Blue Cross of Idaho

Health Insurance Plans

for Individuals from

Blue Cross of Idaho

Choose coverage that fits.

Form No. 3-1021 (08-14)

Policy Form Numbers:
18-061-01/15
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18-075-01/15
18-076-01/15
18-077-01/15
18-206-01/15
18-211-01/15
3-420-05/11

INDIVIDUAL AND FAMILY MEDICAL 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 from Your Health Idaho, you will find robust 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, including emergency room services, maternity and newborn care, annual doctor visits, and medical screenings.

In addition to the information in this brochure, you can learn more about our products and the metal levels at ***shoppers.bcidaho.com***.

Blue Cross of Idaho Metallic Plans

BRONZE	SILVER	GOLD	PLATINUM
Choice	Choice 2000, 3000 4000, & No Deductible	Choice	Connect
HSA Saver	Connect 2000, 3000, 4000 & No Deductible	Connect	
Connect			

Our Connect plans are part of our *ConnectedCare* network. See our *ConnectedCare Plans for Individuals* brochure for more information about these plans.

HOW TO CHOOSE THE RIGHT PLAN

Choosing the right coverage depends on knowing your healthcare needs, what you want from your coverage and what your budget will allow. Consider these questions before you choose a plan to help narrow your options:

DO I QUALIFY FOR A BREAK ON COSTS BASED ON MY INCOME AND FAMILY SIZE?

Take a look at the ***Get a Break on Costs*** on the next page to learn if you may be eligible for financial assistance.

WHAT SORT OF HEALTH SERVICES AND MEDICATIONS MIGHT MY FAMILY AND I NEED?

Think about your current and future healthcare needs. How often do you need to go to the doctor? What is your family's health history? Do you have a job or do activities during which you might get injured? Does your child play a sport in which they might get injured?

DOES THE PLAN INCLUDE MY CURRENT DOCTORS?

Each plan may include a different set of doctors and other health service providers, which is called being "in-network." Look at the list of doctors and hospitals in each plan at ***shoppers.bcidaho.com*** to see if the providers you prefer are in the network of the plans you are considering.

WHAT IS THE BEST WAY FOR ME TO BALANCE THE DEDUCTIBLE AND PREMIUM OPTIONS?

As a general rule of thumb, you can choose to pay a higher monthly premium, so when you need medical care, you pay less. Or you can choose a lower monthly premium but when you need medical care, you pay more. Blue Cross of Idaho has plans in many premium and deductible ranges, so you can choose the level of coverage that best meets your health needs and budget.

WHAT OTHER VALUE DOES MY HEALTH INSURANCE COMPANY OFFER MY FAMILY?

Not all insurance companies provide rich benefit coverage, award-winning customer service, and easy access to the doctors you want. Blue Cross of Idaho plans come with this kind of added value, giving you more for your monthly premium. You can learn more about the ways we are working to bring you the highest quality care at a cost you can afford on page 10.

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 Your Health Idaho. 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. See our *Cost Sharing Plans for Individuals* brochure for more details.

Monthly Premium Tax Credit

This new kind of tax credit can save you money by lowering your monthly premium payments when you buy through Your Health Idaho. 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.

QUALIFY FOR FINANCIAL HELP

To qualify, you'll need to enroll in health coverage through Your Health Idaho at ***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.

FREE SUBSIDY CALCULATOR

Visit our subsidy calculator at ***shoppers.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, there's no need to visit ***yourhealthidaho.org***. You can quickly and easily apply for insurance coverage directly from us at ***shoppers.bcidaho.com***.

THE FEDERAL INCOME GUIDELINES (2014)

Family Size and Income		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	$11,670	$29,175	$46,680
2	$15,730	$39,325	$62,920
3	$19,790	$49,475	$79,160
4	$23,850	$59,625	$95,400
5	$27,910	$69,775	$111,640
6	$31,970	$79,925	$127,880
7	$36,030	$90,075	$144,120
8	$40,090	$100,225	$160,360

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

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	INDIVIDUAL BRONZE HSA SAVER		FAMILY BRONZE HSA SAVER	
Benefit Details	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Deductible	$5,000 per person	$5,000 per person	$10,000 per family*	$10,000 per family*
Coinsurance *The percentage you pay of the allowed amount for covered services after meeting your deductible.*	You pay no coinsurance once you've met your deductible.	Once you've met your deductible, you pay 30% of the cost of your covered care.	You pay no coinsurance once you've met your deductible.	Once you've met your deductible, you pay 30% of the cost of your covered care.
Annual Out-of-Pocket Maximum *Includes your deductible, copayments, coinsurance, and prescription deductible.*	For in-network care, the most you'll pay over the course of a year is $6,350 (individual).	For covered care, the most you'll pay over the course of a year is $8,350 (individual).	For in-network care, the most you'll pay over the course of a year is $12,700 (family).	For covered care, the most you'll pay over the course of a year is $16,700 (family).
WHAT YOU'LL PAY UP TO YOUR ANNUAL OUT-OF-POCKET MAXIMUM				
Doctor's Office Visit/Urgent Care	Once you've met your deductible, you pay nothing.	Once you've met your deductible, you pay 30% of the cost of your covered care.	Once you've met your deductible, you pay nothing.	Once you've met your deductible, you pay 30% of the cost of your covered care.
Emergency Room Services	You pay $150 copayment per visit. Once you've met your deductible, you pay only the copayment.	You pay $150 copayment per visit. Once you've met your deductible, you pay 30% of the cost of your covered care.[2]	You pay $150 copayment per visit. Once you've met your deductible, you only the copayment.	You pay $150 copayment per visit. Once you've met your deductible, you pay 30% of the cost of your covered care.[2]
Prescription Drugs *Prescription drug costs count toward your out-of-pocket maximum.*	You pay nothing for covered generic and brand-name preventive drugs.		You pay nothing for covered generic and brand-name preventive drugs.	
	Once you've met your deductible, you pay $10 copayment for non-preventive generic drugs and 50% for non-preventive brand-name drugs.		Once you've met your deductible, you pay $10 copayment for non-preventive generic drugs and 50% for non-preventive brand-name drugs.	
Diagnostic X-Ray and Lab Services **Inpatient Hospital Services** **Outpatient Rehab Services[3]** **Physician, Surgical & Medical Services** **Pregnancy Services**	Once you've met your deductible, you pay nothing.	Once you've met your deductible, you pay 30% of the cost of your covered care.	Once you've met your deductible, you pay nothing.	Once you've met your deductible, you pay 30% of the cost of your covered care.
Chiropractic Care[4]	Once you've met your deductible, you pay nothing.	Once you've met your deductible, you pay 50% of the cost of your covered care.	Once you've met your deductible, you pay nothing.	Once you've met your deductible, you pay 50% of the cost of your covered care.
Diabetes Education Services	You pay $30 copayment per visit.	Once you've met your deductible, you pay 30% of the cost of your covered care.	You pay $30 copayment per visit.	Once you've met your deductible, you pay 30% of the cost of your covered care.
Outpatient Mental Health & Substance Abuse Services	Once you've met your deductible, you pay nothing.	Once you've met your deductible, you pay 30% of the cost of your covered care.	Once you've met your deductible, you pay nothing.	Once you've met your deductible, you pay 30% of the cost of your covered care.
Preventive Care	You pay nothing for listed preventive care.	Once you've met your deductible, you pay 30% of the cost of your covered care.	You pay nothing for listed preventive care.	Once you've met your deductible, you pay 30% of the cost of your covered care.
Immunizations	You pay nothing for listed immunizations.			

*__Please note:__ *All family members contribute toward the family deductible. Claims will not be paid for any individual family member until the total family deductible has been satisfied.*

[1] *Preventive visits are not included in this total.*

[2] *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	BRONZE CHOICE	
Benefit Details	**In-Network**	**Out-of-Network**
Deductible	$6,350 per person or $12,700 per family	$6,350 per person or $12,700 per family
Coinsurance *The percentage you pay of the allowed amount for covered services after meeting your deductible.*	You pay no coinsurance once you've met your deductible.	Once you've met your deductible, you pay 30% of the cost of your covered care.
Annual Out-of-Pocket Maximum *Includes your deductible, copayments, coinsurance, and prescription deductible.*	For in-network care, the most you'll pay over the course of a year is $6,350 (individual) or $12,700 (family).	For covered care, the most you'll pay over the course of a year is $8,350 (individual) or $16,700 (family).
WHAT YOU'LL PAY UP TO YOUR ANNUAL OUT-OF-POCKET MAXIMUM		
Doctor's Office Visit/Urgent Care	You pay $30 copayment per visit for the first 4 visits per person.[1] For additional visits, once you've met your deductible, you pay nothing.	Once you've met your deductible, you pay 30% of the cost of your covered care.
Emergency Room Services	Once you've met your deductible, you pay nothing.	Once you've met your deductible, you pay 30% of the cost of your covered care.[2]
Prescription Drugs *Prescription drug costs count toward your out-of-pocket maximum.*	Once you've met your deductible, you pay nothing.	
Diagnostic X-Ray and Lab Services **Inpatient Hospital Services** **Outpatient Rehab Services**[3] **Physician, Surgical & Medical Services** **Pregnancy Services**	Once you've met your deductible, you pay nothing.	Once you've met your deductible, you pay 30% of the cost of your covered care.
Chiropractic Care[4]	Once you've met your deductible, you pay nothing.	Once you've met your deductible, you pay 50% of the cost of your covered care.
Diabetes Education Services	You pay $30 copayment per visit.	Once you've met your deductible, you pay 30% of the cost of your covered care.
Outpatient Mental Health & Substance Abuse Services	You pay $30 copayment per visit.	Once you've met your deductible, you pay 30% of the cost of your covered care.
Preventive Care	You pay nothing for listed preventive care.	Once you've met your deductible, you pay 30% of the cost of your covered care.
Immunizations	You pay nothing for listed immunizations.	

[3] *Includes physical, occupational, and speech therapy services. You have a combined total of up to 20 in- and out-of-network visits for covered therapy services per member per year.*

[4] *You have up to a combined total of 18 in- and out-of-network visits for covered chiropractic services per member per year.*

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's 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 for most plans.

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.

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	SILVER CHOICE 4000		SILVER CHOICE 3000	
Benefit Details	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Deductible	$4,000 per person or $8,000 per family	$4,000 per person or $8,000 per family	$3,000 per person or $6,000 per family	$3,000 per person or $6,000 per family
Coinsurance *The percentage you pay of the allowed amount for covered services after meeting your deductible.*	Once you've met your deductible, you pay 30% of the cost of your covered care.	Once you've met your deductible, you pay 50% of the cost of your covered care.	Once you've met your deductible, you pay 30% of the cost of your covered care.	Once you've met your deductible, you pay 50% of the cost of your covered care.
Annual Out-of-Pocket Maximum *Includes your deductible, copayments, coinsurance, and prescription deductible.*	For in-network care, the most you'll pay over the course of a year is $6,350 (individual) or $12,700 (family).	For covered care, the most you'll pay over the course of a year is $8,350 (individual) or $16,700 (family).	For in-network care, the most you'll pay over the course of a year is $6,350 (individual) or $12,700 (family).	For covered care, the most you'll pay over the course of a year is $8,350 (individual) or $16,700 (family).
	WHAT YOU'LL PAY UP TO YOUR ANNUAL OUT-OF-POCKET MAXIMUM			
Doctor's Office Visit/Urgent Care	You pay $10 copayment per visit for the first 4 visits per person.[1] For additional visits, once you've met your deductible, you pay 30% of the cost of your covered care.	Once you've met your deductible, you pay 50% of the cost of your covered care.	You pay $20 copayment per visit for the first 4 visits per person.[1] For additional visits, once you've met your deductible, you pay 30% of the cost of your covered care.	Once you've met your deductible, you pay 50% of the cost of your covered care.
Emergency Room Services	You pay $150 copayment per visit. Once you've met your deductible, you pay copayment and 30% of the cost of your covered care.	You pay $150 copayment per visit. Once you've met your deductible, you pay copayment and 50% of the cost of your covered care.[2]	You pay $150 copayment per visit. Once you've met your deductible, you pay copayment and 30% of the cost of your covered care.	You pay $150 copayment per visit. Once you've met your deductible, you pay copayment and 50% of the cost of your covered care.[2]
Prescription Drugs *Prescription drug costs count toward your out-of-pocket maximum.*	You pay $10 copayment for generic drugs.		You pay $10 copayment for generic drugs.	
	Once you've met a separate $2,350 brand-name and specialty drug deductible, you pay $30 copayment for preferred brand-name, $50 copayment for non-preferred brand-name, and $100 copayment for specialty drugs.		Once you've met a separate $1,000 brand-name and specialty drug deductible, you pay $30 copayment for preferred brand-name, $50 copayment for non-preferred brand-name, and $100 copayment for specialty drugs.	
Diagnostic X-Ray and Lab Services **Inpatient Hospital Services** **Outpatient Rehab Services[3]** **Physician, Surgical & Medical Services** **Pregnancy Services**	Once you've met your deductible, you pay 30% of the cost of your covered care.	Once you've met your deductible, you pay 50% of the cost of your covered care.	Once you've met your deductible, you pay 30% of the cost of your covered care.	Once you've met your deductible, you pay 50% of the cost of your covered care.
Chiropractic Care[4]	Once you've met your deductible, you pay 30% of the cost of your covered care.	Once you've met your deductible, you pay 50% of the cost of your covered care.	Once you've met your deductible, you pay 30% of the cost of your covered care.	Once you've met your deductible, you pay 50% of the cost of your covered care.
Diabetes Education Services	You pay $10 copayment per visit.	Once you've met your deductible, you pay 50% of the cost of your covered care.	You pay $20 copayment per visit.	Once you've met your deductible, you pay 50% of the cost of your covered care.
Outpatient Mental Health & Substance Abuse Services	You pay $10 copayment per visit.	Once you've met your deductible, you pay 50% of the cost of your covered care.	You pay $20 copayment per visit.	Once you've met your deductible, you pay 50% of the cost of your covered care.
Preventive Care	You pay nothing for listed preventive care.	Once you've met your deductible, you pay 50% of the cost of your covered care.	You pay nothing for listed preventive care.	Once you've met your deductible, you pay 50% of the cost of your covered care.
Immunizations	You pay nothing for listed immunizations.		You pay nothing for listed immunizations.	

[1] *Preventive visits are not included in this total.*

[2] *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	SILVER CHOICE 2000		SILVER CHOICE NO DEDUCTIBLE	
Benefit Details	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Deductible	$2,000 per person or $4,000 per family	$2,000 per person or $4,000 per family	$0	$1,000 per person or $2,000 per family
Coinsurance *The percentage you pay of the allowed amount for covered services after meeting your deductible.*	Once you've met your deductible, you pay 30% of the cost of your covered care.	Once you've met your deductible, you pay 50% of the cost of your covered care.	You pay 50% of the cost of your covered care.	Once you've met your deductible, you pay 75% of the cost of your covered care.
Annual Out-of-Pocket Maximum *Includes your deductible, copayments, coinsurance, and prescription deductible.*	For in-network care, the most you'll pay over the course of a year is $6,350 (individual) or $12,700 (family).	For covered care, the most you'll pay over the course of a year is $8,350 (individual) or $16,700 (family).	For in-network care, the most you'll pay over the course of a year is $6,350 (individual) or $12,700 (family).	For covered care, the most you'll pay over the course of a year is $8,350 (individual) or $16,700 (family).
	WHAT YOU'LL PAY UP TO YOUR ANNUAL OUT-OF-POCKET MAXIMUM			
Doctor's Office Visit/Urgent Care	You pay $45 copayment per visit for the first 4 visits per person.[1] For additional visits, once you've met your deductible, you pay 30% of the cost of your covered care.	Once you've met your deductible, you pay 50% of the cost of your covered care.	You pay 50% of the cost of your covered care.	Once you've met your deductible, you pay 75% of the cost of your covered care.
Emergency Room Services	You pay $150 copayment per visit. Once you've met your deductible, you pay copayment and 30% of the cost of your covered care.	You pay $150 copayment per visit. Once you've met your deductible, you pay copayment and 50% of the cost of your covered care.[2]	You pay $150 copayment per visit and 50% of the cost of your covered care.	You pay $150 copayment per visit. Once you've met your deductible, you pay copayment and 75% of the cost of your covered care.[2]
Prescription Drugs *Prescription drug costs count toward your out-of-pocket maximum.*	You pay $10 copayment for generic drugs. Once you've met a separate $1,000 brand-name and specialty drug deductible, you pay $30 copayment for preferred brand-name, $50 copayment for non-preferred brand-name, and $100 copayment for specialty drugs.		You pay 50% of the cost of your covered prescriptions.	
Diagnostic X-Ray and Lab Services **Inpatient Hospital Services** **Outpatient Rehab Services[3]** **Physician, Surgical & Medical Services** **Pregnancy Services**	Once you've met your deductible, you pay 30% of the cost of your covered care.	Once you've met your deductible, you pay 50% of the cost of your covered care.	You pay 50% of the cost of your covered care.	Once you've met your deductible, you pay 75% of the cost of your covered care.
Chiropractic Care[4]	Once you've met your deductible, you pay 30% of the cost of your covered care.	Once you've met your deductible, you pay 50% of the cost of your covered care.	You pay 50% of the cost of your covered care.	Once you've met your deductible, you pay 75% of the cost of your covered care.
Diabetes Education Services	You pay $45 copayment per visit.	Once you've met your deductible, you pay 50% of the cost of your covered care.	You pay 50% of the cost of your covered care.	Once you've met your deductible, you pay 75% of the cost of your covered care.
Outpatient Mental Health & Substance Abuse Services	You pay $45 copayment per visit.	Once you've met your deductible, you pay 50% of the cost of your covered care.	You pay 50% of the cost of your covered care.	Once you've met your deductible, you pay 75% of the cost of your covered care.
Preventive Care	You pay nothing for listed preventive care.	Once you've met your deductible, you pay 50% of the cost of your covered care.	You pay nothing for listed preventive care.	Once you've met your deductible, you pay 75% of the cost of your covered care.
Immunizations	You pay nothing for listed immunizations.		You pay nothing for listed immunizations.	

[3] *Includes physical, occupational, and speech therapy services. You have a combined total of up to 20 in- and out-of-network visits for covered therapy services per member per year.*

[4] *You have up to a combined total of 18 in- and out-of-network visits for covered chiropractic services per member per year.*

Blue Cross of Idaho

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

METAL LEVEL	GOLD CHOICE		COVERED CHOICE*	
Benefit Details	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Deductible	$1,000 per person or $2,000 per family	$1,000 per person or $2,000 per family	$6,600 per person or $13,200 per family	$6,600 per person or $13,200 per family
Coinsurance *The percentage you pay of the allowed amount for covered services after meeting your deductible.*	Once you've met your deductible, you pay 15% of the cost of your covered care.	Once you've met your deductible, you pay 50% of the cost of your covered care.	Once you've met your deductible, you pay nothing.	Once you've met your deductible, you pay 30% of the cost of your covered care.
Annual Out-of-Pocket Maximum *Includes your deductible, copayments, coinsurance, and prescription deductible.*	For in-network care, the most you'll pay over the course of any year is $6,350 (individual) or $12,700 (family).	For covered care, the most you'll pay over the course of any year is $8,350 (individual) or $16,700 (family).	For in-network care, the most you'll pay over the course of any year is $6,600 (individual) or $13,200 (family).	For covered care, the most you'll pay over the course of any year is $8,600 (individual) or $17,200 (family).
WHAT YOU'LL PAY UP TO YOUR ANNUAL OUT-OF-POCKET MAXIMUM				
Doctor's Office Visit/Urgent Care	You pay $10 copayment per visit for the first 4 visits per person.[1] For additional visits, once you've met your deductible, you pay 15% of the cost of your covered care.	Once you've met your deductible, you pay 50% of the cost of your covered care.	You pay $30 copayment per visit for the first 3 visits per person. For additional visits, you pay costs up to your deductible.	Once you've met your deductible, you pay 30% of the cost of your covered care.
Emergency Room Services	You pay $150 copayment per visit. Once you've met your deductible, you pay copayment and 15% of the cost of your covered care.	You pay $150 copayment per visit. Once you've met your deductible, you pay copayment and 50% of the cost of your covered care.[2]	Once you've met your deductible, you pay nothing for covered care.	Once you've met your deductible, you pay 30% of the cost of your covered care.[2]
Prescription Drugs *Prescription drug costs count toward your out-of-pocket maximum.*	You pay $10 copayment for generic drugs. Once you've met your deductible, you pay $30 copayment for preferred brand-name, $50 copayment for non-preferred brand-name, and $100 copayment for specialty drugs.		Once you've met your deductible, you pay nothing for covered prescriptions.	
Diagnostic X-Ray and Lab Services **Inpatient Hospital Services** **Outpatient Rehab Services[3]** **Physician, Surgical & Medical Services** **Pregnancy Services**	Once you've met your deductible, you pay 15% of the cost of your covered care.	Once you've met your deductible, you pay 50% of the cost of your covered care.	Once you've met your deductible, you pay nothing for covered care.	Once you've met your deductible, you pay 30% of the cost of your covered care.
Chiropractic Care[4]	Once you've met your deductible, you pay 15% of the cost of your covered care.	Once you've met your deductible, you pay 50% of the cost of your covered care.	Once you've met your deductible, you pay nothing for covered care.	Once you've met your deductible, you pay 50% of the cost of your covered care.
Diabetes Education Services	You pay $10 copayment per visit.	Once you've met your deductible, you pay 50% of the cost of your covered care.	Once you've met your deductible, you pay nothing for covered care.	Once you've met your deductible, you pay 30% of the cost of your covered care.
Outpatient Mental Health & Substance Abuse Services	You pay $10 copayment per visit.	Once you've met your deductible, you pay 50% of the cost of your covered care.	Once you've met your deductible, you pay nothing for covered care.	Once you've met your deductible, you pay 30% of the cost of your covered care.
Preventive Care	You pay nothing for listed preventive care.	Once you've met your deductible, you pay 50% of the cost of your covered care.	You pay nothing for listed preventive care.	Once you've met your deductible, you pay 30% of the cost of your covered care.
Immunizations	You pay nothing for listed immunizations.		You pay nothing for listed immunizations.	

**Covered Choice* is a catastrophic plan and is only available to people under the age of 30, or to people who qualify for a hardship exemption through the exchange.*

[1] *Preventive visits are not included in this total.*

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

[3] *Includes physical, occupational, and speech therapy services. You have a combined total of up to 20 in- and out-of-network visits for covered therapy services per member per year.*

[4] *You have up to a combined total of 18 in- and out-of-network visits for covered chiropractic services per member per year.*

Do You Live in Eastern or Southwest Idaho?

BRONZE CONNECT	SILVER CONNECT	SILVER CONNECT NO DEDUCTIBLE	GOLD CONNECT	PLATINUM CONNECT	COVERED CONNECT*

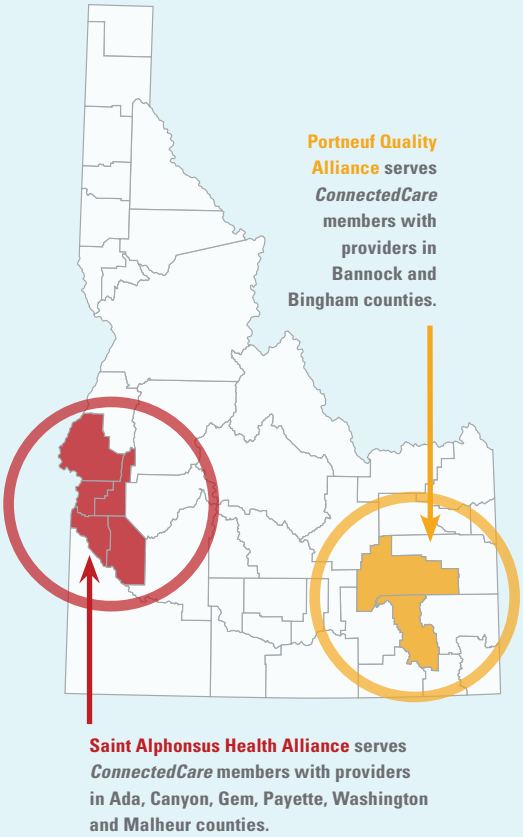
If you live in these areas of the state, you have additional choices through Blue Cross of Idaho's *ConnectedCare*℠ Plans. Our *ConnectedCare* plans, available in every metal level, are full-coverage managed care health insurance plans supported by select provider networks within eastern and southwestern Idaho. You can identify these plans by their *Connect* name.

How is *ConnectedCare* coverage different?

If you choose a *Connect* plan, you must follow some additional requirements to get the full benefit of your coverage.

1. You must visit doctors and hospitals that are part of the *ConnectedCare* network where you live.
2. You must choose one doctor as your primary care provider (PCP). PCPs provide care and arrange other treatments and services when needed.
3. Your PCP must provide you referrals to specialists within your network for your in-network coverage benefits.

Want to know more? See our *ConnectedCare Plans for Individuals* brochure for more information. You can see if a certain provider or hospital is in the *ConnectedCare* network at ***bcidaho.com/findaprovider***.



Additional Plans to Meet Your Needs

Short Term PPO Plan

If you need coverage for a short time, our *Short Term PPO* offers a limited benefit plan for temporary coverage. This plan is only available directly from Blue Cross of Idaho and is not subject to the rules set forth by the Affordable Care Act (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, or visit ***bcidaho.com/plans/individual/STB.asp***.

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 at ***shoppers.bcidaho.com*** or through the Idaho Health Insurance Exchange at ***yourhealthidaho.org***.

It's important to know that dental coverage for members younger than 19 is considered one of 10 essential health benefits (EHBs), which are basic benefits most health insurance plans will provide. Blue Cross of Idaho offers dental plans that meet the ACA requirements separate from our medical plans. See our *Dental Plans for Individuals* brochure for more information.

WHY BLUE CROSS OF IDAHO?

BEST VALUE

Our mission is to provide our members the best value in health insurance and the tools for maintaining—and improving—their health. How do we provide this value? By offering insurance options, extensive provider networks that let you get care from the doctors you want, award-winning customer service and access to the healthcare programs you need to achieve your best health. And even as healthcare costs continue to rise, we work to minimize administrative costs, so we can keep your premiums as low as possible.

STRONG PROVIDER NETWORKS

No insurance company has a more complete network of doctors and hospitals in the state than we do. We contract with every hospital in Idaho and 96 percent of all Idaho physicians and healthcare providers. If you're traveling outside of Idaho, doctors and hospitals all over the United States and in more than 200 countries and territories around the world are in our BlueCard® network.

EXCELLENT CUSTOMER SERVICE

Blue Cross of Idaho takes pride in providing exceptional service from our customer service center located right here in Idaho. We make sure important information is always at your fingertips by providing support over the phone and through our website at ***members.bcidaho.com***. Our website lets you view your health insurance records, including your claims history and explanation of benefits statements. So whether you prefer researching your question on our website or contacting one of our specially trained customer advocates on the phone, we're here for you.

Our customer advocates are available Monday through Friday from 7 a.m. – 8 p.m. and Saturday from 8 a.m. – noon. (They are closed Wednesdays from 8-8:30 a.m. so they can attend a staff meeting.) We also provide our members 24-hour access to our self-service phone system that offers claims history, eligibility and deductible information.

HEALTH AND WELLNESS SUPPORT

As a member, you'll have access to our *WellConnected* tools to help you improve your health. You can track your exercise, food and water intake as well as take a wide range of wellness workshops. There's a mobile app to make tracking even more convenient.

SEE COSTS AND WAYS TO SAVE

With our new Cost Lookup tool, you will see the price you would pay at a specific provider or for a prescription based on where you live, what insurance plan you have, and who is in your network of doctors and hospitals. You can also sign up for Ways to Save, which shows you how you can save money on the services you already use.

HEALTH MANAGEMENT PROGRAMS

We want to help you succeed in creating and sustaining healthy behaviors. Our health management programs focus on supporting your goals, giving you access to the critical information, tools, and even the coaching you need to live a healthier, happier life. We offer programs for asthma, congestive heart failure, depression, diabetes, and chronic obstructive pulmonary disease, among others.

BEHAVIORAL HEALTH MANAGEMENT INTEGRATION

Blue Cross of Idaho believes good mental health is a key part of overall health and wellbeing. Our behavioral health team focuses on improving the quality of life for our members through mental health or substance abuse management, works to coordinate overall member care, and seeks to provide an integrated approach to your entire physical and mental health picture.

HELPFUL ONLINE TOOLS

As a member you have access to ***members.bcidaho.com***, where you can find information on your coverage and claims, estimate the cost of services, take an online health risk assessment and find a doctor or hospital—all available 24 hours a day.

Additionally, members who complete a personal health assessment have access to online health coaching programs[1] that give them personalized action plans, tools and resources to help them meet their health goals.

[1] *Personal health coaching is a value added program and is not health insurance.*
[2] *Blue Extras is a value added program and is not health insurance.*

BLUE EXTRAS!

We know that maintaining good health is important to our members and that there are many different approaches to achieving good health. Whether you follow a formal workout routine or rely on evening walks in the neighborhood, take a daily multi-vitamin or follow a strict naturopathic medicine, acupuncture and massage therapy program, our Blue Extras[2] program can help you succeed.

Blue Extras offers a variety of value-added services, programs and products to help our members achieve their personal health, wellness and fitness goals. The Blue Extras program offers discounted rates to members for the following services:

- Baby health and safety
- Complementary and alternative health
- Fitness clubs
- Hearing services
- Medical alert services
- Orthodontia services
- Vision services

Blue Extras is available to most Blue Cross of Idaho members and is not dependent on your specific benefit plan. However, if your plan includes coverage for a service included in the Blue Extras value added program, the service provider will apply the discount before submitting the claim for payment under your benefit plan. For more information about Blue Extras and for a list of specific clubs and services providers, visit ***bcidaho.com***.

DETAILS ABOUT OUR PLANS

Blue Cross of Idaho's member contracts contain all the important details about our plan benefits including out-of-pocket amounts, covered healthcare services, and specific exclusions and limitations. Here are some important details for you to review.

HOW DO WE PROTECT YOUR PERSONAL INFORMATION?

- We consider all personal information we collect from you to be confidential.
- Our privacy practices apply equally to personal information about future, current and former members.
- We allow access to your information by our employees and business associates only to the extent necessary to conduct our business of serving you.
- We train our employees on our written privacy and security policies and procedures and our employees are subject to disciplinary actions if they violate them.
- We won't disclose your personal information unless we are allowed or required by law, or if you (or your personal representative) give us permission.
- We take steps to secure our buildings and electronic systems from unauthorized access.

For detailed information about our privacy practices and your rights, including your right to see your personal health record, see the Blue Cross of Idaho Notice of Privacy Practices on our website at ***bcidaho.com/about_us/privacy_policy.asp***. You can also contact our information privacy officer at 877-488-7788 for more information.

ABOUT OUT-OF-POCKET LIMITS

Be aware that your actual costs for services provided by an out-of-network provider may exceed the out-of-pocket limit for out-of-network services. Costs for the following Covered Services do not count toward the Out-of-Network Out-of-Pocket Limit: Dental Services, Vision Services and Prescription Drug Services. In addition, Out-of-Network Providers can bill you for the difference between the amount they charge for covered services and the amount Blue Cross of Idaho allows for those services, and that amount does not count toward the Out-of-Network Out-of-Pocket Limit.

Prior Authorization

NOTICE: *Prior Authorization is required to determine if the services listed below are Medically Necessary and a Covered Service. If Prior Authorization has not been obtained to determine Medical Necessity, services may be subject to denial. Any dispute involved in Blue Cross of Idaho's Medical Necessity decision must be resolved by use of the Blue Cross of Idaho appeal process.*

If Non-Medically Necessary services are performed by Contracting Providers, without the Prior Authorization by Blue Cross of Idaho, and benefits are denied, the cost of said services are not the financial responsibility of the Insured. The Insured is financially responsible for Non-Medically Necessary services performed by a provider who does not have a provider contract with Blue Cross of Idaho.

Prior Authorization is a request by the Insured's Contracting Provider to Blue Cross of Idaho, or delegated entity, for authorization of an Insured's proposed treatment. Blue Cross of Idaho may review medical records, test results and other sources of information to ensure that it is a Covered Service and determine whether the proposed treatment meets the standard of Medical Necessity as defined in the Policy. To request Prior Authorization, the Contracting Provider must notify Blue Cross of Idaho of the Insured's intent to receive services that require Prior Authorization.

Blue Cross of Idaho will respond to a request for Prior Authorization for the services listed below received from either the Provider or the Insured within two (2) business days of the receipt of the medical information necessary to make a determination. For additional information, please check with your Provider, call Customer Service at the telephone number listed on the back of the Insured's Identification Card or check the Blue Cross of Idaho Web site at ***bcidaho.com.***

The Insured is responsible for obtaining Prior Authorization when seeking treatment from a Noncontracting Provider. The notification may be completed by telephone call or in writing and must include the information necessary to establish that the proposed services are Covered Services under the Insured's Policy and Medically Necessary.

Prior Authorization is not a guarantee of payment. It is a pre-service determination of Medical Necessity based on information provided to Blue Cross of Idaho at the time the Prior Authorization request is made. Blue Cross of Idaho retains the right to review the Medical Necessity of services, eligibility of services and benefit limitations and exclusions after services are received.

The following services require Prior Authorization:

ADVANCED IMAGING SERVICES:

(not applicable for Emergency room or Inpatient Services)

- Magnetic Resonance Imaging (MRI)
- Magnetic Resonance Angiography (MRA)
- Computed Tomography Scans (CT Scan)
- Positron Emission Tomography (PET)
- Nuclear Cardiology
- Echocardiography

SURGICAL SERVICES – INPATIENT OR OUTPATIENT

- Cellular, tissue and organ Transplants
- Nasal and sinus procedures
- Eyelid Surgery
- Spinal Surgery
- Jaw Surgery
- Plastic and reconstructive Surgery
- Surgery for snoring or sleep problems
- Invasive treatment of lower extremity veins (including but not limited to varicose veins)

OTHER SERVICES – INPATIENT OR OUTPATIENT

- Inpatient admissions
- All Outpatient infusion therapy including Home Intravenous Therapy drugs as listed on the Blue Cross of Idaho Web site, ***bcidaho.com***
- Non-emergent ambulance transport
- Certain Prescription Drugs as listed on the Blue Cross of Idaho Web site, ***bcidaho.com***
- Restorative dental services following Accidental Injury to a Sound Natural Tooth
- Sleep Studies
- Hospice services
- Hospital Grade Breast Pumps
- Growth hormone therapy
- Genetic testing services
- Home health skilled nursing services
- Mental Health and Substance Abuse Services:
  - Outpatient Psychotherapy services after the tenth (10th) visit (does not include medication management services).
  - Intensive Outpatient Program (IOP)
  - Partial Hospitalization Program(PHP)
  - Residential Treatment Program
  - Psychological testing/ neuropsychological evaluation testing
  - Electroconvulsive Therapy (ECT)

OTHER SERVICES

The following services require Prior Authorization when the expected charges exceed five hundred dollars ($500):

- Rental or purchase of Durable Medical Equipment, except for oxygen therapy equipment related to Durable Medical Equipment
- Prosthetic Appliances
- Orthotic Devices
- Oral appliances for Sleep Apnea

EXCLUSIONS & LIMITATIONS

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

PREEXISTING CONDITION WAITING PERIODS

- There is no preexisting condition waiting period for benefits available under this Policy.

GENERAL EXCLUSIONS AND LIMITATIONS

- 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 which 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 or services 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, except as specified as a Covered Service in this Policy; 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, a 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 directly related to the care and treatment of an actual condition, Illness, Disease or Accidental Injury.
- Furnished by a facility that 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 mental or 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 in 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 a 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 that occurred after enrollment.
- Provided outside the United States, which if had been provided in the United States, would not be a Covered Service 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 Dentistry or Dental Treatment, 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

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1910 Channing Way
Idaho Falls, ID 83404

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

Lewiston

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1010 17th Street
Lewiston, ID 83501

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Pocatello

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275 South 5th Avenue
Suite 150
Pocatello, ID 83201

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Twin Falls

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1431 North Fillmore Street
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Twin Falls, ID 83301

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