Blue Cross of Idaho

2027 ACA Decision Guide

Individual and Family plans

Your guide to choosing the right plan.

Form No. 20-013 (04-26)

Policy No. 18-070 (01/27)
18-076 (01/27)
18-3013OE (01/27)

Protect Yourself and Your Family with Health Insurance

WHY BEING INSURED IS IMPORTANT

Health insurance can bring peace of mind knowing you are covered for the unexpected costs of healthcare services. Being covered supports your budget and your health.

- **Protects your finances:** A Blue Cross of Idaho plan safeguards you against unexpected high medical costs, saves you money on out-of-pocket expenses with copays and coinsurance and helps lower costs on some medications.
- **Supports health maintenance:** A Blue Cross of Idaho plan gives you free preventive care such as wellness visits and screenings. Seeing your provider for these preventive services may help detect early health issues early and keep you on a healthy path.
- **Access to providers:** You can select from a variety of network options for access to providers and hospitals throughout the state of Idaho.

CHOOSING A PLAN

There is a lot to consider when choosing a plan, including level of coverage, cost, and support programs. When looking at costs you can check to see if you are eligible for tax credits or subsidies through Your Health Idaho. Reach out to a broker to help you determine the best plan for you. Learn more about tax credits on page 15.

HEALTH INSURANCE FOR EVERYBODY

Get the benefits that meet your unique needs. Blue Cross of Idaho has been serving Idaho for 80 years, offering stability and experience to Idahoans. Our Affordable Care Act (ACA) plans are some of the many ways we offer quality, flexibility and simplicity to members.

LOCAL SUPPORT: Our Idaho-based care management team supports members on their well-being journeys.

EASY ACCESS: We have networks in every Idaho county, so you can get quality care from trusted providers and hospitals.

FREE CARE: $0 preventive care saves you money and keeps your health on track.

WELLNESS DISCOUNTS: We offer member-exclusive savings on health products and programs.

Health Insurance Terms

Annual out-of-pocket maximum
The most you will pay for healthcare each year. Once met, Blue Cross of Idaho covers the rest.

Deductible
This is a set dollar amount you are responsible for paying when you need most* covered services. You will pay the full amount for those services until your deductible is met for your yearly benefit period.

Coinsurance
The percentage you're responsible for after you've met your deductible.

Copayment
A set amount you pay directly to the doctor or hospital for a covered service performed.

Formulary
A list of drugs covered under a health insurance policy's prescription drug plan.

In-Network
A provider network is a group of doctors, hospitals, pharmacies and clinics who agree to see you as a patient and send us the bill for your care. We've negotiated prices for thousands of services you may need, which is good for your wallet.

Out-of-Network
Any provider who isn't in your plan's network. You can see providers who aren't in your network as long as you have a referral from your PCP. You will pay higher out-of-pocket costs if you see an out-of-network provider.

Preventive care
A set of preventive services offered at no cost to you, such as an annual wellness visit.

* Blue Cross of Idaho pays for some healthcare, such as covered preventive services, even if you haven't met your deductible. Check out your member contract for all the details.

Need help choosing a plan?

We know choosing an insurance plan can be a complicated process, which is why we offer two no-cost options for helpful advice.

TALK TO AN AGENT
Get advice from a local, certified, and independent insurance agent near you at ***bcidaho.com/findabroker***.

SPEAK WITH A LOCAL DIRECT SALES REPRESENTATIVE
Call us at **888-GO-CROSS (888-462-7677)**.

Choose the Level That's Right for You.

QUESTIONS TO CONSIDER WHEN CHOOSING A PLAN.

- Do you expect to have higher medical expenses this year than last year?
- Do you take some prescription drugs on a regular schedule?
- Do you need to cover your spouse or family?
- Do you need regular care from a doctor or specialist, or do you only visit the doctor for preventive care?

BRONZE

Noah is healthy and young, living on a tight monthly budget. He wants to keep his monthly premium low and is willing to pay more out of pocket when he needs care. Bronze is best for him, as he gets his preventive care covered at a low monthly cost.

Noah likes
AFFORDABILITY

With a Bronze plan Noah pays:

PREMIUM | DEDUCTIBLE | OUT-OF-POCKET**

SILVER

The Smith family is growing and has a lot of unexpected costs. Both are working, so they can afford a moderate premium to have care covered at reasonable costs. A Silver plan offers them more coverage than a Bronze plan for a lower premium than a Gold plan.

The Smith family like
STABILITY

With a Silver plan the Smith family pays:

PREMIUM | DEDUCTIBLE | OUT-OF-POCKET**

GOLD

John and Cathy are pre-retirees. Cathy has a chronic health condition requiring her to get medical treatment often. They are willing to pay a higher monthly premium to pay less out-of-pocket for care because they will have a lower deductible, copays and coinsurance.

John & Cathy like
SECURITY

With a Gold plan Cathy and John pay:

PREMIUM | DEDUCTIBLE | OUT-OF-POCKET**

All plans cover either a family, couple or individual.

** Out-of-pocket costs include deductibles, coinsurance, copays and out-of-pocket maximum. To learn more about insurance terms read the Blue Bulletin article on health insurance literacy at ***https://bluebulletin.bcidaho.com/articles/health-insurance-literacy***

Silver 6300 Plan - Enroll Direct

2027 Silver 6300

In-Network

WHAT YOU'LL PAY FOR THE CARE YOU RECEIVE EACH YEAR	
Medical Deductible	$6,300
Out-of-Pocket Maximum	$10,000
Rx Deductible	No separate drug deductible
Coinsurance	20%
BENEFITS YOU ARE MOST LIKELY TO NEED AND WHAT YOU PAY	
Preventive Care	$0 for in-network providers.
Primary Care Office Visit	$30
Specialist Office Visit	$60
Urgent Care[1]	$70
Outpatient Mental Health, Substance Use Disorder	$30
OTHER BENEFITS YOU MAY NEED OR WANT	
Emergency Room[2]	20% coinsurance after deductible
Imaging (e.g. MRIs, MRAs, CT scans)	
Diagnostic Labs	
Diagnostic X-rays	
Chiropractic Care[4]	
Speech Therapy, Outpatient Therapy, Physical Therapy[5]	
Inpatient Hospital[6]	
Pregnancy Care[7] (pre/postnatal care and delivery)	
Pediatric Vision (up to age 19)	$0 for one (1) eye exam and one (1) pair of lenses and frame, or one (1) contact lens exam and contact lens materials instead of glasses (lenses and frame) per benefit period.
Pediatric Dental (up to age 19)	$0 oral examination (limit 2 per benefit period)
IF YOU NEED PRESCRIPTIONS, THIS IS WHAT YOU PAY	
Rx Preferred Generic (Tier 1)	$15
Rx Non-Preferred Generic (Tier 2)	$25
Rx Preferred Brand[8] **(Tier 3)**	30% after deductible
Rx Non-Preferred Brand[8] **(Tier 4)**	50% after deductible
Rx Preferred Specialty (Tier 5)	40% after deductible
Rx Non-Preferred Specialty (Tier 6)	50% after deductible

An Affordable Plan Available Direct from Blue Cross of Idaho

The Silver 6300 plan provides complete medical coverage at an affordable premium rate. Advantages of the Silver 6300 plan include:

- No need to use the state marketplace, Your Health Idaho. You can purchase a plan directly from Blue Cross of Idaho.
- More affordable premium than most Silver plans on Your Health Idaho*
- Pediatric dental benefits for preventive, basic, and major services included with the medical plan**

A Silver plan offers lower deductibles, copays, and cost sharing compared to a Bronze plan. This gives you lower medical expense costs at a more affordable monthly rate. Speak with your broker for more information on the Silver 6300 plan or enroll directly at ***bcidaho.com/aca***.

*Premium estimate does not include APTC subsidies offered on plans purchased on Your Health Idaho, the Silver 6300 plan does not qualify for premium subsidies or cost sharing reductions. For APTC and CSR qualified plans please review our full plan offerings on the following pages or visit yourhealthidaho.org.

**See policy contract for full details.

2027 Plan Options
In-Network

	SILVER 7100	SILVER 5500	SILVER 4000	SILVER COPAY 3200
WHAT YOU'LL PAY FOR THE CARE YOU RECEIVE EACH YEAR				
Medical Deductible	$7,100	$5,500	$4,000	$3,200
Out-of-Pocket Maximum	$8,850	$10,000	$10,000	$10,000
Rx Deductible	No separate drug deductible	$1,100	No separate drug deductible	$1,200
Coinsurance	40%	40%	50%	50%
BENEFITS YOU ARE MOST LIKELY TO NEED AND WHAT YOU PAY				
Preventive Care	$0 for in-network providers.			
Pediatric Care Office Visit (up to age 18)	$15	$0	$0	$0
Primary Care Office Visit		$25	$40	$20
Specialist Office Visit	$50	$55	$65	$70
Urgent Care[1]	$70	$50	$70	$40
Outpatient Mental Health, Substance Use Disorder	$15	$25	$40	$20
		$0 Pediatric	$0 Pediatric	$0 Pediatric
OTHER BENEFITS YOU MAY NEED OR WANT				
Emergency Room[2]	40% after deductible[3]	$350 after deductible[3]	50% after deductible[3]	$600 after deductible[3]
Imaging (e.g. MRIs, MRAs, CT scans)		$300 then 40% after deductible		$400
Diagnostic Labs		40% after deductible		$55
Diagnostic X-rays				$100
Chiropractic Care[4]				$35
Speech Therapy, Outpatient Therapy, Physical Therapy[5]				$85
Inpatient Hospital[6]				50% after deductible
Pregnancy Care[7] (pre/postnatal care and delivery)				
Pediatric Vision (up to age 19)	$0 for one (1) eye exam and one (1) pair of lenses and frame, or one (1) contact lens exam and contact lens materials instead of glasses (lenses and frame) per benefit period.			
IF YOU NEED PRESCRIPTIONS, THIS IS WHAT YOU PAY				
Rx Preferred Generic (Tier 1)	$15	$15	$10	$20
Rx Non-Preferred Generic (Tier 2)	$25	$20	$20	$25
Rx Preferred Brand[8] **(Tier 3)**	30% after deductible	$30 after Rx deductible	20% after deductible	$40 after Rx deductible
Rx Non-Preferred Brand[8] **(Tier 4)**	50% after deductible	$50 after Rx deductible	40% after deductible	$60 after Rx deductible
Rx Preferred Specialty (Tier 5)	40% after deductible	30% after Rx deductible	30% after deductible	30% after Rx deductible
Rx Non-Preferred Specialty (Tier 6)	50% after deductible	50% after Rx deductible	50% after deductible	50% after Rx deductible

2027 CSR Plan Options

Cost-Sharing Reduction (CSR)
In-Network

	SILVER 7100 CSR 73	SILVER 5500 CSR 73	SILVER 4000 CSR 73	SILVER COPAY 3200 CSR 73
WHAT YOU'LL PAY FOR THE CARE YOU RECEIVE EACH YEAR				
Medical Deductible	$3,800	$4,750	$3,300	$3,200
Out-of-Pocket Maximum	$8,600	$8,600	$8,500	$8,400
Rx Deductible	No separate drug deductible	$1,100	No separate drug deductible	$1,200
Coinsurance	40%	30%	50%	50%
BENEFITS YOU ARE MOST LIKELY TO NEED AND WHAT YOU PAY				
Preventive Care	$0 for in-network providers.			
Pediatric Care Office Visit (up to age 18)	$15	$0	$0	$0
Primary Care Office Visit		$20	$40	$20
Specialist Office Visit	$50	$55	$60	$65
Urgent Care[1]	$65	$50		$40
Outpatient Mental Health, Substance Use Disorder	$15	$20	$40	$20
		$0 Pediatric	$0 Pediatric	$0 Pediatric
OTHER BENEFITS YOU MAY NEED OR WANT				
Emergency Room[2]	40% after deductible[3]	$350 after deductible[3]	50% after deductible[3]	$350 after deductible[3]
Imaging (e.g. MRIs, MRAs, CT scans)		$300 then 30% after deductible		$400
Diagnostic Labs		30% after deductible		$55
Diagnostic X-rays				$100
Chiropractic Care[4]				$35
Speech Therapy, Outpatient Therapy, Physical Therapy[5]				$85
Inpatient Hospital[6]				50% after deductible
Pregnancy Care[7] (pre/postnatal care and delivery)				
Pediatric Vision (up to age 19)	$0 for one (1) eye exam and one (1) pair of lenses and frame, or one (1) contact lens exam and contact lens materials instead of glasses (lenses and frame) per benefit period.			
IF YOU NEED PRESCRIPTIONS, THIS IS WHAT YOU PAY				
Rx Preferred Generic (Tier 1)	$15	$15	$10	$20
Rx Non-Preferred Generic (Tier 2)	$20	$20	$20	$25
Rx Preferred Brand[8] **(Tier 3)**	30% after deductible	$30 after Rx deductible	20% after deductible	$40 after Rx deductible
Rx Non-Preferred Brand[8] **(Tier 4)**	50% after deductible	$50 after Rx deductible	40% after deductible	$60 after Rx deductible
Rx Preferred Specialty (Tier 5)	40% after deductible	30% after Rx deductible	30% after deductible	30% after Rx deductible
Rx Non-Preferred Specialty (Tier 6)	50% after deductible	50% after Rx deductible	50% after deductible	50% after Rx deductible

Benefit details are for in-network coverage only. This is not a comprehensive list of benefits. See the plan contract for a full list of benefits and coverage details.

2027 CSR Plan Options

Cost-Sharing Reduction (CSR)
In-Network

	SILVER 7100 CSR 87	SILVER 5500 CSR 87	SILVER 4000 CSR 87	SILVER COPAY 3200 CSR 87
WHAT YOU'LL PAY FOR THE CARE YOU RECEIVE EACH YEAR				
Medical Deductible	$700	$650	$0	$200
Out-of-Pocket Maximum	$3,000	$3,100	$3,400	$3,000
Rx Deductible	No separate drug deductible	$250	No separate drug deductible	$400
Coinsurance	40%	20%	50%	40%
BENEFITS YOU ARE MOST LIKELY TO NEED AND WHAT YOU PAY				
Preventive Care	$0 for in-network providers.			
Pediatric Care Office Visit (up to age 18)	$15	$0	$0	$0
Primary Care Office Visit		$20	$40	
Specialist Office Visit	$30	$45	$60	$45
Urgent Care[1]	$55	$30		$30
Outpatient Mental Health, Substance Use Disorder	$15	$20	$40	$0
		$0 Pediatric	$0 Pediatric	$0 Pediatric
OTHER BENEFITS YOU MAY NEED OR WANT				
Emergency Room[2]	40% after deductible	$350 after deductible[3]	50% after deductible[3]	$350 after deductible[3]
Imaging (e.g. MRIs, MRAs, CT scans)		$300 then 20% after deductible		$250
Diagnostic Labs		20% after deductible		$50
Diagnostic X-rays				
Chiropractic Care[4]				$20
Speech Therapy, Outpatient Therapy, Physical Therapy[5]				$50
Inpatient Hospital[6]				40% after deductible
Pregnancy Care[7] (pre/postnatal care and delivery)				
Pediatric Vision (up to age 19)	$0 for one (1) eye exam and one (1) pair of lenses and frame, or one (1) contact lens exam and contact lens materials instead of glasses (lenses and frame) per benefit period.			
IF YOU NEED PRESCRIPTIONS, THIS IS WHAT YOU PAY				
Rx Preferred Generic (Tier 1)	$10	$10	$4	$10
Rx Non-Preferred Generic (Tier 2)	$15	$15	$8	$15
Rx Preferred Brand[8] **(Tier 3)**	30% after deductible	$30 after Rx deductible	20% after deductible	$30 after Rx deductible
Rx Non-Preferred Brand[8] **(Tier 4)**	50% after deductible	$50 after Rx deductible	40% after deductible	$50 after Rx deductible
Rx Preferred Specialty (Tier 5)	40% after deductible	30% after Rx deductible	30% after deductible	30% after Rx deductible
Rx Non-Preferred Specialty (Tier 6)	50% after deductible	50% after Rx deductible	50% after deductible	50% after Rx deductible

2027 CSR Plan Options

Cost-Sharing Reduction (CSR)
In-Network

	SILVER 7100 CSR 94	SILVER 5500 CSR 94	SILVER 4000 CSR 94	SILVER COPAY 3200 CSR 94
WHAT YOU'LL PAY FOR THE CARE YOU RECEIVE EACH YEAR				
Medical Deductible	$0	$0	$0	$0
Out-of-Pocket Maximum	$2,000	$2,350	$2,000	$2,300
Rx Deductible	No separate drug deductible	$100	No separate drug deductible	$100
Coinsurance	20%	20%	20%	30%
BENEFITS YOU ARE MOST LIKELY TO NEED AND WHAT YOU PAY				
Preventive Care	$0 for in-network providers.			
Pediatric Care Office Visit (up to age 18)	$5	$0	$0	$0
Primary Care Office Visit			$10	
Specialist Office Visit	$25	$5	$25	$5
Urgent Care[1]	$40	$30		$20
Outpatient Mental Health, Substance Use Disorder	$5	$0	$10	$0
		$0 Pediatric	$0 Pediatric	$0 Pediatric
OTHER BENEFITS YOU MAY NEED OR WANT				
Emergency Room[2]	20% after deductible	$250 after deductible[3]	20% after deductible[3]	$250 after deductible[3]
Imaging (e.g. MRIs, MRAs, CT scans)		$200 then 20% after deductible		$200
Diagnostic Labs		20% after deductible		$10
Diagnostic X-rays				
Chiropractic Care[4]				
Speech Therapy, Outpatient Therapy, Physical Therapy[5]				
Inpatient Hospital[6]				30% after deductible
Pregnancy Care[7] (pre/postnatal care and delivery)				
Pediatric Vision (up to age 19)	$0 for one (1) eye exam and one (1) pair of lenses and frame, or one (1) contact lens exam and contact lens materials instead of glasses (lenses and frame) per benefit period.			
IF YOU NEED PRESCRIPTIONS, THIS IS WHAT YOU PAY				
Rx Preferred Generic (Tier 1)	$5	$5	$4	$5
Rx Non-Preferred Generic (Tier 2)	$10	$10	$8	$10
Rx Preferred Brand[8] **(Tier 3)**	30% after deductible	$30 after Rx deductible	20% after deductible	$30 after Rx deductible
Rx Non-Preferred Brand[8] **(Tier 4)**	50% after deductible	$50 after Rx deductible	40% after deductible	$50 after Rx deductible
Rx Preferred Specialty (Tier 5)	40% after deductible	30% after Rx deductible	30% after deductible	30% after Rx deductible
Rx Non-Preferred Specialty (Tier 6)	50% after deductible	50% after Rx deductible	50% after deductible	50% after Rx deductible

2027 Plan Options
In-Network

	BRONZE HSA 6250*	BRONZE 8000*	GOLD 2000	CATASTROPHIC 12000**
WHAT YOU'LL PAY FOR THE CARE YOU RECEIVE EACH YEAR				
Medical Deductible	$6,250	$8,000	$2,000	$12,000
Out-of-Pocket Maximum	$9,000	$11,000	$8,000	$12,000
Rx Deductible	No separate drug deductible	No separate drug deductible	$1,000	No separate drug deductible
Coinsurance	20%	40%	20%	0%
BENEFITS YOU ARE MOST LIKELY TO NEED AND WHAT YOU PAY				
Preventive Care	$0 for in-network providers.			
Pediatric Care Office Visit (up to age 18)***	20% after deductible	$0	$0	$30 up to 3 visits, then 0% after deductible[4]
Primary Care Office Visit* **		$50	$20	
Specialist Office Visit		$80	$50	$0 after deductible
Urgent Care[1] * **		$75	$35	$30 up to 3 visits, then 0% after deductible[4]
Outpatient Mental Health, Substance Use Disorder	20% after deductible	40% after deductible	$20	0% after deductible
		$0 Pediatric	$0 Pediatric	
OTHER BENEFITS YOU MAY NEED OR WANT				
Emergency Room[2]	$350 after deductible[3]	$600 after deductible[3]	$350 after deductible[3]	0% after deductible
Imaging (e.g. MRIs, MRAs, CT scans)	$250 then 20% after deductible	$500 then 40% after deductible	$250 then 20% after deductible	
Diagnostic Labs	20% after deductible	$50	20% after deductible	
Diagnostic X-rays		40% after deductible		
Chiropractic Care[4]				
Speech Therapy, Outpatient Therapy, Physical Therapy[5]				
Inpatient Hospital[6]				
Pregnancy Care[7] (pre/postnatal care and delivery)				
Pediatric Vision (up to age 19)	$0 for one (1) eye exam and one (1) pair of lenses and frame, or one (1) contact lens exam and contact lens materials instead of glasses (lenses and frame) per benefit period.			
IF YOU NEED PRESCRIPTIONS, THIS IS WHAT YOU PAY				
Rx Preferred Generic (Tier 1)	$5 after deductible	$20	$0	$0 after deductible
Rx Non-Preferred Generic (Tier 2)	$10 after deductible	$30	$10	
Rx Preferred Brand[8] (Tier 3)	$30 after deductible	$60 after deductible	$30 after Rx deductible	
Rx Non-Preferred Brand[8] (Tier 4)	$50 after deductible	$80 after deductible	$50 after Rx deductible	
Rx Preferred Specialty (Tier 5)	30% after deductible		30% after Rx deductible	0% after deductible
Rx Non-Preferred Specialty (Tier 6)	50% after deductible		50% after Rx deductible	

* **This plan is eligible for use with a Health Savings Account (HSA).** However, an HSA is not required to purchase or enroll in this plan. The Bronze HSA 6250 plan includes an additional list of prescriptions with no copay. The HSA Preventive Drug list is included in the ACA formulary that can be found at ***bcidaho.com/acaformulary***.

** Catastrophic plans are only available to people under the age of 30 or to people who qualify for a hardship exemption through the Idaho health insurance exchange. Visit ***yourhealthidaho.org*** for more information.

*** Catastrophic plan primary care, pediatric and urgent care visits are limited to a combined in-network total of (3) office visits per member per benefit period.

[1] Urgent care is the middle ground between your primary care provider and the emergency room. If you have a minor illness or injury that can't wait until tomorrow, urgent care is the way to go.

[2] An emergency room treats life- or limb-threatening health conditions.

[3] Blue Cross of Idaho provides emergency room services at in-network cost sharing for all providers as defined by the policy.

[4] Visit limitations apply.

[5] Visit limitations apply to habilitative and rehabilitative therapy. Visit limitation does not apply to autism spectrum disorder. Read policy contract for full benefit details.

[6] Services performed while in hospital are covered under those respective cost sharing.

[7] Some pregnancy services are covered in full under preventive care. Visit ***bcidaho.com/preventive-care***.

[8] Prescription drug coverage includes generic substitution requirement. Read policy contract for full benefit details.

Important News

While Blue Cross of Idaho offers Tribal Plans at every metal level, if you qualify for a cost-sharing reduction plan, you'll get the same great benefits.

Keep in Mind

Enroll any month of the year regardless of Open Enrollment with a Special Enrollment Period (SEP) once per month.

American Indians whose income is between 100% and 300% of the Federal Poverty Level (FPL) can enroll in a zero-cost-sharing plan, which means no copays, deductibles, or coinsurance when receiving care from Indian health care providers or when receiving essential health benefits.

Regardless of income, American Indians do not have any out-of-pocket costs for items or services provided by the purchased and referred care, tribal programs, or urban Indian programs (I/T/U).

American Indians with income over 300% of the FPL may have to pay cost-sharing if they do not have a referral when receiving care from a contracted provider that is not an Indian Health Service (IHS) provider.

*Tribal Health Insurance Plans are only available through Idaho's health insurance marketplace, ***yourhealthidaho.org***.

Visit ***yourhealthidaho.org*** to learn more and to sign up for coverage.

2027 Tribal Plan Options

	SILVER COPAY 3200 TRIBAL*	SILVER COPAY 3200 TRIBAL 0*
	IN-NETWORK	IN-NETWORK
WHAT YOU'LL PAY FOR THE CARE YOU RECEIVE EACH YEAR		
Medical Deductible	$3,200	$0
Out-of-Pocket Maximum	$10,000	$0
Rx Deductible	$1,200	$0
Coinsurance	50%	0%
BENEFITS YOU ARE MOST LIKELY TO NEED AND WHAT YOU PAY		
Preventive Care (See EOB for definition of preventive care services)	$0	$0
Pediatric Care Office Visit (up to age 18)	$0	
Primary Care Office Visit	$20	
Specialist Office Visit	$70	
Urgent Care[1]	$40	
OTHER BENEFITS YOU MAY NEED OR WANT		
Emergency Room[2, 3]	$600 after deductible	$0
Imaging (e.g. MRIs, MRAs, CT scans)	$400	
Diagnostic Labs	$55	
Diagnostic X-rays	$100	
Chiropractic Care[4]	$35	
Speech Therapy, Outpatient Therapy, Physical Therapy[5]	$85	
Inpatient Hospital[6]	50% after deductible	
Outpatient Mental Health, Substance Use Disorder	$20, $0 Pediatric	
Pediatric Vision (up to age 19) Member may receive one (1) eye exam, one (1) pair of lenses and frame, or one (1) contact lens exam and contact lens materials instead of glasses (lenses and frame) per benefit period.	$0	
IF YOU NEED PRESCRIPTIONS, THIS IS WHAT YOU PAY		
Rx Preferred Generic	$20	$0
Rx Non-Preferred Generic	$25	
Rx Preferred Brand[7]	$40 after Rx deductible	
Rx Non-Preferred Brand[7]	$60 after Rx deductible	
Rx Preferred Specialty	30% after Rx deductible	
Rx Non-Preferred Specialty	50% after Rx deductible	

[1] Urgent care is the middle ground between your primary care provider and the emergency room. If you have a minor illness or injury that can't wait until tomorrow, urgent care is the way to go.

[2] An emergency room treats life- or limb-threatening health conditions.

[3] Blue Cross of Idaho provides emergency room services at in-network cost sharing for all providers as defined by the policy.

[4] Visit limitations apply.

[5] Visit limitations apply to habilitative and rehabilitative therapy. Visit limitation does not apply to autism spectrum disorder. Read policy contract for full benefit details.

[6] Services performed while in hospital are covered under those respective cost sharing.

[7] Prescription drug coverage includes generic substitution requirement. Read policy contract for full benefit details.

How Does My Choice of Plan Affect What I Pay?

Medical cost is an important factor to consider when selecting a health plan. Here are examples showing you what various plans cover, and what you may have to pay in addition to your monthly premium.

EMERGENCY ROOM VISIT

Ashley got into a car accident, had to be transported to the emergency room (ER) by ambulance, and stayed overnight in the hospital. She had several tests and treatment for her injuries in the hospital, plus follow-up care once she was discharged. Ashley has to cover all expenses until she meets her deductible, the fixed amount she must pay before her insurance begins to share the costs.

	WHAT ASHLEY WOULD HAVE TO PAY			
Medical Care Service	BRONZE 8000	SILVER 4000	GOLD 2000	SILVER COPAY 3200 CSR 87
Emergency Room & Transportation	$4,629	$4,315	$2,526	$1,972
Tests	$2,021	$1,011	$404	$808
Hospital Stay	$1,859	$1,311	$524	$220
Casts & Crutches	$466	$583	$233	$0
After Care	$207	$259	$104	$0
Ashley's Estimated Total Cost	**$9,182**	**$7,478**	**$3,791**	**$3,000***

Scenario is meant for example purposes only. Coinsurance and copay applied to various plan options. Monthly premiums do not apply.
*Member reached maximum out-of-pocket and after that insurance covers 100% of medical expenses.

SURGERY VISIT

Tom needed knee surgery to repair a torn ligament after months of ongoing pain. He had outpatient surgery at a hospital, which included anesthesia, professional surgical fees, and durable medical equipment (DME). After the procedure, he received a medical brace to assist on his road to recovery. Tom is responsible for the costs of these services until he meets his deductible, the fixed amount he must pay before his insurance begins to share the costs.

	WHAT TOM WOULD HAVE TO PAY			
Knee Arthroscopy	BRONZE 8000	SILVER 4000	GOLD 2000	SILVER COPAY 3200 CSR 87
Surgery Center	$2,916	$2,916	$2,183	$1,286
Professional Services	$787	$787	$157	$315
Anesthesia	$776	$537	$155	$310
DME (Anchor/Screw)	$1,250	$625	$250	$500
DME (Knee Brace)	$468	$234	$94	$187
Tom's Estimated Total Cost	**$6,197**	**$5,099**	**$2,839**	**$2,599**

Scenario is meant for example purposes only. Coinsurance and copay applied to various plan options. Monthly premiums do not apply.

Prescription Drugs

DRUG FORMULARY

Blue Cross of Idaho offers a multi-tier pharmacy drug formulary under its pharmacy benefit program, which is administered with support from its pharmacy benefit manager, CarelonRx. In most cases you will be responsible for a portion of the cost of each prescription you fill, and depending on the drug prescribed, your cost can vary.

Check the drug formulary to make sure your drugs are covered and look at the tiers to see how much they cost[1]. Find more information at ***bcidaho.com/acaformulary***.

TIER 1

Preferred generic drugs are equivalent to brand-name drugs but offer the lowest cost to you.

TIER 2

Non-preferred generic drugs are equivalent to brand-name drugs but are more expensive than alternative preferred medications.

TIER 3

Preferred brand-name drugs offer quality and cost-effectiveness when a generic option is not available or selected.

TIER 4

Non-preferred brand-name drugs are clinically effective medications but more expensive than alternatives.

TIER 5

Preferred specialty drugs are cost-effective medications used to treat complex conditions.

TIER 6

Non-preferred specialty drugs are medications used to treat complex conditions but are more expensive than alternatives.

[1] To request approval of a drug that requires prior authorization or a non-preferred medication, your provider will need to send a pharmacy prior authorization request along with supporting clinical information to Blue Cross of Idaho Rx.

MAIL-ORDER PHARMACY

We offer a mail-order pharmacy program where regular medications are delivered directly to you.

- Mail-order service is included with no extra cost. Just pay your usual copayment or coinsurance.
- For your convenience we work with CarelonRx and Amazon Pharmacy so the process is easier for you to receive your medication.

Medication Savings Note

The Medication Savings Note solution helps create savings for members on prescription drugs. Near-real-time claims reviews are conducted to find member-specific, evidence-based drug alternatives that often save you money.

Pharmacists contact the prescribing provider to recommend the alternatives for saving opportunities. Based on that recommendation, the provider determines whether to prescribe that alternative drug.

- Blue Cross of Idaho offers this solution in partnership with CarelonRx.
- Medication Savings Note provides early opportunities for savings.

CarelonRx and Amazon Pharmacy are independent companies contracted to provide prescription drug savings opportunities to Blue Cross of Idaho members and their dependents. Medication Savings Note is a program of CarelonRx. CarelonRx is solely responsible for its products and services. Blue Cross of Idaho is not responsible for the provision of, or failure to provide, any products and services offered by CarelonRx.

More Ways to Save

GET A PLAN FOR LESS

If you are eligible, you may be able to receive subsidies or tax credits depending upon your income.

- **The Advance Premium Tax Credit (APTC):** APTC helps pay for all or part of your monthly premium depending on your household income. You can learn more and apply for subsidies at ***yourhealthidaho.org***.
- **Cost-Sharing Reduction (CSR):** A Silver CSR plan offers discounts on your deductible, copayments and coinsurance, providing lower out-of-pocket costs through the year. Qualifications are determined by household income and size. You must apply for a Silver CSR plan at ***yourhealthidaho.org*** if you qualify.

If you are not eligible for a subsidy or tax credit, consider Silver 6300, an affordable plan available directly from Blue Cross of Idaho.

WHOLE BODY HEALTH

We're Making A Healthy Life More Affordable

Blue365 is a free health and wellness discount program offered exclusively to members of Blue Cross of Idaho.

With Blue365 you will have access to discounts on gym memberships, hearing aids, glasses, contacts and LASIK, nutrition services and more! Learn more at ***www.blue365deals.com/bcidaho***.

Dental Plans For Whole Health

Blue Cross of Idaho offers a variety of dental plans that can enhance your medical coverage. Choose from affordable options based on access to care, copay plans, orthodontia coverage and much more. Visit ***www.bcidaho.com/individual*** under Dental to learn more.

Take Care of Your Eyes with Vision Plans

We partner with VSP to offer vision plans. These include coverage for regular exams, prescription glasses and contacts, savings on laser vision correction surgery and more. Visit ***www.bcidaho.com/individual*** under Vision Plans to learn more.

(Vision products are offered independently by VSP, which is solely responsible. This is not a Blue Cross of Idaho product.)

Understanding Health Insurance
Watch our video at ***bcidaho.com/membercosts*** to get a better understanding of insurance terms and costs.

DO YOU QUALIFY?

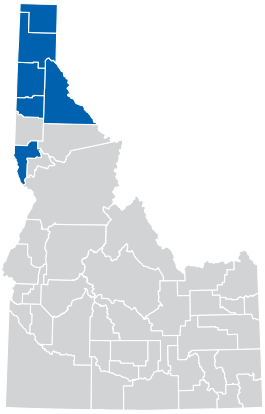
If you qualify for a tax credit or a CSR plan, make sure you choose the right plan. A $0 premium Bronze plan is appealing, but a Silver CSR plan may be the best option for your health care needs.

Network Options

CHOOSE THE RIGHT NETWORK FOR YOU

Before you pick a plan, you will need to also select your provider network. Make sure that your provider and hospital are in the plan's network. A plan network is a set of providers who agree to offer care at a lower cost to members of that plan.

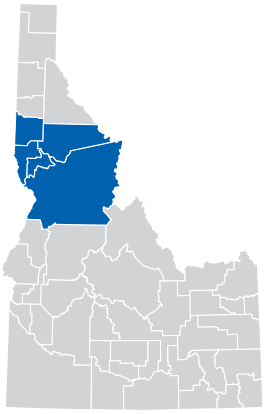
NORTH AND NORTH CENTRAL IDAHO



HOMETOWN NORTH PROVIDER NETWORK (HNPN)

- Hometown North is an integrated health network that consists of a wide network of local healthcare professionals, facilities and clinics, with access to the majority of hospitals across Northern Idaho.
- Hometown North Gold plan is NOT available to purchase in Nez Perce County.
- TriState Health has been added to the Hometown North network.

Available in these counties:
Benewah
Bonner
Boundary
Kootenai
Nez Perce
Shoshone



CLEARWATER PROVIDER NETWORK (CPN)

- CPN is a high-performing network in Idaho, providing access to quality care at affordable costs with a wide network of providers, hospitals, and full-service imaging and laboratory departments.
- Access to a network of hospitals throughout North Central Idaho.
- Gold plan is available to purchase in all counties.

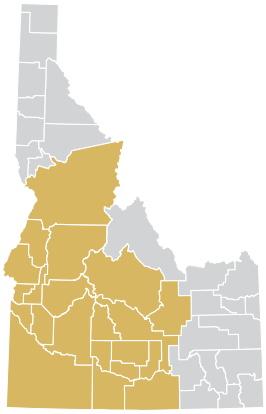
Available in these counties:
Clearwater
Idaho
Latah
Lewis
Nez Perce

Network Options

CONSIDERATIONS WHEN CHOOSING A NETWORK

- Visit ***bcidaho.com/findaprovider*** to see if your provider and preferred hospital is in the plan's network.
- Would you be willing to see a different provider or specialist if your first choice is not in the plan's network?

SOUTHWEST AND SOUTH CENTRAL IDAHO

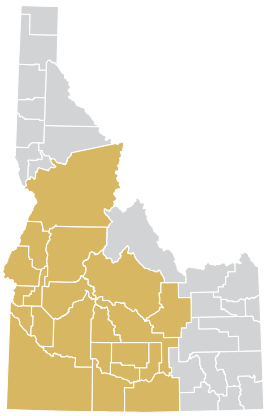


ST. LUKE'S HEALTH NETWORK (SLHN)

» Quality healthcare focusing on the best outcomes to ensure the most cost-effective delivery of care. Offers a range of provider groups, including St. Luke's Health System, that hold multiple medical accreditations.

» Gold plans are available to purchase in Adams, Blaine, Boise, Camas, Elmore, Gooding, Jerome, Lincoln, Twin Falls and Valley counties.

Available in these counties:
Ada, Adams, Blaine, Boise, Butte, Camas, Canyon, Cassia, Custer, Elmore, Gem, Gooding, Idaho, Jerome, Lincoln, Minidoka, Owyhee, Payette, Twin Falls, Valley, Washington

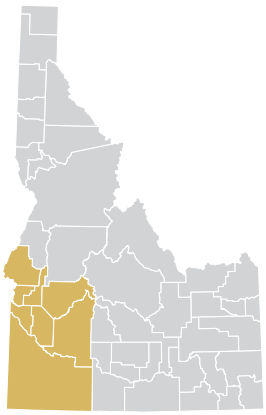


HOMETOWN SOUTHWEST NETWORK (HSWPN)

» Hometown Southwest is an integrated health network that consists of a wide network of local healthcare professionals, facilities and clinics with access to the majority of hospitals across Southwest Idaho, including St. Luke's Health System and St. Alphonsus Health System.

» New for 2027, now offering Gold in Hometown Southwest.

Available in these counties:
Ada, Adams, Blaine, Boise, Butte, Camas, Canyon, Cassia, Custer, Elmore, Gem, Gooding, Idaho, Jerome, Lincoln, Minidoka, Owyhee, Payette, Twin Falls, Valley, Washington



INDEPENDENT DOCTORS OF IDAHO (IDID)

» IDID is not limited to one facility, one doctor or even one hospital. When you choose a medical provider from the IDID Network, your provider is free to choose the highest quality and most affordable options.

» Includes a large group of providers, urgent care facilities and hospitals/surgery centers. Saint Alphonsus Medical Centers in Boise, Nampa and Ontario, and Valor Hospital are in-network.

» IDID, in partnership with Saint Alphonsus Health System, gives members even more options, and you can now select a Saint Alphonsus primary care provider (PCP) or specialty care provider.

» Gold plans are NOT available to purchase in Boise and Elmore counties.

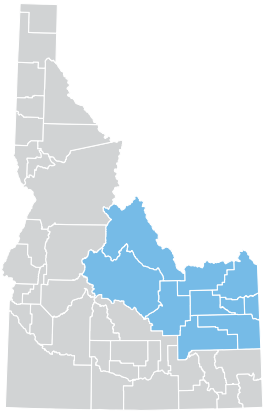
Available in these counties:
Ada
Boise
Canyon
Elmore
Gem
Owyhee
Payette
Washington

Network Options

GET HELP CHOOSING A PLAN

If you need help figuring out which network works best for you, reach out to an independent agent at ***bcidaho.com/findabroker*** or contact our sales team at **888-462-7677**.

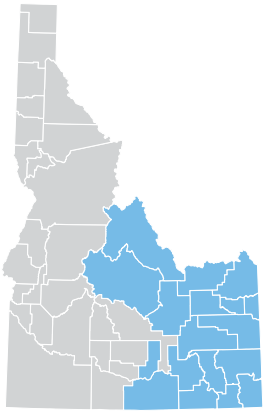
EASTERN IDAHO



MOUNTAIN VIEW NETWORK (MVN)

- MVN gives you access to all the providers in the Mountain View Hospital health system, including generalists and specialists such as orthopedists, neurologists, oncologists, nephrologists and pulmonologists.
- Gold plan is only available to purchase in Bonneville and Jefferson counties.

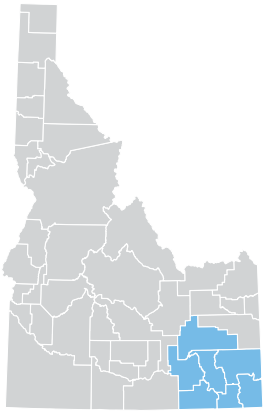
Available in these counties:
Bingham
Bonneville
Butte
Clark
Custer
Fremont
Jefferson
Lemhi
Madison
Teton



HOMETOWN EAST PROVIDER NETWORK (HEPN)

- Hometown East is an integrated health network that consists of a wide network of local healthcare professionals, facilities and clinics, with access to the majority of hospitals across Eastern Idaho.
- Gold plan is NOT available to purchase in Bannock, Bonneville, Jefferson and Bingham counties.

Available in these counties:
Bannock, Bear Lake, Bingham, Bonneville, Butte, Caribou, Cassia, Clark, Custer, Franklin, Fremont, Jefferson, Lemhi, Madison, Minidoka, Oneida, Power, Teton



PATIENT QUALITY ALLIANCE (PQA)

- Patient Quality Alliance (PQA) is a clinically integrated network that partners with a large network of primary care and specialty physicians, a number of post-acute care facilities/organizations and health systems, including Portneuf Medical Center providing a level II trauma center, level III NICU, a Quality Oncology Practice Initiative-certified cancer center, an inpatient behavioral health unit and full suite cardiac care.
- Gold plan is only available to purchase in Bannock and Bingham counties.

Available in these counties:
Bannock
Bear Lake
Bingham
Caribou
Franklin
Oneida
Power

Hospital Options

HOSPITALS	NETWORKS							
	HNPN	CPN	SLHN	HSWPN	IDID	MVN	HEPN	PQA
NORTH AND NORTH CENTRAL IDAHO								
Benewah Community Hospital	●							
Bonner General	●							
Boundary Community	●							
Clearwater Valley	●	●		●				
Gritman Medical Center	●	●						
Kootenai Health	●							
Northern Idaho Advanced Care	●							
Northwest Specialty Hospital	●							
Shoshone Medical Center	●							
St. Joseph Regional Medical Center	●	●						
St. Mary's Hospital	●	●						
Syringa Hospital	●	●		●				
TriState Health	●							
SOUTHWEST AND SOUTH CENTRAL IDAHO								
Saint Alphonsus Boise				●	●			
Saint Alphonsus Eagle (ER only)				●	●			
Saint Alphonsus Nampa				●	●			
Saint Alphonsus Ontario				●	●			
St. Luke's Regional Medical Center - Boise			●	●			●	
St. Luke's Regional Medical Center - Meridian			●	●			●	
St. Luke's Regional Medical Center - Nampa			●	●			●	
St. Luke's Elmore Medical Center			●	●			●	
St. Luke's Wood River Medical Center			●	●			●	
St. Luke's Jerome			●	●			●	
St. Luke's Magic Valley Medical Center			●	●			●	
St. Luke's Fruitland			●	●			●	
St. Luke's McCall			●	●			●	
Treasure Valley Hospital				●	●			
Valor Health			●	●	●			
West Valley Medical Center			●	●				
Weiser Memorial Hospital			●	●	●			
EASTERN IDAHO								
Bear Lake Memorial							●	
Bingham Memorial						●	●	
Caribou Medical Center							●	●
Eastern Idaho Regional Medical Center (EIRMC)	●						●	
Franklin County Medical Center	●						●	●
Idaho Falls Community Hospital						●	●	
Intermountain Health Cassia Regional			●	●			●	
Lost Rivers District Hospital				●		●	●	●
Madison Memorial						●	●	
Minidoka Memorial			●	●			●	
Mountain View						●	●	
Nell J. Redfield Memorial				●			●	●
North Canyon Medical Center			●	●			●	
Portneuf Medical Center							●	●
Power County				●			●	
Steele Memorial			●	●			●	
Teton Valley Health Care							●	

DETAILS ABOUT OUR ACA PLANS

How we protect your personal information

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

Prior authorization

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

What if I don't have prior authorization?

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

Who determines if the service is approved?

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

Important information about your prescription drug coverage

Your Blue Cross of Idaho health insurance plan comes with a list of drugs approved for coverage under your pharmacy benefit. This is also called a formulary. This prescription drug list can help you better understand your coverage and how it works. You can get a copy of our ACA formulary at ***bcidaho.com/acaformulary***. (If you don't have internet access, you can also call Blue Cross of Idaho's Customer Service Department at 855-230-6862.)

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

EXCLUSIONS AND LIMITATIONS SECTION

In addition to the exclusions and limitations listed elsewhere in this Plan Guide, the following exclusions and limitations apply to the entire Contract, unless otherwise specified:.

I. PREEXISTING CONDITION WAITING PERIODS

There is no preexisting condition waiting period for benefits available under this Contract.

II. GENERAL EXCLUSIONS AND LIMITATIONS

There are no benefits for services, supplies, drugs or other charges that are:

A. Not Medically Necessary. If services requiring Prior Authorization by Blue Cross of Idaho are performed by a Contracting Provider and benefits are denied as not Medically Necessary, the cost of said services are not the financial responsibility of the Member. However, the Member could be financially responsible for services found to be not Medically Necessary when provided by a Noncontracting Provider.

B. In excess of the Maximum Allowance.

C. For hospital Inpatient or Outpatient care for extraction of teeth or other dental procedures, unless necessary to treat an Accidental Injury or unless an attending Physician certifies in writing that the Member has a non dental, life endangering condition which makes hospitalization necessary to safeguard the Member's health and life.

D. 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.

E. Investigational in nature.

F. Provided for any condition, Disease, Illness or Accidental Injury to the extent that the Member is entitled to benefits under occupational coverage, obtained or provided by or through the employer under state or federal Workers' Compensation Acts or under Employer Liability Acts or other laws providing compensation for work related injuries or conditions. This exclusion applies whether or not the Member claims such benefits or compensation or recovers losses from a third party.

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

H. Provided for any condition, Accidental Injury, Disease or Illness suffered as a result of any act of war or any war, declared or undeclared.

I. Furnished by a Provider who is related to the Member by blood or marriage and who ordinarily dwells in the Member's household.

J. 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.

K. 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 a Member who is a dependent child.

L. Rendered prior to the Member's Effective Date.

M. For personal hygiene, comfort, beautification (including non-surgical services, drugs, and supplies intended to enhance the appearance) even if prescribed by a Physician.

N. For exercise or relaxation items or services even if prescribed by a Physician, including but not limited to, air conditioners, air purifiers, humidifiers, physical fitness equipment or programs, spas, massage therapy, hot tubs, whirlpool baths, waterbeds or swimming pools.

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

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

Q. Recreational therapy or therapeutic recreation programs, which can include, but are not limited to, diabetes camps, adventure therapy, and/or wilderness therapy (which can include, but are not limited to, programs for outdoor behavioral health, childhood diabetes, and childhood cancer).

R. For telephone consultations, and all computer or Internet communications, except as provided by or in connection with Telehealth Virtual Care Services.

S. For failure to keep a scheduled visit or appointment; for completion of a claim form; for interpretation services; or for personal mileage, transportation, food or lodging expenses, unless specified as a Covered Service in this Contract, or for mileage, transportation, food or lodging expenses billed by a Physician or other Professional Provider.

T. For Inpatient admissions that are primarily for Diagnostic Services, Therapy Services, or Physical Rehabilitation, except as specified in the Contract; or for Inpatient admissions when the Member is ambulatory and/or confined primarily for bed rest, a special diet, environmental change or for treatment not requiring continuous bed care.

U. For Inpatient or Outpatient Custodial Care; or for Inpatient or Outpatient services consisting mainly of educational therapy, behavioral modification, self care or self help training, except as specified as a Covered Service in this Contract.

V. 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).

W. For any of the following:

1. For appliances, splints or restorations necessary to increase vertical tooth dimensions or restore the occlusion, except as specified as a Covered Service in this Contract;
2. For orthognathic Surgery, including services and supplies to augment or reduce the upper or lower jaw;
3. For implants in the jaw; for pain, treatment, or diagnostic testing or evaluation related to the misalignment or discomfort of the temporomandibular joint (jaw hinge), including splinting services and supplies;
4. For alveolectomy or alveoloplasty when related to tooth extraction.

X. For hearing aids or examinations for the prescription or fitting of hearing aids, except as specified as a Covered Service in this Contract.

Y. For orthoptics, eyeglasses or contact lenses or the vision examination for prescribing or fitting eyeglasses or contact lenses, unless specified as a Covered Service in the Contract.

Z. For any treatment of sexual dysfunction, or sexual inadequacy, including erectile dysfunction and/or impotence, even if related to a medical condition.

AA. Made by a Licensed General Hospital for the Member's failure to vacate a room on or before the Licensed General Hospital's established discharge hour.

AB. Not directly related to the care and treatment of an actual condition, Illness, Disease or Accidental Injury.

AC. Furnished by a facility that is primarily a nursing home, a convalescent home, or a rest home.

AD. For Acute Care, Rehabilitative care, diagnostic testing, except as specified as a Covered Service in

the Contract; for Mental or Nervous Conditions and Substance Use Disorder or Addiction services not recognized by the American Psychiatric and American Psychological Associations.

AE. For weight loss or weight control. For reversals or revisions of Surgery for obesity, except when required to correct an immediately life-endangering condition.

AF. For an elective abortion, unless it is the recommendation of one consulting Physician that an abortion is necessary to save the life of the mother, or if the pregnancy is a result of rape as defined by Idaho law, or incest as determined by the court.

AG. For use of operating, cast, examination, or treatment rooms or for equipment located in a Contracting or Noncontracting Provider's office or facility, except for emergency room facility charges in a Licensed General Hospital, unless specified as a Covered Service in the Contract.

AH. For the reversal of sterilization procedures, including but not limited to, vasovasostomies or salpingoplasties.

AI. Treatment for reproductive procedures, including but not limited to, ovulation induction procedures and pharmaceuticals, intrauterine insemination, in vitro fertilization, embryo transfer or similar procedures, or procedures that in any way augment or enhance a Member's reproductive ability, including but not limited to laboratory services, radiology services or similar services related to treatment for reproduction procedures.

AJ. For Transplant services and Artificial Organs, except as specified as a Covered Service in the Contract.

AK. For acupuncture.

AL. 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.

AM. For Hospice, except as specified as a Covered Service in the Contract.

AN. For pastoral, spiritual, bereavement, or marriage counseling.

AO. For homemaker and housekeeping services or home delivered meals.

AP. For the treatment of injuries sustained while committing a felony, voluntarily taking part in a riot, or while engaging in an illegal act or occupation, unless such injuries are a result of a medical condition or domestic violence.

AQ. For which a Member would have no legal obligation to pay in the absence of coverage under the Contract or any similar coverage; or for which no charge or a different charge is usually made in the absence of insurance coverage; or charges in connection with work for compensation or charges; or for which reimbursement or payment is contemplated under an agreement with a third party.

AR. For a routine or periodic mental or physical examination or laboratory test that is not connected with the care and treatment of an actual Illness, Disease or Accidental Injury or for an examination or laboratory test required for any employment-related purpose; or related to an occupational injury; for a marriage license; or for insurance, school or camp application; or for sports participation physicals; or a screening examination including routine hearing examinations, except as specified as a Covered Service in the Contract.

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

AT. For breast reduction Surgery or Surgery for gynecomastia.

AU. For nutritional supplements.

AV. For replacements or nutritional formulas, except when administered enterally due to impairment in digestion and absorption of an oral diet and is the sole source of caloric need or nutrition in a Member.

AW. For vitamins and minerals, unless required through a written prescription and cannot be purchased over the counter.

AX. For alterations or modifications to a home or vehicle.

AY. For special clothing, including shoes (unless permanently attached to a brace).

AZ. 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.

AAA. Provided outside the United States, which if had been provided in the United States, would not be a Covered Service under the Contract.

AAB. Provided outside the United States, which if had been provided in the United States, would not be a Covered Service under the Contract.

AAB. For Outpatient pulmonary and/or cardiac Rehabilitation.

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

AAD. For the use of Hypnosis, as anesthesia or other treatment, except as specified as a Covered Service.

AAE. For arch supports, orthopedic shoes, and other foot devices.

AAF. For wigs.

AAG. For cranial molding helmets, unless used to protect post cranial vault surgery.

AAH. 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.

AAI. For the purchase of Therapy or Service Dogs/ Animals and the cost of training/maintaining said animals.

AAJ. For Dentistry or Dental Treatment, dental implants, appliances (with the exception of sleep apnea devices), and/or prosthetics, and/or treatment related to Orthodontia, even when Medically Necessary, unless specified as a Covered Service in this Contract.

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

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

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

AAN. All services, supplies, devices and treatment that are not FDA approved.

AAO. Any services, interventions occurring within the framework of an educational program or institution; or provided in or by a school/educational setting; or provided as a replacement for services that are the responsibility of the educational system

III. HOSPICE EXCLUSIONS AND LIMITATIONS

In addition to any other exclusions and limitations of this Contract, the following exclusions and limitations apply to Hospice Services. No benefits are available under this Contract for the following:

A. Hospice Services not included in a Hospice Plan of Treatment and not provided or arranged and billed through a Hospice.

B. Continuous Skilled Nursing Care except as specifically provided as a part of Continuous Crisis Care or Respite Care.

C. Hospice benefits provided during any period of time in which a Member is receiving Home Health Skilled Nursing Care benefits.

IV. PEDIATRIC VISION CARE EXCLUSIONS AND LIMITATIONS

In addition to any other exclusions and limitations of this Contract, the following exclusions and limitations apply to Pediatric Vision Care Benefits Section. No benefits are available for professional services or materials connected with:

A. Orthoptics or other vision training and any associated supplemental testing; Plano Lenses; or two (2) pair of eyeglasses in place of bifocals.

B. Replacement of Lenses, Frames or Contact Lenses furnished hereunder that are lost or broken (Lenses, Frames or Contact Lenses are only replaced at the normal intervals when Covered Services are otherwise available).

C. Medical or surgical treatment of the eye(s).

D. Any eye examination or any corrective eyewear required by an employer as a condition of employment.

E. Low vision aids.

V. PRESCRIPTION DRUG EXCLUSIONS AND LIMITATIONS

In addition to any other exclusions and limitations of this Contract, the following exclusions and limitations apply to Prescription Drug Services. No benefits are available under this Contract for the following:

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

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

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

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

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

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

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

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

I. Any Prescription Drug, biological or other agent which is:

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

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

VI. TRANSPLANT EXCLUSIONS AND LIMITATIONS

In addition to any other exclusions and limitations of this Contract, the following exclusions and limitations apply to Transplant or Autotransplant Services. No benefits are available under this Contract for the following:

A. Transplants of brain tissue or brain membrane, intestine, pituitary and adrenal glands, hair Transplants, or any other Transplant not specifically named as a Covered Service in this section; or for Artificial Organs including but not limited to, artificial hearts or pancreases.

B. Any eligible expenses of a donor related to donating or transplanting an organ or tissue unless the recipient is a Member who is eligible to receive benefits for Transplant Services.

C. The cost of a human organ or tissue that is sold rather than donated to the recipient.

D. Transportation costs including but not limited to, Ambulance Transportation Service or air service for the donor, or to transport a donated organ or tissue.

E. Living expenses for the recipient, donor, or family members, except as specifically listed as a Covered Service in this Contract.

F. Costs covered or funded by governmental, foundation or charitable grants or programs; or Physician fees or other charges, if no charge is generally made in the absence of insurance coverage.

G. Costs related to the search for a suitable donor.

H. No benefits are available for services, expenses, or other obligations of or for a deceased donor (even if the donor is a Member).

VII. PEDIATRIC DENTAL EXCLUSIONS AND LIMITATIONS

There are no benefits for services, supplies, drugs or other charges that are:

A. Procedures that are not included in the Closed List of Dental Covered Services; or that are not Medically Necessary for the care of an Insured's covered dental condition; or that do not have uniform professional endorsement.

B. Charges for services that were started prior to the Insured's Effective Date. The following guidelines will be used to determine the date when a service is deemed to have been started:

1. For full dentures or partial dentures: on the date the final impression is taken.
2. For fixed bridges, crowns, inlays or onlays: on the date the teeth are first prepared and final impressions taken.
3. For root canal therapy: on the date the pulp chamber is opened and the canals are explored to the apex.
4. For periodontal Surgery: on the date the Surgery is actually performed.
5. For all other services: on the date the service is performed.
6. For orthodontic services, if benefits are available under this Policy: on the date any bands or other appliances are first inserted.

C. Cast restorations (crowns, inlays or onlays) for teeth that are restorable by other means (i.e., by amalgam or composite fillings).

D. Replacement of an existing crown, inlay or onlay that was installed within the preceding seven (7) years or replacement of an existing crown, inlay or onlay that can be repaired.

E. Appliances, restorations or other services provided or performed solely to change, maintain or restore vertical dimension or occlusion.

F. A service for cosmetic purposes.

G. In excess of the Maximum Allowance.

H. A partial or full removable denture for fixed bridgework, or the addition of teeth thereto, if involving a replacement or modification of a denture or bridgework that was installed during the preceding seven (7) years.

I. Orthodontic services and supplies unless otherwise specifically listed in the Closed List of Dental Covered Services.

J. Replacement of lost or stolen appliances.

K. Any procedure, service or supply required directly or indirectly to treat or diagnose a muscular, neural, orthopedic or skeletal disorder, dysfunction or Disease of the temporomandibular joint (jaw hinge) and its associated structures including, but not limited to, myofascial pain dysfunction syndrome.

L. Orthognathic Surgery, including, but not limited to, osteotomy, ostectomy and other services or supplies to augment or reduce the upper or lower jaw.

M. Temporary dental services. Charges for temporary services are considered an integral part of the final dental services and are not separately payable; provisional services will be considered permanent and will have standard replacement frequencies applied.

N. Any service, procedure or supply for which the prognosis for success is not favorable for at least (3) years from date of service.

O. Myofunctional therapy and biofeedback procedures.

P. For hospital Inpatient or Outpatient care for extraction of teeth or other dental procedures.

Q. Occlusal adjustments, except as specifically listed as a Covered Service in this Policy.

R. Not prescribed by or upon the direction of a Provider.

S. Investigational in nature.

T. 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.

U. Provided or paid for by any federal governmental entity or unit except when payment under this Policy is expressly required by federal law, or provided or paid for by any state or local governmental entity or unit where its charges therefor would vary, or are or would be affected by the existence of coverage under this Policy; or

For which payment has been made under Medicare Part A and/or Part B.

V. Provided for any condition, Accidental Injury, Disease or Illness suffered as a result of any act of war or any war, declared or undeclared.

W. Furnished by a Provider who is related to the Insured by blood or marriage and who ordinarily dwells in the Insured's household.

X. 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.

Y. For personal hygiene, comfort, beautification or convenience items even if prescribed by a Dentist, including but not limited to, air conditioners, air purifiers, humidifiers, physical fitness equipment or programs.

Z. For telephone consultations; for failure to keep a scheduled visit or appointment; for completion of a claim form; for interpretation services; or for personal mileage, transportation, food or lodging expenses, or for mileage, transportation, food or lodging expenses billed by a Dentist or other Provider.

AA. For Congenital Anomalies, or for developmental malformations, unless the patient is an Eligible Dependent child.

AB. For the treatment of injuries sustained while committing a felony, voluntarily taking part in a riot, or while engaging in an illegal act or occupation, unless such injuries are a result of a medical condition or domestic violence.

AC. For treatment or other health care of any Insured in connection with an Illness, Disease, Accidental Injury or other condition which would otherwise entitle the Insured to Covered Services under this Policy, if and to the extent those benefits are payable to or due the Insured under any medical payments provision, no fault provision, uninsured motorist provision, underinsured motorist provision, or other first party or no fault provision of any automobile, homeowner's or other similar policy of insurance, contract or underwriting plan.

In the event Blue Cross of Idaho for any reason makes payment for or otherwise provides benefits excluded by this provision, it shall succeed to the rights of payment or reimbursement of the compensated Provider, the Insured, and the Insured's heirs and personal representative against all insurers, underwriters, self-insurers or other such obligors contractually liable or obliged to the Insured or their estate for such services, supplies, drugs or other charges so provided by Blue Cross of Idaho in connection with such Illness, Disease, Accidental Injury or other condition.

AD. For which an Insured would have no legal obligation to pay in the absence of coverage under this Policy or any similar coverage; or for which no charge or a different charge is usually made in the absence of insurance coverage; or charges in connection with work for compensation or charges; or for which reimbursement or payment is contemplated under an agreement with a third party.

AE. Provided to persons who were enrolled as Eligible Dependents after they cease to qualify as Eligible Dependents due to a change in eligibility status which occurs during the Policy term.

Applies to Silver 6300 only

AF. Provided outside the United States, which if had been provided in the United States, would not be Covered Services under this Policy.

AG. Not directly related to the care and treatment of an actual condition, Illness, Disease or Accidental Injury.

AH. For acupuncture or hypnosis.

AI. Denture duplication.

AJ. Oral hygiene instruction.

AK. Treatment of jaw fractures.

AL. Charges for acid etching.

AM. Charges for oral cancer screening which are included in a regular oral examination.

AN. No benefits are available for replacement and/or repair of orthodontic appliances. This includes removable and/or fixed retainers.

AO. Support service(s) provided for a non-Covered Service.

DISCRIMINATION IS AGAINST THE LAW

Blue Cross of Idaho complies with applicable Federal civil rights laws and does not discriminate, exclude or treat less favorably on the basis of race, color, national origin (including limited English proficiency and primary language), age, disability or sex.

Blue Cross of Idaho:

- Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as:
  - o Qualified sign language interpreters
  - o Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language assistance services to people whose primary language is not English, which may include:
  - o Qualified interpreters
  - o Information written in other languages

If you need these services, contact Blue Cross of Idaho Civil Rights Coordinator at 1-800-627-1188 (TTY: 711).

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

Civil Rights Coordinator
3000 E. Pine Ave., Meridian, ID 83642
Telephone: 1-800-274-4018
Fax: 208-331-7493
Email: ***grievancesandappeals@bcidaho.com***
TTY: 711

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at ***https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf***, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at ***https://www.hhs.gov/ocr/complaints/index.html***.

ATTENTION: If you speak Arabic, Bantu, Chinese, Farsi, French, German, Japanese, Korean, Nepali, Romanian, Russian, Serbo-Croatian, Spanish, Tagalog, or Vietnamese, appropriate auxiliary aids and language assistance services are available free of charge. Call 1-800-627-1188 (TTY: 711).

Arabic انتبه: إذا كنت تتحدث اللغة العربية ، فإن خدمات المساعدة اللغوية متاحة لك مجانًا اتصل على 1-800-627-1188 (للصم والبكم: 711).

Bantu: ICITONDERWA: Nimba uvuga Ikirundi, uzohabwa serivisi zo gufasha mu ndimi, ku buntu. Woterefona 1-800-627-1188 (TTY: 711).

Chinese: 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-627-1188（TTY：711）。

Farsi توجه: اگر به زبان فارسی صحبت می کنید، خدمات رایگان پشتیبانی زبان، در دسترس شما است. شماره تماس 1-800-627-1188 (TTY:711).

French: ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-627-1188 (ATS : 711).

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-627-1188 (TTY: 711).

Japanese: 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-627-1188（TTY:711）まで、お電話にてご連絡ください。

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-627-1188 (TTY: 711)번으로 전화해 주십시오.

Nepali: ध्यान दिनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् 1-800-627-1188 (टिटिवाइ: 711) ।

Romanian: ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-800-627-1188 (TTY: 711).

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-627-1188 (телетайп: 711).

Serbo-Croatian: OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-800-627-1188 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 711).

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-627-1188 (TTY: 711).

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-627-1188 (TTY: 711.

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-627-1188 (TTY: 711).

Ready to enroll?

When you've found your perfect plan, or want more information, go to ***BCIdaho.com/ACA*** or call us at **888-GO-CROSS (888-462-7677, TTY: 711)**.

Check to see if you are eligible for a subsidy or if you would like to purchase a Blue Cross of Idaho plan by visiting ***yourhealthidaho.org***.

This information is not a complete description of benefits. All descriptions of coverage are subject to the provisions of the corresponding policy, which contains all the terms and conditions of coverage. Certain services not specifically noted may be excluded. Please refer to the policy issued for a complete description of benefits, exclusions, limitations and conditions of coverage. If there is a difference between this comparison and its corresponding policy, the policy will control. This comparison is subject to annual update and may not reflect the information contained in the corresponding policy.

Blue Cross and Blue Shield Association is an independent company that contracts with Blue Cross of Idaho to offer services that connect qualified members to the Blue365 program. This is not a Blue Cross of Idaho product. Blue Cross and Blue Shield Association is solely responsible for its products and services. Blue Cross of Idaho is not responsible for the provision of, or failure to provide, any products and services offered by Blue Cross and Blue Shield Association.

In the Health Insurance Marketplace, you can see if you are eligible for a tax credit that lowers your monthly premiums and cost-sharing reductions (amounts that lower your out-of-pocket costs for deductibles, coinsurance, and copayments) and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. You can also learn if you qualify for free or low-cost coverage from Medicaid or the Children's Health Insurance Program (CHIP). Visit ***yourhealthidaho.org*** to learn more.

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