Blue Cross® of Idaho

Essential Blue℠ Plus PPO

A LIMITED BENEFIT PLAN

Individual Health Insurance

one TO one

It's a ratio that most accurately represents our dedication to unparalleled customer service and to you, our number-one priority.

Form No 3-144 (02-08)

Policy Form number:
Essential Blue Plus Policy 14-065 (01-07)

Inpatient Notification

Non-emergency preadmission notification

Non-emergency preadmission notification is a notification to Blue Cross of Idaho by you and is required for all inpatient admissions except covered services subject to emergency or maternity admission notification. You must notify Blue Cross of Idaho of all proposed inpatient admissions as soon as you know you will be admitted as an inpatient. The notification must be made before any inpatient admission.

Non emergency preadmission notification informs Blue Cross of Idaho, or a delegated entity, of your proposed inpatient admission to a licensed general hospital, or any other facility provider. This notification alerts Blue Cross of Idaho of the proposed stay. When timely notification of an inpatient admission is provided by you to Blue Cross of Idaho, payment of benefits is subject to the specific benefit levels, limitations, exclusions and other provisions of the policy. For non-emergency preadmission notification, call Blue Cross of Idaho at the telephone number listed on the back of your identification card.

Emergency or Maternity Admission Notification

When an emergency admission occurs for emergency medical conditions, an unscheduled cesarean section delivery, or (if covered under the policy) maternity delivery services, and notification cannot be completed prior to admission due to your condition, you or your representative must notify Blue Cross of Idaho within twenty-four hours of the admission. If the admission is on a weekend or legal holiday, Blue Cross of Idaho must be notified by the end of the next working day after the admission. If the emergency medical condition, unscheduled cesarean section delivery or (if covered under the policy) maternity delivery services, renders it medically impossible for you to provide such notice, you must immediately notify Blue Cross of Idaho of the admission when it is no longer medically impossible to do so. This notification alerts Blue Cross of Idaho to the emergency stay.

Continued Stay Review

Blue Cross of Idaho will contact the hospital utilization review department and/or the attending physician regarding your proposed discharge. If you will not be discharged as originally proposed, Blue Cross of Idaho will evaluate the medical necessity of the continued stay and approve or disapprove benefits for the proposed course of inpatient treatment. Payment of benefits is subject to the specific benefit levels, limitations, exclusions and other provisions of the policy.

Discharge Planning

Blue Cross of Idaho will provide information about benefits for various post-discharge courses of treatment.

Prior Authorization

NOTICE: The medical necessity of covered services should be determined to be eligible for benefits under the terms of the policy. If prior authorization has not been obtained to determine medical necessity, services may be subject to denial. Any dispute involved in this decision to deny must be resolved by use of the Blue Cross of Idaho appeal process as outlined in the general provisions section of the policy.

If non-medically necessary services are performed by contracting providers, without prior authorization by Blue Cross of Idaho, and benefits are denied, the cost of those services are not your financial responsibility. You are financially responsible for non-medically necessary services provided by a noncontracting provider.

Prior authorization is a request by your contracting provider to Blue Cross of Idaho, or delegated entity, for authorization of your proposed treatment. Blue Cross of Idaho may review medical records, test results and other sources of information to ensure that it is a covered service and make a determination as to medical necessity or alternative treatments. You are responsible for obtaining prior authorization when seeking treatment from a noncontracting provider.

To request prior authorization, the contracting provider must notify Blue Cross of Idaho of your intent to receive services that require prior authorization. You are responsible for notifying Blue Cross of Idaho if the proposed treatment will be provided by a noncontracting provider. The notification may be completed by telephone call or in writing and must include the information necessary to establish that the proposed services are covered services under your policy and medically necessary. Blue Cross of Idaho will respond to a request for prior authorization received from either you or the provider within two business days of the receipt of the medical information necessary to make a determination.

Preexisting Condition*

- A condition that would have caused an ordinarily prudent person to seek medical advice, diagnosis, care, or treatment during the six months immediately preceding the effective date of coverage; or
- A condition for which medical advice, diagnosis, care, or treatment was recommended or received during the six months immediately preceding the effective date of coverage; or
- A pregnancy existing on the effective date of coverage under the policy.

Preexisting Condition Waiting Period*

- There are no benefits available under these policies for services, supplies, drugs, or other charges that are provided within 12 months after an insured's effective date for any preexisting condition.
- Blue Cross of Idaho shall credit any qualifying previous coverage, as defined by the Individual Health Insurance Availability Act, to the preexisting condition waiting period for new enrollees and dependents. This only applies if there was not more than a 63 day lapse in health coverage prior to the effective date of the new coverage.

Determination of Eligibility

Applicants to Blue Cross of Idaho for individual coverage must reside in Idaho and must meet the requirements of "eligible individual" as defined by state law.*

Disclosure of Premium Practices & Guarantees

How Premiums Are Set

Your premium is determined by two factors – case characteristics and health status. The case characteristics of your policy include the benefits you selected, your geographic location, and the age and gender of the individuals covered on your policy. These case characteristics determine your index rate, which is the same for all individuals with the same case characteristics. The index rate is then adjusted for the health status of the individuals covered on your policy. Health status may cause the premiums to be set anywhere from 50% above to 50% below the index rate. In addition to an index rate change, no more than a 15% premium increase will be given each year due to changes in health status. The remaining portion of any premium increase is due to changes in case characteristics or general medical trends.

Premium Guarantee

We guarantee your initial premium for 12 months for the benefits selected. Your premium may change if you change your benefits. Any new premium applies from the date benefit changes begin. An exception to the premium guarantee may be made if any state or federal law unexpectedly increases our administrative costs or claims liability. Each policy is subject to a premium adjustment at its renewal.

Renewable Coverage Guaranteed With Exceptions

No individual's coverage will be terminated because of claims utilization or any particular medical condition. Coverage may be terminated if any of the following circumstances exist:

- Nonpayment of the required premiums.
- Fraud or intentional misrepresentation of material fact with respect to insured individuals, or their representative.
- Repeated misuse of a provider network provision.
- Blue Cross of Idaho chooses not to renew all of its health benefit plans in Idaho.
- The individual no longer resides in the state of Idaho.
- No qualification for coverage under the Individual Health Insurance Availability Act.*
- The director finds that the continuation of the coverage would:
    1. Not be in the best interests of the policyholders or certificate holders; or
    2. Impair the carrier's ability to meet its contractual obligations. In such instance, the director shall assist affected individuals in finding replacement coverage.

** For information regarding "preexisting condition" and "eligible individual" provisions, you may wish to contact your insurance agent or local Blue Cross of Idaho district office.*

Maximum Allowance

For covered services under the terms of the policy, maximum allowance is the lesser of the billed charge or the amount established as the highest level of compensation for a covered service. If the covered services are rendered outside the state of Idaho by a noncontracting or contracting provider with a Blue Cross and/or Blue Shield affiliate in the location of the covered services, the maximum allowance is the lesser of the billed charge or the amount established by the affiliate as compensation.

The maximum allowance is determined using many factors, including pre-negotiated payment amounts; diagnostic related groupings (DRGs); a resource based relative value scale (RBRVS); ambulatory payment classifications (APCs); the provider's charge(s); the charge(s) of providers with similar training and experience within a particular geographic area; Medicare reimbursement amounts; and/or the cost of rendering the covered service.

Moreover, maximum allowance may differ depending on whether the provider is contracting or noncontracting.

In addition, maximum allowance for covered services provided by contracting or noncontracting dentists is determined using many factors, including pre negotiated payment amounts, a calculation of charges submitted by contracting Idaho dentists, and/or a calculation of the average charges submitted by all Idaho dentists.

Essential Blue Plus PPO

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 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, except as specified as a covered service in the policy.
- 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 except when payment under the policy 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 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 the policy 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 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:
    - Reconstructive surgery necessary to treat an accidental injury, infection or other disease of the involved part; or
    - Reconstructive surgery to correct congenital anomalies in an insured who is a dependent child.
- Rendered prior to the insured's effective date; or during an inpatient admission commencing prior to the insured's effective date, subject to the requirements of the Health Insurance Portability and Accountability Act of 1996.

- 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, massage, or music.
- For telephone consultations, and all computer or Internet communications; 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 the 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 outpatient occupational therapy; inpatient or outpatient custodial care; or for inpatient or outpatient services consisting mainly of educational therapy, including diabetes education, behavior modification, self-care or self-help training, except as specified as a covered service in the policy.
- 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).
- Related to dentistry or dental treatment, even if medically necessary, including but not limited to, dental implants, appliances, or prosthetics, or treatment related to orthodontia and orthognathic surgery and any surgical or other treatment of temporomandibular joint syndrome, unless specified as a covered service in the policy.
- 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 specifically provided as a covered service in the 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 or diagnostic testing or evaluation of inpatient and outpatient mental or nervous conditions, alcoholism, substance abuse or addiction, or for pain rehabilitation, except as specified as a covered service in the policy.
- Incurred by an enrolled eligible dependent child for care or treatment of any condition arising from or related to pregnancy, childbirth, delivery or an involuntary complication of pregnancy, unless specified as a covered service in the policy.

- 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, surgical or medical, or complications from an elective abortion, unless to preserve the life of the female upon whom the abortion is performed.
- 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 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.
- For transplant services and artificial organs, except as specified as a covered service under the policy.
- For acupuncture.
- For chiropractic care.
- 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 home care, except as specified as a covered service in the policy.
- For pastoral, spiritual, and bereavement 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.
- Any services or supplies for which an insured would have no legal obligation to pay in the absence of coverage under the policy or any similar coverage; or for which no charge or a different charge is usually made in the absence of insurance coverage.
- 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, except as specified as a covered service in the policy.
- For immunizations, except as specified as a covered service in the policy.
- For breast reduction surgery or surgery for gynecomastia.
- For nutritional supplements, nutritional replacements, nutritional formulas, prescription vitamins and minerals.
- 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 policy.
- Speech therapy, physical therapy, growth hormone therapy, and home intravenous therapy except as specifically provided as a covered service under the policy.
- Furnished by a provider or caregiver that is not listed as a covered provider, including but not limited to, naturopaths.
- 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 treatment or care of mental or nervous conditions.
- Contraceptives, oral or other, whether medication or device.
- For orthotics and durable medical equipment.
- For wigs and cranial molding helmets.
- 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 allergy shots or other injections unless related to surgery, emergency room covered services, inpatient covered services, or selected therapy services.

This brochure is a brief overview describing the general features and benefits of Blue Cross of Idaho's individual Essential Blue Plus PPO health care coverage policy. This is not a contract. All of the provisions, exclusions, and limitations stated in the policy apply. If you have any questions regarding your health care coverage, or if you would like to see a copy of these policies, please contact your insurance agent or your local Blue Cross of Idaho district office.

Blue Cross of Idaho

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ESSENTIAL BLUE℠ PLUS PPO
A LIMITED BENEFIT PLAN

OPTIONS AND BENEFITS	ESSENTIAL BLUE PLUS PPO 1000		ESSENTIAL BLUE PLUS PPO 2000		ESSENTIAL BLUE PLUS PPO 3000		ESSENTIAL BLUE PLUS PPO 5000	
	In-network	*Out-of-network*	*In-network*	*Out-of-network*	*In-network*	*Out-of-network*	*In-network*	*Out-of-network*
Deductible Choices *(Includes in-network and out-of-network covered services)*	$1,000 per person – $2,000 per family aggregate*		$2,000 per person – $4,000 per family aggregate*		$3,000 per person – $6,000 per family aggregate*		$5,000 per person – $10,000 per family aggregate*	
Coinsurance *(The amount you pay after meeting your deductible, unless otherwise indicated)*	You pay 20% of the allowed amount for covered services from contracting providers You pay 50% of the allowed amount for covered services from non-contracting providers							
Out-of-Pocket Maximum *(Includes your deductible but does not include $5,000 pregnancy deductible)*	$3,000 per person for in-network services	$3,000 per person for out-of-network services	$4,000 per person for in-network services	$4,000 per person for out-of-network services	$5,000 per person for in-network services	$5,000 per person for out-of-network services	$7,000 per person for in-network services	$7,000 per person for out-of-network services
	In-network				*Out-of-network*			
Physician Office Visits *(You pay deductible and/or coinsurance for other services during a physician office visit)*	You pay a $30 copayment for specifically listed services				You pay 50% of the allowed amount for covered services after meeting your deductible			
Preventive Care Services	You pay nothing for services specifically listed up to $500. For services in excess of $500 you pay your deductible and coinsurance				You pay 50% of the allowed amount after meeting your deductible			
	Physician office visits and preventive care services are limited to a combined total of 10 office visits per person, per benefit period							
Immunizations	You pay nothing for specifically listed immunizations							
Pregnancy Services *(A separate $5,000 deductible applies, except in cases of involuntary complications)*	You pay 20% after meeting a separate $5,000 deductible				You pay 50% after meeting a separate $5,000 deductible			
Emergency Room Facility Services	You pay a $100 copayment, after which you pay 20% of the allowed amount for covered services after meeting your deductible				You pay a $100 copayment, after which you pay 50% of the allowed amount for covered services after meeting your deductible			
Emergency Room Physician Services	You pay 20% of the allowed amount for covered services after meeting your deductible				You pay 50% of the allowed amount for covered services after meeting your deductible			
Prescription Drugs *(Brand name and generic drugs)*	You pay 50% coinsurance, no deductible required. Prescription drug benefit limited to a maximum of $1,200 per person, per benefit period, 90-day supply limit.							
Diagnostic Mammogram Services **Inpatient Physician, Surgical and Medical Professional Services** **Hospital Services** *(Inpatient care, outpatient surgery and preadmission testing)* **Inpatient Diagnostic Laboratory and X-ray Services** *(From contracting providers only)* **Outpatient Diagnostic Laboratory and X-ray Services** *(Limited to a combined total of $2,000 per person, per benefit period)*	You pay 20% of the allowed amount for covered services after meeting your deductible				You pay 50% of the allowed amount for covered services after meeting your deductible			
Inpatient Physical Rehabilitation *(From contracting providers only)* **Hospice Services** *(Lifetime benefit limit of $10,000 per person, no deductible required)*	You pay 20% of the allowed amount for covered services after meeting your deductible				Not covered, you pay 100% of the billed charges			
Selected Therapy Services *(Radiation, chemotherapy and renal dialysis)* **Ambulance Transportation Services** *(Limited to $500 per person, per benefit period)* **Inpatient Dental Services Related to Accidental Injury** *(Covered only for the 12-month period immediately following the date of injury)* **Prosthetic Appliances** **Skilled Nursing Facility** *(Limited to 30 days per person, per benefit period)* **Transplant Services**	You pay 20% of the allowed amount for covered services after meeting your deductible				You pay 50% of the allowed amount for covered services after meeting your deductible			
Comprehensive Lifetime Benefit Limit	$1,000,000 lifetime benefit limit per person							

SERVICES NOT COVERED UNDER ESSENTIAL BLUE PLUS *(See Exclusions and Limitations for complete list of services not covered)*

Chiropractic Care Services Durable Medical Equipment Orthotic Devices	Outpatient Occupational Therapy Outpatient Physical Therapy Outpatient Speech Therapy	Psychiatric Inpatient Services Psychiatric Outpatient Services	Growth Hormone Therapy Home Intravenous Therapy

** One family member cannot contribute more than their individual deductible amount toward the total family deductible.*

ESSENTIAL BLUE PLUS PROVIDES LIMITED BENEFITS THAT ARE SUPPLEMENTAL AND NOT INTENDED TO COVER ALL MEDICAL EXPENSES.

The options and benefits listed above are provided for general information purposes only; they are intended to give you a summary of the plan's benefits. Upon joining, you will receive a copy of the policy and an outline of coverage, which will provide further information on benefits, limitations and exclusions that are not described in this summary. If you have any questions or if you would like to see a copy of these policies, please contact your insurance agent or your local Blue Cross of Idaho district office.

Boise

(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

2116 East 25th Street
Idaho Falls, ID 83404

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

Lewiston

1010 17th Street

(Mailing Address)
P.O. Box 1468
Lewiston, ID 83501
(208) 746-0531

Pocatello

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

(Mailing Address)
P.O. Box 2578
Pocatello, ID 83206
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Twin Falls

1431 North Fillmore Street, Suite 200
Twin Falls, ID 83301

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Blue Cross® of Idaho