Connected Care Plans
for Individuals from
Blue Cross of Idaho

Choose coverage that fits.

Form No. 3-191 (08-14) Policy Form Numbers:
18-067-01/15
18-068-01/15
18-069-01/15
18-070-01/15
18-071-01/15
18-072-01/15
18-073-01/15
18-078-01/15
18-216-01/15
18-226-01/15
3-420-05/11
WHAT IS CONNECTEDCARE?

ConnectedCare℠ brings you, your medical providers and Blue Cross of Idaho together to bring you proactive, affordable quality managed care.

ConnectedCare is a group of managed care health insurance plans that are supported by select provider networks within southwestern and eastern Idaho. You can identify these plans by their Connect name.

With a Connect plan, you partner with a primary care physician (PCP) of your choice from the Connect network where you live. These physicians and providers are dedicated to delivering effective and efficient care.

You can view a complete list of providers on the Blue Cross of Idaho website at bcidaho.com/saintalphonsus or bcidaho.com/portneuf.

You and your PCP will work together to navigate your medical options and effectively manage your health and wellness.

When you need specialized medical care, your PCP will coordinate care between all of your providers to ensure you receive the best treatment possible.

Blue Cross of Idaho Connect Plans

<table>
<thead>
<tr>
<th>Plan</th>
<th>Connect</th>
<th>Connect 2000, 3000, 4000, &amp; No Deductible</th>
<th>Connect</th>
</tr>
</thead>
<tbody>
<tr>
<td>BRONZE</td>
<td>Connect</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SILVER</td>
<td>Connect</td>
<td></td>
<td></td>
</tr>
<tr>
<td>GOLD</td>
<td>Connect</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PLATINUM</td>
<td>Connect*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CATASTROPHIC</td>
<td>Connect</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*At this time, our Platinum plan is part of our ConnectedCare network in southwest Idaho only.
Where is ConnectedCare offered?

In southwest Idaho, ConnectedCare is supported by the Saint Alphonsus Health Alliance network of more than 1,500 highly-skilled physicians and providers, including those at Saint Alphonsus, Primary Health, and independent practices throughout Ada, Canyon, Gem, Payette, Washington, and Malheur counties.

In eastern Idaho, ConnectedCare is supported by the Portneuf Quality Alliance network of more than 650 highly-skilled physicians and providers, including those at Portneuf Medical Center and independent practices throughout Bannock and Bingham counties.

QUALITY CARE IN SOUTHWEST IDAHO...

Saint Alphonsus is the Region’s only certified Level II Trauma Center, Chest Pain Center, Inpatient Diabetes Center and Stroke Center. US News & World Report ranked Saint Alphonsus Regional Medical Center the #1 Hospital in Idaho, 2013–2014.

It is a four-hospital regional system with over 4,300 associates and nearly 1,100 independent and employed medical staff serving 700,000 people in Idaho and Oregon. It provides the most experienced care to critically ill and injured patients, and highest quality care to all.

...AND EASTERN IDAHO

Portneuf Medical Center is an acute care facility that has served the healthcare needs of eastern Idaho since 1907. With more than 1,100 employees, Portneuf Medical Center has emerged as the second largest employer in Bannock County. Portneuf Medical Center was given the highest quality rating for surgery outcomes by a leading consumer magazine and their heart surgery program is nationally recognized.

Portneuf Medical Center’s services include full Neonatal Intensive Care, Trauma, Cardiovascular Surgery, a comprehensive Cancer Center, Neurosurgery, and Behavioral Health including an inpatient Geropsych program.
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)

<table>
<thead>
<tr>
<th>Family Size and Income</th>
<th>Cost Sharing Reduction 250% of FPL</th>
<th>Monthly Premium Tax Credit 400% of FPL</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>If you make less than this, you may qualify for help paying expenses such as deductible and coinsurance payments.</td>
<td>If you make less than this, you may qualify for help paying your monthly premiums.</td>
</tr>
<tr>
<td>1</td>
<td>$11,670</td>
<td>$29,175</td>
</tr>
<tr>
<td>2</td>
<td>$15,730</td>
<td>$39,325</td>
</tr>
<tr>
<td>3</td>
<td>$19,790</td>
<td>$49,475</td>
</tr>
<tr>
<td>4</td>
<td>$23,850</td>
<td>$59,625</td>
</tr>
<tr>
<td>5</td>
<td>$27,910</td>
<td>$69,775</td>
</tr>
<tr>
<td>6</td>
<td>$31,970</td>
<td>$79,925</td>
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<tr>
<td>7</td>
<td>$36,030</td>
<td>$90,075</td>
</tr>
<tr>
<td>8</td>
<td>$40,090</td>
<td>$100,225</td>
</tr>
</tbody>
</table>

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

**Benefit Details**

<table>
<thead>
<tr>
<th>Deductible</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>$6,350 per person or $12,700 per family</td>
<td>$6,350 per person or $12,700 per family</td>
<td></td>
</tr>
</tbody>
</table>

**Coinsurance**

The percentage you pay of the allowed amount for covered services after meeting your deductible.

**Annual Out-of-Pocket Maximum**

Includes your deductible, copayments, coinsurance, and prescription deductible.

<table>
<thead>
<tr>
<th>Benefit Details</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductible</td>
<td>$6,350 per person or $12,700 per family</td>
<td>For in-network care, the most you’ll pay over the course of a year is $6,350 (individual) or $12,700 (family).</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>You pay no coinsurance once you’ve met your deductible.</td>
<td>Once you’ve met your deductible, you pay 30% of the cost of your covered care.</td>
</tr>
<tr>
<td>Annual Out-of-Pocket Maximum</td>
<td>For in-network care, the most you’ll pay over the course of a year is $6,350 (individual) or $12,700 (family).</td>
<td>For covered care, the most you’ll pay over the course of a year is $10,000 (individual) or $20,000 (family).</td>
</tr>
</tbody>
</table>

**WHAT YOU’LL PAY UP TO YOUR ANNUAL OUT-OF-POCKET MAXIMUM**

<table>
<thead>
<tr>
<th>Doctor’s Office Visit/Urgent Care</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>You pay $30 copayment for primary care $50 copayment for specialist visits, up to a combined total of 5 visits per person.</td>
<td>Once you’ve met your deductible, you pay 30% of the cost of your covered care.</td>
<td></td>
</tr>
<tr>
<td>Emergency Room Services</td>
<td>Once you’ve met your deductible, you pay nothing.</td>
<td>Once you’ve met your deductible, you pay 30% of the cost of your covered care.</td>
</tr>
<tr>
<td>Prescription Drugs</td>
<td>Prescription drug costs count toward your out-of-pocket maximum.</td>
<td>Once you’ve met your deductible, you pay nothing.</td>
</tr>
<tr>
<td>Diagnostic X-Ray and Lab Services</td>
<td>Once you’ve met your deductible, you pay nothing.</td>
<td>Once you’ve met your deductible, you pay 30% of the cost of your covered care.</td>
</tr>
<tr>
<td>Inpatient Hospital Services</td>
<td>Once you’ve met your deductible, you pay nothing.</td>
<td>Once you’ve met your deductible, you pay 30% of the cost of your covered care.</td>
</tr>
<tr>
<td>Outpatient Rehab Services</td>
<td>Once you’ve met your deductible, you pay nothing.</td>
<td>Once you’ve met your deductible, you pay 30% of the cost of your covered care.</td>
</tr>
<tr>
<td>Physician, Surgical &amp; Medical Services</td>
<td>Once you’ve met your deductible, you pay nothing.</td>
<td>Once you’ve met your deductible, you pay 30% of the cost of your covered care.</td>
</tr>
<tr>
<td>Pregnancy Services</td>
<td>Once you’ve met your deductible, you pay nothing.</td>
<td>Once you’ve met your deductible, you pay 30% of the cost of your covered care.</td>
</tr>
<tr>
<td>Chiropractic Care</td>
<td>Once you’ve met your deductible, you pay nothing.</td>
<td>Once you’ve met your deductible, you pay 50% of the cost of your covered care.</td>
</tr>
<tr>
<td>Diabetes Education Services</td>
<td>You pay $30 copayment per visit.</td>
<td>Once you’ve met your deductible, you pay 30% of the cost of your covered care.</td>
</tr>
<tr>
<td>Outpatient Mental Health &amp; Substance Abuse Services</td>
<td>You pay $30 copayment per visit.</td>
<td>Once you’ve met your deductible, you pay 30% of the cost of your covered care.</td>
</tr>
<tr>
<td>Preventive Care</td>
<td>You pay nothing for listed preventive care.</td>
<td>Once you’ve met your deductible, you pay 30% of the cost of your covered care.</td>
</tr>
<tr>
<td>Immunizations</td>
<td>You pay nothing for listed immunizations.</td>
<td>Once you’ve met your deductible, you pay 30% of the cost of your covered care.</td>
</tr>
</tbody>
</table>

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**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.

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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.
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.

<table>
<thead>
<tr>
<th>METAL LEVEL</th>
<th>SILVER CONNECT 4000</th>
<th>SILVER CONNECT 3000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benefit Details</td>
<td>In-Network</td>
<td>Out-of-Network</td>
</tr>
<tr>
<td>Deductible</td>
<td>$4,000 per person or $8,000 per family</td>
<td>$4,000 per person or $8,000 per family</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>Once you’ve met your deductible, you pay 30% of the cost of your covered care.</td>
<td>Once you’ve met your deductible, you pay 50% of the cost of your covered care.</td>
</tr>
<tr>
<td>Annual Out-of-Pocket Maximum</td>
<td>For in-network care, the most you’ll pay over the course of a year is $6,350 (individual) or $12,700 (family).</td>
<td>For covered care, the most you’ll pay over the course of a year is $10,000 (individual) or $20,000 (family).</td>
</tr>
</tbody>
</table>

**WHAT YOU’LL PAY UP TO YOUR ANNUAL OUT-OF-POCKET MAXIMUM**

**Doctor’s Office Visit/Urgent Care**
- You pay $10 copayment for primary care and $40 copayment for specialists up to a combined total of 5 visits per person.1 For additional visits, once you’ve met your deductible, you pay 30% of the cost of your covered care.
- You pay $150 copayment per visit. Once you’ve met your deductible, you pay copayment and 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 30% of the cost of your covered care.

**Prescription 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.

**Diagnostic X-Ray and Lab Services**
- 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

**Inpatient Hospital Services**
- 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

**Outpatient Rehab Services3**
- 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

**Physician, Surgical & Medical Services**
- 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

**Pregnancy Services**
- 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

**Chiropractic Care4**
- You pay $10 copayment per visit.
- You pay $10 copayment per visit.

**Diabetes Education Services**
- You pay $20 copayment per visit.
- You pay $20 copayment per visit.

**Outpatient Mental Health & Substance Abuse Services**
- You pay $20 copayment per visit.
- You pay $20 copayment per visit.

**Preventive Care**
- You pay $0 copayment for listed preventive care.
- You pay $0 copayment for listed preventive care.

**Immunizations**
- You pay nothing for listed immunizations.
- You pay nothing for listed immunizations.

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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 Some services may require additional copayments, coinsurance, and prescription deductible.

4 Preventive services typically do not require a deductible.
**METAL LEVEL**

<table>
<thead>
<tr>
<th>Benefit Details</th>
<th>Silver Connect 2000</th>
<th>Silver Connect NO Deductible</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Deductible</strong></td>
<td>In-Network</td>
<td>Out-of-Network</td>
</tr>
<tr>
<td></td>
<td>$2,000 per person or $4,000 per family</td>
<td>$2,000 per person or $4,000 per family</td>
</tr>
<tr>
<td></td>
<td>Once you’ve met your deductible, you pay 30% of the cost of your covered care.</td>
<td>Once you’ve met your deductible, you pay 50% of the cost of your covered care.</td>
</tr>
<tr>
<td><strong>Annual Out-of-Pocket Maximum</strong></td>
<td>Includes your deductible, copayments, coinsurance, and prescription deductible.</td>
<td>You pay 50% of the cost of your covered care.</td>
</tr>
<tr>
<td></td>
<td>For in-network care, the most you’ll pay over the course of a year is $6,350 (individual) or $12,700 (family).</td>
<td>For in-network care, the most you’ll pay over the course of a year is $10,000 (individual) or $20,000 (family).</td>
</tr>
</tbody>
</table>

**WHAT YOU’LL PAY UP TO YOUR ANNUAL OUT-OF-POCKET MAXIMUM**

<table>
<thead>
<tr>
<th>Doctor’s Office Visit/Urgent Care</th>
<th>Silver Connect 2000</th>
<th>Silver Connect NO Deductible</th>
</tr>
</thead>
<tbody>
<tr>
<td>You pay $45 copayment for primary care and $65 copayment for specialists up to a combined total of 5 visits per person.</td>
<td>Once you’ve met your deductible, you pay 30% of the cost of your covered care.</td>
<td>You pay 50% of the cost of your covered care.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Emergency Room Services</th>
<th>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.</th>
</tr>
</thead>
<tbody>
<tr>
<td>You pay $150 copayment per visit. Once you’ve met your deductible, you pay copayment and 30% of the cost of your covered care.</td>
<td>Once you’ve met your deductible, you pay copayment and 50% of the cost of your covered care.</td>
</tr>
<tr>
<td>Prescription Drugs</td>
<td>Prescription drug costs count toward your out-of-pocket maximum.</td>
</tr>
</tbody>
</table>
| You pay $10 copayment for generic drugs. | You pay 50% of the cost of your covered prescriptions.  

| Diagnostic X-Ray and Lab Services |  
|-----------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Inpatient Hospital Services      | You pay $45 copayment for primary care and $65 copayment for specialists up to a combined total of 5 visits per person.  

| Outpatient Rehab Services³       | You pay nothing for listed preventive care.                                                                                                                                                    |
|                                  | You pay nothing for listed preventive care.  

| Physician, Surgical & Medical Services |  
|---------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Pregnancy Services                  | You pay $45 copayment for primary care and $65 copayment for specialists up to a combined total of 5 visits per person.  

| Chiropractic Care⁴                 | You pay $50 copayment for primary care and $65 copayment for specialists up to a combined total of 5 visits per person.  

| Diabetes Education Services        | You pay $0 copayment for primary care and $65 copayment for specialists up to a combined total of 5 visits per person.  

| Outpatient Mental Health & Substance Abuse Services | You pay $45 copayment for primary care and $65 copayment for specialists up to a combined total of 5 visits per person.  

| Preventive Care                    | You pay $45 copayment for primary care and $65 copayment for specialists up to a combined total of 5 visits per person.  

| Immunizations                      | You pay $45 copayment for primary care and $65 copayment for specialists up to a combined total of 5 visits per person.  

³Includes 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.

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

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

<table>
<thead>
<tr>
<th>Benefit Details</th>
<th>GOLD CONNECT</th>
<th>PLATINUM CONNECT</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Deductible</strong></td>
<td>In-Network</td>
<td>Out-of-Network</td>
</tr>
<tr>
<td>$1,000 per person or $2,000 per family</td>
<td>$1,000 per person or $2,000 per family</td>
<td>$550 per person or $1,100 per family</td>
</tr>
<tr>
<td><strong>Coinsurance</strong></td>
<td>Once you’ve met your deductible, you pay 15% of the cost of your covered care.</td>
<td>Once you’ve met your deductible, you pay 50% of the cost of your covered care.</td>
</tr>
<tr>
<td><strong>Annual Out-of-Pocket Maximum</strong></td>
<td>For in-network care, the most you’ll pay over the course of a year is $12,700 (individual) or $20,000 (family).</td>
<td>For covered care, the most you’ll pay over the course of a year is $10,000 (individual) or $12,700 (family).</td>
</tr>
</tbody>
</table>

### WHAT YOU’LL PAY UP TO YOUR ANNUAL OUT-OF-POCKET MAXIMUM

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Gold Connect</th>
<th>Platinum Connect</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Doctor’s Office Visit/Urgent Care</strong></td>
<td>You pay $10 copayment for primary care and $40 copayment for specialists, up to a combined total of 5 visits per person.</td>
<td>You pay $10 copayment for primary care and $40 copayment for specialists, up to a combined total of 5 visits per person.</td>
</tr>
<tr>
<td><strong>Emergency Room Services</strong></td>
<td>You pay $150 copayment per visit. Once you’ve met your deductible, you pay copayment and 15% of the cost of your covered care.</td>
<td>You pay $150 copayment per visit. Once you’ve met your deductible, you pay copayment and 50% of the cost of your covered care.</td>
</tr>
<tr>
<td><strong>Prescription Drugs</strong></td>
<td>You pay $10 copayment for generic drugs.</td>
<td>You pay $10 copayment for generic drugs, $30 copayment for preferred brand-name, $50 copayment for non-preferred brand-name, and $100 copayment for specialty drugs.</td>
</tr>
<tr>
<td><strong>Diagnostic X-Ray and Lab Services</strong></td>
<td>Once you’ve met your deductible, you pay 15% of the cost of your covered care.</td>
<td>You pay $200 copayment for facility services related to pregnancy care. For other listed services, once you’ve met your deductible, you pay nothing.</td>
</tr>
<tr>
<td><strong>Inpatient Hospital Services</strong></td>
<td>Once you’ve met your deductible, you pay 50% of the cost of your covered care.</td>
<td>Once you’ve met your deductible, you pay 50% of the cost of your covered care.</td>
</tr>
<tr>
<td><strong>Outpatient Rehab Services</strong></td>
<td>Once you’ve met your deductible, you pay 15% of the cost of your covered care.</td>
<td>Once you’ve met your deductible, you pay 50% of the cost of your covered care.</td>
</tr>
<tr>
<td><strong>Physician, Surgical &amp; Medical Services</strong></td>
<td>Once you’ve met your deductible, you pay 50% of the cost of your covered care.</td>
<td>Once you’ve met your deductible, you pay 50% of the cost of your covered care.</td>
</tr>
<tr>
<td><strong>Pregnancy Services</strong></td>
<td>Once you’ve met your deductible, you pay nothing.</td>
<td>Once you’ve met your deductible, you pay 50% of the cost of your covered care.</td>
</tr>
<tr>
<td><strong>Chiropractic Care</strong></td>
<td>You pay $10 copayment per visit.</td>
<td>You pay $10 copayment per visit.</td>
</tr>
<tr>
<td><strong>Diabetes Education Services</strong></td>
<td>Once you’ve met your deductible, you pay 50% of the cost of your covered care.</td>
<td>Once you’ve met your deductible, you pay 50% of the cost of your covered care.</td>
</tr>
<tr>
<td><strong>Outpatient Mental Health &amp; Substance Abuse Services</strong></td>
<td>You pay $10 copayment per visit.</td>
<td>You pay $10 copayment per visit.</td>
</tr>
<tr>
<td><strong>Preventive Care</strong></td>
<td>You pay nothing for listed preventive care.</td>
<td>You pay nothing for listed preventive care.</td>
</tr>
<tr>
<td><strong>Immunizations</strong></td>
<td>You pay nothing for listed immunizations.</td>
<td>You pay nothing for listed immunizations.</td>
</tr>
</tbody>
</table>

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.
### COVERED CONNECT

Covered Connect is one of two high-deductible, low payment “catastrophic” plans available to people under age 30 or to people who qualify for a hardship exemption through Your Health Idaho.

Like our other Connect plans, Covered Connect requires you to select a Primary Care Physician (PCP) who will see you for primary care and coordinate any other care you need. This plan provides benefits for 3 primary care visits a year with only a $30 copayment due each time — even if you haven’t met your deductible yet. And like Blue Cross of Idaho’s other qualified health plans, you pay nothing for covered preventive care and immunizations.

If you are under age 30, or if you meet certain income criteria through Your Health Idaho, one of these plans may be a good choice for you. The catastrophic plans are not eligible for the monthly premium tax credit or cost-sharing subsidy available when you purchase health insurance through Your Health Idaho.

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**METAL LEVEL**

<table>
<thead>
<tr>
<th>Benefit Details</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductible</td>
<td>$6,600 per person or $13,200 per family</td>
<td>$6,600 per person or $13,200 per family</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>Once you’ve met your deductible, you pay nothing.</td>
<td>Once you’ve met your deductible, you pay 30% of the cost of your covered care.</td>
</tr>
<tr>
<td>Annual Out-of-Pocket Maximum</td>
<td>For in-network care, the most you’ll pay over the course of a year is $6,600 (individual) or $13,200 (family).</td>
<td>For covered care, the most you’ll pay over the course of a year is $10,000 (individual) or $20,000 (family).</td>
</tr>
</tbody>
</table>

**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 3 primary care visits per person. For additional visits, and specialists, you pay costs up to your deductible.
  - 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.

- **Emergency Room Services:**
  - 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.

- **Prescription Drugs**
  - Prescription drug costs count toward your out-of-pocket maximum.
  - You pay nothing for covered prescriptions.
  - Once you’ve met your deductible, you pay nothing for covered prescriptions.

- **Diagnostic X-Ray and Lab Services**
  - Once you’ve met your deductible, you pay nothing for covered care.

- **Inpatient Hospital Services**
  - 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 Rehab Services**
  - 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.

- **Physician, Surgical & Medical Services**
  - 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**
  - 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**
  - 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**
  - 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 30% of the cost of your covered care.

- **Immunizations**
  - You pay nothing for listed immunizations.

*Catastrophic plans are only available to people under the age of 30, or to people who qualify for a hardship exemption through the exchange.*
YOU MIGHT BE WONDERING

WHAT IF I RECEIVE HEALTHCARE SERVICES FROM A DOCTOR OR HOSPITAL THAT ISN’T PART OF THE CONNECTEDCARE NETWORK?
You will incur higher out-of-pocket costs if you receive services from a provider outside your ConnectedCare network.

WHAT HAPPENS IF I DON’T CHOOSE A CONNECTEDCARE PCP?
Blue Cross of Idaho will automatically assign a PCP to you. However, you are free to change to a different PCP anytime. If you do select a different PCP, we ask that you call customer service at the number on the back of your member ID card so we can note it in our records.

HOW DO I RECEIVE CARE FROM A SPECIALIST?
You must obtain a referral from your PCP to see a specialist to receive the highest level of benefits. So, don’t wait until you get sick or need medical services to establish care with your PCP. Remember, your PCP is responsible for coordinating your overall care, and you’ll likely incur additional costs if you receive services outside your network or from a specialist without a referral. You do not need a referral to see a network obstetrician and gynecologist for covered maternity care, annual exams, or follow-up care for conditions diagnosed during maternity care or an annual exam. Also, you do not need a referral before seeking emergency room services.

WHAT IF I NEED URGENT CARE OR EMERGENCY SERVICES?
If you experience a medical emergency, you do not need a referral and should seek medical treatment immediately. You do not need a referral for an urgent care provider, but you will pay a slightly higher copayment amount. See pages 5–9 for specific copayment amounts for each plan.

SHOULD I CHOOSE CONNECTEDCARE?
If you have a strong relationship with a provider who is not a member of the ConnectedCare network, you might consider one of Blue Cross of Idaho’s Choice plans instead. Our Choice plans use our Preferred Provider Network, which contracts with every hospital in Idaho and 96 percent of all Idaho physicians and healthcare providers. See our Health Insurance Plans for Individuals brochure for more details.
ADDITIONAL PLANS TO MEET YOUR NEEDS

PPO Network Plans
In addition to the Connect plans in this brochure, our Choice plans come with access to our robust Preferred Provider Organization (PPO) network, featuring 96 percent of doctors and all hospitals in Idaho. This gives you the freedom to choose any provider you want to receive care from. Blue Cross of Idaho's Choice plans come in Bronze, Silver, and Gold metal levels. See our Health Insurance Plans for Individuals to learn more.

A Health Savings Account
Blue Cross of Idaho’s Bronze HSA Saver is a health plan that you can pair with a Health Savings Account (HSA) you set up at your financial institution, such as a bank. You can use the tax-free money you deposit into your HSA to cover a wide range of medical costs like your deductible and other qualified medical costs. If you don’t use the money, you can keep it in your account to earn interest and use for qualified medical costs when you need it at any time in the future.

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. Dental coverage for members under 19 is considered one of ten 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.

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.
 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 Member. The Member is financially responsible for Non-Medically Necessary services performed by a provider who does not have a provider contract with Blue Cross of Idaho.

Blue Cross of Idaho will respond to a request for Prior Authorization for the services listed below received from either the Provider or the Member 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 Member’s Identification Card or check the Blue Cross of Idaho website at www.bcidaho.com.

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.

When Prior Authorization for a Covered Service is required of and obtained by or on behalf of a Member, we will provide benefits in accordance with the Prior Authorization and the terms of this Contract after the Covered Service has been
provided except in cases of fraud, intentional misrepresentation, nonpayment of premium, exhaustion of benefits or if the Member for whom the Prior Authorization was granted is not enrolled at the time the Covered Service was provided.

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

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 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, 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:
  o Reconstructive Surgery necessary to treat an Accidental Injury, infection or other Disease of the involved part; or
  o 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.
EXCLUSIONS AND LIMITATIONS

- 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 prescribng 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 homeopathists.
- 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.