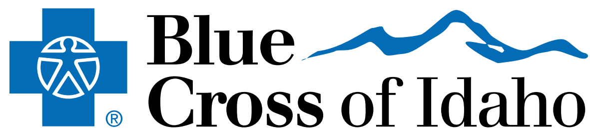
Full Coverage Plans for Individuals and Families

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

Form No. 3-714 (04-11)



Full Coverage Plans for Individuals and Families

	Simply Blue®		BlueCare® PPO		HSA Blue℠ PPO	
	Depending on the option, YOU PAY:		Depending on the option, YOU PAY:		Depending on the option, YOU PAY:	
Deductible	**Per Person** Option 1: $2,500 Option 2: $5,000 Option 3: $7,5000 Option 4: $10,000	**Per Family** Option 1: $5,000 Option 2: $10,000 Option 3: $15,000 Option 4: $20,000	**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 Family**[1] Option 1a: $4,000 Option 1b: $4,000 Option 2a: $6,000 Option 2b: $6,000 Option 3: $10,000
Coinsurance *(Deductible applies unless otherwise indicated)*	**In-network** Options 1,2 and 3: 30% Option 4: Nothing	**Out-of-network** 50%	**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
Out-of-Pocket Maximum	**In and out-of-network** Options 1, 2 and 3: 10,000 limit, combined in and out-of network, includes deductible **In-network** Option 4: $10,000 in-network limit, includes deductible	**Out-of-network** Option 4 only: $15,000 out-of-network includes deductible	**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**	**In-network**	**Out-of-network**
Physician Office Visits	You pay $25 copayment per visit: not subject to deductible, limit of four office visits per person, per benefit period and then you pay 30% after deductible	You pay applicable deductible and coinsurance	You pay Option 1: $25 copayment Option 2: $30 copayment Option 3: $35 copayment	You pay applicable deductible and coinsurance	You pay applicable deductible and coinsurance	You pay applicable deductible and coinsurance
Prescription Drugs	You pay $15 copayment per prescription for generics. Brand-name prescriptions require separate $5,000 deductible, and then you pay a $30 copayment per prescription. The smoking cessation drug Chantix is limited to a 30-day supply at one time and a 90-day supply per person per benefit period.		You pay $15 copayment per prescription for generics. Brand-name prescriptions require separate $5,000 deductible, and then you pay a $30 copayment per prescription. The smoking cessation drug Chantix is limited to a 30-day supply at one time and a 90-day supply per person per benefit period.		Brand Name & Generic Drugs[2] Generic Drugs only	You pay 50% coinsurance after meeting your deductible. 90-day supply limit, mail order available.[2] Option 3: You pay nothing after meeting your deductible
Inpatient and Outpatient Hospital Services	You pay applicable deductible and coinsurance	You pay applicable deductible and coinsurance	You pay applicable deductible and coinsurance	You pay applicable deductible and coinsurance	You pay applicable deductible and coinsurance	You pay applicable deductible and coinsurance
Emergency Room Services	You pay $100 copayment (waived if admitted to hospital) after which your deductible and coinsurance apply.		You pay applicable deductible and coinsurance	You pay applicable deductible and coinsurance	You pay applicable deductible and coinsurance	You pay applicable deductible and coinsurance
Normal Pregnancy Services	*A separate combined in-network and out-of-network $10,000 deductible applies, except in cases of involuntary complications* Option 1, 2, and 3: You pay deductible and coinsurance Option 4: You pay nothing after deductible		*Separate $5,000 deductible applies* You pay applicable deductible and coinsurance		Not covered	Not covered
Preventive Care Services	You pay nothing for specifically listed services; not subject to deductible and coinsurance	You pay applicable deductible and coinsurance	You pay nothing for specifically listed services; not subject to deductible and coinsurance	You pay applicable deductible and coinsurance	You pay nothing for specifically listed services; not subject to deductible and coinsurance	You pay applicable deductible and coinsurance
Immunizations *(Limited to specifically listed immunizations)*	You pay nothing for specifically listed immunizations; travel vaccines excluded		You pay nothing for specifically listed immunizations; travel vaccines excluded		You pay nothing for specifically listed immunizations; travel vaccines excluded	
Chiropractic Care Services *(limited to $800 per person, per benefit period)*	Not covered	Not covered	You pay applicable deductible and coinsurance	You pay applicable deductible and coinsurance	You pay applicable 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 applicable deductible and coinsurance	You pay applicable deductible and coinsurance	You pay applicable deductible and coinsurance	You pay applicable deductible and coinsurance	You pay applicable deductible and coinsurance	You pay applicable deductible and coinsurance
Diagnostic Laboratory and X-ray Services	You pay applicable deductible and coinsurance	You pay applicable deductible and coinsurance	You pay applicable deductible and coinsurance	You pay applicable deductible and coinsurance	You pay applicable deductible and coinsurance	You pay applicable deductible and coinsurance
Annual Maximum Benefit Limit	$1,250,000	$1,250,000	$1,250,000	$1,250,000	$1,250,000	$1,250,000

Definitions You Need to Know

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 benefit period.
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.
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.
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.
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.
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.
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.
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.
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.
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.

Note: These definitions are for summary explanation only. Please refer to your policy for specific definitions related to your benefits.

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

[2] The brand name smoking cessation prescription drug Chantix is limited to a 30-day supply at one time and a 90-day supply per person per benefit period.

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 website at ***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

- For insured's under the age of nineteen (19) there are no waiting periods, limitations or exclusions for covered services, supplies, drugs or other charges that are incurred on or after the insured's effective date for any preexisting condition.
- For insured's age nineteen (19) and over there are no benefits available under this policy for services, supplies, drugs or other charges that are provided within twelve (12) months after an insured's enrollment 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.

Exclusions and Limitations

	Simply Blue®	BlueCare® PPO	HSA Blue℠ PPO
Physician Office Visit	Limited to four office visits per person, per benefit period. Once you have met the limit you pay 30% of the maximum allowance after deductible.	You pay deductible and/or coinsurance for other services during a physician office visit.	Not limited.
Prescription Drugs	The smoking cessation drug Chantix is limited to a 30-day supply at one time and a 90-day supply per person per benefit period.		
Inpatient and Outpatient Hospital Services	Two bedroom, including a special care or a nursery unit and related services and supplies; blood transfusions and cost of commercial blood.	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	Copayment waived if admitted.	Not limited.	Not limited.
Pregnancy Services	The pregnancy services deductible is separate from and does not waive the annual individual deductible for eligible expenses for other conditions.	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 Services	Full coverage 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.		
Immunizations	Specifically listed immunizations may be adjusted accordingly to coincide with federal government changes, updates, and revisions.		
Chiropractic Care Services	Not covered.	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	Includes surgery, consultations, surgery assistance, administration of anesthesia, in-hospital visits and first aid care.	Not limited.	Not limited.
Diagnostic Laboratory and X-ray Services	Includes diagnostic mammograms.	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.

If you have questions or need additional information, please contact your Independent Insurance Agent or go online to bcidaho.com to view all plans.
Simply Blue Policy – 3-679 (10/10), BlueCare PPO Policy – 3-856 (10/10), HSA Blue PPO Policy – 3-677 (10/10)

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