emergency Room Visit	**You pay $150 copayment** (Not subject to deductible.)	**You pay $150 copayment** and then 50% (Not subject to deductible.)[1]
Maternity	**You pay $200 copayment** for facility services and costs up to your deductible for physician's care.	**You pay costs** up to your deductible and then 50%.
Outpatient Mental Health Services	**You pay $10 copayment** for outpatient psychotherapy services. For facility and other professional services, you pay costs up to deductible.	**You pay costs** up to your deductible and then 50%.
Physician, Surgical & Medical Services	**You pay costs** up to your deductible.	**You pay costs** up to your deductible and then 50%.
Diabetes Education Services	**You pay $10 copayment** per visit.	**You pay costs** up to your deductible and then 50%.
Chiropractic Care	**You pay costs** up to your deductible.	**You pay costs** up to your deductible and then 50%.
	Up to a combined total of 18 visits per member, per benefit period.	
Outpatient Rehab Services *Physical Therapy (PT) Occupational Therapy (OT) Speech Therapy (ST)*	**You pay costs** up to your deductible.	**You pay costs** up to your deductible and then 50%.
	Limited to a combined total of 20 visits per member, per benefit period.	
Diagnostic X-Ray and Lab Services	**You pay costs** up to your deductible.	**You pay costs** up to your deductible and then 50%.

Provider networks in southwest and southeast Idaho support the Bronze, Silver, Gold Connect plans and members must visit doctors or hospitals within a specific service area and receive referrals to see specialists from a Primary Care Provider (PCP). See Connect description on Page 3.

Key terms

PREMIUM
The amount you pay each month for your health insurance plan.

DEDUCTIBLE
The amount you pay each year for out-of-pocket expenses before the health insurer picks up expenses. You won't have to pay any deductible for some services.

COINSURANCE
Your share of the costs you pay, calculated as a percentage. (For example, you pay 20 percent, insurance pays 80 percent).

COPAYMENT
A flat fee you pay for services such as a doctor visit, emergency room visit, or prescription medication.

NETWORK
The group of physicians, hospitals and other providers that an insurer has contracted with to deliver medical services to its members.

OUT-OF-POCKET EXPENSES
Money you pay for health-related services in addition to your monthly premium. Depending on your health insurance plan, these may include an annual deductible, coinsurance, and copayments for doctor visits and prescriptions.

OUT-OF-POCKET MAXIMUM
After your premium payments, the most in a year you will pay for covered healthcare services from in-network providers is $6,350 for individuals and $12,700 for families.

THE COST OF YOUR CARE
When you use in-network providers, your cost of care is lower because even when you are paying your deductible, you only pay Blue Cross of Idaho's discounted fee.

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[1]For treatment of emergency medical conditions as defined in the policy, Blue Cross of Idaho will provide in-network benefits for covered services.

Blue Cross of Idaho

Benefit grid outlines coverage for in-network and out-of-network services. This is not a comprehensive list of benefits. You can find a comprehensive list of services in the member contract.

METAL LEVEL	CATASTROPHIC PLANS *(Minimum Benefit)*	
Plans	COVERED CHOICE AND COVERED CONNECT*	
	In-Network	Out-of-Network
Deductible	Individual – $6,350 Family – $12,700	Individual – $6,350 Family – $12,700
Annual Out-of-Pocket Maximum Costs *Includes deductible*	Individual – $6,350 Family – $12,700	**Covered Choice** $8,350 / $16,700 **Covered Connect** $10,000 / $20,000
Coinsurance	**You pay nothing.** (Services may be subject to deductible.)	**You pay 30%.** (Services may be subject to deductible.)
	WHAT YOU'LL PAY UP TO YOUR ANNUAL OUT-OF-POCKET MAXIMUM	
Preventive Care Services	**You pay nothing** for covered preventive care services.	**You pay costs** up to your deductible and then 30%.
Doctor's Office Visit	**Covered Choice : You pay $30** each for first 3 office visits, then costs up to your deductible.	**You pay costs** up to your deductible and then 30%.
	Covered Connect : You pay $30 copayment (each for first 3 PCP office visits, then costs up to your deductible.) **You pay costs** up to your deductible for non-PCP visits with referral.	
Prescription Drugs *Costs for prescription drugs count toward the member's out-of-pocket maximum*	**You pay costs** up to your deductible and then nothing.	
Immunizations	**You pay nothing** for covered immunizations.	**You pay nothing** for covered immunizations.
Inpatient Hospital Services	**You pay costs** up to your deductible.	**You pay costs** up to your deductible and then 30%.
Emergency Room Visit	**You pay costs** up to your deductible.	**You pay costs** up to your deductible and then 30%.[1]
Maternity	**You pay costs** up to your deductible.	**You pay costs** up to your deductible and then 30%.
Outpatient Mental Health Services	**You pay costs** up to your deductible.	**You pay costs** up to your deductible and then 30%.
Physician, Surgical & Medical Services	**You pay costs** up to your deductible.	**You pay costs** up to your deductible and then 30%.
Diabetes Education Services	**You pay costs** up to your deductible.	**You pay costs** up to your deductible and then 30%.
Chiropractic Care	**You pay costs** up to your deductible.	**You pay costs** up to your deductible and then 50%.
	Up to a combined in and out-of-network total of 18 visits per member, per benefit period.	
Outpatient Rehab Services *Physical Therapy (PT) Occupational Therapy (OT) Speech Therapy (ST)*	**You pay costs** up to your deductible.	**You pay costs** up to your deductible and then 30%.
	Limited to a combined total of 20 visits per member, per benefit period	
Diagnostic X-Ray and Lab Services	**You pay costs** up to your deductible.	**You pay costs** up to your deductible and then 30%.

**Our Connect plans are supported by the Saint Alphonsus Health Alliance Network in southwestern Idaho and the Portneuf Quality Alliance Network in eastern Idaho. When you choose managed care through ConnectedCare networks, you must choose a primary care physician from these networks to serve as your care coordinator. You must obtain a referral from your PCP to see a specialist.*

[1]For treatment of emergency medical conditions as defined in the policy, Blue Cross of Idaho will provide in-network benefits for covered services.

GET A BREAK ON COSTS

Depending on your income and family size, you may be eligible for financial assistance with your monthly health insurance costs or out-of-pocket expenses.

Cost Sharing Reduction

This can lower your out-of-pocket expenses (your deductible and coinsurance payments) when you buy through the Exchange. If your household income is less than 250 percent of the federal poverty level you may qualify for the cost sharing reduction if you don't have access to insurance through your employer.

Monthly Premium Tax Credit

This new kind of tax credit can save you money by lowering your monthly premium payments when you buy through the Idaho Health Insurance Exchange. If your household income is less than 400 percent of the federal poverty level and you don't have access to insurance through your employer you can qualify.

THE FEDERAL POVERTY LEVEL (2013)

Family Size and Federal Poverty Level		Cost Sharing Reduction 250% of FPL If you make less than this, you may qualify for help paying expenses such as deductible and coinsurance payments	Monthly Premium Tax Credit 400% of FPL If you make less than this, you may qualify for help paying your monthly premiums
1	$11,490	$28,725	$45,960
2	$15,510	$38,775	$62,040
3	$19,530	$48,825	$78,120
4	$23,550	$58,875	$94,200
5	$27,570	$68,925	$110,280
6	$31,590	$78,975	$126,360
7	$35,610	$89,025	$142,440
8	$39,630	$99,075	$158,520

** For families with more than 8 persons, add $4,020 for each additional person.*

Free Subsidy Calculator

Visit our subsidy calculator at bcidaho.com to get an estimate on how much money you might be able to save. If you don't qualify for a tax credit or cost-sharing reduction, then there's no need to use the Idaho exchange. You can quickly and easily apply for insurance coverage directly from us at ***shoppers.bcidaho.com***.

IDAHO HEALTH INSURANCE EXCHANGE

To get this financial help, you'll need to enroll in health coverage through Idaho's Health Insurance Exchange, ***Yourhealthidaho.org***. The exchange is a website where you can compare insurance plans, apply for financial assistance, and buy a plan that best fits the needs of you and your family.

OPEN ENROLLMENT

Open Enrollment is from November 15, 2014 through February 15, 2015. Depending upon the type of plan you currently have, you may only be allowed to make changes during the annual open enrollment period or during your normal plan renewal period.

DENTAL PLANS

We know oral health is important to you. That's why we offer flexible and affordable individual and family dental plans. We offer dental insurance direct to you, or through the Idaho Health Insurance Exchange at ***Yourhealthidaho.org***. Our plans ensure you have the dental coverage you and your family need.

Dental Choice Plans

Federal law requires everyone under age 19 to have dental insurance that meets certain coverage requirements of the Affordable Care Act (ACA). Blue Cross of Idaho's ***Dental Choice*** and ***Dental Choice Plus*** plans have you covered with the benefit designs that protect your oral health and meet all requirements of the ACA. ***Dental Choice*** and ***Dental Choice Plus*** plans are available directly from Blue Cross of Idaho or through the Idaho Health Insurance Exchange.

DENTAL PLANS	DENTAL CHOICE		DENTAL CHOICE PLUS	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Individual Deductible	**$50** per member, per benefit period	**$100** per member, per benefit period	**$50** per member, per benefit period	**$100** per member, per benefit period
Annual Out-of-Pocket Maximum *(For members under age 19)*	**$1,000**	**$10,000**	**$1,000**	**$10,000**
Benefit Period Maximum *(For members age 19 and over)*	**$1,000**	**$1,000**	**$1,000**	**$1,000**
Preventive Dental Services	**You pay $25** copayment, not subject to deductible	**You pay costs** up to deductible and then 50%	**You pay $10** copayment, not subject to deductible	**You pay costs** up to deductible and then 50%
Basic Dental Services *(Six-month waiting period for members age 19 and over)*	**You pay costs** up to deductible and then 50%	**You pay costs** up to deductible and then 50%	**You pay costs** up to deductible and then 20%	**You pay costs** up to deductible and then 50%
Major Dental Services *(Members age 19 and over, subject to a 12-month waiting period)*	**You pay costs** up to deductible and then 50%	**You pay costs** up to deductible and then 50%	**You pay costs** up to deductible and then 50%	**You pay costs** up to deductible and then 50%
Orthodontia *(Only available to members under age 19, must be medically necessary)*	**You pay costs** up to deductible and then 50%	**You pay costs** up to deductible and then 80%	**You pay costs** up to deductible and then 50%	**You pay costs** up to deductible and then 80%

HealthySmiles℠

Healthy Smiles Plans

Healthy Smiles is a family of individual dental plans that are flexible and affordable. Each Healthy Smiles plan (Preventive, Plus and Preferred) has something unique to offer and provides the coverage you need to maintain or improve your oral health. Healthy Smiles plans are only available directly from Blue Cross of Idaho. ***These plans do not meet the ACA coverage requirements for people under age 19.***

DENTAL PLANS	HEALTHY SMILES PREVENTIVE		HEALTHY SMILES PLUS		HEALTHY SMILES PREFERRED	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Individual Deductible	**$0**	**$50** per member, per benefit period	**$50** per member, per benefit period		**$50** per member, per benefit period	
Benefit Maximum Period	**None**		**$1,000** per member, per benefit period		**$1,000** per member, per benefit period	
Preventive Services	**You pay $20** copayment per visit.	**You pay costs** up to your deductible and then 50%	**You pay $20** copayment per visit.	**You pay costs** up to your deductible and then 50%	**You pay $20** copayment per visit.	**You pay costs** up to your deductible and then 50%
Basic Dental Services	**Not Covered**		**You pay costs** up to your deductible and then 20%	**You pay costs** up to your deductible and then 50%	**You pay costs** up to your deductible and then 20%	**You pay costs** up to your deductible and then 50%
Major Dental Services	**Not Covered**				**You pay costs** up to your deductible and then 50%	**You pay costs** up to your deductible and then 50%
Dental Maximum Carryover	**Not Covered**				**$250** per member, per benefit period (up to a maximum of $1,000, per insured)	

EXCLUSIONS & LIMITATIONS

In addition to the exclusions and limitations listed elsewhere in this booklet, the following exclusions and limitations apply to the entire Policy, unless otherwise specified:

THERE ARE NO BENEFITS FOR SERVICES, SUPPLIES, DRUGS, OR OTHER CHARGES THAT ARE:

- Not Medically Necessary. If services requiring Prior Authorization by Blue Cross of Idaho are performed by a Contracting Provider and benefits are denied as not Medically Necessary, the cost of said services are not the financial responsibility of the Insured. However, the Insured could be financially responsible for services found to be not Medically Necessary when provided by a Noncontracting Provider.
- In excess of the Maximum Allowance.
- For Hospital Inpatient or Outpatient care for extraction of teeth or other dental procedures, unless necessary to treat an Accidental Injury or unless an attending Physician certifies in writing that the Insured has a non-dental, life-endangering condition that makes hospitalization necessary to safeguard the Insured's health and life.
- Not prescribed by or upon the direction of a Physician or other Professional Provider; or which are furnished by any individuals or facilities other than Licensed General Hospitals, Physicians, and other Providers.
- Investigational in nature.
- Provided for any condition, Disease, Illness, or Accidental Injury to the extent that the Insured is entitled to benefits under occupational coverage, obtained or provided by or through the employer under state or federal Workers' Compensation Acts or under Employer Liability Acts or other laws providing compensation for work-related Injuries or conditions. This exclusion applies whether or not the Insured claims such benefits or compensation or recovers losses from a third party.
- Provided or paid for by any federal governmental entity or unit except when payment under this Policy is expressly required by federal law, or provided or paid for by any state or local governmental entity or unit where its charges therefore would vary, or are or would be affected by the existence of coverage under this Policy; or for which payment has been made under Medicare Part A and/or Medicare Part B or would have been made if an Insured had applied for such payment except when payment under this Policy is expressly required by federal law.
- Provided for any condition, Accidental Injury, Disease or Illness suffered as a result of any act of war or any war, declared or undeclared.
- Furnished by a Provider who is related to the Insured by blood or marriage and who ordinarily dwells in the Insured's household.
- Received from a dental, vision, or medical department maintained by or on behalf of an employer, a mutual benefit association, labor union, trust, or similar person or group.
- For Surgery intended mainly to improve appearance or for complications arising from Surgery intended mainly to improve appearance, except for:
  - Reconstructive Surgery necessary to treat an Accidental Injury, infection, or other Disease of the involved part; or
  - Reconstructive Surgery to correct Congenital Anomalies in an Insured who is a dependent child.
- Rendered prior to the Insured's Effective Date.
- For personal hygiene, comfort, beautification (including non-surgical services, drugs, and supplies intended to enhance the appearance), or convenience items, even if prescribed by a Physician, including, but not limited to, air conditioners, air purifiers, humidifiers, physical fitness equipment or programs, spas, massage therapy, hot tubs, whirlpool baths, waterbeds or swimming pools and therapies, including but not limited to, educational, recreational, art, aroma, dance, sex, sleep, electro sleep, vitamin, chelation, homeopathic or naturopathic, massage, or music.
- For telephone consultations, and all computer or Internet communications; for failure to keep a scheduled visit or appointment; for completion of a claim form; or for personal mileage, transportation, food or lodging expenses or for mileage, transportation, food or lodging expenses billed by a Physician or other Professional Provider.
- For Inpatient admissions that are primarily for Diagnostic Services, Therapy Services, or Physical Rehabilitation, except as specifically provided in this Policy; or for Inpatient admissions when the Insured is ambulatory and/or confined primarily for bed rest, special diet, behavioral problems, environmental change or for treatment not requiring continuous bed care.
- For Inpatient or Outpatient Custodial Care; or for Inpatient or Outpatient services consisting mainly of educational therapy, behavioral modification, self care or self help training, except as specified as a Covered Service in this Policy.
- For any cosmetic foot care, including but not limited to, treatment of corns, calluses and toenails (except for surgical care of ingrown or Diseased toenails).

- For any of the following:
  - For appliances, splints or restorations necessary to increase vertical tooth dimensions or restore the occlusion, except as specified as a Covered Service in this Policy;
  - For orthognathic Surgery, including services and supplies to augment or reduce the upper or lower jaw;
  - For implants in the jaw; for pain, treatment, or diagnostic testing or evaluation related to the misalignment or discomfort of the temporomandibular joint (jaw hinge), including splinting services and supplies;
  - For alveolectomy or alveoloplasty when related to tooth extraction.
- For hearing aids or examinations for the prescription or fitting of hearing aids.
- For orthoptics, eyeglasses or contact lenses or the vision examination for prescribing or fitting eyeglasses or contact lenses, unless specifically provided as a Covered Service in this Policy.
- For any treatment of either gender leading to or in connection with transsexual Surgery, gender transformation, sexual dysfunction, or sexual inadequacy, including erectile dysfunction and/or impotence, even if related to a medical condition.
- Made by a Licensed General Hospital for the Insured's failure to vacate a room on or before the Licensed General Hospital's established discharge hour.
- Not related directly to the care and treatment of an actual condition, Illness, Disease, or Accidental Injury.
- Furnished by a facility which is primarily a place for treatment of the aged or that is primarily a nursing home, a convalescent home, or a rest home.
- For Acute Care, rehabilitative care, diagnostic testing, except as specified as a Covered Service in this Policy; for Mental or Nervous Conditions and Substance Abuse or Addiction services not recognized by the American Psychiatric and American Psychological Association.
- For weight control or treatment of obesity or morbid obesity, including but not limited to Surgery for obesity, except when Surgery for obesity is Medically Necessary to control other medical conditions that are eligible for Covered Services under the Policy, and nonsurgical methods have been unsuccessful in treating the obesity. For reversals or revisions of Surgery for obesity, except when required to correct an immediately life-endangering condition.
- For an elective abortion, unless it is the recommendation of one consulting Physician that an abortion is necessary to save the life of the mother, or if the pregnancy is a result of rape as defined by Idaho law, or incest as determined by the court.
- For use of operating, cast, examination, or treatment rooms, or for equipment located in a Contracting or Noncontracting Provider's office or facility, except for emergency room facility charges in a Licensed General Hospital, unless specified as a Covered Service in this Policy.
- For the reversal of sterilization procedures, including, but not limited to, vasovasostomies or salpingoplasties.
- Treatment for infertility and fertilization procedures, including, but not limited to, ovulation induction procedures and pharmaceuticals, artificial insemination, in vitro fertilization, embryo transfer or similar procedures, or procedures that in any way augment or enhance an Insured's reproductive ability, including but not limited to laboratory services, radiology services or similar services related to treatment for fertility or fertilization procedures.
- For Transplant services and Artificial Organs, except as specified as a Covered Service under this Policy.
- For acupuncture.
- For surgical procedures that alter the refractive character of the eye, including, but not limited to, radial keratotomy, myopic keratomileusis, Laser-in-Situ Keratomileusis (LASIK), and other surgical procedures of the refractive-keratoplasty type, to cure or reduce myopia or astigmatism, even if Medically Necessary. Additionally, reversals, revisions and/or complications of such surgical procedures are excluded, except when required to correct an immediately life-endangering condition.
- For Hospice, except as specified as a Covered Service in this Policy.
- For pastoral, spiritual, bereavement or marriage counseling.
- For homemaker and housekeeping services or home-delivered meals.
- 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, unless such injuries are a result of a medical condition or domestic violence.
- Any services or supplies for which an Insured would have no legal obligation to pay in the absence of coverage under this Policy or any similar coverage; or for which no charge or a different charge is usually made in the absence of insurance coverage or for which reimbursement or payment is contemplated under an agreement entered into with a third party.
- For a routine or periodic physical examination that is not connected with the care and treatment of an actual Illness, Disease or Accidental Injury, or for an examination required on account of employment; or related to an occupational injury; for a marriage license; or for insurance, school or camp application; or for sports participation physical; or a screening examination including routine hearing examinations, except as specified as a Covered Service under this Policy.
- For immunizations, except as specified as a Covered Service in this Policy.
- For breast reduction Surgery or Surgery for gynecomastia.
- For nutritional supplements.
- For replacements or nutritional formulas, except when administered enterally due to impairment in digestion and absorption of an oral diet and is the sole source of caloric need or nutrition in an Insured.
- For vitamins and minerals, unless required through a written prescription and cannot be purchased over the counter.
- For alterations or modifications to the home or vehicle.
- For special clothing, including shoes (unless permanently attached to a brace).
- Provided to a person enrolled as an Eligible Dependent, but who no longer qualifies as an Eligible Dependent due to a change in eligibility status which occurred after enrollment.
- Provided outside the United States, which if had been provided in the United States would not be Covered Services under this Policy.
- Furnished by a Provider or caregiver that is not listed as a Covered Provider, including but not limited to, naturopaths and homeopaths.
- For Outpatient pulmonary and/or cardiac Rehabilitation.
- For complications arising from the acceptance or utilization of noncovered services.
- For the use of Hypnosis, as anesthesia or other treatment, except as specified as a Covered Service.
- For arch supports, orthopedic shoes, and other foot devices.
- Any services or supplies furnished by a facility that is primarily a health resort, sanatorium, residential treatment facility, transitional living center, or primarily a place for Outpatient treatment or residential facility care of Mental or Nervous Conditions.
- For wigs.
- For cranial molding helmets, unless used to protect post cranial vault surgery.
- For surgical removal of excess skin that is the result of weight loss or gain, including but not limited to association with prior weight reduction (obesity) surgery.
- For the purchase of Therapy or Service Dogs/Animals and the cost of training/maintaining said animals.
- For dental implants, appliances (with the exception of sleep apnea devices), and/or prosthetics, and/or treatment related to Orthodontia, even when Medically Necessary, unless specified as a Covered Service in this Policy.

Meridian

STREET ADDRESS
3000 East Pine Avenue
Meridian, ID 83642-5995

MAILING ADDRESS
P.O. Box 7408
Boise, ID 83707
208-387-6683
800-365-2345

CLAIMS INQUIRIES
(208) 331-7347 | (800) 627-1188

Coeur d'Alene

1450 Northwest Boulevard, Suite 106
Coeur d'Alene, ID 83814
208-666-1495

Idaho Falls

STREET ADDRESS
1910 Channing Way
Idaho Falls, ID 83404

MAILING ADDRESS
P.O. Box 2287
Idaho Falls, ID 83403
208-522-8813

Lewiston

STREET ADDRESS
1010 17th Street
Lewiston, ID 83501

MAILING ADDRESS
P.O. Box 1468
Lewiston, ID 83501
208-746-0531

Pocatello

STREET ADDRESS
275 South 5th Avenue
Suite 150
Pocatello, ID 83201

MAILING ADDRESS
P.O. Box 2578
Pocatello, ID 83206
208-232-6206

Twin Falls

STREET ADDRESS
1431 North Fillmore Street
Suite 200
Twin Falls, ID 83301

MAILING ADDRESS
P.O. Box 5025
Twin Falls, ID 83303-5025
208-733-7258