

Choosing a Regence EvolveSM

Individual and family plan



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Boise, ID 83701

Thank you for expressing interest in a Regence Individual and family health plan.

Choosing health coverage is an important process, and we're looking forward to helping you find the Regence plan that will give you what you're looking for.

In order to meet the changing needs of our neighbors here in Idaho, we've developed a suite of new plans called Regence Evolve. These plans focus on affordability, practical coverage, wellness and protection. You'll find a variety of benefits and costs—and even two HSA options that give you the ability to save money tax-free for eligible medical expenses. This booklet contains valuable tools designed to help you choose and apply for the coverage that's right for you.

You'll find plan comparisons, brief explanations of how coverage works, a description of our wellness-focused programs and all the forms you'll need to apply.

If you want to explore Regence or our plans in more detail, please visit our website at regence.com. You can also talk to your local agent or an Individual plan specialist at 1-888-REGENCE (1-888-734-3623).

We look forward to hearing back from you soon.

Sincerely,

Kory Porter
Consumer Sales

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Step 1

Choose a plan that's right for you

Want a variety of choices?

Regence Evolve plans provide a number of options when it comes to coverage and cost. With three plans to choose from and multiple cost-sharing options within each plan, you're sure to find the right coverage for you.

Considering an HSA?

Many consider these Consumer-Directed Health Plans to be the future of health care coverage. They combine a specially designed, high-deductible health plan and a tax-advantaged savings account to use for out-of-pocket medical expenses or to save for future medical expenses. We offer a variety of HSA options.

Need dental coverage?

Good overall health includes good dental health, too. And good dental health requires regular dental care. If you're interested in coverage for overall well-being, you'll probably want to add dental coverage to your medical benefits.

There are two optional dental plans that can accompany your Evolve medical plan. Each one provides flexibility, choices and control over how you spend your dental coverage dollars, all with an eye to maintaining overall good health.

If you have questions about any of the plans, talk to your local agent or call us at 1-888-REGENCE (1-888-734-3623).

Comparing medical plans

What you need to know

When shopping for a health plan, it can be helpful to know a little more about how health coverage works.

Below is information that will help you better understand what you're comparing when you're looking at our options side by side.

If you have any questions or want to learn more, please visit our website at regence.com or call us at 1-888-REGENCE (1-888-734-3623).

What is coinsurance?

Coinsurance is your share of the cost of health care services after you've met your deductible and paid any applicable copay. For example, if your plan pays 80%, the remaining 20% is your coinsurance. Coinsurance amounts can vary from plan to plan.

What is an allowed amount?

An allowed amount is the fee that most providers agree to accept as payment in full for covered services. (Any deductible, coinsurance or copay is part of your share of the allowed amount.)

What is a coinsurance maximum?

Standard (non-HSA) plans have a coinsurance maximum, which is the most you would pay in coinsurance in a calendar year. Only your coinsurance counts toward this limit; money you pay in copays or toward the deductible does not accumulate toward this maximum. You would still be responsible for non-coinsurance out-of-pocket expenses, such as office-visit copays, after this maximum is reached.

How does the HSA annual out-of-pocket maximum work?

Your out-of-pocket maximum is the limit to how much you would pay out of pocket during a calendar year. Coinsurance and deductibles both count toward this maximum. This amount varies by plan. After you have reached your out-of-pocket maximum, Regence pays 100% of remaining covered medical expenses for that calendar year.

How does the deductible work?

Your deductible is the cost of covered medical services you incur and are responsible to pay each calendar year before the benefits are available. On standard plans, the family deductible is met when two or more covered family members reach the equivalent of two individual deductible amounts. On HSA family plans, the entire family deductible needs to be met before any family member receives benefits. (On HSA Individual plans, an individual needs to meet just the one individual deductible.)

What is a Consumer-Directed Health Plan?

It's a health plan design that involves consumers more directly in their health care through higher cost-sharing. Typically, such products are paired with a tax-advantaged health savings account offered through a bank. Funds in this account can be used to cover a portion of out-of-pocket expenses or saved for future medical needs.

What is a pre-existing condition?

It's 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; 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. Pre-existing condition waiting periods do not apply to members up to age 19.

Frequently asked questions about applying for coverage

Going to our website, regence.com, is the quickest and easiest way to apply. We've even built some decision-making tools that can help you choose the plan that's right for you. You can also complete and submit the application form that's at the back of this booklet. To help you through the application process, here are some frequently asked questions:

Q. Who can apply for coverage?

A. Individuals and families who are not eligible for Medicare can apply for coverage under these plans if they reside in Idaho. Eligible family members may include your spouse or domestic partner, and any children up to age 26, regardless of student status, marital status or financial dependence.

Q. Can I apply online?

A. Yes, you can apply online. Online shopping is quick and easy. Compare plans, get a rate quote, find participating doctors and hospitals, and complete an application online. Our website makes it easy to find or match a doctor and hospital to the plan you're considering. To find out more, visit regence.com, then click on *Shop Now*.

Q. How do I apply on paper?

A. Simply complete the enclosed application (one per family) and the application cover sheet. Then return the forms to us. Once we receive all the needed documents, we'll begin our review process.

Q. When will my coverage begin?

Your start date will be determined by when the application is submitted:

- Applications received during the first calendar week of the month (the first through the seventh) can have an effective date of the day after we receive the application.
- If we receive your application on or after the eighth day of the month, your effective date will be the first day of the following month.

Your annual renewal date is the first day of the month in which you initially enrolled. We'll also review health factors, which can affect your rate. Health factors are determined by prior medical conditions and/or claims submitted on a policy for both medical and prescription services.

We'll begin to process your application immediately once we receive it. If we need additional information, processing could be delayed. Once coverage is offered, we'll send you your member card(s) and a contract.

Q. Does it cost more to buy through an agent?

A. No. There is never an extra cost or obligation when you use an appointed agent. Agents appointed to represent Regence products provide a valuable service to their clients. They can help you decide which of our products is best for you and your family.

Q. Will my rate ever change?

A. We evaluate Individual rates each quarter for new members coming onto these plans. But once you are a member, may not see a rate change for your coverage for one year after your enrollment date. For example, if you became a member on July 1, 2010, the next time you may see a rate change is July 1, 2011, unless the state or federal government requires additional benefit changes.

Q. What about prior coverage credit?

A. If we receive your application within 63 days after any other coverage you may have had ends, we'll credit the time you were enrolled in the other coverage to the 12-month pre-existing condition waiting period. We need to receive a copy of your Certificate of Coverage from your previous coverage in order to apply credits. We can help you obtain a certificate from a prior plan or insurer or suggest other documents that will serve as alternatives to a certificate of creditable coverage as provided by federal law. Pre-existing condition waiting periods do not apply to members up to age 19.

Qualifying coverage means with respect to an individual, health benefits or coverage provided under any of the following: Group health benefit plan; health insurance coverage without regard to whether the coverage is offered in the group market, Individual market or otherwise; Medicare; Medicaid; medical and dental care for members and certain former members of the uniformed services and their dependents ("uniformed services" means the armed forces, the Commissioned Corps of the National Oceanic and Atmospheric Administration and the Public Health Service); a medical care program of the Indian Health Services or of a tribal organization; a state high-risk pool coverage; Federal Employees Health Benefits Program (FEHBP); a public health plan (a plan established or

Frequently asked questions about applying for coverage

maintained by a state, a foreign country, the U.S. government, or other political subdivision of a state, the U.S. government or foreign country that provides health insurance coverage to individuals enrolled in the plan); or a health plan issued under the Peace Corps Act. A state Children's Health Insurance Program (CHIP) is creditable coverage, whether it is a stand-alone separate program, a CHIP Medicaid expansion program, or a combination program, and whether it is provided through a group health plan, health insurance, or any other mechanism.

Q. How do I pay for my plan?

A. Choose from three convenient billing options: monthly automatic bank deduction (Surepay), quarterly billing, or monthly paper billing. Don't send money with your application. We'll bill after we've processed your application.

If you choose monthly automatic bank deduction, it may take a month or two to get your bank deduction set up. So, please be sure to pay the monthly bills that you receive in the mail until the bank deduction is finalized.

Q. What if I want to add a dependent in the future?

Newborns and children placed with you for adoption are covered by your policy for 60 days after birth or adoption. Coverage will be provided beyond those 60 days only if we have received a completed application within 60 days of the birth or placement. See your contract for details.

To add a spouse, domestic partner or other children, send us a completed application form. Once we receive the application, we'll begin the review process.

Q. Can I purchase the dental options separately from the medical plans?

A. No. The Evolve dental options are available only to individuals and families who purchase Regence Evolve medical plans during initial enrollment. If you want a stand-alone dental plan (one that's not combined with medical coverage), please visit Regence Life & Health Insurance Company at regenceLife.com.

Q. Can individual family members decline dental coverage?

A. If more than one family member is applying for a health plan and dental options on the same application, all family members will have the dental coverage. If individual family members complete separate applications for medical coverage they can choose to add or not add a dental option.

Q. What should I do if I have questions?

A. This booklet is a summary of the Regence Evolve plans. You may find it useful if you need a quick answer to a question about your coverage. The plan contract will provide complete details about your plan.

Please call us at 1 (888) REGENCE (1-888-734-3623) if you have more questions before you've been accepted for coverage. Once your coverage is effective, please call Customer Service at 1 (888) 232-5763. The TTY line for people with a hearing impairment is 711. If you prefer, an agent appointed to represent our products can also answer questions and help you apply.

For the most up-to-date list of medical providers, please visit our website at regence.com, and choose *Provider Search*.

Q. Can my employer pay for my coverage?

A. No. Individual plans are not intended for sale as an employer-sponsored health plan for employees. You're required to certify on your application for Individual coverage that your employer is not paying for your plan. For information on employer health benefit plans, contact our Group Sales department at one of our local offices.

Q. How do I know if my doctor is covered?

A. You may see any of our contracted providers. For a list, visit our website at regence.com. Simply click on *Find a Provider* at the top of the page and follow the prompts. You will see all the networks the providers are part of as well as other useful information (such as location, hours and languages spoken).

Health Savings Accounts explained

A smarter way to manage your health care

The power of HSA: ownership

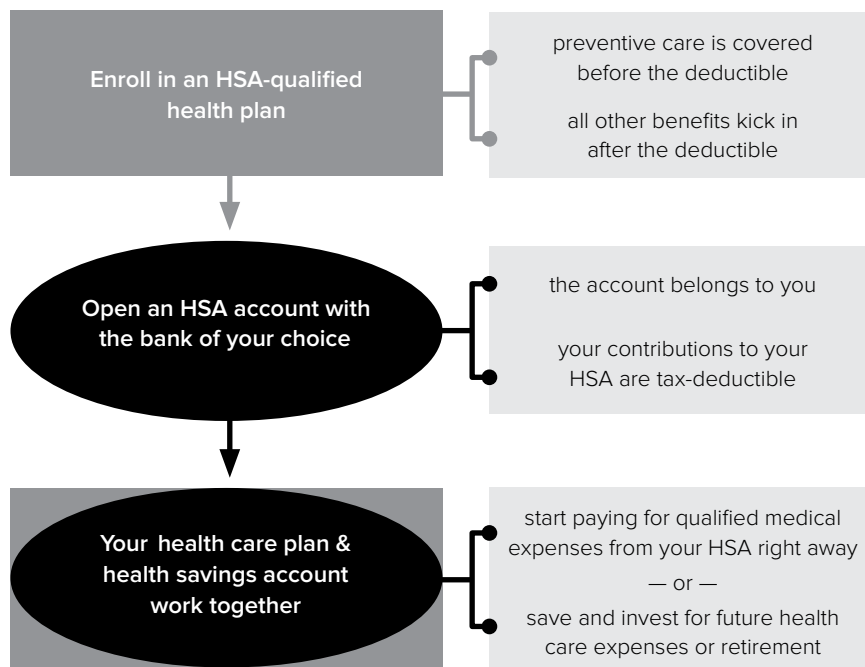
There are many options to choose from when searching for Individual health care coverage for yourself or your family. A new concept in health care—called a Health Savings Account (HSA)—may be the right choice for you if you're looking for coverage that's personalized, tax-advantaged and flexible.

Why should you consider an HSA?

With an HSA, you have more ownership over your health care.

- An HSA offers unique tax savings. Contributions are tax-deductible, interest is earned tax-free, and qualified medical expenses are paid tax-free.
- Your HSA funds belong to you. Your funds roll over each year and follow you wherever you go, allowing you to save and invest for future medical expenses and retirement.
- Your benefits are personalized. The HSA account gives you the flexibility to spend your health care dollars on the services you need most. Even more, you can choose from a list of services that expands beyond what is covered by your health plan.

How an HSA plan works



Health Savings Accounts explained

The power of Regence: unparalleled support

The Regence Evolve HSA options offer full-service solutions that include all the tools and support you need to make the plan your own. From robust benefits to guided tours—we're committed to your success.

Regence Evolve HSA offers robust coverage

- Preventive care covered at 100% and before you meet your deductible when you see an in-network provider
- Integrated wellness programs
- Comprehensive coverage after the deductible

Regence Evolve HSA 100

- Preventive care covered at 100% and before you meet your deductible when you see an in-network provider
- 100% coverage after yearly deductible
- Integrated wellness programs
- Easy-to-use benefits and features

Our tools make the difference

- myRegence.com takes you from the basics to a deeper understanding of plan personalization, tax savings and investment options, with:
 - Guided online tours
 - Webinars
 - Ask an HSA Expert
 - Online community of Regence members

Personalized support

- A team of member advocates is available to answer questions about your health plan, your health savings account and all our HSA tools.
- CareEnhance® 24-hour nurse hotline is available to answer medical questions quickly and conveniently.

Getting started is easy

Follow these simple steps:

1. Obtain an application from your local agent, apply online at regence.com, or call us toll-free: 1 (888) REGENCE (1-888-734-3623).
2. Once you're approved for coverage you can open a Health Savings Account. You can work with one of Regence's preferred banking partners or you may choose your own bank.

3. Put your HSA to work for you. Spend your HSA dollars on qualified medical expenses, or save and invest for the future.

Frequently asked questions

What is an HSA-qualified plan?

For a plan to be HSA-qualified, it must meet requirements set by the IRS that include the deductible and out-of-pocket expense amounts.

Who is eligible to enroll in an HSA?

Individuals may open an HSA if:

- They are enrolled in a qualified high-deductible health plan
- They don't have coverage under another health plan, such as a spouse's plan
- They are not enrolled in Medicare
- They are not claimed as a dependent on someone else's tax return

How much can be contributed to an HSA?

Combined HSA contributions cannot exceed the maximum contribution limit as determined by the IRS. For 2012, the annual limits are \$3,100 for individual coverage, or \$6,250 for family coverage.

How do I get the account set up?

Once you're enrolled in an Evolve HSA medical plan, you will need to set up an account with the banking partner of your choice by contacting the bank and filling out the appropriate forms. A list of Regence's preferred banking partners can be found on the following page.

When should I set up the account?

You may set up the account at any time, but you cannot fund the account until you have been approved for the health plan. To take full advantage of the value of the HSA, we encourage you to have the account set up and funded as soon as you have received approval. Only claims that occurred since the account has been open can be paid out of the account.

For investment or tax advice, please talk to an accountant or tax advisor.

Regence Financial Services Partners

The Regence Evolve HSA is a combination of a specially designed, high-deductible Regence health plan and a tax-advantaged savings account. For your convenience, we have developed partnerships with a select group of financial institutions that offer HSA accounts along with some added benefits to Regence members. You may choose to open an account with one of our partners or with any financial institution that offers HSAs.

Benefits of using a Regence Financial Services Partner

- They offer high-quality customer service.
- Our members have access to our negotiated fee schedule.
- All partners have extensive experience working with HSAs.
- The connection process between banking partners and Regence provides seamless member service over the phone.
- You can link from myRegence.com to the bank's member login page.

Financial Services Partner website and contact information

HealthEquity
regenceid.healthequity.com
1 (866) 960-8055

US Bank
healthsavings.usbank.com
1 (877) 472-6789

HSA Bank
hsabank.com/idregence
1 (800) 357-6246

Additional information

Feature/item	HealthEquity	HSA Bank	US Bank
Member services availability	24/7/365	M-F	M-F
Paper check available	No	Yes	Yes
Debit card provider	Yes	Yes	Yes
PIN available (for ATM usage)	Yes	Yes*	No
Ability to pay provider online	Yes	No	No
Minimum balance required to invest funds	\$2,000	\$1	\$2,500

**Subject to transaction fees*

Key features of Regence Evolve:

Coverage, savings, flexibility

Regence Evolve Core

- Preventive care covered at 100% and before you meet your deductible when you see an in-network provider
- Four up-front office visits per member per year covered before you meet your deductible (\$35 copay per visit)
- Generic medications covered with a \$10 copay, before you meet your prescription deductible
- Up to \$200 per member per year outpatient X-ray and lab services covered at 100% per year before you meet your deductible

Regence Evolve HSA Plan

- Preventive care covered at 100% and before you meet your deductible when you see an in-network provider
- Simple plans with either 80% and 50% coverage options
- Personal service and help from dedicated Regence HSA Customer Service department

Regence Evolve HSA 100 Plan

- Preventive care covered at 100% and before you meet your deductible when you see an in-network provider
- Unique plan that covers you at 100% once your yearly deductible is met
- Simple to understand and use
- Personal service and help from dedicated Regence HSA Customer Service department

Regence Evolve Dental Option 1

- \$750 annual maximum that increases on a rewards basis. *(When you incur services less than \$750, you may be rewarded with an additional benefit of \$250 the following year, not to exceed a total benefit of \$1,500. No deductible for preventive care.)*
- Discounts available through the national **Regence Dental network**

Regence Evolve Dental Option 2

- Annual maximum of \$750 (basic, restorative and major services combined)
- Your coinsurance is 0% for the first \$200 and then 50% up to the \$750 calendar-year maximum
- No deductibles
- Discounts available through the national **Regence Dental network**

Regence Evolve CoreSM

- Category 1:** Preferred providers. You'll generally have lower out-of-pocket costs when you see providers in this category.
- Category 2:** Participating providers. When you see providers in this category, you'll generally pay more out of pocket than you would with providers in Category 1.
- Category 3:** Non-contracted providers. You'll have the highest out-of-pocket costs when you see these providers. Also, they may bill you for the balance of their charge after we pay the claim.

Benefits	Per individual		Per family
Annual deductible Deductible does not apply to certain benefits	\$2,500, \$5,000, \$7,500, \$10,000		Family deductible is two times the individual amount
Annual coinsurance maximum Once you reach this amount, Regence pays 100%	\$4,000		Family coinsurance is two times the individual amount
Annual maximum	\$2,000,000 annual maximum		
Provider networks	Category 1 (Preferred)	Category 2 (Participating)	Category 3 (Nonparticipating)
Coinsurance Percentage you pay after the deductible	You pay 30%	You pay 50%	You pay 50%
Preventive care and immunizations Preventive services and immunizations are covered according to guidelines set by the United States Preventive Services Task Force (USPSTF), Centers for Disease Control and Prevention (CDC), and Health Resources and Services Administration (HRSA). Standard plan benefits apply for any service that does not meet these guidelines.	Categories 1 and 2: You pay 0%, no deductible		Category 3: Standard Category 3 benefits apply
Up-front office visits (injury and illness) First four per calendar year Not subject to deductible	\$35 office-visit copay		
Prescription medications	Generics - \$10 copay Brand formulary - \$3,000 deductible, 50% coinsurance. Self-administered chemotherapy drugs: not subject to deductible. \$10 generics; \$50 brand formulary; \$100 brand non-formulary We follow USPSTF guidelines for certain preventive medications covered with no deductible, no copay at participating pharmacies only. Member must have a prescription.		
Up-front outpatient radiology and laboratory Limit does not apply to complex outpatient imaging	First \$200 per calendar year, not subject to deductible		
Vision care - refraction and hardware	Not covered		
Emergency room	30% coinsurance and deductible; \$150 copay per ER visit (waived if directly admitted)		
Hospitalizations Inpatient and outpatient services	Deductible and coinsurance		
Maternity Diagnosis, prenatal care, labor and delivery	Separate \$7,500 maternity deductible per pregnancy then coinsurance		
Individual dental options Optional with medical plan	Dental Option 1 or Dental Option 2		
Complex outpatient imaging CT Scan, MRI, PET, MRA, SPECT, bone density	Deductible and coinsurance		
After the up-front benefits are exhausted Office visits, laboratory and radiology services	Deductible and coinsurance		

Regence Evolve HSA PlanSM

Category 1: Preferred providers. You'll generally have lower out-of-pocket costs when you see providers in this category.

Category 2: Participating providers. When you see providers in this category, you'll generally pay more out of pocket than you would with providers in Category 1.

Category 3: Non-contracted providers. You'll have the highest out-of-pocket costs when you see these providers. Also, they may bill you for the balance of their charge after we pay the claim.

Benefits		Individual	Family	
Annual deductible Deductible does not apply to certain benefits		\$1,500 or \$3,500	\$3,000 or \$7,000	
Annual out-of-pocket maximum Once you reach this amount, Regence pays 100%		\$5,000 per member	\$10,000 per family	
Annual maximum		\$2,000,000 annual maximum		
Provider networks		Category 1 (Preferred)	Category 2 (Participating)	Category 3 (Nonparticipating)
Coinsurance Percentage you pay after the deductible You may choose 20/40/40 or 50/50/50 option	20/40/40	You pay 20%	You pay 40%	You pay 40%
	50/50/50	You pay 50%	You pay 50%	You pay 50%
Preventive care and immunizations Preventive services and immunizations are covered according to guidelines set by the United States Preventive Services Task Force (USPSTF), Centers for Disease Control and Prevention (CDC), and Health Resources and Services Administration (HRSA). Standard plan benefits apply for any service that does not meet these guidelines.		Categories 1 and 2: You pay 0%, no deductible		Category 3: Standard Category 3 benefits apply
Office visits		Deductible and coinsurance		
Prescription medications Generics only; RegenceRx discount available		Deductible and coinsurance. Self-administered chemotherapy medications covered (includes generics / formulary brand / non-formulary brand). We follow USPSTF guidelines for certain preventive medications covered with no deductible, no coinsurance at participating pharmacies only. Member must have a prescription.		
Surgeries and procedures		Deductible and coinsurance		
Vision care - refraction and hardware		Not covered		
Diagnostic laboratory and radiology services		Deductible and coinsurance		
Emergency room		Deductible and coinsurance		
Hospitalizations Inpatient and outpatient services		Deductible and 20% or 50% and coinsurance (depending on your coinsurance choice)		
Maternity Diagnosis, prenatal care, labor and delivery		Not covered, except for involuntary complications of pregnancy, which shall be covered as any illness condition		
Individual dental options Optional with medical plan		Dental Option 1 or Dental Option 2		

Regence Evolve HSA 100 PlanSM

Category 1: Preferred providers. You'll generally have lower out-of-pocket costs when you see providers in this category.

Category 2: Participating providers. When you see providers in this category, you'll generally pay more out of pocket than you would with providers in Category 1.

Category 3: Non-contracted providers. You'll have the highest out-of-pocket costs when you see these providers. Also, they may bill you for the balance of their charge after we pay the claim.

Benefits	Individual		Family
Annual deductible Deductible does not apply to certain benefits	\$5,000 per member		\$10,000 per family
Annual out-of-pocket maximum Once you reach this amount, Regence pays 100%	Annual out-of-pocket maximum includes all deductibles. After annual out-of-pocket maximum is met, you pay 0% for all covered services; some limits apply.		
Annual maximum	\$2,000,000 annual maximum		
Provider networks	Category 1 (Preferred)	Category 2 (Participating)	Category 3 (Nonparticipating)
Coinsurance Percentage you pay after the deductible	0%	0%	0%
Preventive care and immunizations Preventive services and immunizations are covered according to guidelines set by the United States Preventive Services Task Force (USPSTF), Centers for Disease Control and Prevention (CDC), and Health Resources and Services Administration (HRSA). Standard plan benefits apply for any service that does not meet these guidelines.	Categories 1 and 2: You pay 0%, no deductible		Category 3: Standard Category 3 benefits apply
Office visits	You pay 0% after deductible		
Prescription medications Generics only	You pay 0% after deductible. Self-administered chemotherapy medications covered (includes generics / formulary brand / non-formulary brand). We follow USPSTF guidelines for certain preventive medications covered with no deductible, no coinsurance at participating pharmacies only. Member must have a prescription.		
Surgeries and procedures	You pay 0% after deductible		
Vision care - refraction and hardware	Not covered		
Diagnostic laboratory and radiology services	You pay 0% after deductible		
Emergency room	You pay 0% after deductible		
Hospitalizations Inpatient & outpatient services	You pay 0% after deductible		
Maternity Diagnosis, prenatal care, labor and delivery	Not covered, except for involuntary complications of pregnancy, which shall be covered as any illness condition		
Individual dental options Optional with medical plan	Dental Option 1 or Dental Option 2		

Medical plan

Limitations and exclusions

A pre-existing condition is a condition, regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was recommended or received within the six-month period before the effective date of coverage and terminates 12 months following the effective date of coverage. Pre-existing condition waiting periods do not apply to members up to age 19.

We will not provide benefits for any of the following conditions, treatments, services, supplies or accommodations, including any direct complications or consequences that arise from them. However, these exclusions will not apply with regard to an otherwise Covered Service for a preventive service as specified under the Preventive Care benefit in the Medical Benefits Section.

Medical limitations and exclusions	Regence Evolve Core	Regence Evolve HSA Plans
Complementary Care (naturopathic, chiropractic, and acupuncture services and supplies)	Excluded	Excluded
Condition Caused By Active Participation in a War or Insurrection	Excluded	Excluded
Condition Incurred In or Aggravated During Performances In the Uniformed Services	Excluded	Excluded
Cosmetic/Reconstructive Services and Supplies (except to treat a congenital anomaly for members up to age 18, to restore a physical bodily function lost as a result of injury or illness; or related to breast reconstruction following a medically necessary mastectomy, to the extent required by law)	Excluded	Excluded
Counseling in the Absence of Illness	Excluded	Excluded
Custodial Care	Excluded	Excluded
Elective Abortion (except when performed to preserve the life of the enrolled female insured)	Excluded	Excluded
Expenses Before Coverage Begins or After Coverage Ends	Excluded	Excluded
Fees, Taxes, Interest	Excluded	Excluded
Foot Care (Routine)	Excluded	Excluded
Government Programs	Excluded	Excluded
Growth Hormone Therapy (coverage for these services may be provided under the prescription medication benefit)	Excluded	Excluded
Hearing Care (including hearing aids)	Excluded	Excluded
Home Health Care	130 visits per calendar year maximum benefit	130 visits per calendar year maximum benefit
Infertility Treatment	Excluded	Excluded
Investigational Services	Excluded	Excluded
Maternity Care	Separate routine maternity deductible \$7,500 per pregnancy, then coinsurance	Excluded except for complications
Mental Health and Chemical Dependency Treatment	Excluded	Inpatient: 8 days per calendar year Outpatient: 20 visits per calendar year
Motor Vehicle Coverage and Other Insurance Liability	Excluded	Excluded
Non-Direct Patient Care	Excluded	Excluded
Nutritional Counseling (except diabetic)	Excluded	Excluded
Obesity or Weight Reduction/Control	Excluded	Excluded
Orthognathic Surgery (except for a temporomandibular joint disorder, congenital conditions, injury, and sleep apnea)	Excluded	Excluded
Personal Comfort Items	Excluded	Excluded
Physical Exercise Programs and Equipment	Excluded	Excluded
Private Duty Nursing	Excluded	Excluded

Medical plan

Limitations and exclusions

Medical limitations and exclusions	Regence Evolve Core	Regence Evolve HSA Plans
Rehabilitation (includes neurodevelopmental, physical, speech, and occupational therapies)	Inpatient: 15 days per calendar year maximum benefit Outpatient: 20 visits per calendar year maximum benefit for each type of therapy	Inpatient: 15 days per calendar year maximum benefit Outpatient: 20 visits per calendar year maximum benefit for each type of therapy
Reversal of Sterilizations	Excluded	Excluded
Riot, Rebellion and Illegal Acts	Excluded	Excluded
Self-Help, Self-Care, Training or Instructional Programs	Excluded	Excluded
Services and Supplies Provided by a Member of Your Family	Excluded	Excluded
Services and Supplies That Are Not Medically Necessary	Excluded	Excluded
Sexual Dysfunction	Excluded	Excluded
Sexual Reassignment Treatment and Surgery	Excluded	Excluded
Third-Party Liability	Excluded	Excluded
Tobacco Addiction Treatment	Excluded	Excluded
Travel and Transportation Expenses (other than covered ambulance services)	Excluded	Excluded
Vision Care	Excluded	Excluded
Work-Related Conditions	Excluded	Excluded
Prescription medication exclusions	Regence Evolve Core	Regence Evolve HSA Plans
Brand-Name Medications not on the Formulary	Excluded	Excluded
Cosmetic Purposes	Excluded	Excluded
Foreign Prescription Medications	Excluded	Excluded
Growth Hormones	Excluded (except when preauthorized)	Excluded (except when preauthorized)
Biological Sera, Blood or Blood Plasma	Excluded	Excluded
Inhibition and/or Suppression of Sleepiness	Excluded	Excluded
Nonprescription Medications	Excluded	Excluded
Prescription Medications Dispensed in a Facility	Excluded	Excluded
Prescription Medications Dispensed in Connection with Participation in a Clinical Trial	Excluded	Excluded
Prescription Medications For Smoking Cessation	Excluded	Excluded
Prescription Medications For Treatment of Infertility	Excluded	Excluded
Prescription Medications Not Dispensed by a Pharmacy Pursuant to a Prescription Order	Excluded	Excluded
Prescription Medications not within a Provider's License	Excluded	Excluded
Prescription Medications with No FDA Proven Therapeutic Indication	Excluded	Excluded
Prescription Medications Without Examination	Excluded	Excluded
Professional Charges for Administration of Any Medication	Excluded	Excluded

This chart does not contain all limitations and exclusions. Please refer to your policy for a complete list of benefits and the limitations and exclusions that apply

Accidental death benefit

All Regence Evolve plans include a death benefit payable when we receive proof of death caused by accidental means. Adult subscribers, covered spouses and covered children are eligible for this benefit.

The accidental death benefits are outlined below for the Regence Evolve Core plan:

Insured	Death Benefit
Adult policyholder	\$10,000
Covered spouse or domestic partner	\$10,000
Covered dependent child	\$2,500 per child

The accidental death benefits are outlined below for the Regence Evolve HSA Plan and the Evolve HSA 100 Plan:

Insured	Death Benefit
Adult policyholder	\$25,000
Covered spouse or domestic partner	\$25,000
Covered dependent child	\$5,000 per child

Benefits are subject to the terms set forth in the Policy.

Regence Evolve Dental Option 1

Summary of benefits

Dental benefits	
Deductible per calendar year	\$50 per insured \$100 per family (2 times the insured amount)
Maximum benefit per calendar year	When you incur services less than \$750, you may be rewarded with an additional benefit of \$250 the following year, not to exceed a total benefit of \$1,500.
Important note: The dental deductible is calculated separately from any other deductible of the policy.	
Understanding your dental benefits	
<p>We will begin to pay benefits for covered services in any calendar year only after your deductible is satisfied unless otherwise specified.</p> <p>Once you have satisfied any applicable deductible, we pay a percentage of the allowed amount for covered services up to the maximum benefit. When our payment is less than 100%, you pay the remaining percentage. This is your coinsurance (insured responsibility).</p> <p>Under the policy, you have the opportunity to qualify for a reward increase and add certain unused portions of the maximum benefit for the current calendar year to the maximum benefit for the following calendar year. For more information please refer to the policy.</p> <p>We do not reimburse dentists for charges above the allowed amount. A participating dentist will not charge you for any balances for covered services beyond your deductible and/or coinsurance amount. Nonparticipating dentists, however, may bill you for any balances over our payment level in addition to any deductible and/or coinsurance amount. You can find a list of providers at our Web site or by calling Customer Service.</p>	
Covered dental services (per Member)	Member responsibility
Preventive dental services Bitewing X-rays: 2 per calendar year Complete intra-oral mouth X-rays: Once in a 3-year period Cleanings: 2 per calendar year (in lieu of periodontal maintenance) Oral examinations: 2 per calendar year Panoramic mouth X-rays: Once in a 3-year period Sealants (permanent bicuspid and molars only): Under 18 years of age Space maintainers: Under 12 years of age Topical fluoride application: Under 18 years of age, 2 treatments per calendar year	0% deductible waived
Basic dental services (six-month waiting period) Endodontic services including root canal treatment, pulpotomy and apicoectomy Emergency treatment for pain relief Fillings consisting of composite and amalgam restorations General dental anesthesia or intravenous sedation (subject to necessity) Uncomplicated and complex oral surgery procedures Periodontal maintenance: 2 per calendar year (in lieu of preventive cleanings) Periodontal debridement: Once in a 3-year period Periodontal scaling and root planing: Once per quadrant in a 2-year period	20%
Major dental services (12-month waiting period) Bridges: Except no benefits are provided for replacement made fewer than seven-years after placement Crowns, inlays and onlays: Except no benefits are provided for replacement made fewer than seven-years after placement Dentures (full and partial): Except no benefits are provided for replacement made fewer than seven-years after placement Implants (endosteal): 4 per insured lifetime	50%

Regence Evolve Dental Option 2

Summary of benefits

Dental benefits	
Deductible per calendar year	\$0
Maximum benefit per calendar year	\$750 per insured
Important note: You will not be eligible for any dental benefits until the first day of the seventh month of continuous coverage under the policy.	
Understanding your dental benefits	
<p>We pay a percentage of the allowed amount for covered services up to the maximum benefit. When our payment is less than 100%, you pay the remaining percentage. This is your coinsurance (insured responsibility).</p> <p>We do not reimburse dentists for charges above the allowed amount. A participating dentist will not charge you for any balances for covered services beyond your deductible and/or coinsurance amount. Nonparticipating dentists, however, may bill you for any balances over our payment level in addition to any deductible and/or coinsurance amount. You can find a list of providers at our Web site or by calling Customer Service.</p> <p>There are no age limits or frequency limits for Dental Option 2.</p>	
Covered dental services (per Member)	Member responsibility
Preventive, basic and major dental services The first \$200 of covered services per calendar year	0%
Preventive, basic and major dental services After the first \$200 of covered services each calendar year	50%

Regence Evolve Dental

Limitations and exclusions

Exclusions applicable to both Dental Option 1 and Dental Option 2 except where noted.

Additional procedures to construct new crown under existing partial denture framework

Application of desensitizing medicaments

Application of desensitizing resin for cervical and/or root surface

Behavior management, for Dental Option 1 only

Bleaching of teeth

Broken retainers

Collection of cultures and specimens

Connector bar or stress breaker

Diagnostic casts or study models

Duplicate x-rays, for Dental Option 1 only

Endodontic endosseous implants, for Dental Option 1 only

Exfoliative cytology sample collection or brush biopsy, for Incentive Dental only

Experimental or investigational services: experimental or investigational services as determined by Regence dental policy, for Dental Option 1 only

Fees, Taxes, Interest

Gold foil restorations, for Dental Option 1 only

Hospitalizations for dentistry

House/extended care facility calls

Implant maintenance procedures, including: removal of prosthesis, cleansing of prosthesis and abutments, reinsertion of prosthesis

Incision and drainage of abscess extraoral soft tissue, complicated or non-complicated

Indirect pulp capping

Interim partial or complete dentures

Labial veneers

Local anesthesia, sterilization, and supplies billed as separate charges (these procedures are considered inclusive of billed procedures)

Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue per tooth, for Dental Option 1 only

Lost or stolen items

Maxillofacial prosthetic procedures

Military service related conditions: Any condition resulting from military service in the armed forces of any country or any act of war (declared or undeclared)

Modification of removable prosthesis following implant surgery

Nitrous oxide, for Dental Option 1 only

Occlusal analysis and adjustments

Occlusal guards, for Dental Option 1 only

Oral hygiene instructions

Oral/facial photographic images

Orthodontic services, including craniomandibular orthopedic treatment: procedures for tooth movement, regardless of purpose, correction of malocclusion, preventive orthodontic procedures, and other orthodontic treatment

Pediatric dentures, for Dental Option 1 only

Pin retention in addition to restoration

Precision attachments

Prescription drugs, including take home prescription drugs, pre-medications, or supplies

Provisional splinting, for Dental Option 1 only

Pulp vitality tests

Radical resection of maxilla or mandible

Radiographic/surgical implant index

Removal of nonodontogenic cyst, tumor, or lesion

Replacement of lost, stolen, or broken dental appliances

Services and supplies provided by a family member: services and supplies provided to a member by an immediate family member

Services and supplies that are not Medically necessary: Services and supplies that are not medically necessary for the treatment of an illness, injury or physical disability

Services performed in a laboratory, for Dental Option 1 only

Surgical procedures for isolation of a tooth with rubber dam

Surgical stent, for Dental Option 1 only

Therapeutic drug injections

Third Party Coverage: Services and supplies for treatment of illness or injury for which a third party is responsible [e.g. automobile medical, personal injury protection (PIP), automobile no-fault (Idaho only; unless the automobile contract contains a COB provision in which case the COB provision of the plan shall apply), homeowner, commercial premises coverage or similar coverage]

Tobacco or nutritional counseling for the control and prevention of oral disease

Tooth transplantation, for Dental Option 1 only

Travel and transportation expenses

Treatment of complications (post surgical); unusual circumstances

Treatment of simple or compound fractures of the mandible

Treatment of Temporomandibular Joint Dysfunction

Unspecified implant procedures

This page does not contain all limitations and exclusions. Please refer to your policy for a complete list of benefits and the limitations and exclusions that apply

Step 2

See what Regence membership means

As a Regence member, you and enrolled family members have access to a wide range of resources, tools and programs designed to help you improve and maintain your health. Your participation in these programs is free, voluntary and completely confidential.

Want to learn more? Keep reading!

Value-added programs

THESE PROGRAMS ARE NOT INSURANCE BUT ARE OFFERED IN ADDITION TO YOUR MEDICAL PLAN TO HELP YOU GET INFORMATION AND SUPPORT WHEN YOU NEED IT.



Join the conversation at myRegence.com—an online resource designed to advise, navigate and reward you in your health care decisions. On myRegence.com, you can:

- Take a General Health Assessment
- Check your claims
- Enroll in a wellness program
- Find a doctor
- Get an estimate on costs of care
- Learn about health issues
- Earn Rewards points
- Talk to other Regence members

Want to try it out? Visit myRegence.com and click on *Guest Pass Registration*.

Integrated Care Management

When you or your family are dealing with a health challenge, a helping hand can make all the difference. A Personal Care Team of clinical experts is ready to assist you with an ongoing medical condition, or serious illness or injury. The program provides easy access to one-on-one support at no additional cost to you. We'll assign an experienced specialist to serve as your personal contact and advocate during a time when you need it most, to help you understand your treatment options, show you how to get the most out of your benefits, help you to understand what actions you can take to improve your health, and work with your physician to support your treatment plan.

CareEnhance®

Call toll-free, 24 hours a day, for confidential health care advice. A registered nurse can answer any question and even tell you if symptoms call for a trip to the ER, a visit to the doctor or self-care at home.

Value-added programs

Regence Advantages

As a Regence member, you can enjoy savings on the following health-related products and services. This discount program is offered to all Regence members at no additional cost (although some discounted programs offered by vendors may carry separate fees). **Regence Advantages is not insurance but is offered in addition to your medical and/or dental plan(s) to help you get information and support when you need it.**

- **TruVision™:** Significant discounts are offered on laser vision correction procedures such as LASIK and PRK. Also, save 10% to 15% on mail-order contact lenses.
 - **TruHearing™™:** Special contracted health plan pricing on hearing aids and a 45-day money-back guarantee, a one-time three-year replacement for loss or damage, and a one-year supply of batteries with each purchase.
 - **QualSight®:** Save 40% to 50% on traditional or custom LASIK through the QualSight network. IntraLase bladeless LASIK is also available for an additional \$450 per eye.
 - **Epic® Dental:** Purchase smile-protecting supplies at 25% off, including mouthwash, gums, mints and toothpaste. All items contain xylitol, a natural ingredient that fights cavities.
 - **CHP CAMaffinity Program:** As a Regence member, you're eligible for the CHP CAMaffinity Program, which provides a 20% discount on complementary and alternative medicine (CAM) services offered through The CHP Group's growing network of chiropractors, acupuncturists, naturopathic physicians and massage therapists.
 - **CHP Active and Healthy:** CHP Active and Healthy is the discount program that gets you up, moving, and saving money! With discounts offered by thousands of participating vendors (e.g. health clubs, ski resorts, sporting events, museums, etc.) for a small annual fee, it's your source for great deals on healthy and fun activities.
- **Take Shape for Life®:** This safe weight management and health program uses clinically proven Medifast® products and a personal health coach to provide one-on-one guidance and encouragement. The program helps you lose weight and manage disease and health through nutritional intervention, free access to health care professionals, educational materials, and healthy habits that last a lifetime. The goal: to help you optimize your health to lead a richer and more fulfilling life. There are no hidden costs or start-up fees. Learn more at myhealthyhuddle.com. Special savings for Regence members:
 - **\$25 special credit on your first order**
 - **Additional \$25 to \$50 off first month's order for the progressive "BeSlim" savings plan: 5% to 10% off monthly order and free shipping (minimum order required)**
 - **Free "The Secret is Out" book**
 - **Redeemable rewards points**
 - **CorCell® Saving Baby's Cord Blood®:** Cord blood stem cells are now being used to treat more than 70 diseases, and research is ongoing to find treatments for even more. Regence has partnered with CorCell to offer a \$350 discount when you bank your baby's umbilical cord blood. Protect your child or give the gift of cord blood preservation to your grandchild, niece, nephew, friend or other loved one. Visit corcell.com for more information.
 - **HearPO®:** Receive a 40% discount on diagnostic services, including hearing exams, and significant savings on hearing aids. You'll enjoy a 60-day no-risk trial period; one-year follow-up care; a three-year warranty, including coverage for loss and damage; and free batteries (160 cells per hearing aid)—all with a lowest-price guarantee.

* Food and, if applicable, shipping not included. Offer applies to initial membership fee only and is valid at participating centers in the United States, Canada and Puerto Rico and through Jenny Craig At Home. Each offer is a separate offer and can be used only once per person. Restrictions apply.

**Discounts through Beltone, Newport Audiology and TruHearing are available to members and their parents and grandparents.

Regence is completely independent from the companies that provide these products and services. Regence does not endorse or guarantee the products and services offered or their effectiveness. Regence reserves the right to change the program at any time without prior notice.

Value-added programs

- **EyeMed Vision Care®:** Save 35% on a complete pair of glasses (frames and lenses). Save 15% on non-disposable contacts and \$10 on contact lens fittings. These discounts are available at LensCrafters, Pearle Vision, Sears Optical, Target Optical, JCPenney Optical and many private practice locations.
- **Jenny Craig®:** Jenny Craig plans are personalized and offer one-on-one support from trained weight-loss consultants. With every Jenny Craig Program you'll receive weekly scheduled consultations, planned or personalized menus, and free e-tools and online support at jennycraig.com. Choose from these options:
 - **A Free 30-day Program***
 - **25% off a Premium Program***
- **Beltone™**:** Receive a free screening, a 25% discount on Beltone hearing aids, a one-year supply of hearing-aid batteries and free follow-up visits and testing.
- **Newport Audiology™ Centers**:** Receive a free hearing exam if you're Medicare-eligible, or \$25 off an exam if you're at least age 15. Save 32% on all hearing-aids and receive a free two-year supply of batteries (up to 96 batteries) with a hearing-aid purchase.
- **Safe Beginnings®:** Enjoy a 15% discount on everything you need to baby-proof your home, including safety gates, cabinet locks, outlet covers, window guards, and other items to help keep your baby safe.

Want to learn more?

Go to myRegence.com/advantages

Step 3

Apply for coverage

Try our new and improved online shopping tool

Our online application process is quick and easy. It even features tools that can help you decide which plan is right for you. Just go to regence.com and follow the step-by-step directions.

Paper applications

If you prefer to mail in your application, we've provided all the forms you need.

If you're applying for medical coverage, you'll need to **complete and return** the following:

1. *Idaho Individual Application* (required and included in this booklet)
2. *Idaho Individual Application Cover Sheet* (required and included in this booklet)
3. *Domestic Partner Affidavit* (required when applicable and included in this booklet)

Return all materials to us in the enclosed envelope. Please allow seven working days before inquiring about the status of your application.

Applications received during the first calendar week of the month (the first through the seventh) can have an effective date of the day after we receive the application.

If we receive your application on or after the eighth day of the month, your effective date of will be the first day of the following month.

Your annual renewal date is the first day of the month in which you initially enrolled. We'll send you your member card and a contract after we offer coverage.

If you have questions about the application, please call us at 1-888-REGENCE (1-888-734-3623).

Please note: If you are declined coverage or are HIPAA-eligible with 12 months of creditable coverage, you may be eligible for your choice of the following High Risk Pool Plans: Basic, Standard, Catastrophic A, Catastrophic B, or the HSA compatible plan. You may also be eligible for any High Risk plan if your insurance carrier refuses to issue a health benefit plan providing coverage substantially similar to coverage offered under an equivalent High Risk Pool plan except at a rate exceeding the rate of the High Risk Pool Plan. Please contact us for more information.



Individual Application Cover Sheet (to be used with the Idaho Individual Application)

SECTION 1 - GENERAL INFORMATION

Applicant's Name (please print) _____

Social Security Number _____ Idaho Driver's License Number _____

(Note: If applying for underage child only, please list parent/legal guardian's Idaho Driver's License Number)

If you are currently eligible for Medicare, or will be on the requested effective date of coverage for which you are applying, you are not eligible for private individual or family health coverage and should not fill out this application cover sheet or the Individual Application.

Note: If you are requesting a change to your existing plan or deductible, your policy must be paid current in order for the change to be made.

SECTION 2 - EFFECTIVE DATE

Your application is subject to review and approval by Regence BlueShield of Idaho. Complete applications received in our office by 5:00 PM Pacific Time on the last business day of the month will be eligible for an effective date of the first of the following month, unless otherwise indicated. Incomplete applications may receive a later effective date.

Requested Effective Date _____

SECTION 3 - MEMBER CARD (check one)

- Family Level Card (all members listed on the same card)
- Member Level Card (each member on a separate card)

SECTION 4 - PLAN SELECTION (Detailed benefit information can be found online at regence.com)

MEDICAL PLANS (check one):

Evolve Core

Deductibles are per member (2 individual deductibles satisfy the family deductible)

- \$2,500
- \$5,000
- \$7,500
- \$10,000

Evolve HSA

Self-Only Deductibles

- \$1,500 with 50% coinsurance
- \$1,500 with 80% coinsurance
- \$3,500 with 50% coinsurance
- \$3,500 with 80% coinsurance

Family Deductibles

- \$3,000 with 50% coinsurance
- \$3,000 with 80% coinsurance
- \$7,000 with 50% coinsurance
- \$7,000 with 80% coinsurance

Evolve HSA 100

- \$5,000 self-only deductible
- \$10,000 family deductible

DENTAL OPTIONS (check one)

- No Dental
- Dental Option 1 - 100/80/50; \$750 annual maximum benefit that may increase over time to \$1,500
- Dental Option 2 - 100% of first \$200 and 50% of next \$1,100 (\$750 annual maximum benefit)



SECTION 5 - PARENT OR GUARDIAN CONSENT
(Complete only if applicant is under age 18 and will be the only insured)

Notice is hereby given that _____ Social Security Number _____ who is under the age of eighteen years is making application for individual health care coverage, with my full knowledge and consent. I request that you consider the child for such health care coverage. I accept full responsibility for the payment of monthly premium and the contents of the application attached hereto.

Signature _____ Date _____

Print Name _____ Relationship to Child _____

Address _____ Phone Number (____) _____

SECTION 6 - DEFINITION OF DEPENDENT

Dependent means: (1) The legal spouse or domestic partner of the Policyholder; and/or (2) the child of a Policyholder or Policyholder's spouse or domestic partner, up to the age of twenty-six (26); or (3) a child of any age who is medically certified as disabled. The term "children" includes natural, step, or adopted children, or children in the process of adoption from the time placed with the Policyholder.

SECTION 7 - MEDICARE

If you or any listed dependents have Medicare, please list family member's name and the Medicare Health Insurance Claim (HIC) number shown on his/her Medicare card:

SECTION 8 - ACKNOWLEDGEMENT

By signing the attached Individual Application, you understand and agree to the terms and conditions set forth on this cover sheet as well as the terms and conditions set forth on the attached application. If you are declined the coverage you applied for, the carrier must offer the High Risk Pool (HRP) Plans.

I certify that all statements contained herein are true to the best of my knowledge. I understand that any misrepresentation, omission, or inaccurate information required herein shall prevent recovery under the policy if such answer is fraudulent or materially affects the risk assumed by Regence BlueShield of Idaho. I understand this request will be underwritten to determine the extent of my eligibility, and that Regence BlueShield of Idaho will consider all medical information currently on file. I hereby expressly authorize any physician or hospital, or any other health care provider, to disclose to Regence BlueShield of Idaho any information obtained by having attended me or hereafter attending or examining me, and I understand that Regence BlueShield of Idaho will not disclose any information so obtained.

SECTION 9 - YOUR PRIVACY

For information about the use and disclosure of health information, including uses and disclosures required by law, please refer to the Regence Consumer Privacy Notice. A copy is available on our Web site at **regence.com**.

Federally Eligible Individual Information

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), guaranteed availability of individual coverage means that if you are HIPAA eligible, you cannot be denied the right to buy individual coverage. In addition, a pre-existing condition exclusion cannot be applied to your coverage.

You are HIPAA eligible, also called an "eligible individual," if ALL of the following are true at the time you apply for individual coverage.

- ◆ You have at least 12 months of continuous creditable coverage without any break in coverage greater than 63 days.
- ◆ Your most recent coverage was under a group health plan, a governmental plan, or a church plan (or health insurance offered in connection with such a plan).
- ◆ You are not covered under another group health plan.
- ◆ Your most recent coverage was not cancelled because you did not pay your premiums or because you committed fraud.
- ◆ You are not currently eligible for Medicare or Medicaid.

If you are HIPAA eligible, you will lose your right to get individual coverage without an exclusion unless you submit an application for individual coverage within 63 days after the day your group health coverage or continuation coverage ends. Act promptly to protect your rights.



SECTION 10 – PREMIUM BILLING OPTIONS

BILLING ADDRESS (Complete only if billing should be sent to an address other than the Mailing Address listed on the application.)

Name (First, Last)

Address

City, State, ZIP Code

EMPLOYER CONTRIBUTION

Yes No Is your employer reimbursing or paying for any portion of this policy's premium? Individual benefit plans are not intended for sale as an employer-sponsored health benefit plan for employees.

PAYMENT OPTIONS (check one):

If no payment option is checked, your policy will automatically default to Monthly Billing.

Monthly Billing Surepay (premium is automatically deducted from your bank account on the 5th of each month).

It may take 45 - 90 days from the approval of your application to set up Surepay. To cover initial month(s) you will receive an invoice and need to make your payment by check in order to keep your account paid current.

If selecting the **Surepay** option:

1. Complete the following **Authorization To My Bank** section.
2. Write 'void' on one of your checks and return your voided check with this application (not a deposit slip). *For savings account, please provide proof of ownership of the account.*

AUTHORIZATION TO MY BANK

As a convenience and on behalf of the Account Holder identified below, I/we hereby request and authorize you to pay and charge to the account identified below, checks or electronic debits drawn on the account by and payable to the order of Regence BlueShield of Idaho, Lewiston, Idaho. I/we agree that your rights to each such check or electronic debit shall be the same as if it were an actual check drawn on you and signed by me/us. This authority is to remain in effect until revoked by me/us in writing, and until you actually receive such notice, I/we agree that you shall be fully protected in honoring any such check. I/we further agree that if any checks or electronic debits be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in forfeiture of insurance. A photocopy of this executed authorization shall be as valid as the original.

Financial Institution or Bank Name	Transit/Routing Numbers	Account Number

Check One: Checking Account Savings Account

Account Holder's Name (please print)

Account Holder's Signature (as it appears on bank records)

Date



IDAHO INDIVIDUAL APPLICATION

Please type or print legibly in black ink and complete all applicable sections.

SECTION 1—ENROLLMENT INFORMATION		
Are you: <input type="checkbox"/> a new applicant <input type="checkbox"/> adding dependents	Are you a resident of the state of Idaho? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes: _____ years _____ months	REQUESTED EFFECTIVE DATE <i>(subject to insurance carrier approval)</i>

SECTION 2—APPLICANT INFORMATION							
FIRST NAME		LAST NAME			MIDDLE INITIAL		
STREET ADDRESS		CITY, STATE, ZIP CODE					
MAILING ADDRESS <i>(Street, Route, P.O. Box) (if different than street address)</i>		CITY, STATE, ZIP CODE					
BILLING ADDRESS <i>(if different than mailing address)</i>		CITY, STATE, ZIP CODE					
PREFERRED PHONE NUMBER		ALTERNATE PHONE NUMBER		E-MAIL ADDRESS			
MARITAL STATUS <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Other <i>(explain)</i> _____		DATE OF BIRTH	AGE	GENDER <input type="checkbox"/> Male <input type="checkbox"/> Female	WEIGHT	HEIGHT	SOCIAL SECURITY NUMBER

SECTION 3—DEPENDENT INFORMATION							
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). Refer to Section 8.h. for dependent eligibility requirements for High Risk Pool plans. Use extra paper if necessary.							
DEPENDENT'S NAMES <i>(first, initial, last)</i>	RELATIONSHIP TO APPLICANT <i>(spouse, child, etc.)</i>	DATE OF BIRTH <i>(mm/dd/yy)</i>	AGE	GENDER <input type="checkbox"/> Male <input type="checkbox"/> Female	WEIGHT	HEIGHT	SOCIAL SECURITY NUMBER
				<input type="checkbox"/> Male <input type="checkbox"/> Female			
				<input type="checkbox"/> Male <input type="checkbox"/> Female			
				<input type="checkbox"/> Male <input type="checkbox"/> Female			
				<input type="checkbox"/> Male <input type="checkbox"/> Female			
				<input type="checkbox"/> Male <input type="checkbox"/> Female			
				<input type="checkbox"/> Male <input type="checkbox"/> Female			

SECTION 4— CURRENT/PRIOR COVERAGE (For proper crediting of preexisting condition waiting periods AND Coordination of Benefits, please complete the section below.) Use extra paper if necessary.
<p>If any person listed on this application has been covered during the 12 months prior to the requested effective date of this application, with a 63-day or less break in coverage, please complete the following information. Please provide a Certificate of Creditable Coverage from your prior insurance carrier or other appropriate documents to establish prior creditable coverage. If coverage is provided for a dependent from a previous marriage or relationship, please attach a copy of the court documentation that shows who is responsible for the dependent(s)' health care insurance so that the insurance carrier can determine whose coverage is primary (please use additional paper if needed).</p> <p>To reduce the 12-month exclusion period by your creditable coverage, you should give your new insurance carrier a copy of any Certificates of Creditable Coverage you have. If you do not have a certificate, but you do have prior health coverage, you should work with your prior plan or insurer to obtain evidence of coverage. Please contact your new insurance carrier if you need help demonstrating creditable coverage.</p> <p>If you have cancelled state of Idaho individual High Risk Pool mandated plan coverage within the past 12 months, you may not be eligible for coverage unless you are a federally defined eligible individual. Please read the Notice of Federal Eligibility on the bottom of page 3 of this application.</p>

Other Insurance Carrier Information: Insurance Carrier Name, Policy Number, Phone Number	Policyholder Name	Names of Covered Members: Self and Dependent(s)	Coverage Start Date <i>(mm/dd/yy)</i>	Coverage End Date <i>(mm/dd/yy)</i>	Type of Coverage	Will this coverage continue?
					<input type="checkbox"/> Group <input type="checkbox"/> HRP <input type="checkbox"/> Indiv <input type="checkbox"/> COBRA	<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Group <input type="checkbox"/> HRP <input type="checkbox"/> Indiv <input type="checkbox"/> COBRA	<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Group <input type="checkbox"/> HRP <input type="checkbox"/> Indiv <input type="checkbox"/> COBRA	<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Group <input type="checkbox"/> HRP <input type="checkbox"/> Indiv <input type="checkbox"/> COBRA	<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Group <input type="checkbox"/> HRP <input type="checkbox"/> Indiv <input type="checkbox"/> COBRA	<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Group <input type="checkbox"/> HRP <input type="checkbox"/> Indiv <input type="checkbox"/> COBRA	<input type="checkbox"/> Yes <input type="checkbox"/> No

List applicants eligible for coverage under any other plan (group, Medicare, Medicaid, etc.) and type of plan eligibility: _____

COMPLETE THE REMAINDER OF THE APPLICATION ONLY IF YOU ARE APPLYING FOR COVERAGE.

SECTION 5A—HEALTH STATEMENT

Please answer each question completely and accurately. Each medical question set forth below applies to each person you listed on this application for whom you wish to obtain coverage, and they apply to both past and present symptoms, conditions, diseases, illnesses, accidental injuries, or deformities (“health conditions”). Coverage under the individual policy will not commence until the application is approved by the insurer’s Underwriting Department. No independent producer, agent, or any other person can waive its requirements or is authorized to set forth anything less than a complete and accurate response to each of the questions. The insurer shall not be bound by any attempted waiver of complete answers to the questions set forth below. **If you learn at any time before the policy is effective that any answer on this application is incomplete or inaccurate or is no longer complete and accurate, you must advise the insurer.**

Answer the questions below YES or NO. Each of the questions must be answered, even if the answer is NO. **Answer a question YES, if you or any dependent(s) for whom you want to obtain coverage, for which medical advice, diagnosis, care or treatment was recommended or received for a health condition or event specified in that question. IF YOU ANSWER YES TO ANY QUESTION BELOW, PLEASE COMPLETE SECTION 5B.**

RESPOND to the following questions, for everyone applying for coverage: Yes No

- 1. Are you, your spouse or any eligible dependent family member listed on this application, now pregnant? Yes No
If Yes, due date _____
- Do you anticipate complications? Yes No
- Prior/anticipated multiple births? Yes No
- 2. **Pregnancy/Fertility Related Treatment:** Are you, your spouse, or any eligible dependent family member being treated for infertility, fertility evaluation or treatment (including medication)? Yes No

WITHIN the past 12 MONTHS has any applicant: Yes No

- 3. Used any medication or drug? Yes No

WITHIN the past 5 YEARS has any applicant been diagnosed with or treated for any of the following: Yes No

- 4. **Urinary, bladder, incontinence, kidney or liver conditions or disorders?** Kidney stones, jaundice, nephritis, or any other disorder of the liver, kidneys, or pancreas? Yes No
- 5. **Neurological disorders:** Recurring headaches, migraines, head injury, epilepsy, seizures, or convulsions or other neurological disorder? Yes No
- 6. **Metabolic and endocrine conditions or disorders:** Lupus, thyroid disorder, goiter, or any other lymph system disorder Yes No
- 7. **Eyes, ears, nose, sinus, or throat conditions or disorders** or any other respiratory system disorder including allergies or hay fever? Yes No
- 8. **Skin conditions or disorders:** Acne, psoriasis, eczema, growths (except warts), cysts, abnormal moles or birthmarks, any other skin disorder? Yes No
- 9. **Breast conditions or disorders:** breast lumps, fibrocystic breast disease, breast augmentation, or breast reduction? Yes No
- 10. **Heart conditions or disorders:** Chest pain, high blood pressure, high cholesterol, irregular heartbeat, or any other heart condition? Yes No
- 11. **Male reproductive conditions or disorders:** Impotence, prostate or testicular disorder, or abnormal PSA or other reproductive disorder? Yes No
- 12. **Circulatory system conditions or disorders:** Varicose veins, or any other circulatory disorder? Yes No
- 13. **Sexually transmitted diseases?** Yes No
- 14. **Female reproductive conditions or disorders:** Irregular bleeding, abnormal Pap smear/test, endometriosis, recurring pelvic pain, or pelvic inflammatory disease or any other disorder of the reproductive system? Yes No
- 15. **Nervous, mental and behavioral:** Mental health counseling, psychotherapy, depression, stress, anxiety, attention deficit hyperactivity disorder (ADHD), mental health disorder, or chemical imbalance that required consultation or medication? Yes No

WITHIN the past 10 YEARS has any applicant been diagnosed with or treated for any of the following: Yes No

- 16. **Arthritis or rheumatism?** Yes No
 Osteoarthritis Rheumatoid Other _____
If Yes, joints affected: _____
- 17. **Musculoskeletal conditions or disorders:** Ankylosing spondylitis, neuropathy, osteogenesis imperfecta, osteoporosis, herniated and/or ruptured disc, spina bifida, kyphosis, scoliosis, spinal stenosis, or spondylosis or other musculoskeletal disorders? Yes No

WITHIN the past 10 YEARS has any applicant been diagnosed with or treated for any of the following (continued): Yes No

- 18. **Digestive conditions or disorders:** Ulcers, hernias, chronic diarrhea, diverticulitis, irritable bowel syndrome, reflux, GERD, hemorrhoids, polyps, Crohn’s disease, colitis, colostomy or ileostomy, or any other gallbladder, digestive or rectal disorders? Yes No
- 19. **Alcohol or Drug Use/Abuse:** Alcoholism, drinking problem, convicted of DUI/DWI, drug dependency, abuse, or misuse of prescribed or non-prescribed drugs such as opiates, stimulants, depressants, and/or hallucinogens? Yes No
- 20. **Eating disorders/obesity treatment:** including bulimia, anorexia, or obesity and any surgical services for obesity? Yes No
- 21. **Back, neck, bone, joint or spinal disorders:** bone infection, bone or joint disorders (including foot, knee, jaw, fracture, dislocation or joint replacement)? Yes No
- 22. **Blood conditions or disorders:** Hemophilia, anemia, blood or bleeding disorder? Yes No

HAS any applicant EVER been diagnosed with or treated for any of the following: Yes No

- 23. **Respiratory conditions or disorders:** Respiratory Syncytial Virus (RSV), reactive airway disease, tuberculosis, asthma, chronic bronchitis, sleep apnea, pleurisy, COPD, sarcoidosis, or emphysema? Yes No
- 24. **Transplant or implanted device:** Any organ or tissue transplant, pacemaker or other implanted device? Yes No
- 25. **Nervous, mental and behavioral:** Bipolar affective disorder, manic depression, schizophrenia, chronic organic brain syndrome, attempted suicide, or psychotic disorder? Yes No
- 26. **Birth defect/congenital abnormalities:** premature birth, development or learning disability, mental impairment, Down syndrome, autism spectrum disorder or physical deformities? Yes No
- 27. **Heart and circulatory conditions or disorders:** Heart murmur, heart attack, bypass surgery, angioplasty/stent, blood clot, stroke, heart surgery, coronary artery disease, or congestive heart failure? Yes No
- 28. **Brain/nervous system conditions or disorders:** Multiple sclerosis, polio, stroke, paralysis, muscular dystrophy, cerebral palsy, Lou Gehrig’s disease (ALS), Parkinson’s disease, Alzheimer’s disease, or dementia? Yes No
- 29. **Diabetes or insulin resistance?** Yes No
If you have diabetes, is it: Type 1 Type 2
- 30. **Immune system conditions or disorders:** Immune system diseases, human immunodeficiency virus (HIV), acquired immune deficiency syndrome (AIDS), or AIDS related complex (ARC)? Yes No
- 31. **Cancer (including skin cancer or melanoma) or tumors?** Yes No
- 32. **Hospitalization/Surgery:** Has anyone listed on this application been hospitalized or had surgery? Yes No
- 33. **Any medical conditions not mentioned in the previous questions?** Yes No
If Yes, list: _____

OTHER MEDICAL INFORMATION Yes No

- 34. **Do you have a family doctor?** Yes No
If Yes, list name: _____

SECTION 5B—HEALTH STATEMENT (If you answered Yes to any question in Section 5A, please complete the information in this section. Use extra paper if necessary.)

Question #	Person Affected		Name of Disease, Symptom or Condition	Type of Treatment	Complete Recovery? (Y/N)
	Date of Onset (mm/yy)	Last Treated (mm/yy)	Name of Physician and/or Hospital	Medication Name	Frequency/Last Date Taken
Question #	Person Affected		Name of Disease, Symptom or Condition	Type of Treatment	Complete Recovery? (Y/N)
	Date of Onset (mm/yy)	Last Treated (mm/yy)	Name of Physician and/or Hospital	Medication Name	Frequency/Last Date Taken
Question #	Person Affected		Name of Disease, Symptom or Condition	Type of Treatment	Complete Recovery? (Y/N)
	Date of Onset (mm/yy)	Last Treated (mm/yy)	Name of Physician and/or Hospital	Medication Name	Frequency/Last Date Taken
Question #	Person Affected		Name of Disease, Symptom or Condition	Type of Treatment	Complete Recovery? (Y/N)
	Date of Onset (mm/yy)	Last Treated (mm/yy)	Name of Physician and/or Hospital	Medication Name	Frequency/Last Date Taken

List any medications or drugs (that are not listed in previous sections) taken by all applicants within the past 12 months. Use extra paper if necessary.

Patient's Name	Type or Name of Drug	Dosage or Frequency of Use	Date Last Taken or Ongoing	Condition Requiring Medication	Physician's Name

35. Are you or any of your dependents listed on this application currently disabled?..... Yes No
 Name of disabled person _____ Physician's Name and Phone _____
 Date of Disability _____ Physician's Address _____
 Nature of Disability _____
36. Has any person listed on this application used a tobacco product during the past 12 months? Yes No
 If Yes, list name(s) _____ Quit date(s) _____
37. Has surgery, diagnostic testing, medical treatment or follow-up visit been advised (but not yet performed)..... Yes No
 for anyone on this application? **If Yes**, list person's name and details? _____
38. Has any named person incurred medical expenses or claims exceeding \$10,000 in the past 24 months? Yes No
If Yes, give person's name and details: _____
39. Are you or any dependent listed on this application covered on Medicare or have received Social Security Disability or Workers' Compensation payments or are now eligible to receive such payments? Yes No
If Yes, give person's name, specific type and details: _____
40. Has any insurance carrier refused, restricted (including waiver or condition), or rated any health coverage for you or any dependents listed on this application?..... Yes No
If YES, please explain (list applicant's name, medical condition and whether refusal, waiver, or restriction) _____
 Name of Insurance Carrier _____ Date of refusal, etc. _____
 (Please attach a copy of refusal letter, if applicable)

SECTION 6—FEDERALLY ELIGIBLE INDIVIDUAL INFORMATION

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), guaranteed availability of individual coverage means that if you are HIPAA eligible, you cannot be denied the right to buy individual coverage. In addition, a preexisting condition exclusion cannot be applied to your coverage.

You are HIPAA eligible, also called an "eligible individual," if **ALL** of the following are true at the time you apply for individual coverage in Idaho.

- You have at least 12 months of continuous creditable coverage without any break in coverage greater than 63 days
- Your most recent coverage was under a group health plan, a governmental plan or a church plan (or health insurance offered in connection with such a plan)
- You are not covered under another group health plan
- Your most recent coverage was not cancelled because you did not pay your premiums or because you committed fraud
- You are not currently eligible for Medicare or Medicaid

If you are HIPAA eligible, you will lose your right to get individual coverage without an exclusion unless you submit an application for individual coverage within 63 days after the day your group coverage or continuation coverage ends. Act promptly to protect your rights.

SECTION 7—AFFIRMATION

I affirm the answers given in this "Idaho Individual Application" are complete and correct. I am providing these answers as part of the application procedure required by this insurance carrier to enroll in its insurance coverage. I understand that the insurance carrier will rely on each answer in making its determination to extend coverage and to determine the type of coverage offered. I understand if this application contains any material misstatements or omissions, the insurance carrier may, within the first 24 months of coverage, deny coverage retroactively and/or take any other legal action available by law. I will promptly inform the insurance carrier in writing if anything happens before my coverage takes effect that makes any answer in this application incomplete or incorrect. I understand that a twelve month waiting period for coverage of preexisting conditions may apply. I understand and agree no coverage shall be in force until approved by the insurance carrier. If approved, coverage will be in force as of the effective date determined by the insurance carrier.

SECTION 8—STATEMENT OF UNDERSTANDING

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

- a. No independent producer, agent or employee of the insurance carrier can change any part of this application or waive the requirement that I answer all questions completely and accurately.
- b. The insurance carrier may terminate or rescind an insured's coverage for any misrepresentation, omission of fact by, concerning, or on behalf of any insured that was or would have been material to the insurance carrier's acceptance of a risk, extension of coverage, provision of benefits or payment of any claim.
- c. If this application is approved, coverage for me and any eligible persons named on this application will begin on the effective date assigned by the insurance carrier.
- d. I understand that this application will become part of the contract between the insurance carrier and me.
- e. I affirm that I have reviewed all answers given on this application and, regardless of whether an independent producer or other person has filled out the answers for me, I verify that the answers are true and complete.
- f. The following preexisting condition exclusion applies to NON-HIGH RISK POOL (HRP) PLANS:
For individuals enrolled in a grandfathered policy effective prior to January 1, 2014, the following preexisting condition exclusion will be applied:

"A preexisting condition is (i) 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; (ii) 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; or (iii) a pregnancy existing on the effective date of coverage."

This exclusion may last up to 12 months from your first day of coverage; however, the exclusion period will be reduced by the number of days of your prior "creditable coverage." Most prior health coverage is considered creditable coverage and can be used to reduce the preexisting condition exclusion period if you have not experienced a break in coverage of 63 days or more.

This preexisting condition exclusion **does not** apply to a child who is enrolled in the plan within 60 days after birth, adoption or placement for adoption.

The preexisting condition exclusion defined above **will not** be applied to individuals under the age of 19 years who are enrolled in a non-grandfathered plan, beginning with renewals on or after September 23, 2010, as provided in the federal Patient Protection and Affordable Care Act (PPACA).

- g. The following preexisting condition exclusion applies to HIGH RISK POOL (HRP) PLANS:
A preexisting condition is 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; 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; or a pregnancy existing on the effective date of coverage.

This exclusion may last up to 12 months from your first day of coverage or, if you were in a waiting period, from the first day of your waiting period. However, you can reduce the length of this exclusion period by the number of days of your prior "creditable coverage." Most prior health coverage is considered creditable coverage and can be used to reduce the preexisting condition exclusion if you have not experienced a break in coverage of at least 63 days.

- h. If enrolling in a High Risk Pool plan, eligible dependents include any unmarried child who is under the age of 25 and more than 1/2 financially dependent on parent for support; or who is medically certified as disabled and dependent on parent for support (copy of certification required).

I understand that if I am declined coverage under the plan I am applying for, that I may be eligible for my choice of the state of Idaho individual High Risk Pool mandated plans. I also understand that I may be eligible for one of the state of Idaho individual High Risk Pool mandated plans, if my insurance carrier refuses to issue a health benefit plan providing coverage substantially similar to coverage offered under an equivalent High Risk Pool plan except at a rate exceeding the rate of the High Risk Pool plan.

SECTION 9—ACKNOWLEDGEMENT

I acknowledge and understand my health plan may request or disclose health information about me or my dependents (persons who are eligible for benefits coverage and are listed on the application) 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.

Health information requested or disclosed may be related to treatment or services performed by:

- A physician, dentist, pharmacist or other physical or behavioral health care practitioner;
- A clinic, hospital, long-term care or other medical facility;
- Any other institution providing care, treatment, consultation, pharmaceuticals or supplies or;
- An insurance carrier or group health plan.

Health information requested or disclosed may include, but is not limited to: claims records, correspondence, medical records, billing statements, diagnostic imaging reports, laboratory reports, dental records, or hospital records (including nursing records and progress notes).

This acknowledgement does not apply to obtaining information regarding psychotherapy notes. A separate authorization will be used for psychotherapy notes.

Signature of Applicant _____ Date _____

Signature of Spouse _____ Date _____
(if applying for coverage)

SECTION 10—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 health coverage with my full knowledge and consent. I hereby accept full responsibility for the payment of premiums and the answers and information provided in this application.

Signature _____ Print Name _____ Date (mm/dd/yy) _____

SECTION 11—AGENT INFORMATION

Agent's Name _____ ID No. _____

Signature of Agent _____ Date _____



Regence BlueShield of Idaho is an Independent Licensee of the BlueCross and Blue Shield Association

Regence BlueShield of Idaho
1602 21st Avenue
Lewiston, Idaho 83501
Mail form to: PO Box 1106
MS: LC1NW
Lewiston, ID 83501-1106

AFFIDAVIT OF DOMESTIC PARTNERSHIP
For Individual Health Benefit Plans

Please complete and submit this form if you are enrolling a domestic partner.

SECTION I - Statement of Domestic Partnership

Name of Policyholder, ID Number, Domestic Partner's Name, Date Domestic Partnership Began

I certify that [Name of Domestic Partner] and I are domestic partners and that we meet the following criteria:

- Each domestic partner is at least 18 years of age;
The domestic partners share a close personal relationship and are responsible for each other's common welfare;
The domestic partners are each other's sole domestic partner;
The domestic partners share the same regular and permanent residence with the current intent to continue doing so indefinitely;
The domestic partners are jointly financially responsible for "basic living expenses," defined as the cost of basic food, shelter, and medical expense;
Neither domestic partner is legally married to anyone else, nor has had another domestic partnership within the 30 days immediately prior to application;
The domestic partners are not related by blood closer than would bar marriage in the state issuing the contract; and
Each domestic partner was mentally competent to contract when their domestic partnership began.

SECTION II - Change in Domestic Partnership

I [Name of Contract Holder] agree to notify Regence BlueShield of Idaho within 30 days of any change in our domestic partnership status that would make the domestic partner no longer eligible under the above criteria, and such notice will be treated as a request for termination of the domestic partner.

I, the contract holder, understand that another Affidavit of Domestic Partnership cannot be filed within 90 days after a request for termination of a domestic partner has been filed with Regence BlueShield of Idaho.

SECTION III - Acknowledgment

We understand that this information will be held confidential and will be subject to disclosure only upon our express written authorization, in any action involving the enrollment or eligibility of the domestic partner, or if otherwise required by law. We understand that this declaration of responsibility for our common welfare may have legal implications under our State law. We understand that a civil action may be brought against us for any losses, including reasonable attorney's fees, arising from a false statement contained in the Affidavit of Domestic Partnership. We also certify under penalty of perjury, under our State laws, that the foregoing is true and correct.

Signature of Policyholder, Date, Signature of Domestic Partner, Date

Address

City, State and ZIP Code



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Regence

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