Exclusions and Limitations

	Essential Blue Plus PPO	Essential Blue PPO
Physician Office Visit	Limited to 4 office visits per person, per benefit period. Once you have met the limit you pay 20% of the maximum allowance after deductible.	Not covered
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.	Not covered
Inpatient and Outpatient Hospital Services	Not limited	Coverage not provided for unlimited hospital or medical/ surgical expenses. Limited to inpatient diagnostic and hospital services, outpatient surgery and preadmission testing.
Emergency Room Services	No limitations after $100 emergency room facility copayment.	
Normal Pregnancy Services	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.	
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	Benefit limited to specifically listed immunizations. Travel vaccines excluded.	
Physician, Surgical and Professional Services	Coverage not provided for unlimited medical/surgical expenses. Benefit limited to inpatient, physician, surgical and medical services.	
Diagnostic Laboratory and X-ray Services	Including diagnostic mammograms.	Benefit excludes outpatient diagnostic services except for mammography.

If you have questions or need additional information, please contact your Independent Insurance Agent or go online to bcidaho.com to view all plans including dental.
Essential Blue Plus PPO – 14-061 (10/10), Essential Blue PPO – 14-065 (10/10), Latitude – 3-388 (10/10). Also available BlueCare PPO – 3-308 (10/10),
HSA Blue PPO – 14-053 (10/10), Healthy Smiles – 3-073P (10/10), 3-074P (10/10), 3-075P (10/10).

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

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

Idaho Falls

STREET ADDRESS
2116 East 25th Street
Idaho Falls, ID 83404

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

Lewiston

STREET ADDRESS
1010 17th Street
Lewiston, ID 83501

MAILING ADDRESS
P.O. Box 1468
Lewiston, ID 83501
(208) 746-0531

Pocatello

STREET ADDRESS
275 South 5th Avenue
Suite 150
Pocatello, ID 83201

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Pocatello, ID 83206
(208) 232-6206

Twin Falls

STREET ADDRESS
1431 North Fillmore Street
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P.O. Box 5025
Twin Falls, ID 83303-5025
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Form No. 3-714LB (01-11)

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

Limited Coverage Plans for Individuals and Families

	Essential Blue℠ Plus PPO A Limited Benefit Plan		Essential Blue℠ PPO A Limited Benefit Plan	
	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: $3,000 Option 4: $5,000	**Per Family** Option 1: $2,000 Option 2: $4,000 Option 3: $6,000 Option 4: $10,000	**Per Person** Option 1: $1,000 Option 2: $2,000 Option 3: $3,000 Option 4: $5,000	**Per Family** Option 1: $2,000 Option 2: $4,000 Option 3: $6,000 Option 4: $10,000
Coinsurance *(Deductible applies unless otherwise indicated)*	**In-network** 20%	**Out-of-network** 50%	**In-network** 20%	**Out-of-network** 50%
Out-of-Pocket Maximum	**In-network** Option 1: $3,000 Option 2: $4,000 Option 3: $5,000 Option 4: $7,000	**Out-of-network** Option 1: $3,000 Option 2: $4,000 Option 3: $5,000 Option 4: $7,000	**In-network** Option 1: $3,000 Option 2: $4,000 Option 3: $5,000 Option 4: $7,000	**Out-of-network** Option 1: $3,000 Option 2: $4,000 Option 3: $5,000 Option 4: $7,000
	In-network	**Out-of-network**	**In-network**	**Out-of-network**
Physician Office Visits	You pay $30 copayment; not subject to deductible	You pay applicable deductible and coinsurance	Not covered (except for specifically listed preventive care services)	
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.		Not covered	
Inpatient and Outpatient Hospital Services *(Unlimited visits)*	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 *(Subject to $100 copayment, waived if admitted)*	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 Physician 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
Normal Pregnancy Services *(Separate $5,000 deductible applies)*	You pay applicable deductible and coinsurance	You pay applicable deductible and coinsurance	You pay applicable deductible and coinsurance	You pay applicable deductible and coinsurance
Preventive Care Services	You pay nothing for listed services. You pay deductible and coinsurance for services not listed.	You pay applicable deductible and coinsurance	You pay nothing for listed services. You pay deductible and coinsurance for services not listed.	You pay applicable deductible and coinsurance
Immunizations *(Limited to specifically listed immunizations)*	You pay nothing		You pay nothing for specifically listed immunizations; you pay deductible and coinsurance for non-listed immunizations.	
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
Diagnostic Laboratory and X-ray Services	You pay applicable deductible and coinsurance	You pay applicable deductible and coinsurance	You pay deductible and coinsurance Inpatient and diagnostic mammograms only	You pay deductible and coinsurance Inpatient and diagnostic mammograms only
Annual Maximum Benefit Limit	$1,250,000 lifetime benefit per person		$1,250,000 lifetime benefit per person	

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 year.

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.

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 ***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

- 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.

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