



FULL COVERAGE PLANS FOR INDIVIDUALS AND FAMILIES

| BENEFITS | BLUECARE [®] PPO | | HSA BLUE SM PPO | | DEFINITIONS YOU NEED TO KNOW |
|---|---|--|--|---|--|
| | Depending on the option, YOU PAY: | | Depending on the option, YOU PAY: | | |
| Deductible | Per Person Option 1: \$1,000 Option 2: \$2,000 Option 3: \$5,000 | Per Family Option 1: \$2,000 Option 2: \$4,000 Option 3: \$10,000 | Per Person Option 1a: \$2,000 Option 1b: \$2,000 Option 2a: \$3,000 Option 2b: \$3,000 Option 3: \$5,000 | Per Family¹ Option 1a: \$4,000 Option 1b: \$4,000 Option 2a: \$6,000 Option 2b: \$6,000 Option 3: \$10,000 | <p>1. Deductible – A set dollar amount you pay each benefit period for covered services before your health insurance policy begins paying benefits. Deductibles are reset each year.</p> <p>2. Coinsurance – A percentage (for example 20%) of the allowed amount you pay for a health care covered service. Coinsurance applies after the deductible has been met.</p> <p>3. Copayment – A fixed dollar amount (for example \$20 or \$30) you pay for specified covered services such as a doctor office visit. A copay applies each time the service is provided.</p> <p>4. Amount Charged vs. Amount Allowed – A provider can charge you any amount for a service, but a health insurer may establish the maximum they will pay for a given covered service. This amount is often less than the charged amount. Contracting or “in-network” providers agree to accept the allowed amount (called the maximum allowance in your policy) as payment in full for a covered service and as part of their contract agree not to bill you the difference between the allowed amount and charged amount.</p> <p>5. In-Network vs. Out-of-Network – Depending on your policy there may be a different benefit level for in and out-of-network providers. When you use providers out of the network, you may have to pay significantly more for your health care service.</p> <p>6. Out-of-Pocket Maximum – A fixed dollar amount that is the most you will pay for deductibles and coinsurance for most covered services in the course of a benefit period. Once the out-of-pocket maximum is met, most covered services are paid at 100% of the allowed amount.</p> <p>7. Generic Drug – Drugs with identical active ingredients as corresponding brand name drugs. Generic drugs on average cost less than one-third of brand name drugs but have the same therapeutic benefit.</p> <p>8. Formulary Drug – A list of drugs covered under a health insurer’s prescription drug plan. Non-formulary drugs may be covered, but at a much higher cost to you.</p> <p>9. EOB – An explanation of benefits form (EOB) lists the services for which you or your providers have sent claims for coverage. These forms are not bills but explain the result for each service submitted.</p> <p>10. Non-Covered Service – A service or type of service that is specifically excluded from coverage in your policy. Read your policy for a full list, but non-covered services often include those considered investigational or convenience items.</p> <p>Note: These definitions are for summary explanation only. Please refer to your policy for specific definitions related to your benefits.</p> |
| Coinsurance <i>(Deductible applies unless otherwise indicated)</i> | In-network 20% | Out-of-network 50% | In-network Option 1a and 2a: 20% Option 1b and 2b: 10% Option 3: Nothing | Out-of-network Option 1a and 2a: 40% Option 1b and 2b: 30% Option 3: Nothing | |
| Copayment <i>(Per person, per visit)</i> | Option 1: \$25 Option 2: \$30 Option 3: \$35 | | None | | |
| Out-of-Pocket Maximum | In-network Option 1: \$3,000 Option 2: \$4,000 Option 3: \$7,000 | Out-of-network Option 1: \$3,000 Option 2: \$4,000 Option 3: \$7,000 | Per Person Option 1a and 1b: \$4,000 Option 2a and 2b: \$5,000 Option 3: \$5,000 | Per Family Option 1a and 1b: \$8,000 Option 2a and 2b: \$10,000 Option 3: \$10,000 | |
| | In-network | Out-of-network | In-network | Out-of-network | |
| Physician Office Visits | You pay Option 1: \$25 copayment Option 2: \$30 copayment Option 3: \$35 copayment | You pay deductible and coinsurance | You pay deductible and coinsurance | You pay deductible and coinsurance | |
| Prescription Drugs | 50% for all options. No deductible required. | | Options 1 and 2: You pay 50% after deductible. Option 3: You pay nothing after deductible. | | |
| Inpatient and Outpatient Hospital Services <i>(Unlimited visits)</i> | You pay deductible and coinsurance | You pay deductible and coinsurance | You pay deductible and coinsurance | You pay deductible and coinsurance | |
| Emergency Room Services | You pay deductible and coinsurance | You pay deductible and coinsurance | You pay deductible and coinsurance | You pay deductible and coinsurance | |
| Normal Pregnancy Services <i>(Separate \$5,000 deductible applies)</i> | You pay deductible and coinsurance | You pay deductible and coinsurance | Not covered | Not covered | |
| Preventive Care and Wellness Services | You pay nothing up to \$500 | You pay deductible and coinsurance | You pay nothing up to \$500 | You pay deductible and coinsurance | |
| Immunizations | You pay nothing for specific listed immunizations | You pay nothing for specific listed immunizations | You pay nothing for specific listed immunizations | You pay nothing for specific listed immunizations | |
| Chiropractic Care Services | You pay deductible and coinsurance | You pay deductible and coinsurance | You pay deductible and coinsurance | Options 1 and 2: You pay 50% after deductible. Option 3: You pay nothing after deductible. | |
| Physician, Surgical and Professional Services | You pay deductible and coinsurance | You pay deductible and coinsurance | You pay deductible and coinsurance | You pay deductible and coinsurance | |
| Diagnostic Laboratory and X-ray Services | You pay deductible and coinsurance | You pay deductible and coinsurance | You pay deductible and coinsurance | You pay deductible and coinsurance | |
| Lifetime Comprehensive Benefit Limit | \$1,000,000 lifetime benefit per person | | | | |

¹ When family coverage is chosen, the entire family deductible amount must be met before you begin paying coinsurance.

Please Note: This chart is intended as a summary of our plans and benefits. This chart does not contain all benefits, exclusions, limitations or non-covered services. For additional information, you can visit our Web site at www.bcIdaho.com or call 1-888-GO-CROSS (1-888-462-7677). Upon joining, you will receive a copy of the policy and an outline of coverage. Please refer to your policy for a complete list of benefits, exclusions and limitations that apply.

Preexisting Condition

- A condition that would have caused an ordinarily prudent person to seek medical advice, diagnosis, care, or treatment during the six months immediately preceding the effective date of coverage; or
- A condition for which medical advice, diagnosis, care, or treatment was recommended or received during the six months immediately preceding the effective date of coverage; or
- A pregnancy existing on the effective date of coverage under the policy.

Preexisting Condition Waiting Period

- There are no benefits available under these policies for services, supplies, drugs, or other charges that are provided within 12 months after an insured's effective date for any preexisting condition.
- Blue Cross of Idaho shall credit any qualifying previous coverage, as defined by the Individual Health Insurance Availability Act, to the preexisting condition waiting period for new enrollees and dependents. This only applies if there was not more than a 63 day lapse in health coverage prior to the effective date of the new coverage.

Determination of Eligibility

Applicants to Blue Cross of Idaho for individual coverage must reside in Idaho and must meet the requirements of “eligible individual” as defined by state law.



FULL COVERAGE PLANS for Individuals and Families



AT BLUE CROSS OF IDAHO,
WE HAVE ONE GOAL
WHEN IT COMES TO PROVIDING
FOR OUR MEMBERS:

offering you a product
that fits your lifestyle
AT A PRICE YOU CAN AFFORD

one **to** one

BOISE

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

2100 Northwest Boulevard,
Suite 120
Coeur d'Alene, ID 83814
(208) 666-1495

IDAHO FALLS
2116 East 25th Street
Idaho Falls, ID 83404
(Mailing Address)
P.O. Box 2287
Idaho Falls, ID 83403
(208) 522-8813

LEWISTON
1010 17th Street
(Mailing Address)
P.O. Box 1468
Lewiston, ID 83501
(208) 746-0531

POCATELLO

275 South 5th Avenue,
Suite 150
Pocatello, ID 83201
(Mailing Address)
P.O. Box 2578
Pocatello, ID 83206
(208) 232-6206

TWIN FALLS

1431 North Fillmore Street,
Suite 200
Twin Falls, ID 83301
(Mailing Address)
P.O. Box 5025
Twin Falls, ID 83303-5025
(208) 733-7258

EXCLUSIONS AND LIMITATIONS

| | BlueCare® PPO | HSA Blue™ PPO |
|--|---|---|
| Physician Office Visit | You pay deductible and/or coinsurance for other services during a physician office visit. | Not limited. |
| Prescription Drugs | Prescription drug benefit limited to a maximum of \$1,200 per person, per benefit period. 90-day supply limit, mail order available. | Prescription drug benefit limited to a maximum of \$1,200 per person, per benefit period. 90-day supply limit, mail order available. |
| Inpatient and Outpatient Hospital Services | Not limited. Includes physician services, preadmission testing, outpatient surgery and diagnostic mammography. | Not limited. Includes physician services, preadmission testing, outpatient surgery and diagnostic mammography. |
| Emergency Room Services | Not limited. | Not limited. |
| Pregnancy Services | A separate \$5,000 deductible applies, except in cases of involuntary complications. Involuntary complications of pregnancy covered as any other illness. | Not covered. |
| Preventive Care and Wellness Services | Subject to deductible and coinsurance when in excess of \$500. Specifically listed services only. Deductible and coinsurance apply to non-listed and out-of-network services. (Including but not limited to, well-baby and well-child care and adult examinations.) | Subject to deductible and coinsurance when in excess of \$500. Specifically listed services only. Deductible and coinsurance apply to non-listed and out-of-network services. (Including but not limited to, well-baby and well-child care and adult examinations.) |
| Immunizations | Benefit limited to specifically listed immunizations. | Benefit limited to specifically listed immunizations. |
| Chiropractic Care Services | Limited to \$800 per person, per benefit period, deductible applies. | Limited to \$800 per person, per benefit period, deductible applies. |
| Physician, Surgical and Professional Services | Not limited. | Not limited. |
| Diagnostic Laboratory and X-ray Services | Not limited. | Not limited. |

This chart does not contain all benefits, exclusions, limitations or non-covered services. Upon joining, you will receive a copy of the policy and an outline of coverage. Please refer to your policy for a complete list of benefits, exclusions and limitations that apply.