



# LIMITED COVERAGE PLANS FOR INDIVIDUALS AND FAMILIES

BENEFITS	ESSENTIAL BLUE <sup>SM</sup> PLUS PPO A LIMITED BENEFIT PLAN		ESSENTIAL BLUE <sup>SM</sup> BASIC PPO A LIMITED BENEFIT PLAN		LATITUDE <sup>SM</sup> AN INTRODUCTORY LIMITED BENEFIT PLAN		DEFINITIONS YOU NEED TO KNOW
	Depending on the option, YOU PAY:		Depending on the option, YOU PAY:		Depending on the option, YOU PAY:		
Deductible	<b>Per Person</b> Option 1: \$1,000 Option 2: \$2,000 Option 3: \$3,000 Option 4: \$5,000	<b>Per Family</b> Option 1: \$2,000 Option 2: \$4,000 Option 3: \$6,000 Option 4: \$10,000	<b>Per Person</b> Option 1: \$1,000 Option 2: \$2,000 Option 3: \$3,000 Option 4: \$5,000	<b>Per Family</b> Option 1: \$2,000 Option 2: \$4,000 Option 3: \$6,000 Option 4: \$10,000	<b>Per Person</b> \$250	<b>Per Family</b> \$500	<p><b>1. Deductible</b> – 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><b>2. Coinsurance</b> – 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><b>3. Copayment</b> – 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><b>4. Amount Charged vs. Amount Allowed</b> – 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><b>5. In-Network vs. Out-of-Network</b> – 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><b>6. Out-of-Pocket Maximum</b> – 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><b>7. Generic Drug</b> – 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><b>8. Formulary Drug</b> – 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><b>9. EOB</b> – 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><b>10. Non-Covered Service</b> – 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><b>Note: These definitions are for summary explanation only. Please refer to your policy for specific definitions related to your benefits.</b></p>
Coinsurance ( <i>Deductible applies unless otherwise indicated</i> )	<b>In-network</b> 20%	<b>Out-of-network</b> 50%	<b>In-network</b> 20%	<b>Out-of-network</b> 50%	<b>In-network</b> 20%	<b>Out-of-network</b> 50%	
Copayment ( <i>Per person, per visit unless otherwise indicated</i> )	Option 1: \$30 Option 2: \$30 Option 3: \$30 Option 4: \$30		Not applicable except for Emergency Room Services		\$25 for primary care provider \$50 for specialist		
Out-of-Pocket Maximum	<b>In-network</b> Option 1: \$3,000 Option 2: \$4,000 Option 3: \$5,000 Option 4: \$7,000	<b>Out-of-network</b> Option 1: \$3,000 Option 2: \$4,000 Option 3: \$5,000 Option 4: \$7,000	<b>In-network</b> Option 1: \$3,000 Option 2: \$4,000 Option 3: \$5,000 Option 4: \$7,000	<b>Out-of-network</b> Option 1: \$3,000 Option 2: \$4,000 Option 3: \$5,000 Option 4: \$7,000	<b>In-network</b> \$3,000	<b>Out-of-network</b> \$3,000	
	<b>In-network</b>	<b>Out-of-network</b>	<b>In-network</b>	<b>Out-of-network</b>	<b>In-network</b>	<b>Out-of-network</b>	
Physician Office Visits	You pay \$30 copayment	You pay deductible and coinsurance	Not covered		\$25 for primary care provider \$50 for specialist (non primary care provider)	You pay deductible and coinsurance	
Prescription Drugs	You pay 50% coinsurance for all options. No deductible required. Benefit limited to \$1,200 per person, per benefit period.		Not covered		You pay 50% coinsurance for all options. No deductible required. \$1,200 maximum for brand-name drugs. Coverage includes contraceptives.		
Inpatient and Outpatient Hospital Services	You pay deductible and coinsurance	You pay deductible and coinsurance	You pay deductible and coinsurance	You pay deductible and coinsurance	You pay deductible and coinsurance	You pay deductible and coinsurance	
Emergency Room Facility Services ( <i>Subject to \$100 copayment, waived if admitted</i> )	You pay deductible and coinsurance	You pay deductible and coinsurance	You pay deductible and coinsurance	You pay deductible and coinsurance	You pay deductible and coinsurance	You pay deductible and coinsurance	
Emergency Room Physician Services	You pay deductible and coinsurance	You pay deductible and coinsurance	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	You pay deductible and coinsurance	You pay deductible and coinsurance	You pay deductible and coinsurance	You pay deductible and coinsurance	
Preventive Care and Wellness Services	You pay nothing up to \$500	You pay deductible and coinsurance	Not covered		You pay nothing up to \$500	You pay deductible and coinsurance	
Immunizations	You pay nothing		Not covered		You pay nothing		
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	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 Inpatient only	You pay deductible and coinsurance Inpatient only	You pay deductible and coinsurance	You pay deductible and coinsurance	
Lifetime Comprehensive Benefit Limit	\$1,000,000 lifetime benefit per person						

**Please Note: THESE PLANS PROVIDE LIMITED BENEFITS THAT ARE SUPPLEMENTAL AND NOT INTENDED TO COVER ALL MEDICAL EXPENSES.** 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](http://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. To see the Exclusions and Limitations that pertain to the benefits and services listed above, please refer to the table on the back of this brochure. For a complete list of benefits, exclusions and limitations that apply, please refer to your policy.

**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.

If you have questions or need additional information, please contact your Independent Insurance Agent or go online to [www.bcidaho.com](http://www.bcidaho.com) to view all plans including dental.

Essential Blue Plus PPO – 14-061 (01/08), Essential Blue Basic PPO – 14-065 (01/08), Latitude – 3-388 (01/08). Also available BlueCare PPO – 3-308 (01/07), HSA Blue PPO – 14-053 (01/07), Personal Blue – 3-375 (01/07), Dental Blue PPO – 3-390 (01/07).



## LIMITED 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

Form No. 3-714LB (05-08)

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

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### EXCLUSIONS AND LIMITATIONS

	Essential Blue Plus PPO	Essential Blue Basic PPO	Latitude
<b>Benefits</b>			
<b>Physician Office Visit</b>	Limited to 10 office visits per person, per benefit period, including preventive care services.	Not covered	Limited to 10 office visits per person, per benefit period, including preventive care services.
<b>Prescription Drugs</b>	Maximum benefit limited of \$1,200 per person, per benefit period for all prescription drugs. Brand name and generic drugs limited to 90-day supply at one time. Smoking cessation drug limit of \$600 per person, per benefit period and a 30-day supply at one time.	Not covered	Maximum benefit limited of \$1,200 per person, per benefit period for brand name prescription drugs. Brand name and generic drugs limited to 90-day supply at one time. Smoking cessation drug limit of \$600 per person, per benefit period and a 30-day supply at one time.
<b>Inpatient and Outpatient Hospital Services</b>	Not limited	Coverage not provided for unlimited hospital or medical/surgical expenses. Limited to inpatient diagnostic and hospital services, outpatient surgery and preadmission testing.	Not limited
<b>Emergency Room Services</b>	No limitations after \$100 emergency room facility copayment.		
<b>Normal Pregnancy Services</b>	Separate \$5,000 deductible, does not waive family or individual deductibles and is not included in out-of-pocket limit. Coverage limited to only enrollee or their enrolled eligible dependent spouse. Pregnancy services do not apply to office visit and outpatient diagnostic services limits. Involuntary complications of pregnancy treated as any other illness. A pregnancy existing on the policy effective date considered a preexisting condition. There are no benefits for an elective abortion, unless to preserve the life of the female upon whom the abortion is performed.		
<b>Preventive Care and Wellness Services</b>	\$500 first-dollar benefit covers specifically listed in-network services. Deductible and coinsurance apply to non-listed and out-of-network services. Preventive and wellness office visits apply to physician office visit limit.	Not covered	\$500 first dollar benefit covers specifically listed in-network services. Deductible and coinsurance apply to non-listed and out-of-network services. Preventive and wellness office visits apply to physician office visit limit.
<b>Immunizations</b>	Benefit limited to specifically listed immunizations. Travel vaccines excluded.	Not covered	Benefit limited to specifically listed immunizations. Travel vaccines excluded.
<b>Physician, Surgical and Professional Services</b>	Coverage not provided for unlimited medical/surgical expenses. Benefit limited to inpatient, physician, surgical and medical services.		
<b>Diagnostic Laboratory and X-ray Services</b>	Outpatient diagnostic services limited to combined total of \$2,000 per person, per benefit period. Non-listed preventive diagnostic services apply to limit. Limit does not include outpatient diagnostic mammography, preoperative lab and x-ray or normal pregnancy related diagnostic services.	Benefit excludes outpatient diagnostic services except for mammography.	Outpatient diagnostic services limited to combined total of \$2,000 per person, per benefit period. Non-listed preventive diagnostic services apply to limit. Limit does not include outpatient diagnostic mammography, preoperative lab and x-ray or normal pregnancy related diagnostic services.