Blue Cross of Idaho

Contacting Blue Cross of Idaho

Feel free to contact Blue Cross of Idaho at

1-800-365-2345

On our website ***bcidaho.com/short_term***

Visit our local offices at:

MERIDIAN
3000 East Pine Avenue
Meridian, ID 83642-5995
208-387-6683

COEUR D'ALENE
1450 Northwest Boulevard, Suite 106
Coeur d'Alene, ID 83814
208-666-1495

LEWISTON
1010 17th Street
Lewiston, ID 83501
208-746-0531

TWIN FALLS
1431 North Fillmore Street
Suite 200
Twin Falls, ID 83301
208-733-7258

POCATELLO
275 South 5th Avenue
Suite 150
Pocatello, ID 83201
208-232-6206

IDAHO FALLS
1910 Channing Way
Idaho Falls, ID 83404
208-522-8813

Blue Cross of Idaho

Short Term PPO℠

Individual Health Insurance

Policy Form No:
Short Term PPO Policy – 3-420 (05-11)

Form No: 3-614 (07-14)

SHORT TERM PPO℠

Temporary health insurance coverage from Blue Cross of Idaho

Short Term PPO is tailored for the times in life when you need temporary health insurance coverage. Designed to cover you and your family when you're between full benefit programs. Short Term PPO provides coverage for you and your eligible dependents within 24 hours of submitting your application.

You can choose coverage for just one month, or up to 10 months, depending on your needs. The number of months of coverage you choose determines your monthly rate. Contact Blue Cross of Idaho at 800-365-2345, or visit our website at ***bcidaho.com/short_term*** for a rate card with our current prices and choose the coverage that's right for you.

Short Term PPO Protects You and the people you care about

- Multiple deductible options to fit your needs.
- Low coinsurance for covered services after you meet your deductible.
- Low out-of-pocket maximums that mean you pay nothing for covered expenses after you've reached it. (limit applies to your deductible and coinsurance only.)
- Flexible benefit periods to choose from.
- Your enrolled eligible dependents will have coverage through the last day of the benefit period until they are 26 years old.
- You can reapply for new Short Term PPO coverage after you have had a break in coverage of more than 63 days.

HOW TO APPLY

To Apply Online

- Go to ***bcidaho.com/short_term.***
- Complete the application and submit it online.
- Print your Blue Cross of Idaho identification card.

To Submit a Paper Application

- Complete and return the attached application with your payment to your local Blue Cross of Idaho district office listed on the back of this brochure.
- Blue Cross of Idaho will send you an ID card with your policy once we have approved your application. If you need medical services before you receive your ID card, you or the healthcare provider may contact Blue Cross of Idaho at 800-365-2345 to verify your coverage.

WHAT YOU NEED TO KNOW

- Remember to enroll every family member you want covered.
- You must pay your first month's premium with the application. If your benefit period extends beyond one month, you can choose to pay in full for all months of coverage.
- When your application is approved, your coverage will begin at 12:01 a.m. the day after we receive your completed application, or on the effective date you request, whichever is later.

Short Term PPO

ensures you and your family have the quality coverage you need.

OPTIONS AND BENEFITS	SHORT TERM PPO	
	In-network	*Out-of-network*
Deductible	Option A: $500 Option B: $1,000 Option C: $2,000 *(individual deductible only)*	
Out of Pocket Maximum	Option A: $2,500 Option B: $3,000 Option C: $4,000	Option A: $2,500 Option B: $3,000 Option C: $4,000
Lifetime Maximum	$1,000,000	
Annual Maximum	NA	
Coinsurance	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
COVERED SERVICES	*In-network*	*Out-of-network*
Ambulance Transportation 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
Dental Services Related to Accidental Injury		
Diabetes Self-Management Education Services *(limited to $500 combined in- and out-of-network, per insured per benefit period)*		
Diagnostic Laboratory and X-ray Services		
Durable Medical Equipment		
Home Health Skilled Nursing Care Services *(limited to $5,000 combined in- and out-of-network, per insured per benefit period)*		
Home IV Therapy	You pay 20% of the allowed amount for covered services after meeting your deductible	You pay 80% of the allowed amount for covered services after meeting your deductible
Hospital 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
Involuntary Complications of Pregnancy *(available only for the insured and enrolled eligible dependents; there are no additional benefits for maternity services under the policy)*		
Orthotic Devices		
Outpatient Physical Therapy Services *(limited to $800 combined in- and out-of-network, per insured, per benefit period)*		
Physician Services *(includes physician office visits)*		
Prosthetic Services		
Skilled Nursing Facility *(limited to 30 days per person, per benefit period)*		
Surgical and Medical Professional Services *(including anesthesia services)*		
Therapy Services *(therapies such as radiation, chemotherapy, renal dialysis, respiratory, inpatient occupational, enterostomal, growth hormone)*		
Transplant Services *(see policy for a list of covered transplant services)*		
Prescription Drug Benefits	You pay a separate deductible of $100, then 20% for generic and brand name drugs	

PRIOR AUTHORIZATION

NOTICE: The medical necessity of covered services listed below should be determined to be eligible for benefits under the terms of this 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.

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

Prior authorization is a request by the insured's contracting provider to Blue Cross of Idaho, or delegated entity, for authorization of an insured's 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 determine whether the proposed treatment meets the standard of medical necessity as defined in this policy. The insured is responsible for obtaining prior authorization when seeking treatment from a noncontracting provider.

Please refer to Attachment A of the outline of coverage, check the Blue Cross of Idaho website at Blue Cross of Idaho, ***bcidaho.com***, or call customer service at the telephone number listed on the back of the insured's identification card to determine if the insured's proposed services require prior authorization. To request prior authorization, the contracting provider must notify Blue Cross of Idaho of the insured's intent to receive services that require prior authorization.

The insured is 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 the insured's policy and medically necessary. Blue Cross of Idaho will respond to a request for prior authorization received from either the provider or the insured within two (2) business days of the receipt of the medical information necessary to make a determination.

NON-EMERGENCY PREADMISSION NOTIFICATION

Non-emergency preadmission notification is a notification to Blue Cross of Idaho by the insured and is required for all inpatient admissions except covered services subject to emergency or maternity admission notification. An insured should notify Blue Cross of Idaho of all proposed inpatient admissions as soon as he or she knows they will be admitted as an inpatient. The notification should be made before any inpatient admission. Non-emergency preadmission notification informs Blue Cross of Idaho, or a delegated entity, of the insured's proposed inpatient admission to a licensed general hospital, alcohol or substance abuse treatment facility, psychiatric 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 the insured to Blue Cross of Idaho, payment of benefits is subject to the specific benefit levels, limitations, exclusions and other provisions of this policy.

For Non-emergency preadmission notification call Blue Cross of Idaho at the telephone number listed on the back of the enrollee's 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 this policy) maternity delivery services, and notification cannot be completed prior to admission due to the insured's condition, the insured, or his or her representative, should notify Blue Cross of Idaho within twenty-four (24) hours of the admission. If the admission is on a weekend or legal holiday, Blue Cross of Idaho should 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 this policy) maternity delivery services, renders it medically impossible for the insured to provide such notice, the insured should 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 the insured's proposed discharge. If the insured 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 this policy.

DISCHARGE PLANNING

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

PREEXISTING CONDITION WAITING PERIOD

There are no benefits available under the policy for services, supplies, drugs or other charges related to any symptoms or conditions that existed before you enrolled in Short Term PPO. No credit is given under the policy for any prior coverage, including prior Short Term PPO or Short Term Blue coverage or its successor.

A PREEXISTING CONDITION IS THE EXISTENCE OF:

1. A condition that would have caused an ordinarily prudent person to seek medical advice, diagnosis, care or treatment during the six (6) months immediately preceding the effective date of coverage under this policy; or
2. A condition for which medical advice, diagnosis, care or treatment was recommended or received during the six (6) months immediately preceding the effective date of coverage under this policy; or
3. A pregnancy existing on the effective date of coverage under this policy.

GENERAL EXCLUSIONS AND LIMITATIONS SECTION

In addition to the exclusions and limitations listed elsewhere in the policy, the following exclusions and limitations apply to the entire policy, unless otherwise specified:

You are not covered for services, supplies, drugs or other charges that are:

- Not medically necessary. If services requiring prior authorization by Blue Cross of Idaho are performed by a contracting provider and benefits are denied as not medically necessary, the cost of said services are not the financial responsibility of the insured. However, the insured could be financially responsible for services found to be not medically necessary when provided by a noncontracting provider.
- In excess of the maximum allowance.
- For hospital inpatient or outpatient care for extraction of teeth or other dental procedures, unless necessary to treat an accidental injury or unless an attending physician certifies in writing that the insured has a non dental, life endangering condition which makes hospitalization necessary to safeguard the insured's health and life.
- Not prescribed by or upon the direction of a physician or other professional provider; or which are furnished by any individuals or facilities other than licensed general hospitals, physicians, and other providers.
- Investigational in nature.
- Provided for any condition, disease, illness or accidental injury to the extent that the insured is entitled to benefits under occupational coverage, obtained or provided by or through the employer under state or federal Workers' Compensation Acts or under Employer Liability Acts, or other laws providing compensation for work related injuries or conditions. This exclusion applies whether or not the insured claims such benefits or compensation or recovers losses from a third party.
- Provided or paid for by any federal governmental entity 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:
  1. Reconstructive surgery necessary to treat an Accidental Injury, infection or other disease of the involved part; or
  2. 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.
- 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, hot tubs, whirlpool baths, waterbeds or swimming pools and therapies, including but not limited to, educational, recreational, art, aroma, dance, sex, sleep, electro sleep, vitamin, chelation, homeopathic or naturopathic, massage, or music.
- For telephone consultations, and all computer or Internet communications; 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 outpatient occupational therapy; outpatient speech therapy, inpatient or outpatient custodial care; or for inpatient or outpatient services consisting mainly of educational therapy, behavior modification, self care or self help training, except as specified as a covered service in the policy.
- For inpatient admissions that are primarily for diagnostic services, therapy services, or physical rehabilitation, except as specified 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 or when skilled nursing is not required.
- 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 when 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.
- For hearing aids or examinations for the prescription or fitting of hearing aids.
- 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.
- For orthoptics, eyeglasses or contact lenses or the vision examination for prescribing or fitting eyeglasses or contact lenses.
- 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, except as specified as a covered service in the policy.
- 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, evaluation or treatment of mental or nervous conditions, alcoholism, substance abuse or addiction, or for pain rehabilitation.

- Incurred by an insured for care or treatment of any condition arising from or related to pregnancy, childbirth, or delivery, except as 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 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 an elective abortion unless to preserve the life of the female upon whom the abortion is performed.
- For sterilization, or the reversal of sterilization procedures, including but not limited to, vasovasostomies or salpingoplasties.
- Treatment for infertility and fertilization procedures, including but not limited to, ovulation induction procedures and pharmaceuticals, artificial insemination, in vitro fertilization, embryo transfer or similar procedures, or procedures that in any way augment or enhance an insured's reproductive ability, including but not limited to laboratory services, radiology services or similar services related to treatment for fertility or fertilization procedures.
- For transplant services and artificial organs, except as specified as a covered service in the policy.
- For chiropractic care.
- 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 pastoral, spiritual, and bereavement counseling.
- For homemaker and housekeeping services or home delivered meals.
- For hospice home care.
- 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, unless such injuries are a result of a medical condition or domestic violence.
- 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.
- For routine or preventive immunizations.
- For breast reduction surgery or surgery for gynecomastia.
- For nutritional supplements.
- For replacements or nutritional formulas, except when administered enterally due to impairment in digestion and absorption of an oral diet and is the sole source of caloric need or nutrition in an insured.
- For vitamins and minerals, unless required through a written prescription and cannot be purchased over the counter.
- Any services or supplies furnished by a facility that is primarily a health resort, sanatorium, residential treatment facility, transitional living center, or primarily a place for outpatient treatment or residential facility care of mental or nervous conditions.
- For 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.
- Furnished by a provider or caregiver that is not listed as a covered Provider, including but not limited to, naturopaths and homeopaths.
- 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.
- For well-baby or well-child care furnished by a physician or other professional provider to an Insured who is not a patient at a licensed general hospital or ambulatory surgical facility.
- Contraceptives, oral or other, whether medication or device, except as specified as a covered service.
- 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.
- Any prescription drug, biological or other agent which is:
  - Prescribed primarily to aid or assist the Insured in the cessation of the use of tobacco.

SHORT TERM PPO℠ ENROLLMENT APPLICATION

Blue Cross of Idaho

Applicant Information *(Please complete each section of this application in ink)*

Your Name *(first, initial, last)*	Social Security Number	Date of Birth *(mm/dd/yy)*	Age	❑ Male ❑ Female
Mailing Address *(street or route)*	City, State, Zip Code		County	
Billing Address *(if different from mailing address)*	City, State, Zip Code		County	
Idaho Resident ❑ Yes ❑ No / Preferred Phone	Alternate Phone	❑ I don't have a phone	Marital Status: ❑ Single ❑ Married	

List all eligible dependents you wish to enroll, including any child who is under the age of 26; or who is medically certified as disabled and dependent on parent for support (copy of certification required). If you have more than two dependents, please include the information on a separate sheet of paper.

Family Member's Name *(first, initial, last)*	Relationship to Applicant *(spouse, child, stepchild, etc.)*	Date of Birth	Social Security Number	Age	
		/ /	/ /		❑ Male ❑ Female
Family Member's Name *(first, initial, last)*	Relationship to Applicant	Date of Birth / /	Social Security Number / /	Age	❑ Male ❑ Female
Family Member's Name *(first, initial, last)*	Relationship to Applicant	Date of Birth / /	Social Security Number / /	Age	❑ Male ❑ Female
Family Member's Name *(first, initial, last)*	Relationship to Applicant	Date of Birth / /	Social Security Number / /	Age	❑ Male ❑ Female
Family Member's Name *(first, initial, last)*	Relationship to Applicant	Date of Birth / /	Social Security Number / /	Age	❑ Male ❑ Female
Family Member's Name *(first, initial, last)*	Relationship to Applicant	Date of Birth / /	Social Security Number / /	Age	❑ Male ❑ Female

Benefit Period Desired: ❑ 1 mth ❑ 2 mths ❑ 3 mths ❑ 4 mths ❑ ____ mths (maximum 10 mths)

Deductible Option: ❑ $500 ❑ $1,000 ❑ $2,000

Requested Effective Date_____/_____/_____ Total Payment $ __________

When your application is approved, your coverage will begin at 12:01 a.m. the day after we receive your completed application, or the effective date you request, whichever is later. You must submit your first month's payment with this application. If your benefit period extends beyond one month, and you choose not to pay in full, you must complete the Authorization Agreement for Automatic Withdrawal found at ***bcidaho.com/_forms/automaticwithdrawal.pdf*** *and include it with this application.*

Please answer each question below. If any question is answered **YES**, you are not eligible for Short Term PPO coverage.

1. Has anyone listed on this application been refused health insurance coverage or offered coverage under the Idaho State Mandated High-risk Pool plans within the last 12 months? ❑ **YES** ❑ **NO**
2. Does anyone listed on this application currently have other health insurance coverage, Medicare, or Medicaid that will remain in force beyond the effective date of this coverage? ❑ **YES** ❑ **NO**
3. Are you, your spouse, or any eligible dependent, whether or not listed on this application, now pregnant? ❑ **YES** ❑ **NO**
4. Is anyone listed on this application currently admitted to a health care facility, or has surgery or other inpatient treatment been planned (but not yet performed) for anyone listed on this application? ❑ **YES** ❑ **NO**
5. Has anyone listed on this application had a short term policy within the past 63 days with Blue Cross of Idaho? ❑ **YES** ❑ **NO**

Smoker Designation and Certification

Has any person listed on this application used tobacco during the past twelve months? ❑ **YES** ❑ **NO**

(over)

This application is approved by Blue Cross of Idaho.

Benefit Period

____________________	___/___/___	___/___/___	___/___/___
District Manager's Signature	*Date*	*Effective Date*	*Expiration Date*

(Dates assigned by District Manager)

3000 E. Pine Ave. • Meridian, Idaho 83642 • (208) 345-4550
Mailing Address: P.O. Box 7408 • Boise, ID 83707-1408

– FOR INDEPENDENT PRODUCER'S USE ONLY –

Independent Producer Certification

1. Who actually completed this application? ❑ Applicant ❑ Independent Producer ❑ Other
   If Independent Producer or Other, please explain: _____
2. Were you present at the time the application was filled out? ❑ **YES** ❑ **NO**
   If **NO,** please explain: _____

I have explained the eligibility provisions to the applicant. I have not made any representations about benefits, conditions, or limitations of the policy except through written material furnished by Blue Cross of Idaho. I hereby certify that the information supplied to me by the applicant has been completely and accurately recorded.

Independent Producer's Printed Name	*Independent Producer's Signature*	*Date*	*Blue Cross of Idaho No.*

Type of Company Appointment ❑ *Personal* ❑ *Agency* _____ *Name* _____ *Business Phone*

Replacement of Existing Coverage

Will this policy replace any other accident and sickness insurance presently in force? ❑ **YES** ❑ **NO**

If **YES**, please read, sign and date the following notice.

Notice to Applicant Regarding Replacement of Accident and Sickness Insurance

According to this application, you intend to allow to lapse or otherwise terminate existing accident and sickness insurance and replace it with a program to be issued by Blue Cross of Idaho. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the health care coverage available to you under the new program.

1. Health conditions which you may presently have (preexisting conditions), may not be immediately or fully covered under the new program or the new program may also require a waiting period for certain specified conditions. This could result in denial or delay of a claim for benefits under the new program, whereas a similar claim might have been payable under your present program.
2. You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present program. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.
3. If, after due consideration, you still wish to terminate your present program and replace it with new coverage, please be certain to completely and accurately answer all questions on this application. Failure to include all information on an application may provide a basis for the company to deny any future claims and to refund your premiums as though your policy had never been in force. After the application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded.

I confirm that a copy of "Notice to Applicant Regarding Replacement of Accident and Sickness Insurance" was furnished to me.

X _____ ____/____/____
Applicant's Signature *Date*
(Parent or Guardian's signature if applicant is under age 18)

Parental or Guardian Consent to Application

I, the undersigned, represent that the person listed as the applicant on this application is under 18 years of age and is making application for Blue Cross of Idaho health coverage with my full knowledge and consent. I hereby accept full responsibility for the payment of premiums and for the answers and information provided in this application.

X *Signature*	*Date*	*Print Name*	*Relationship*

Statement of Understanding

By signing this application, I represent that all my answers are complete and accurate, and that I understand and agree to the following conditions:

- No independent producer, agent, or employee of Blue Cross of Idaho can change any part of this application or waive the requirement that I answer all questions completely and accurately, nor can any such person change the terms of the policy, except by endorsement issued expressly for that purpose over the signature or facsimile signature of the President of Blue Cross of Idaho.
- Blue Cross of Idaho may review this application and, at its discretion, request supplemental information from me, any family member listed on this application, or any health care providers before deciding whether to approve or reject the application.
- Blue Cross of Idaho may deny benefits or terminate or rescind my policy retroactive to its effective date for any misrepresentation, omission, or concealment of fact by, concerning, or on behalf of any persons listed on this application that was or would have been material to Blue Cross of Idaho's acceptance of a risk, extension of coverage, provision of benefits, or payment of any claim.
- If this application is not approved for the program applied for, any payment submitted with this application will be refunded. Upon the refund of the payment, Blue Cross of Idaho will have no further obligations to me or any family member listed on this application.
- If this application is approved, coverage for myself and any eligible family members named on this application will begin on the date assigned by Blue Cross of Idaho.
- I authorize any physician, hospital or other health care provider to furnish Blue Cross of Idaho information regarding the history, diagnosis or treatment of any symptom, condition, disease, illness or accidental injury of any person named on this application.
- On behalf of myself and all enrolled family members, I authorize Blue Cross of Idaho to release information to enrolled family members, health care providers, other insurers and government agencies to the extent required to process claims, coordinate benefits, conduct utilization review, and perform audits and fraud investigations.
- **This program does not cover services received for any Preexisting Conditions. Preexisting Condition means any condition:**
  - that would cause an ordinarily prudent person to seek medical advice, diagnosis, care or treatment within the six month period preceding the effective date; or
  - for which medical advice, diagnosis, care or treatment was recommended by or received from a health care provider within the six month period preceding the effective date; or
  - a pregnancy existing on the effective date of coverage, except for involuntary complications of pregnancy incurred after the effective date.
- I acknowledge and understand my health plan may request or disclose health information about me or my dependents (persons who are listed for benefits coverage on the enrollment form) from time to time for the purpose of facilitating health care treatment, payment or for the purpose of business operations necessary to administer health care benefits; or as required by law. For more information about such uses and disclosures, including uses and disclosures required by law, please refer to the Blue Cross of Idaho Notice of Privacy Practices that is available at ***bcidaho.com***.
- ***I affirm that I have reviewed all the answers given on this application and, regardless of whether an independent producer or other person has filled out the answers for me and on my behalf, I verify the answers accurately reflect all the information given by me. I understand that this application will become part of any agreement or policy that Blue Cross of Idaho issues.***

X _____ ____/____/____
Applicant's Signature *Date*
(Parent or Guardian's signature if applicant is under age 18)

Blue Cross of Idaho

One mission: **you**

SHORT TERM PPO℠

Effective March 1, 2017 through April 30, 2017

Monthly rates when you choose 1–4 months of coverage

Age of Applicant or Spouse	Male Non Smoker	Male Smoker	Female Non Smoker	Female Smoker
Deductible of $500				
Under 30	$ 95.64	114.45	132.10	157.95
30 – 39	127.67	152.88	183.21	220.20
40 – 49	189.37	226.31	237.40	284.38
50 – 59	340.67	407.81	316.35	378.62
60 – 64	493.65	590.67	447.97	536.03
One child (non-smoker/smoker)			$74.70 / $89.61	
Two or more children (non-smoker/smoker)			$149.38 / $179.29	
Deductible of $1,000				
Under 30	$ 65.62	78.51	90.63	108.39
30 – 39	87.61	104.89	125.69	151.07
40 – 49	129.95	155.28	162.88	195.12
50 – 59	233.73	279.81	217.05	259.78
60 – 64	338.71	405.25	307.32	367.76
One child (non-smoker/smoker)			$51.24 / $61.48	
Two or more children (non-smoker/smoker)			$102.49 / $123.00	
Deductible of $2,000				
Under 30	$ 52.08	62.30	71.88	85.99
30 – 39	69.47	83.23	99.72	119.85
40 – 49	103.10	123.19	129.22	154.81
50 – 59	185.42	222.00	172.18	206.09
60 – 64	268.71	321.52	243.81	291.79
One child (non-smoker/smoker)			$40.67 / $48.78	
Two or more children (non-smoker/smoker)			$81.32 / $97.62	

Monthly rates when you choose 5–6 months of coverage

Deductible of $500

Age of Applicant or Spouse	Male Non Smoker	Male Smoker	Female Non Smoker	Female Smoker
Under 30.....	$ 100.42	120.17	138.68	165.86
30 – 39	134.05	160.53	192.38	231.21
40 – 49.....	198.86	237.64	249.28	298.60
50 – 59.....	357.69	428.22	332.16	397.54
60 – 64.....	518.33	620.22	470.36	562.83

One child (non-smoker/smoker)	$78.43 / $94.10
Two or more children (non-smoker/smoker)	$ 156.84 / $188.25

Deductible of $1,000

Under 30.....	$ 72.58	86.86	100.23	119.90
30 – 39	96.91	116.01	139.04	167.10
40 – 49.....	143.70	171.75	180.19	215.85
50 – 59.....	258.50	309.48	240.07	287.32
60 – 64.....	374.64	448.24	339.94	406.79

One child (non – smoker/smoker)	$56.68 / $67.98
Two or more children (non – smoker/smoker)	$113.35 / $136.04

Deductible of $2,000

Under 30.....	$ 53.53	64.03	73.91	88.43
30 – 39	71.45	85.57	102.54	123.26
40 – 49.....	106.01	126.69	132.88	159.17
50 – 59.....	190.66	228.26	177.04	211.90
60 – 64.....	276.28	330.59	250.69	300.01

One child (non-smoker/smoker)	$41.82 / $50.16
Two or more children (non-smoker/smoker)	$83.60 / $100.35

Nonsmoker rates apply when no one on this coverage has used tobacco for the past 12 months. List all eligible dependents you wish to enroll, including any child who is younger than 26; or who is medically certified as disabled and dependent on parent for support (copy of certification required).

Rate is based on age on the effective date of coverage.

Monthly rates when you choose 7–8 months of coverage

Deductible of $500				
Age of Applicant or Spouse	**Male Non Smoker**	**Male Smoker**	**Female Non Smoker**	**Female Smoker**
Under 30.....	$ 103.31	123.60	142.65	170.58
30 – 39.....	137.88	165.13	197.88	237.80
40 – 49.....	204.54	244.43	256.40	307.15
50 – 59.....	367.92	440.42	341.67	408.91
60 – 64.....	533.16	637.93	483.78	578.92

One child (non-smoker/smoker)	$80.69 / $96.77
Two or more children (non-smoker/smoker)	$161.30 / $193.64

Deductible of $1,000				
Under 30.....	$ 82.47	98.69	113.91	136.22
30 – 39.....	110.07	131.84	157.98	189.86
40 – 49.....	163.30	195.15	204.70	245.22
50 – 59.....	293.74	351.67	272.79	326.49
60 – 64.....	425.67	509.32	386.24	462.20

One child (non-smoker/smoker)	$64.41 / $77.25
Two or more children (non-smoker/smoker)	$128.80 / $154.59

Deductible of $2,000				
Under 30.....	$ 56.12	67.14	77.48	92.65
30 – 39	74.89	89.69	107.48	129.17
40 – 49.....	111.11	132.77	139.26	166.83
50 – 59.....	199.82	239.25	185.57	222.10
60 – 64.....	289.58	346.52	262.78	314.44

One child (non-smoker/smoker)	$43.82 / $52.58
Two or more children (non-smoker/smoker)	$87.64 / $105.18

Nonsmoker rates apply when no one on this coverage has used tobacco for the past 12 months. List all eligible dependents you wish to enroll, including any child who is younger than 26; or who is medically certified as disabled and dependent on parent for support (copy of certification required).

Rate is based on age on the effective date of coverage.

SHORT TERM PPO℠

Effective March 1, 2017 through April 30, 2017

Monthly rates when you choose 9–10 months of coverage

Deductible of $500

Age of Applicant or Spouse	Male Non Smoker	Male Smoker	Female Non Smoker	Female Smoker
Under 30	$ 109.60	131.15	151.37	181.02
30 – 39	146.29	175.20	209.99	252.33
40 – 49	217.04	259.36	272.07	325.91
50 – 59	390.39	467.35	362.54	433.89
60 – 64	565.73	676.91	513.35	614.30

One child (non-smoker/smoker)	$85.63 / $102.68
Two or more children (non-smoker/smoker)	$171.17 / $205.46

Deductible of $1,000

Under 30	$ 92.51	110.69	127.75	152.81
30 – 39	123.48	147.86	177.19	212.94
40 – 49	183.16	218.89	229.61	275.07
50 – 59	329.47	394.43	305.96	366.20
60 – 64	477.48	571.30	433.25	518.45

One child (non-smoker/smoker)	$72.23 / $86.67
Two or more children (non-smoker/smoker)	$144.49 / $173.38

Deductible of $2,000

Under 30	$ 62.04	74.23	85.67	102.48
30 – 39	82.80	99.18	118.86	142.84
40 – 49	122.85	146.80	154.02	184.46
50 – 59	220.98	264.55	205.18	245.61
60 – 64	320.23	383.16	290.56	347.73

One child (non-smoker/smoker)	$48.46 / $58.14
Two or more children (non-smoker/smoker)	$96.92 / $116.32

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