IMPORTANT:

This is a short-term, limited-duration policy, NOT comprehensive health coverage.

This is a temporary, limited policy that has fewer benefits and federal protections than other types of health insurance options, like those on HealthCare.gov.

THIS POLICY	INSURANCE ON HEALTHCARE.GOV
Might not cover you due to preexisting health conditions like diabetes, cancer, stroke, arthritis, heart disease, mental health & substance use disorders	Can't deny you coverage due to preexisting health conditions
Might not cover things like prescription drugs, preventive screenings, maternity care, emergency services, hospitalization, pediatric care, physical therapy & more	Covers all essential health benefits
Might have no limit on what you pay out-of-pocket for care	Protects you with limits on what you pay each year out-of-pocket for essential health benefits
You won't qualify for federal financial help to pay premiums & out-of-pocket costs	Many people qualify for federal financial help
Doesn't have to meet federal standards for comprehensive health coverage	All plans must meet federal standards

This coverage is not required to comply with certain federal market requirements for health insurance, principally those contained in the Affordable Care Act. Be sure to check your policy carefully to make sure you are aware of any exclusions or limitations regarding coverage of preexisting conditions or health benefits (such as hospitalization, emergency services, maternity care, preventive care, prescription drugs, and mental health and substance use disorder services). Your policy might also have lifetime and/or annual dollar limits on health benefits. If this coverage expires or you lose eligibility for this coverage, you might have to wait until an open enrollment period to get other health insurance coverage.

LOOKING FOR COMPREHENSIVE HEALTH INSURANCE?

- Visit HealthCare.gov or call 1-800-318-2596 (TTY: 1-855-889-4325) to find health coverage options.
- To find out if you can get health insurance through your job, or a family member's job, contact the employer.

QUESTIONS ABOUT THIS POLICY?

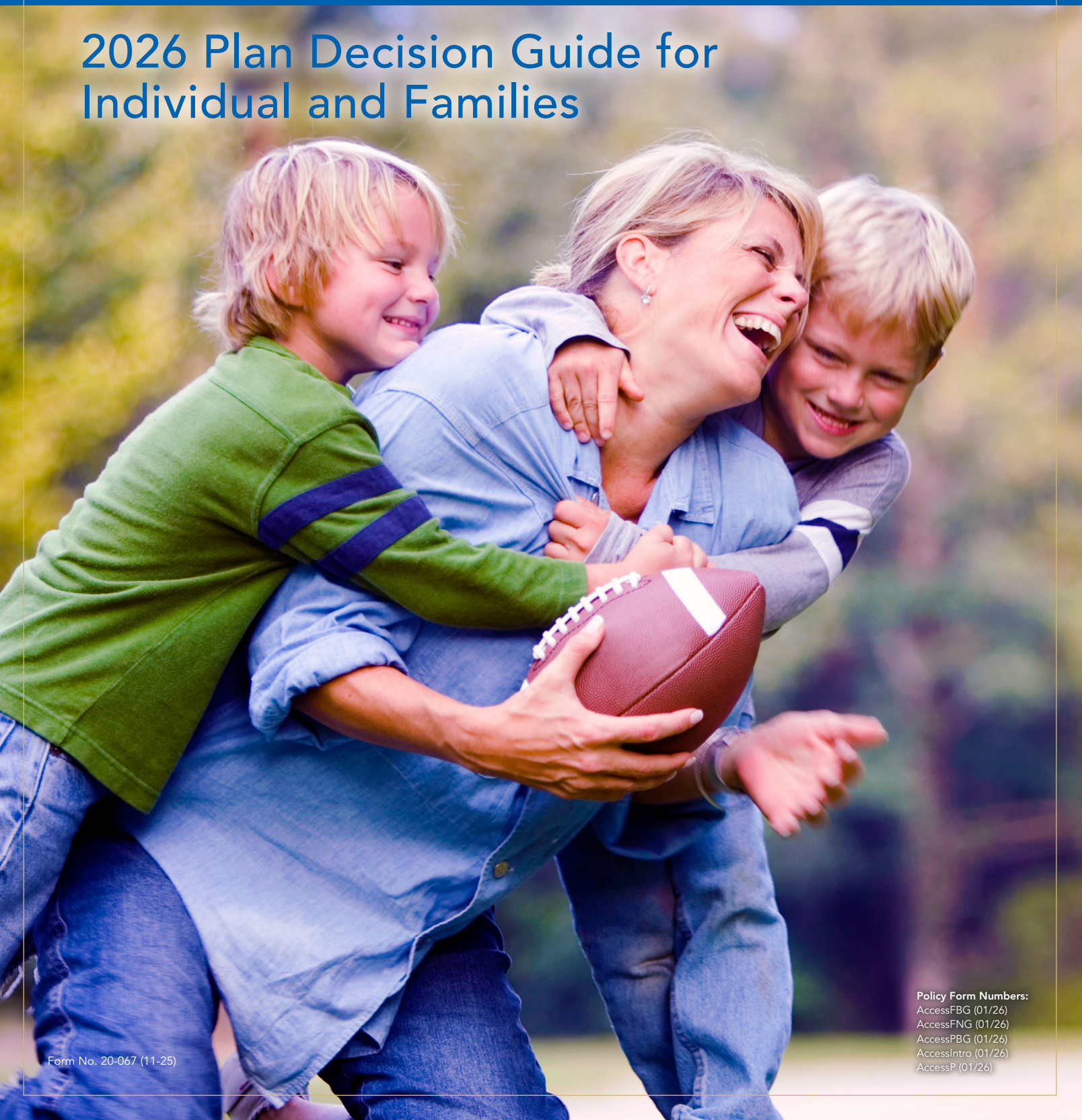
For questions or complaints about this policy, contact your State Department of Insurance. Find their number on the National Association of Insurance Commissioners' website (naic.org) under "Insurance Departments."

Form No. 20-3840 (11-25)

Blue Cross of Idaho

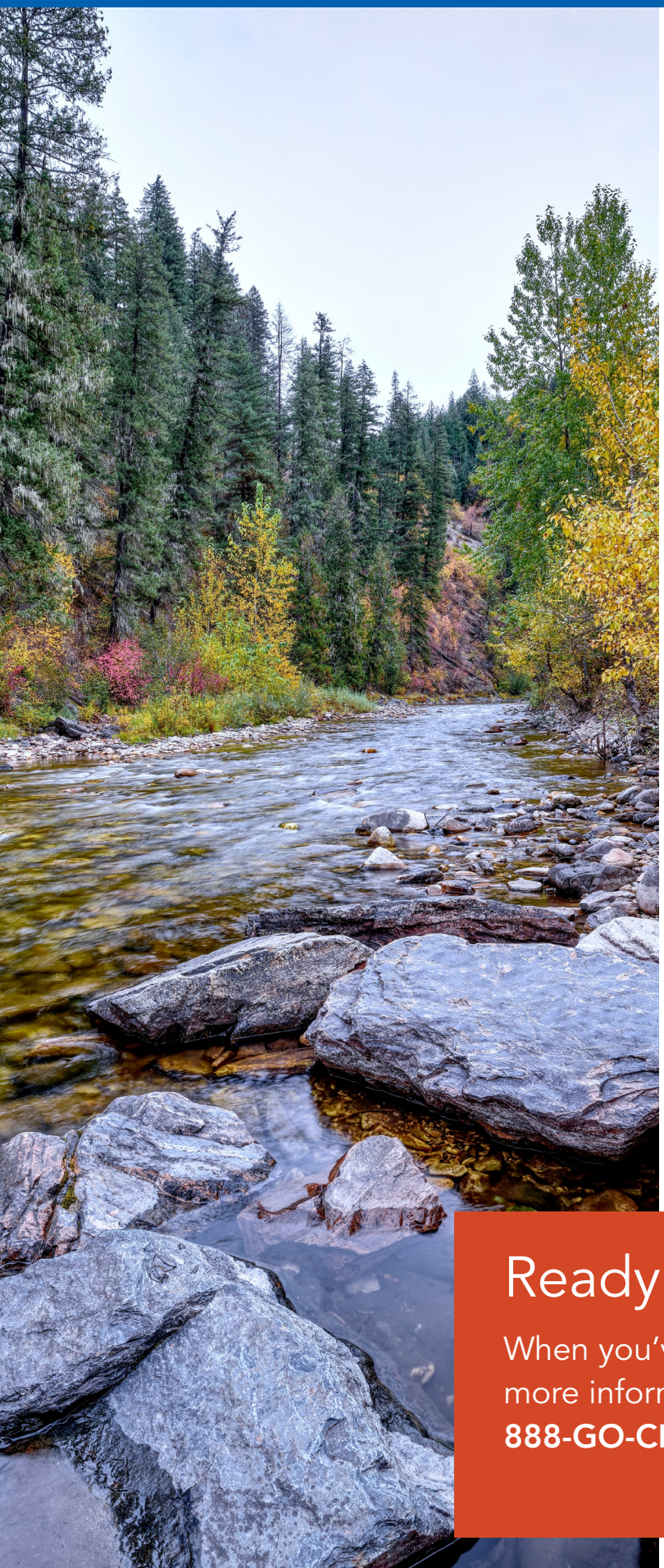
Access Plans

2026 Plan Decision Guide for Individual and Families



Policy Form Numbers:
AccessFBG (01/26)
AccessFNG (01/26)
AccessPBG (01/26)
AccessIntro (01/26)
AccessP (01/26)

Form No. 20-067 (11-25)



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Ready to enroll?

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

Access Health Insurance Plans

MORE AFFORDABLE HEALTH INSURANCE OPTIONS

At Blue Cross of Idaho, we understand Idahoans must have options for affordable healthcare coverage, with the financial peace of mind they deserve.

Our mission, for more than 80 years, has been to advocate for the health of all Idahoans, including you. It's critical to have the right health coverage that meets your needs and budget. Blue Cross of Idaho has been there with affordable individual and family health insurance plans for more than 40 years.

The Access plans by Blue Cross of Idaho are renewable for up to 36 months, and they can be a good option for those who are uninsured or looking for an affordable plan.

Access plans are underwritten based on current health information (see page 11) provided on the plan application. Each family member listed on the plan will be assigned their own rate. Additionally, there is a 12-month waiting period for preexisting conditions, although that period can be greatly reduced or even eliminated if the applicant has prior creditable health coverage before purchasing an Access plan.

Access at a Glance

PLAN OPTIONS

Access plans are designed for those who want a more affordable health insurance plan that offers access to our statewide provider network.

These plans are each underwritten (see page 11), with a rate assigned to each person on the plan. The Blue Cross of Idaho Underwriting Department assigns rates based on:

- Height and weight
- Tobacco use
- Health history listed on the application
- Blue Cross of Idaho claims history, if applicable
- Prescription history – Prescription drug history may be accessed from a national database

Missing information on the application could impact the rates.

WHO IS ELIGIBLE?

Access plans are available to any Idaho resident or dependent of an Idaho resident who:

- Is younger than 65, is not eligible for coverage under a group health plan, is not eligible for Part A or Part B of Medicare or for Medicaid and who does not have other health insurance coverage, or
- Is a federally eligible individual under the federal law known as HIPAA (see 42 United States Code § 300gg-41(b))

ACCESS PLANS ARE AVAILABLE IN THREE OPTIONS:

ACCESS FIT	This plan offers a higher deductible, lower premiums and more coinsurance costs.
ACCESS NURTURE	This plan has a mid-level deductible and premium. There are more copays than coinsurance levels, so you can have a clearer understanding of healthcare costs.
ACCESS PATHWAY	This option has the highest premiums but offers the best coverage levels and lowest deductible for those who want a little more protection.

A valid state of Idaho ID or proof of change of address is acceptable proof of residency. If you have questions about what is accepted as proof of residency, email us at ***iss@bcidaho.com***.

Health and Wellness Programs

CARE MANAGEMENT

Helps you and your covered dependents who may be facing a complex health condition. Care managers can help guide you through the maze of complex decision-making that may come with a serious health situation.

CONDITION SUPPORT

Condition support care managers offer personal health support to you for conditions like asthma, diabetes, chronic obstructive pulmonary disease (COPD), coronary artery disease and congestive heart failure.

MOBILE APP

Our Mobile app helps you take your healthcare into your own hands with the convenient member app. Use it to find in-network care, choose hospitals or doctors, manage your claims or find out what you might owe at your next doctor's visit.

BEHAVIORAL HEALTH MANAGEMENT

You can get support from a care manager who will make sure you get the highest quality and right site of care.

DIABETES PREVENTION PROGRAM

Each personalized program teaches you to make lasting lifestyle changes by eating healthier, getting more physical activity and managing challenges that come up along the way.

BLUE365 SAVINGS

As a member of Blue Cross of Idaho, you will have access to savings on health and wellness products and services to help you achieve the healthy lifestyle you desire.

Coverage Highlights

UNDERSTANDING NETWORKS

Access plans include our statewide network. This is our largest network, and includes 96% of healthcare providers and 100% of acute hospitals in the state.

It also gives you access to provider discounts across the country who are in the networks of other Blue Cross and Blue Shield (BCBS) plans as part of the BlueCard® Program. BlueCard is a national program that enables members traveling away from home or living in another BCBS plan area to receive healthcare services through a single, electronic claim processing reimbursement network. This means you can get access to quality care no matter where you are.

REFERRALS REQUIRED

Primary care providers (PCPs) will refer you for care they cannot provide, such as care not available in your area, care you'll need while away from home or from a provider who does not have a direct contract with Blue Cross of Idaho (called a noncontracting provider). It is important to call Blue Cross of Idaho to register a PCP for each family member that is enrolled on a new plan. Your PCP can help save you time and money by sending you to the right place to see the right person the first time.

When do you need a referral?

Blue Cross of Idaho In-Network Providers	NO
Noncontracting Providers	YES

IN AN EMERGENCY, YOU'RE COVERED

Your plan treats medical emergencies at all hospitals as if they were in your network. For care that is urgent, but not an emergency, you can take your pick from our large selection of in-network urgent care clinics.

ALL ACCESS PLANS INCLUDE:

- Urgent care visits
- Mental health and substance abuse visits
- Dependent coverage up to the age of 26
- Option to renew, for up to 36 months of coverage

PHARMACY BENEFITS

- Covers generic prescription drugs with a copay
- Brand-name and specialty prescription drugs are subject to exclusions and additional cost sharing
- Access Pathway offers a separate pharmacy deductible

Preexisting Conditions

PREEXISTING CONDITIONS

All Access plans include a 12-month waiting period for the treatment of preexisting conditions that have occurred or been treated within six months of the start date of the plan. But if you have had other creditable health insurance coverage in the last year, you may use that to shorten or even eliminate the waiting period.

Example

1. Someone who had coverage for the past seven months can use that coverage to shorten the preexisting condition waiting period from 12 months to five months.
2. Someone who has had continuous health insurance coverage for the past 12 months would have no waiting period.

PREEXISTING CONDITIONS MAY AFFECT THE FINAL PREMIUM RATE IN YOUR QUOTE

A preexisting condition may affect your premium rate because rates are determined by an individual's health status. The list provided is not a complete list of possible preexisting conditions. If you have questions about a specific condition or would like more information about preexisting conditions, please call Blue Cross of Idaho at **855-230-6862**. You can also email ***iss@bcidaho.com*** with questions.

PREEXISTING CONDITIONS MAY INCLUDE

- AIDS/HIV
- Asthma
- Cancers
- Certain behavioral health diagnoses
- Certain spinal conditions
- Chronic kidney disease
- Dementia/Alzheimer's
- Diabetes
- Drug dependence/abuse
- Epilepsy
- Heart disease/failure
- Hepatitis C
- Hypertension
- Opioid dependence/abuse
- Osteoarthritis
- Pregnancy
- Rheumatoid arthritis
- Severe obesity
- Sleep apnea
- Thyroid disease

Access Fit

This plan is ideal for anyone who wants to save on their monthly expenses but still have access to standard healthcare services. Its benefits include coverage for provider visits and generic prescriptions, as well as $0 preventive care and $0 child primary care, but exclude allergy services, sleep studies, and chiropractic care.

Access Fit helps you save on monthly premiums, but you pay more when you use services compared to the other Access plans. Choose this plan if you are generally healthy and want affordable coverage that fits your lifestyle, while keeping you protected from the unexpected.

2026 Plan Options: Access Fit

In-Network

HOW MUCH YOU'LL PAY EACH YEAR FOR CARE YOU RECEIVE	
Medical Deductible - Individual	$8,000
Medical Out-of-Pocket Maximum - Individual	$10,600
Rx Deductible	Intgegrated Medical & Rx Deductible
Medical Coinsurance	50%
Plan Year Limit	$1,000,000
BENEFITS YOU ARE MOST LIKELY TO NEED	
Child Primary Care / Telehealth	$0
Primary Care / Telehealth	$40 up to 3 visits then 50% after deductible
Urgent Care / Telehealth	$40 up to 3 visits then 50% after deductible
Mental Health & Substance Abuse / Telehealth	50% after deductible
Specialist / Telehealth	
Outpatient Rehabilitation / Habilitation - 25 visit limit	50% after deductible
Immunizations	$0
Preventive Care / Telehealth	$0
Lab Work, X-rays, & Diagnostic Imaging	50% after deductible
Preventive Dental Care (Adult & Child)	$20
Vision	$100 allowance
BENEFITS FOR THE UNEXPECTED	
Emergency Room	50% after deductible
Imaging (MRIs, MRAs, & CT Scans)	
Surgery (Doctors Charges, Anesthesia, & Other Covered Charges)	
Maternity Care (Pre/Postnatal Care & Delivery)	
IN CASE YOU NEED PRESCRIPTIONS	
Prescription Deductible	Integrated Medical & Rx Deductibles
Preferred Generic Rx	$20
Non-Preferred Generic Rx	$30
Preferred Brand Name Rx	In-Network Pharmacy Discount Only
Non-Preferred Brand Name Rx	
Preferred Specialty Rx	
Non-Preferred Specialty Rx	

Access Nurture

The Access Nurture plan is a good choice for families. Access Nurture includes $0 preventive care and $0 child primary care, broader prescription coverage and allergy services.

Choose this plan if you prefer a mid-level monthly premium, and predictable costs with set copays for many services – so you can focus on your family, not surprise costs.

2026 Plan Options: Access Nurture

In-Network

HOW MUCH YOU'LL PAY EACH YEAR FOR CARE YOU RECEIVE	
Medical Deductible - Individual	$6,000
Medical Out-of-Pocket Maximum - Individual	$10,600
Rx Deductible	Intgegrated Medical & Rx Deductible
Medical Coinsurance	35%
Plan Year Limit	$1,000,000
BENEFITS YOU ARE MOST LIKELY TO NEED	
Child Primary Care / Telehealth	$0
Primary Care / Telehealth	$40
Urgent Care / Telehealth	$50
Mental Health & Substance Abuse / Telehealth	$40
Specialist / Telehealth	$100
Outpatient Rehabilitation / Habilitation - 25 visit limit	$40
Immunizations	$0
Preventive Care / Telehealth	$0
Lab Work, X-rays, & Diagnostic Imaging	35% after deductible
Preventive Dental Care (Adult & Child)	$20
Vision	$100 allowance
Allergy	35% after deductible
BENEFITS FOR THE UNEXPECTED	
Emergency Room	35% after deductible
Imaging (MRIs, MRAs, & CT Scans)	
Surgery (Doctors Charges, Anesthesia, & Other Covered Charges)	
Maternity Care (Pre/Postnatal Care & Delivery)	
IN CASE YOU NEED PRESCRIPTIONS	
Prescription Deductible	Integrated Medical & Rx Deductibles
Preferred Generic Rx	$10
Non-Preferred Generic Rx	$25
Preferred Brand Name Rx	30% after deductible
Non-Preferred Brand Name Rx	50% after deductible
Preferred Specialty Rx	40% after deductible
Non-Preferred Specialty Rx	In-Network Pharmacy Discount Only

Access Pathway

Feel confident knowing you are protected. This plan offers lower cost copays and the lowest deductibles. Access Pathway covers all the services as the other plans do, but offers additional coverage for sleep studies and chiropractic care.

If you are a pre-retiree, Access Pathway is a good option since it provides less out-of-pocket costs for services. This is a good choice for those who are not eligible for Medicare yet but still want reliable health coverage.

2026 Plan Options: Access Pathway

In-Network

HOW MUCH YOU'LL PAY EACH YEAR FOR CARE YOU RECEIVE	
Medical Deductible - Individual	$4,000
Medical Out-of-Pocket Maximum - Individual	$10,600
Rx Deductible	$1,000
Medical Coinsurance	50%
Plan Year Limit	$1,000,000
BENEFITS YOU ARE MOST LIKELY TO NEED	
Child Primary Care / Telehealth	$0
Primary Care / Telehealth	$10
Urgent Care / Telehealth	$50
Mental Health & Substance Abuse / Telehealth	$10
Specialist / Telehealth	$75
Outpatient Rehabilitation / Habilitation - 25 visit limit	$10
Immunizations	$0
Preventive Care / Telehealth	$0
Lab Work, X-rays, & Diagnostic Imaging	$20
Preventive Dental Care (Adult & Child)	$20
Vision	$100 allowance
Allergy	50% after deductible
Sleep Study Services	$250 Copay then 50% after deductible
BENEFITS FOR THE UNEXPECTED	
Emergency Room	$500 Copay after deductible
Imaging (MRIs, MRAs, & CT Scans)	$500
Surgery (Doctors Charges, Anesthesia, & Other Covered Charges)	50% after deductible
Maternity Care (Pre/Postnatal Care & Delivery)	50% after deductible
Chiropractice Care	$50 18 visit maximum
IN CASE YOU NEED PRESCRIPTIONS	
Prescription Deductible	$1,000
Preferred Generic Rx	$10
Non-Preferred Generic Rx	$25
Preferred Brand Name Rx	30% after deductible
Non-Preferred Brand Name Rx	50% after deductible
Preferred Specialty Rx	40% after deductible
Non-Preferred Specialty Rx	In-Network Pharmacy Discount Only

Underwriting

UNDERWRITING TIPS

Below is a list of commonly missed items that will speed up the application and underwriting process.

Be prepared to provide the following information for each person applying for coverage.

DEMOGRAPHICS

- Name
- Relationship to applicant
- Date of birth
- Height/weight
- Residency verification
- County and ZIP code

CURRENT/PRIOR COVERAGE

Include details about your current/prior coverage. This information is used to evaluate preexisting condition waiting periods.

HEALTH QUESTIONS

- Make sure details are provided for questions answered "yes"
- Include information about the condition and the medication (if applicable)
- Include onset/last-treated dates if recovery is complete

MEDICATIONS

- Medication name
- Name of the condition for which the medication is prescribed
- Whether the medication is still being taken

Note: Every medication must include a condition and detailed information about the prescription.

ALL ACCESS PLANS

- Access plans are guaranteed to be issued, so all applicants will be offered coverage
- Rates are gender-neutral
- Applicant and all dependents will be underwritten and assigned a rate based on health status, meaning certain health conditions like high cholesterol, obesity, acid reflux and others may affect your assigned premium rate
- Tobacco users are assigned higher premium rates than non-tobacco users
  - » E-cigarettes and vaping products are considered tobacco use

RATES AND RENEWALS

- Only pay premiums for the oldest three dependent children younger than 21 years of age
- Renewals:
  - » Plans renew every 12 months based on your enrollment date
  - » Plans can be renewed twice, for up to 36 months total
  - » Coverage can be reissued after 36 months
  - » Rates renew in January regardless of enrollment date.

Complete Health History

A detailed explanation of a medical condition will help us process your application faster.

EXCLUSIONS AND LIMITATIONS SECTION

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

I. PREEXISTING CONDITION WAITING PERIODS

There are no benefits available under this Contract for services, supplies, drugs or other charges that are provided within twelve (12) months after a Member's Effective Date for any Preexisting Condition.

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. 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.

AAP. For Chiropractic Care Services, except as specified as a Covered Service in the Contract.

AAQ. For Home Health Skilled Nursing Care Services, except as specified as a Covered Service in the Contract.

AAR. For Skilled Nursing Facility Services, except as specified as a Covered Service in the Contract.

AAS. For Sleep Study Services, except as specified as a Covered Service in the Contract.

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. DENTAL EXCLUSIONS AND LIMITATIONS

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

B. Charges incurred for services that were started prior to the Member's Effective Date. The following guidelines will be used to determine the date on which a service shall be 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
3. For root canal therapy: on the later of the date the pulp chamber is opened or the date 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

C. A service furnished to a Member for cosmetic purposes;

D. In excess of the Maximum Allowance;

E. 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;

F. 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;

G. Any service, procedure or supply for which the prognosis for success is not favorable for at least three (3) years from the date of service, as determined by BCI;

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

I. Not prescribed by or upon the direction of a Provider;

J. Investigational in nature;

K. 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 an 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;

L. 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 therefor 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 Part B;

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

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

O. 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;

P. 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;

Q. 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;

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

S. 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;

T. For which a Member would have no legal obligation to pay in the absence of coverage under this 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;

U. 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 Contract term;

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

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

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

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

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).

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 1188-627-800-1 (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 1188-627-800-1 (711:TTY).

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 (टटिविइ: 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 ***shoppers.BCIdaho.com*** or call us at **888-GO-CROSS (888-462-7677, TTY: 711)**.

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 of Idaho

3000 East Pine Avenue
Meridian, Idaho 83642-5995

P.O. Box 7408
Boise, Idaho 83707-1408

Customer Service: **855-230-6862**

Visit ***bcidaho.com***