2018 Health Insurance Plans
for Individuals and Families

REGION 5
Blaine | Camas | Cassia | Gooding | Jerome | Lincoln | Minidoka | Twin Falls
Welcome to Guided Care

All Blue Cross of Idaho individual and family health insurance plans use a tailored network of doctors, hospitals, pharmacies and clinics. Research shows that patients who have a strong relationship with their primary care provider (PCP) have better health outcomes, meaning that their illnesses get better, their costs are lower, and they are more satisfied with their care.

This approach, which puts you and your personal healthcare provider at the center, is one Blue Cross of Idaho believes in.

With one of our plans, you’ll have the benefit of a personal medical advisor who will care for you. You won’t be left to wander alone through the confusing (and expensive!) world of healthcare.

Your PCP will give you a referral for care you may need that he or she can’t provide. No matter the network you choose, you’ll have access to urgent and emergency care wherever you need it.
Let’s get started.

**STEP 1**
Check to see if you qualify for a tax credit or cost-sharing reduction.

**STEP 2**
See the available networks where you live.

**STEP 3**
Find a plan that fits your lifestyle and budget.

**STEP 4**
Buy your plan. Open enrollment is November 1 through December 15, 2017.

Ready to find a plan that’s right for you? The following pages walk you through our networks and plans. If you need help picking a plan, call your insurance agent or talk to one of our sales reps today at **1-888-GO-CROSS** (1-888-462-7677).
Tax Credit

Depending on your income, you may qualify for a tax credit, also known as a subsidy. This is where the government pays part of your monthly premium, which could result in significant savings for you. You can quickly determine your tax credit by using our calculator at shoppers.bcIdaho.com. You can also use the first column in the chart below to see if you qualify.

Cost-Sharing Reduction

You may also be eligible for cost-sharing reduction plans that lower the amount you pay out of pocket for deductibles, coinsurance and copayments. Use the second column in the chart below to see if you qualify.

If you qualify for a tax credit or cost-sharing reduction, you need to purchase your plan at yourhealthidaho.org to take advantage of your savings. However, you can still work with a local insurance agent or one of our sales reps to help you find the right plan.

Find your family size using the left-hand column of this chart. If your income falls within the ranges listed, you may qualify for a tax credit or cost-sharing reduction. For additional details, see our cost-sharing brochure.

<table>
<thead>
<tr>
<th>Family Size</th>
<th>MONTHLY PREMIUM TAX CREDIT</th>
<th>COST-SHARING REDUCTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$12,060 – $48,240</td>
<td>$12,060 – $30,150</td>
</tr>
<tr>
<td>2</td>
<td>$16,240 – $64,960</td>
<td>$16,240 – $40,600</td>
</tr>
<tr>
<td>3</td>
<td>$20,420 – $81,680</td>
<td>$20,420 – $51,050</td>
</tr>
<tr>
<td>4</td>
<td>$24,600 – $98,400</td>
<td>$24,600 – $61,500</td>
</tr>
<tr>
<td>5</td>
<td>$28,780 – $115,120</td>
<td>$28,780 – $71,950</td>
</tr>
<tr>
<td>6</td>
<td>$32,960 – $131,840</td>
<td>$32,960 – $82,400</td>
</tr>
<tr>
<td>7</td>
<td>$37,140 – $148,560</td>
<td>$37,140 – $92,850</td>
</tr>
<tr>
<td>8</td>
<td>$41,320 – $165,280</td>
<td>$41,320 – $103,300</td>
</tr>
</tbody>
</table>

* From CMS report “2017 Effectuated Enrollment Snapshot,” dated 6/12/2017
Metal Levels Explained

**BRONZE**
If you don’t see a doctor very often, a Bronze plan is a great way to save on your monthly premium. We’ll pay about 60 percent of average medical costs.*

**SILVER**
If you see a doctor once in a while, a Silver plan is a good option. This is our middle-of-the-road plan where we pay about 70 percent of average medical costs.*

**GOLD**
If you go to the doctor regularly, a Gold plan may be right for you. You’ll pay a higher monthly premium, but we’ll pay about 80 percent of average medical costs.*

Key Terms

**COINSURANCE**
This means we share the cost of your covered healthcare with you. For example, if we cover 70 percent of the doctor’s allowed amount, you’d cover the remaining 30 percent.

**COPAYMENT**
A set amount you pay directly to a doctor, hospital or pharmacy when you need a service. Depending on your plan, you might pay a copayment to see your primary care doctor, have an MRI or visit the ER.

**DEDUCTIBLE**
This is the set dollar amount you will pay when you need most covered services. For many types of care, you’ll have to pay your deductible before your insurance begins to pay. Some plans have one deductible for medical care and a different deductible for prescriptions.

**IN-NETWORK**
An in-network healthcare provider is a doctor, hospital, clinic, or pharmacy that has a contract with us to provide you services for pre-negotiated rates.

You can find a list of healthcare providers for your plan network at [bcidaho.com/findaprovider](http://bcidaho.com/findaprovider).

**OUT-OF-NETWORK**
An out-of-network healthcare provider does not have a contract with Blue Cross. Though there are some exceptions, you will usually pay much more for services from an out-of-network healthcare provider than you would from one in your network.

Out-of-network healthcare providers can also bill you for whatever isn’t covered by insurance; this is called balance billing and is a major reason you should use in-network healthcare providers.

**OUT-OF-POCKET MAXIMUM**
What you pay for covered healthcare each year through a deductible, copayments, and coinsurance, up to a maximum amount. This is in addition to whatever insurance premium you pay each month.

**PREMIUM**
The amount you pay each month for your health insurance plan.

*Payment percentages are based on an average person’s healthcare expenses over a year.
See the network available where you live:

**ST. LUKE’S HEALTH PARTNERS (SLHP)**
St. Luke’s Health Partners serves southwest and south central Idaho with more than 2,100 providers. SLHP includes 29 hospitals and 34 urgent care centers.


**PORTNEUF QUALITY ALLIANCE (PQA)**
Portneuf Quality Alliance is supported by more than 600 highly skilled providers, including those at Portneuf Medical Center.

PQA plans are available to residents of Bannock*, Bear Lake, Bingham*, Butte, Caribou, Franklin, Minidoka, Oneida, and Power counties. *PQA Gold only available in these counties.

**HOMETOWN EAST PROVIDER NETWORK (HEPN)**
Hometown East Provider Network consists of local healthcare professionals, facilities, and clinics in central and eastern Idaho. HEPN includes Bear Lake Memorial, Caribou Memorial, Cassia Regional, Eastern Idaho Regional Medical Center, Franklin County Medical Center, Lost Rivers District, Madison Memorial, Minidoka Memorial, Mountain View, Nell J Redfield Memorial, North Canyon Medical Center, Portneuf Medical Center, Pover County, Steele Memorial, and Teton Valley Health Care hospitals.

OUR PLANS ARE SUPPORTED BY REGIONAL PROVIDER NETWORKS.

When you choose one of these managed care plans, you must choose a primary care provider (PCP) from your regional provider network to serve as your care coordinator. You must have referrals from your PCP to see specialists and other healthcare providers. Please visit bcidaho.com/SBC for a Summary of Benefits and Coverage. Benefit grids outline common in-network and out-of-network services. This is not a comprehensive list of benefits.

<table>
<thead>
<tr>
<th>ANNUAL COSTS</th>
<th>Bronze 5500, Bronze CarePoint 5500, or Bronze Connect 5500</th>
<th>Bronze 6000, Bronze CarePoint 6000, or Bronze Connect 6000</th>
<th>Bronze HSA 6550, Bronze CarePoint 6550, or Bronze HSA Connect 6550</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Deductible</td>
<td>$5,500 per individual / $11,000 per family</td>
<td>$6,000 per individual / $12,000 per family</td>
<td>$6,550 per individual / $13,100 per family</td>
</tr>
<tr>
<td></td>
<td>$50,000 per individual / $100,000 per family</td>
<td>$50,000 per individual / $100,000 per family</td>
<td>$50,000 per individual / $100,000 per family</td>
</tr>
<tr>
<td>Coin insurance</td>
<td>35% 80%</td>
<td>20% 80%</td>
<td>No coinsurance 80%</td>
</tr>
<tr>
<td>Combined Medical &amp; Drug Out-of-Pocket Maximum</td>
<td>$7,250 per individual / $14,700 per family</td>
<td>$6,550 per individual / $13,100 per family</td>
<td>$6,550 per individual / $13,100 per family</td>
</tr>
<tr>
<td></td>
<td>$75,000 per individual / $150,000 per family</td>
<td>$75,000 per individual / $150,000 per family</td>
<td>$75,000 per individual / $150,000 per family</td>
</tr>
<tr>
<td>Primary Care Provider (PCP) Office Visit</td>
<td>$40 copay 80% coinsurance after deductible</td>
<td>$20% coinsurance after deductible</td>
<td>No charge after deductible</td>
</tr>
<tr>
<td>Specialist Visit with a Referral</td>
<td>$80 copay</td>
<td>$80% coinsurance after deductible</td>
<td>80% coinsurance after deductible</td>
</tr>
<tr>
<td>Drug Deductible</td>
<td>No separate drug deductible</td>
<td>No separate drug deductible</td>
<td>No separate drug deductible</td>
</tr>
<tr>
<td>Preventive Drugs</td>
<td>$10 copay for preferred and non-preferred generic</td>
<td>No charge after deductible for preferred generic drugs; $10 copay after deductible for non-preferred generic drugs</td>
<td>No charge after deductible</td>
</tr>
<tr>
<td>Generic Drugs</td>
<td>$30 copay after deductible</td>
<td>$30 copay after deductible</td>
<td>No charge after deductible</td>
</tr>
<tr>
<td>Preferred Brand Drugs</td>
<td>$50 copay after deductible</td>
<td>$50 copay after deductible</td>
<td>No charge after deductible</td>
</tr>
<tr>
<td>Non-Preferred Brand Drugs</td>
<td>30% coinsurance after deductible</td>
<td>30% coinsurance after deductible</td>
<td>No charge after deductible</td>
</tr>
<tr>
<td>Preferred Specialty Drugs</td>
<td>50% coinsurance after deductible</td>
<td>50% coinsurance after deductable</td>
<td>No charge after deductible</td>
</tr>
<tr>
<td>Non-Preferred Specialty Drugs</td>
<td>35% coinsurance after deductible</td>
<td>35% coinsurance after deductible</td>
<td>No charge after deductible</td>
</tr>
<tr>
<td>Emergency Room</td>
<td>$350 copay after deductible</td>
<td>$350 copay after deductible</td>
<td>No charge after deductible</td>
</tr>
<tr>
<td>Outpatient Services</td>
<td>35% coinsurance after deductible</td>
<td>80% coinsurance after deductible</td>
<td>80% coinsurance after deductible</td>
</tr>
<tr>
<td>Inpatient Hospital Services</td>
<td>20% coinsurance after deductible</td>
<td>80% coinsurance after deductible</td>
<td>No charge after deductible</td>
</tr>
<tr>
<td>Prenatal &amp; Postnatal Maternity Care</td>
<td>$250 copay, then 35% coinsurance after deductible</td>
<td>$250 copay, then 20% coinsurance after deductible</td>
<td>80% coinsurance after deductible</td>
</tr>
<tr>
<td>Chiropractic Care</td>
<td>$250 copay, then 35% coinsurance after deductible</td>
<td>$250 copay, then 20% coinsurance after deductible</td>
<td>No charge after deductible</td>
</tr>
<tr>
<td>Imaging (CT/PET Scans, MRIs)</td>
<td>$500 copay, then 35% coinsurance after deductible</td>
<td>$500 copay, then 80% coinsurance after deductible</td>
<td>80% coinsurance after deductible</td>
</tr>
<tr>
<td>Outpatient Psychotherapy Services</td>
<td>$40 copay</td>
<td>$20% coinsurance after deductible</td>
<td>No charge after deductible</td>
</tr>
<tr>
<td>Diabetes Education</td>
<td>$20 copay</td>
<td>$20% coinsurance after deductible</td>
<td>No charge after deductible</td>
</tr>
<tr>
<td>Immunizations &amp; Preventive Care</td>
<td>No charge</td>
<td>No charge after deductible</td>
<td>No charge after deductible</td>
</tr>
</tbody>
</table>

1 Prescription drug coverage includes a generic substitution requirement. If you or your doctor requests a brand-name prescription when a generic equivalent is available, you are responsible for paying the difference between the allowed cost of the generic drug and the brand-name drug and any applicable brand-name copayment. The extra costs do not count toward your deductible or out-of-pocket maximum. You or your healthcare provider can ask Blue Cross to review this policy on a case-by-case basis. 2 For treatment of emergency medical conditions as defined in the policy, Blue Cross will provide in-network benefits for covered services. 3 Includes physical, occupational, and speech therapy services. You have a total of 20 in- and out-of-network visits for covered rehabilitative therapy services per member per year and a total of 20 in- and out-of-network visits for covered habilitative 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 care services per member per year.
OUR PLANS ARE SUPPORTED BY REGIONAL PROVIDER NETWORKS.
When you choose one of these managed care plans, you must choose a primary care provider (PCP) from your regional provider network to serve as your care coordinator. You must have referrals from your PCP to see specialists and other healthcare providers.

### Annual Costs

<table>
<thead>
<tr>
<th></th>
<th>Bronze 7000, Bronze CarePoint 7000, or Bronze Connect 7000</th>
<th>Silver 3500, Silver CarePoint 3500, or Silver Connect 3500</th>
<th>Silver 4000, Silver CarePoint 4000, or Silver Connect 4000</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Medical Deductible</strong></td>
<td>$7,000 per individual $14,000 per family</td>
<td>$3,500 per individual $7,000 per family</td>
<td>$4,000 per individual $8,000 per family</td>
</tr>
<tr>
<td></td>
<td>$50,000 per individual $100,000 per family</td>
<td>$50,000 per individual $100,000 per family</td>
<td>$50,000 per individual $100,000 per family</td>
</tr>
<tr>
<td><strong>Combined Medical &amp; Drug Out-of-Pocket Maximum</strong></td>
<td>$7,350 per individual $14,700 per family</td>
<td>$7,350 per individual $14,700 per family</td>
<td>$7,350 per individual $14,700 per family</td>
</tr>
<tr>
<td></td>
<td>$75,000 per individual $150,000 per family</td>
<td>$75,000 per individual $150,000 per family</td>
<td>$75,000 per individual $150,000 per family</td>
</tr>
<tr>
<td><strong>Primary Care Provider (PCP) Office Visit</strong></td>
<td>$50 copay 80% coinsurance after deductible</td>
<td>$40 copay 80% coinsurance after deductible</td>
<td>$20 copay 80% coinsurance after deductible</td>
</tr>
<tr>
<td></td>
<td>$100 copay</td>
<td>$60 copay</td>
<td>$50 copay</td>
</tr>
<tr>
<td><strong>Drug Deductible</strong></td>
<td>No separate drug deductible</td>
<td>$1,500 per person</td>
<td>$1,000 per person</td>
</tr>
<tr>
<td><strong>Preventive Drugs</strong></td>
<td>No charge</td>
<td>No charge</td>
<td>No charge</td>
</tr>
<tr>
<td><strong>Generic Drugs</strong></td>
<td>$10 copay for preferred and non-preferred generic drugs</td>
<td>No copay for preferred generic drugs; $10 copay for non-preferred generic drugs</td>
<td>No copay for preferred generic drugs; $10 copay for non-preferred generic drugs</td>
</tr>
<tr>
<td><strong>Preferred Brand Drugs</strong></td>
<td>$30 copay after deductible</td>
<td>$30 copay after drug deductible</td>
<td>$30 copay after drug deductible</td>
</tr>
<tr>
<td><strong>Non-Preferred Brand Drugs</strong></td>
<td>$50 copay after deductible</td>
<td>$50 copay after drug deductible</td>
<td>$50 copay after drug deductible</td>
</tr>
<tr>
<td><strong>Preferred Specialty Drugs</strong></td>
<td>30% coinsurance after deductible</td>
<td>30% coinsurance after drug deductible</td>
<td>30% coinsurance after drug deductible</td>
</tr>
<tr>
<td><strong>Non-Preferred Specialty Drugs</strong></td>
<td>50% coinsurance after deductible</td>
<td>50% coinsurance after drug deductible</td>
<td>50% coinsurance after drug deductible</td>
</tr>
<tr>
<td><strong>Emergency Room</strong></td>
<td>$350 copay after deductible</td>
<td>$350 copay after deductible</td>
<td>$350 copay after deductible</td>
</tr>
<tr>
<td><strong>Outpatient Services</strong></td>
<td>40% coinsurance after deductible</td>
<td>80% coinsurance after deductible</td>
<td>80% coinsurance after deductible</td>
</tr>
<tr>
<td><strong>Prenatal &amp; Postnatal Maternity Care</strong></td>
<td>50% coinsurance after deductible</td>
<td>80% coinsurance after deductible</td>
<td>80% coinsurance after deductible</td>
</tr>
<tr>
<td><strong>Chiropractic Care</strong></td>
<td>50% coinsurance after deductible</td>
<td>80% coinsurance after deductible</td>
<td>80% coinsurance after deductible</td>
</tr>
<tr>
<td><strong>Lab/X-Rays</strong></td>
<td>$250 copay, then 50% coinsurance after deductible</td>
<td>$250 copay, then 80% coinsurance after deductible</td>
<td>$250 copay, then 80% coinsurance after deductible</td>
</tr>
<tr>
<td><strong>Imaging (CT/PET Scans, MRIs)</strong></td>
<td>$250 copay, then 30% coinsurance after deductible</td>
<td>$250 copay, then 80% coinsurance after deductible</td>
<td>$250 copay, then 80% coinsurance after deductible</td>
</tr>
<tr>
<td><strong>Outpatient Psychotherapy Services</strong></td>
<td>$50 copay</td>
<td>$40 copay</td>
<td>$20 copay</td>
</tr>
<tr>
<td><strong>Diabetes Education</strong></td>
<td>$20 copay</td>
<td>$20 copay</td>
<td>$20 copay</td>
</tr>
<tr>
<td><strong>Immunizations &amp; Preventive Care</strong></td>
<td>No charge</td>
<td>No charge</td>
<td>No charge</td>
</tr>
</tbody>
</table>

1 Prescription drug coverage includes a generic substitution requirement. If you or your doctor requests a brand-name prescription when a generic equivalent is available, you are responsible for paying the difference between the allowed cost of the generic drug and the brand-name drug and any applicable brand-name copayment. The extra costs do not count toward your deductible or out-of-pocket maximum. You or your healthcare provider can ask Blue Cross to review this policy on a case-by-case basis. 2 For treatment of emergency medical conditions as defined in the policy, Blue Cross will provide in-network benefits for covered services. 3 Includes physical, occupational, and speech therapy services. You have a total of 20 in- and out-of-network visits for covered habilitative 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.
Please visit [bcidaho.com/SBC](http://bcidaho.com/SBC) for a Summary of Benefits and Coverage. Benefit grids outline common in-network and out-of-network services. This is not a comprehensive list of benefits.

### ANNUAL COSTS

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Silver 6000, Silver CarePoint 6000, or Silver Connect 6000</th>
<th>Gold 1200, Gold CarePoint 1200, or Gold Connect 1200</th>
<th>Catastrophic 7350*, Catastrophic CarePoint 7350*, or Catastrophic Connect 7350*</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Medical Deductible</strong></td>
<td><strong>WHAT YOU PAY IN-NETWORK</strong> $6,000 per individual $12,000 per family <strong>WHAT YOU PAY OUT-OF-NETWORK</strong> $50,000 per individual $100,000 per family</td>
<td><strong>WHAT YOU PAY IN-NETWORK</strong> $1,200 per individual $2,400 per family <strong>WHAT YOU PAY OUT-OF-NETWORK</strong> $50,000 per individual $100,000 per family</td>
<td><strong>WHAT YOU PAY IN-NETWORK</strong> $7,350 per individual $14,700 per family <strong>WHAT YOU PAY OUT-OF-NETWORK</strong> $50,000 per individual $100,000 per family</td>
</tr>
<tr>
<td><strong>Coinsurance</strong></td>
<td>20%</td>
<td>20%</td>
<td>No coinsurance</td>
</tr>
<tr>
<td><strong>Combined Medical &amp; Drug Out-of-Pocket Maximum</strong></td>
<td><strong>$7,350 per individual $14,700 per family</strong></td>
<td><strong>$5,500 per individual $11,000 per family</strong></td>
<td><strong>$7,350 per individual $14,700 per family</strong></td>
</tr>
<tr>
<td><strong>Primary Care Provider (PCP) Office Visit</strong></td>
<td><strong>$20 copay 80% coinsurance after deductible</strong></td>
<td><strong>$20 copay 80% coinsurance after deductible</strong></td>
<td><strong>$30 copay up to 3 visits, then deductible 80% coinsurance after deductible</strong></td>
</tr>
<tr>
<td><strong>Specialist Visit with a Referral</strong></td>
<td><strong>$50 copay</strong></td>
<td><strong>$50 copay</strong></td>
<td>No charge after deductible</td>
</tr>
<tr>
<td><strong>Drug Deductible</strong></td>
<td>No separate drug deductible</td>
<td>$1,000 per person</td>
<td>No separate drug deductible</td>
</tr>
<tr>
<td><strong>Preventive Drugs</strong></td>
<td><strong>No charge</strong></td>
<td><strong>No charge</strong></td>
<td><strong>No charge</strong></td>
</tr>
<tr>
<td><strong>Generic Drugs</strong></td>
<td>$10 copay for preferred and non-preferred generic drugs</td>
<td><strong>No charge for preferred generic drugs; $10 copay for non-preferred generic drugs</strong></td>
<td><strong>No charge after deductible</strong></td>
</tr>
<tr>
<td><strong>Preferred Brand Drugs</strong></td>
<td>$30 copay after deductible</td>
<td><strong>$30 copay after drug deductible</strong></td>
<td><strong>No charge after deductible</strong></td>
</tr>
<tr>
<td><strong>Non-Preferred Brand Drugs</strong></td>
<td>$50 copay after deductible</td>
<td><strong>$50 copay after drug deductible</strong></td>
<td><strong>No charge after deductible</strong></td>
</tr>
<tr>
<td><strong>Preferred Specialty Drugs</strong></td>
<td>30% coinsurance after deductible</td>
<td>30% coinsurance after deductible</td>
<td><strong>No charge after deductible</strong></td>
</tr>
<tr>
<td><strong>Non-Preferred Specialty Drugs</strong></td>
<td>50% coinsurance after deductible</td>
<td><strong>50% coinsurance after deductible</strong></td>
<td><strong>80% coinsurance after deductible</strong></td>
</tr>
<tr>
<td><strong>Emergency Room</strong></td>
<td><strong>20% coinsurance after deductible 80% coinsurance after deductible</strong></td>
<td><strong>20% coinsurance after deductible 80% coinsurance after deductible</strong></td>
<td>No charge after deductible</td>
</tr>
<tr>
<td><strong>Outpatient Services</strong></td>
<td>20% coinsurance after deductible</td>
<td>20% coinsurance after deductible</td>
<td><strong>80% coinsurance after deductible</strong></td>
</tr>
<tr>
<td><strong>Inpatient Hospital Services</strong></td>
<td><strong>$250 copay, then 20% coinsurance after deductible 80% coinsurance after deductible</strong></td>
<td><strong>$250 copay, then 20% coinsurance after deductible 80% coinsurance after deductible</strong></td>
<td>No charge after deductible</td>
</tr>
<tr>
<td><strong>Prenatal, Postnatal, &amp; Maternity Care</strong></td>
<td><strong>$250 copay, then 20% coinsurance after deductible 80% coinsurance after deductible</strong></td>
<td><strong>$250 copay, then 20% coinsurance after deductible 80% coinsurance after deductible</strong></td>
<td>No charge after deductible</td>
</tr>
<tr>
<td><strong>Chiropractic Care</strong></td>
<td><strong>$20 copay 80% coinsurance after deductible</strong></td>
<td><strong>$20 copay 80% coinsurance after deductible</strong></td>
<td><strong>$20 copay 80% coinsurance after deductible</strong></td>
</tr>
<tr>
<td><strong>Lab/X-Rays</strong></td>
<td><strong>$250 copay, then 20% coinsurance after deductible 80% coinsurance after deductible</strong></td>
<td><strong>$250 copay, then 20% coinsurance after deductible 80% coinsurance after deductible</strong></td>
<td>No charge after deductible</td>
</tr>
<tr>
<td><strong>Outpatient Psychotherapy Services</strong></td>
<td><strong>$20 copay 80% coinsurance after deductible</strong></td>
<td><strong>$20 copay 80% coinsurance after deductible</strong></td>
<td>No charge after deductible</td>
</tr>
<tr>
<td><strong>Diabetes Education</strong></td>
<td><strong>No charge</strong></td>
<td><strong>No charge</strong></td>
<td>No charge</td>
</tr>
<tr>
<td><strong>Immunizations &amp; Preventive Care</strong></td>
<td><strong>No charge</strong></td>
<td><strong>No charge</strong></td>
<td>No charge</td>
</tr>
</tbody>
</table>

---

1 Prescription drug coverage includes a generic substitution requirement. If you or your doctor requests a brand-name prescription when a generic equivalent is available, you are responsible for paying the difference between the allowed cost of the generic drug and any applicable brand-name copayment. The extra costs do not count toward your deductible or out-of-pocket maximum. You or your healthcare provider can ask Blue Cross to review this policy on a case-by-case basis.  

2 For treatment of emergency medical conditions as defined in the policy, Blue Cross will provide in-network benefits for covered services. This includes physical, occupational, and speech therapy services. You have a total of 20 in- and out-of-network visits for covered rehabilitative therapy services per member per year and a total of 20 in- and out-of-network visits for covered habilitative therapy services per member per year.  

3 Catastrophic plans are only available to people under the age of 30 or to people who qualify for a hardship exemption through the Idaho health insurance exchange. See yourhealthidaho.org for more information on catastrophic coverage.
Purchase a Plan

READY TO BUY? HERE ARE THREE WAYS TO APPLY.

ONLINE
Complete the entire enrollment process at shoppers.bcidaaho.com.

IN PERSON
Visit an enrollment center and have a rep walk you through the process in person.

WITH AN AGENT
Find an insurance agent near you by visiting shoppers.bcidaaho.com.

NEW DATES TO SIGN UP FOR COVERAGE
This year, Open Enrollment is from November 1 through December 15, 2017, so you have less time to make a decision about coverage for 2018.

If open enrollment is over, you can still get covered if you have a qualifying life event, such as getting married, adopting a child, or losing coverage through your job. Learn more about qualifying life events and how to enroll during a special enrollment period by contacting a local insurance agent or calling our sales team at 1-888-GO-CROSS (1-888-462-7677). If you don’t have a qualifying life event, our Short Term plan might be a good choice. See “Covering a Gap” on the next page for more.

If you’re eligible for a tax credit or cost-sharing reduction, you’ll need to buy your plan at yourhealthidaho.org. See page 2 for more information.
Covering a Gap

SHORT-TERM COVERAGE
When you're between plans and need temporary medical insurance, Blue Cross of Idaho offers three short-term plans at affordable rates to help you bridge that gap in coverage.

Choose from one to 10 months of coverage. Learn more about this plan by calling us at 1-888-GO-CROSS (1-888-462-7677) or visit bcidaho.com/short_term.

Our short term plans don't meet the Affordable Care Act’s minimum coverage requirements. If you buy this plan, check with the IRS or your tax preparer to learn more.

A Healthier Smile

DENTAL COVERAGE
Good oral health is a key part of your overall health, so we offer flexible and affordable dental insurance plans that enhance your medical insurance plan.

Our Dental Choice℠ and Dental Choice Plus℠ plans offer low deductibles and out-of-pocket maximums and meet all of the Affordable Care Act (ACA) requirements. We also offer flexible, affordable dental coverage in three benefit levels with our Healthy Smiles℠ Preventive, Plus, and Preferred plans.*

Learn more about our dental plans by calling your insurance agent, Blue Cross at 1-888-GO-CROSS (1-888-462-7677) or visit shoppers.bcidaho.com.

*Our Healthy Smiles plans are not ACA-qualified plans and do not meet coverage requirements for people under age 19.
Details about Our Plans

How we protect your personal information
• We keep all of your personal information private and confidential.
• We only allow access to your personal information by our employees and business partners when needed to conduct business for you.
• We only disclose your personal information to conduct business for you, when we are required by law, or if you (or your personal representative) give us permission.
• For detailed information about our privacy practices see the Blue Cross of Idaho Notice of Privacy Practices on our website at bcidaho.com/about_us/privacy_policy.asp.

Prior Authorization
Some services require prior approval and your physician will request our review prior to receiving services. When you are in the hospital, we may also work with the hospital and your physician to determine when you are ready to return home. Some procedures are reviewed after the claim is submitted to BCI, to evaluate eligibility for coverage. The appeals process is available to you at all times, if you do not agree with a coverage decision. You do not need prior authorization in emergency situations.

What if I don’t have prior authorization?
We want you to receive the best care at the right time and place. We also want to ensure you receive the right technology that addresses your particular clinical issue. We’re here to work with you, your doctor and the facility so you have the best possible health outcome. If you receive services that are not medically necessary from one of Blue Cross of Idaho’s contracting providers without getting prior authorization and payment for the services is denied, you are not financially responsible. However, if you receive services that are not medically necessary from a provider not contracting with Blue Cross of Idaho, you may be responsible for the entire cost of the services.

Who determines if the service is approved?
Our team of licensed physicians, registered nurses, and pharmacy technicians receives and reviews all prior authorization requests. Typically, they complete this review within two business days, and notify the member and his or her healthcare provider of their decision. Prior authorization is not a guarantee of payment or coverage. It is a pre-service approval based on information provided to Blue Cross of Idaho at the time the request is made. Blue Cross of Idaho retains the right to review the medical necessity of services, eligibility for services, and benefit limitations and exclusions after you receive the services.

IMPORTANT INFORMATION ABOUT YOUR PRESCRIPTION DRUG COVERAGE
Your Blue Cross of Idaho health insurance plan comes with a list of drugs approved for coverage under your pharmacy benefit. This is also called a “formulary.” This prescription drug list can help you better understand your coverage and how it works. You can get a copy of our formulary for any of our plans at shoppers.bcidaho.com. Select Health & Wellness from the top menu, then Pharmacy Management. Then select Prescription Drugs from the right navigation menu, then Individual & Family Medical Prescriptions. (If you don’t have internet access, you can also call Blue Cross of Idaho’s Customer Service Department at 800-627-1188.)

In most cases, you are responsible to pay a portion of the cost of each prescription drug you have filled. Your cost is determined by the formulary tier assignment of the drug, and the benefit your plan assigns to that tier. Members can find a copy of Blue Cross of Idaho’s pharmaceutical management procedures and check the pharmacy coverage provided by their plan by logging in to the members’ website at members.bcidaho.com.

Exclusions and Limitations*
In addition to the exclusions and limitations listed in the plan contracts and sales materials, the following exclusions and limitations apply to the Bronze, Silver, Gold, and Catastrophic plans listed herein, unless otherwise specified:

PREEXISTING CONDITION WAITING PERIODS
There is no preexisting condition waiting period for benefits available under this Contract.

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 Member. However, the Member 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 Member has a non dental, life endangering condition which makes hospitalization necessary to safeguard the Member’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 Member 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 Member claims such benefits or compensation or recovers losses from a third party.

Provided or paid for by any federal governmental entity except when payment under the Contract is expressly required by federal law, or provided or paid for by any state or local governmental entity where its charges therefore would vary, or are or would be affected by the existence of coverage under the Contract, or for which payment has been made under Medicare Part A and/or Medicare Part B, or would have been made if a Member had applied for such payment except when payment under the Contract is expressly required by federal law.

Provided for any condition, Accidental Injury, 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 Member by blood or marriage and who ordinarily dwells in the Member’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:
• Reconstructive Surgery necessary to treat an Accidental Injury, infection or other Disease of the involved part; or
• Reconstructive Surgery to correct Congenital Anomalies in a Member who is a dependent child.

Rendered prior to the Member’s Effective Date.

*Exclusions and limitations apply to the Bronze, Silver, Gold, and Catastrophic plans listed herein, unless otherwise specified.
For personal hygiene, comfort, beautification (including non-surgical services, drugs, and supplies intended to enhance the appearance) even if prescribed by a Physician.

For exercise or relaxation 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.

For convenience items including but not limited to Durable Medical Equipment such as bath equipment, cold therapy units, duplicate items, home traction devices, or safety equipment.

For relaxation or exercise therapies, including but not limited to, educational, recreational, art, aroma, dance, sex, sleep, electro sleep, vitamin, chelation, homeopathic or naturopathic, massage, or music even if prescribed by a Physician.

For telephone consultations, and all computer or Internet communications, except as specified as a Covered Service in this Contract.

For failure to keep a scheduled visit or appointment; for completion of a claim form; for interpretation services; or for personal mileage, transportation, food or lodging expenses, unless specified as a Covered Service in this Contract, 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 specified in the Contract; or for Inpatient admissions when the Member is ambulatory and/or confined primarily for bed rest, a special diet, 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 Contract.

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 Contract;
- 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 alveolecctomy 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 prescribing or fitting eyeglasses or contact lenses, unless specified as a Covered Service in the Contract.

For any treatment of 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 Member’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 the Contract; for Mental or Nervous Conditions and Substance Abuse or Addiction services not recognized by the American Psychiatric and American Psychological Association.

For weight loss or weight control. 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 the Contract.

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 a Member’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 in the Contract.

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 the Contract.

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 a Member would have no legal obligation to pay in the absence of coverage under the Contract 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 the Contract.

For immunizations, except as specified as a Covered Service in the Contract.
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 a Member.

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 the Contract.

For Outpatient pulmonary and/or cardiac Rehabilitation.

For complications arising from the acceptance or utilization of services, supplies or procedures that are not a Covered Service.

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 Therapeutic Boarding School, a facility that is primarily a health resort, or sanatorium, Residential Treatment Facility, transitional living center, except as specified as a Psychiatric Care Covered Service listed in the Contract.

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 Contract.

For procedures including but not limited to breast augmentation, liposuction, Adam's apple reduction, rhinoplasty and facial reconstruction and other procedures considered cosmetic in nature.

Any newly FDA approved Prescription Drug, biological agent, or other agent until it has been reviewed and implemented by BCI’s Pharmacy and Therapeutics Committee.

For the treatment of injuries sustained while operating a motor vehicle under the influence of alcohol and/or narcotics. For purposes of this Contract exclusion, “Under the influence” as it relates to alcohol means having a whole blood alcohol content of .08 or above or a serum blood alcohol content of .10 or above as measured by a laboratory approved by the State Police or a laboratory certified by the Centers for Medicare and Medicaid Services. For purposes of this Contract exclusion, “Under the influence” as it relates to narcotics means impairment of driving ability caused by the use of narcotics not prescribed or administered by a Physician.

**PRESCRIPTION DRUG EXCLUSIONS AND LIMITATIONS**

No benefits are provided for the following:

Drugs used for the termination of early pregnancy, and complications arising therefrom, except when required to correct an immediately life-endangering condition.

Over-the-counter drugs other than insulin, even if prescribed by a Physician. Notwithstanding this exclusion, BCI, through the determination of the BCI Pharmacy and Therapeutics Committee may choose to cover certain over-the-counter medications when Prescription Drug benefits are provided under this Contract. Such approved over-the-counter medications must be identified by BCI in writing and will specify the procedures for obtaining benefits for such approved over-the-counter medications. Please note that the fact a particular over-the-counter drug or medication is covered does not require BCI to cover or otherwise pay or reimburse the Member for any other over-the-counter drug or medication.

Charges for the administration or injection of any drug, except for vaccinations listed on the Prescription Drug Formulary.

Therapeutic devices or appliances, including hypodermic needles, syringes, support garments, and other non-medicinal substances except for Diabetic Supplies, regardless of intended use.

Drugs labeled “Caution—Limited by Federal Law to Investigational Use,” or experimental drugs, even though a charge is made to the Member.

Immunization agents, except for vaccinations listed on the Prescription Drug Formulary, biological sera, blood or blood plasma. Benefits may be available under the Medical Benefits Section of this Contract.

Medication that is to be taken by or administered to a Member, in whole or in part, while the Member is an Inpatient in a Licensed General Hospital, rest home, sanatorium, Skilled Nursing Facility, extended care facility, convalescent hospital, nursing home, or similar institution which operates or allows to operate on its premises, a facility for dispensing pharmaceuticals.

Any prescription refilled in excess of the number specified by the Physician, or any refill dispensed after one (1) year from the Physician’s original order.

Any Prescription Drug, biological or other agent which is:

- Prescribed primarily to aid or assist the Member in weight loss, including all anorectics, whether amphetamine or nonamphetamine.
- Prescribed primarily to retard the rate of hair loss or to aid in the replacement of lost hair.
- Prescribed primarily to increase fertility, including but not limited to, drugs which induce or enhance ovulation.
- Prescribed primarily for personal hygiene, comfort, beautification, or for the purpose of improving appearance.
- Prescribed primarily to increase growth, including but not limited to, growth hormone.
- Provided by or under the direction of a Home Intravenous Therapy Company, Home Health Agency or other Provider approved by BCI. Benefits are available for this Therapy Service under the Medical Benefits Section of this Contract only as preauthorized and when Medically Necessary.

Lost, stolen, broken or destroyed medications, except in the case of loss due directly to a natural disaster.

*Do not apply to Blue Cross of Idaho dental or short-term plans. See those policies for a full list of exclusions and limitations. Policy numbers: 18-072-01/18, 18-080-01/18, 18-081-01/18, 3-073P-10/10, 3-074P-10/10, 3-075P-10/10, 3-420-05/11.
Nondiscrimination Statement

Blue Cross of Idaho complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. Blue Cross of Idaho does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

Blue Cross of Idaho:
• Provides free aids and services to people with disabilities to communicate effectively with, such as:
  • Qualified sign language interpreters
  • Written information in other formats (large print, audio, accessible electronic formats, other formats)
• Provides free language services to people whose primary language is not English, such as:
  • Qualified interpreters
  • Information written in other languages

If you need these services, contact Blue Cross of Idaho’s Customer Service Department. Call 1-800-627-1188 (TTY: 1-800-377-1363), or call the customer service phone number on the back of your card.

If you believe that Blue Cross of Idaho has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with Blue Cross of Idaho’s Grievances and Appeals Department at:

Manager, Grievances and Appeals
3000 East Pine Avenue, Meridian, Idaho 83642
Telephone: (800) 274-4018 ext. 5838, Fax: 208-331-7493
Email: grievances&amp;appeals@bcidaho.com
TTY: 1-800-377-1363

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our Grievances and Appeals team is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://oocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-868-1019, 800-537-7697 (TTY). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html. Reference: https://federalregister.gov/a/2016-11458

Language Assistance
ATTENTION: If you speak Arabic, Chinese, French, German, Korean, Japanese, Persian (Farsi), Romanian, Russian, Serbo-Croatian, Spanish, Sudanic Fulfulde, Tagalog, Ukrainian, or Vietnamese, language assistance services, free of charge, are available to you. Call 1-800-627-1188 (TTY: 1-800-377-1363).

Chinese 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-627-1188 (TTY: 1-800-377-1363)。


Japanese 注意事項： 日本語を話される場合、無料の言語支援をご利用いただけます。 1-800-627-1188 (TTY: 1-800-377-1363)まで、お電話にてご連絡ください。


Persian-Farsi
توجه:گزاره به زبان فارسی گفتوگویی را دیدنی نمی‌نماید و به شما راهنمایی میدهد. 1-800-627-1188 (TTY: 1-800-377-1363)

Romanian ATENŢIE: Daţi vorbitori limba română, vă stau la dispoziţie servicii de asistenţă lingvistică, gratuit. Sunaţi la 1-800-627-1188 (TTY: 1-800-377-1363).

Russian ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните на 1-800-627-1188 (телетайп: 1-800-377-1363).


Sudanic Fulfulde MAANDO: To a waawi [Adamawa], e woodi ballooji-ma to ekkitaki wolde caahu. Noddu 1-800-627-1188 (TTY: 1-800-377-1363).


Ukrainian УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутись до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-800-627-1188 (телетайп: 1-800-377-1363).
