Bannock County – Summary of Benefits

Benefit Period: January 1 through December 31

GemPlan General Manager

1575 Baldy Ave.
Pocatello, ID 83201
(208) 237-9696 or (800) 632-0905

Blue Cross of Idaho
An Independent Licensee of the Blue Cross and Blue Shield Association

Preferred Blue® PPO

Summary of Benefits – Bannock County Effective Date: October 1, 2021		Preferred Blue® Large Group	
		In-Network	**Out-of-Network**
Benefit Period* Deductible (Individual/Family)		$500/$1,000	
Coinsurance		You pay 20% of the allowed amount for covered services	You pay 40% of the allowed amount for covered services
Individual Out-of-Pocket Limit (Does not include: deductible, drugs, Temporomandibular Joint (TMJ) Services, dental and vision, non-covered services and charges over the allowed amount)		$1,500	$3,000
Family Out-of-Pocket Limit (Does not include deductible, drugs, Temporomandibular Joint (TMJ) Services, dental and vision, non-covered services and charges over the allowed amount.) *(No Participant may contribute more than the Individual Out-of-Pocket amount toward the Family Out-of-Pocket amount)*		$3,000	$6,000
COVERED SERVICES *By choosing a non-contracting provider you may be responsible for the difference between what Blue Cross allows and what the non-contracting provider charges. Some services may require prior authorization.*	**In-Network deductible and/or coinsurance payment required before insurance pays?**	**In-Network** **The amount you pay**	**Out-of-Network**
Ambulance Transportation Services	Yes	You pay 20% of the allowed amount	You pay 40% of the allowed amount
Chiropractic Care (Limited to 18 visits combined per participant, per benefit period.)	No	You pay a $20 copayment per visit	You pay 50% of the allowed amount
Colonoscopy/Sigmoidoscopy Services: • ***Preventive – Members over 50*** (*Limited to 1 Preventive Colonoscopy/Sigmoidoscopy per participant, per benefit period.)*	No	You pay nothing of the allowed amount	Not covered, you pay 100% of the allowed amount
• ***Preventive – Members under 50*** (*Limited to 1 Preventive Colonoscopy/Sigmoidoscopy per participant, per benefit period.)*	Yes	You pay 20% of the allowed amount	Not covered, you pay 100% of the allowed amount
• ***Diagnostic***	Yes	You pay 20% of the allowed amount	You pay 40% of the allowed amount
Contraceptive Services: • **Diaphragms and Intrauterine Devices**	No	You pay a $25 copayment per device	You pay 40% of the allowed amount
• **Depo-Provera Injections**	No	You pay a $20 copayment per injection	
• **Implantables**	No	You pay a $100 copayment per implant	
Dental Services Related to Injury (Covered only for the 12-month period immediately following the date of injury, providing your group's contract remains in effect during that 12-month period.)	Yes	You pay 20% of the allowed amount	You pay 40% of the allowed amount
Diabetes Self-Management Education Services (Only for accredited providers approved by BCI.)			
Diagnostic Services (Including diagnostic mammogram.)	Yes	You pay 20% of the allowed amount	
Durable Medical Equipment			

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COVERED SERVICES *By choosing a non-contracting provider you may be responsible for the difference between what Blue Cross allows and what the non-contracting provider charges. Some services may require prior authorization.*		**In-Network deductible and/or coinsurance payment required before insurance pays?**	**In-Network**	**Out-of-Network**
			The amount you pay	
Emergency Services – Facility and Professional Services**		Yes	You pay 20% of the allowed amount	You pay 40% of the allowed amount
Home Health Skilled Nursing		Yes	You pay 20% of the allowed amount	You pay 40% of the allowed amount
Home Intravenous Therapy		Yes		
Hospice Services		No	You pay nothing of the allowed amount	You pay 40% of the allowed amount
Hospital Services (Inpatient and outpatient services at a licensed general hospital or ambulatory surgical facility.)		Yes	You pay 20% of the allowed amount	
Inpatient Physical Rehabilitation		Yes	You pay 20% of the allowed amount	You pay 40% of the allowed amount
Mammogram Preventive Screening Services		No	You pay nothing of the allowed amount	
Maternity Services and/or Involuntary Complications of Pregnancy		Yes	You pay 20% of the allowed amount	
Mental Health– Inpatient (Facility and Professional Services)				
Mental Health– Outpatient	**Psychotherapy Services**	No	You pay a $20 copayment per visit	
	Facility and other Professional Services	Yes	You pay 20% of the allowed amount	
Morbid Obesity ($25,000 combined lifetime benefit limit per participant.)				
Orthotic Devices				
Outpatient Rehabilitation and Habilitation Therapy Services (Includes physical, speech and occupational therapies. Limited to 20 visits combined per participant, per benefit period.)		Yes	You pay 50% of the allowed amount	Not covered, you pay 100% of the allowed amount
Physician Office Visit (Other services rendered during a physician office visit will be subject to deductible and coinsurance.)		No	You pay a $20 copayment per visit	You pay 40% of the allowed amount
Post Mastectomy Reconstructive Surgery		Yes	You pay 20% of the allowed amount	
Prosthetic Appliances				
Skilled Nursing Facility (Limited to 30 days combined per participant, per benefit period)				
Selected Therapy Services (Including chemotherapy, enterostomal therapy, growth hormone therapy, radiation, renal dialysis, respiratory therapy, and inpatient occupational therapy.)				
Surgical/Medical (Professional Services)				
Temporomandibular Joint (TMJ) Services ($2,000 combined lifetime benefit limit per participant.)			You pay 50% of the allowed amount	You pay 50% of the allowed amount

Transplant Services	Yes	You pay 20% of the allowed amount	You pay 40% of the allowed amount
Preventive Care Benefits (See plan for specifically listed preventive care services)	Yes/No	You pay nothing for services specifically listed up to $500 per participant, per benefit period. For services in excess of $500 you pay deductible and coinsurance	You pay 40% of the allowed amount
Immunizations (See plan for specifically listed immunizations)	No	You pay nothing for listed immunizations	

*The specified period of time during which charges for covered services must be incurred in order to accumulate toward annual benefit limits, deductible amounts and out-of-pocket limits.

****Emergency Services**

For the treatment of Emergency Medical Conditions or Accidental Injuries of sufficient severity to necessitate immediate medical care by, or that require Ambulance Transportation Service to, the nearest appropriate Facility Provider, BCI will provide In-Network benefits for Covered Services provided by either a Contracting or Noncontracting Facility Provider and facility-based Professional Providers only. If the nearest Facility Provider is Noncontracting, once the Participant is stabilized and is no longer receiving emergency care the Participant (at BCI's option) may transfer to the nearest appropriate Contracting Facility Provider for further care in order to continue to receive In-Network benefits for Covered Services. If the Participant is required to transfer, transportation to the Contracting Facility Provider will be a Covered Service under the Ambulance Transportation Service provision of this Plan.

Supplemental Accident Benefits	
For Covered Providers and Services	Plan pays up to $300 combined per participant, per Benefit Period (after which Deductibles and Coinsurance apply)

Prescription Drug Benefits		
Retail **(34 day supply or 100 units, whichever is greater with one copayment)**	**Generic**	You pay $5 plus 1% copayment
	Brand Name	You pay $20 plus 1% copayment
Mail Order **(90 day supply with one copayment)**	**Generic**	You pay $5 plus 1% copayment
	Brand Name	You pay $20 plus 1% copayment
Diabetic Supplies • *Insulin Syringes* • *Needles/Pen Needles* • *Lancets* • *Test Strips* • *Insulin Pump Supplies*	You pay a $10 copayment per item. Insulin syringes/needles have no Copayment if purchased within ninety (90) days of insulin purchase.	

*For brand name drugs that have a corresponding generic substitute your pharmacist should fill your prescription with the generic (unless indicated otherwise by your physician) and you will pay the lowest copayment. If you purchase the brand name drug and it has a corresponding generic equivalent, you will be responsible for the difference in cost between the generic and brand name drug plus the applicable brand name copayment.

This summary describes the general features of this program; it is not a contract.
All provisions of the Group Master Plan apply to this program
Noncontracting providers may bill you for amounts over the maximum allowance.

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Preferred Blue® Dental PPO

Summary of Benefits – Bannock County Effective Date: October 1, 2021	Preferred Blue® Dental PPO	
Individual/Family Deductible (Deductible applies to In-Network basic, major services, and all Orthodontia and Out-of-network services. The Family Deductible is satisfied after three (3) Participants of the same family have met their Individual Deductible.)	$50 / 3 Family Maximum	
Individual Benefit Period Maximum	$1,000	
Waiting Period	Twenty-four (24) month waiting period for Late Enrollees for Major Dental Services.	
Orthodontia Lifetime Maximum for Eligible Dependent Children up to age 19	$1,000	
Orthodontia Waiting Period	Twenty-four (24) month waiting period for Late Enrollees for Orthodontia Services	
	In-Network	**Out-of-Network**
In/Out-of-Network	By choosing an in-network provider you pay only coinsurance amounts for allowed charges.	By choosing an Out-of-Network provider you pay your deductible, coinsurance, and are responsible for the difference between what Blue Cross allows and what the Out-of-Network provider charges.**
Preventive Services		
Oral Examinations One examination every six months.	You pay nothing	By choosing an Out-of-Network provider you pay 20% of the allowed amount**
Fluoride Limited to one (1) application per benefit period and limited to Participant's who are under age twenty (20).		
Sealants: Limited to permanent posterior unrestored dentition of Participants under age sixteen (16). Also limited to one (1) time per tooth in any three (3) consecutive Benefit Periods.		
X-rays, Bitewings Once per benefit period.		
X-rays, Complete Mouth Series or Panoramic x-ray One time in any five consecutive benefit periods.		
Prophylaxis (Cleaning) Once every six months. (Regardless of type)		
Basic Services		
Fillings Restorations involving multiple surfaces will be combined and paid according to the number of surfaces treated; same tooth surface restoration is covered once in a two year period.	You pay 20% of the allowed amount	By choosing an Out-of-Network provider you pay 30% of the allowed amount**
Extractions		
Root Canal Therapy		
Periodontal Maintenance Once every six months. (Regardless of type)		
Scaling and Root planing Once per quadrant of the mouth every three benefit periods.		
Occlusal Guard One appliance every two benefit periods.		
Osseous Surgery Once per quadrant of the mouth every three years.		
Space Maintainers Limited to Participant's who are under age sixteen (16). Benefits limited to deciduous teeth. Includes all adjustments made within six (6) months of installation.		
Major Services Predetermination required on all major services		
Bridges, Inlays, Onlays, Crowns, Veneers, and Full or Partial Dentures Five year replacement.	You pay 50% of the allowed amount	By choosing an Out-of-Network provider you pay 60% of the allowed amount**
Dental Implants Including the implant body, implant abutment and implant crown – benefits may be available up to the Maximum Allowance of a standard complete or partial denture, or bridge. Implant body and abutment-limited to once per tooth per lifetime. Implant crown –five year replacement.		
Orthodontia		
Orthodontia For enrolled eligible dependent children up to age 19.	You pay 50% of the allowed amount**	

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Preferred Blue® Dental PPO

The Preferred Provider Organization (PPO) dental program offers access to a large network of dental providers who have agreed to offer covered services at or below established maximum allowances, and, by choosing an in-network PPO provider, you maximize your dental benefit dollars.

***See Group Master Plan for requirements of the Dental Maximum Carryover, if this is a selected benefit.**

****By choosing an Out-of-Network provider you pay your coinsurance, deductible, and any difference between what Blue Cross of Idaho allows and what the Out-of-Network provider charges.**

This summary describes the general features of this program; it is not a contract. All provisions of the Group Master Plan apply to this program.

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Bannock County Effective Date: October 1, 2021	VISION CARE BENEFITS (VSP)
For Covered Providers and Services	
Copayment	You pay $0 per eye exam and/or $25 per Frame and Lenses or Medically Necessary Contact Lenses.
Service Frequency Limitations	
Prescription Glasses—Basic Lenses and Medically Necessary Contact Lenses are covered in full. Frame allowance of $105, and 20% off any out-of-pocket expenses. **Elective Contacts**—includes an allowance of $120 for contact lens exam and materials in place of benefits for Prescribed Lenses and Frames.	You may receive one (1) eye exam and/or one (1) pair of Lenses and/or one (1) Frame or one (1) pair of Medically Necessary Contact Lenses (in lieu of eyeglasses) every twelve (12) months.
Payment for Services Rendered	
Participating VSP Doctor	You pay nothing of Maximum Allowance after Copayment
Nonparticipating VSP Doctor **Professional Fees** Eye Exam **Materials—lenses per pair** Single Vision Bifocals, up to Trifocals, up to Frame, up to **Contact Lenses— per pair** **Medically Necessary, up to** **Elective**—includes basic eye exam & an allowance in place of benefits for Prescribed Lenses and Frames	 $45 $48 $65 $90 $45 $250 $120

This summary describes the general features of this program; it is not a contract. All provisions of the Group Master Plan apply to this program.

ASC PPO - Bannock

Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services

Coverage Period: 01/01/2021 - 12/31/2021

Coverage for: Enrollee + Eligible Dependents | **Plan Type: PPO**

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. Note: Information about the cost of the plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit https://members.bcidaho.com/my-account/my-account-my-contract.page. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary or call 1-800-627-1188 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall Deductible?	**$500** person/**$1,000** family	Generally, you must pay all of the costs from Providers up to the Deductible amount before this Plan begins to pay. If you have other family members on the Plan, each family member must meet their own individual Deductible until the total amount of Deductible expenses paid by all family members meets the overall family Deductible.
Are there services covered before you meet your Deductible?	Yes. Pharmacy, services that require Copays, listed immunizations or In-Network hospice care and preventive mammograms are covered before you meet your Deductible.	This Plan covers some items and services even if you haven't yet met the Deductible amount. But a Copayment or Coinsurance may apply.
Are there other Deductibles for specific services ?	No. There are no other specific Deductibles.	You don't have to meet Deductibles for specific services.
What is the Out-of-pocket Limit for this Plan?	For In-Network Provider **$1,500** person/**$3,000** family For Out-of-Network Provider **$3,000** person/**$6,000** family	The Out-of-pocket Limit is the most you could pay in a year for covered services. If you have other family members in this Plan, they have to meet their own Out-of-pocket Limits until the overall family Out-of-pocket Limit has been met.
What is not included in the Out-of-pocket Limit ?	Premiums, Balance-Billing charges, Deductibles, Copays, pharmacy and health care this Plan doesn't cover.	Even though you pay these expenses, they don't count toward the Out-of-pocket Limit.
Will you pay less if you use a Network Provider?	Yes. See **www.bcidaho.com or call 1-800-627-1188** for a list of Network Providers.	This Plan uses a Provider Network. You will pay less if you use a Provider in the Plan's Network. You will pay the most if you use an Out-of-Network Provider, and you might receive a bill from a Provider for the difference between the Provider's charge and what your Plan pays (Balance Billing). Be aware your Network Provider might use an Out-of-Network Provider for some services (such as lab work). Check with your Provider before you get services.
Do you need a Referral to see a Specialist?	No.	You can see the Specialist you choose without a Referral.

All copayments and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 Copay/visit	40% Coinsurance	Does not apply to additional services.
	Specialist visit	$20 Copay/visit	40% Coinsurance	Does not apply to additional services.
	Preventive Care/Screening/immunization	No charge for listed immunizations or preventive Screening mammograms. No charge for listed Preventive Services up to $500 then 20% Coinsurance.	No charge for listed immunizations, 40% Coinsurance preventive and Screening.	You may have to pay for services that aren't preventive. Ask your Provider if the services needed are preventive. Then check what your Plan will pay for.
If you have a test	Diagnostic Test (x-ray, blood work)	20% Coinsurance	40% Coinsurance	---------- none ----------
	Imaging (CT/PET scans, MRIs)	20% Coinsurance	40% Coinsurance	---------- none ----------
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.bcidaho.com	Generic drugs	$5 Copay/prescription, 1% Coinsurance (retail and mail order)	$5 Copay/prescription, 1% Coinsurance (retail and mail order)	Covers up to a 34 day supply or 100 units, whichever is greater (retail prescription); or up to a 90 day supply (mail order prescription). Additional Out-of-Network charges may apply.
	Preferred brand drugs	$20 Copay/prescription, 1% Coinsurance (retail and mail order)	$20 Copay/prescription, 1% Coinsurance (retail and mail order)	Covers up to a 34 day supply or 100 units, whichever is greater (retail prescription); or up to a 90 day supply (mail order prescription). Additional Out-of-Network charges may apply.
	Non-preferred brand drugs	$20 Copay/prescription, 1% Coinsurance (retail and mail order)	$20 Copay/prescription, 1% Coinsurance (retail and mail order)	Covers up to a 34 day supply or 100 units, whichever is greater (retail prescription); or up to a 90 day supply (mail order prescription). Additional Out-of-Network charges may apply.
	Specialty Drugs	$20 Copay/prescription, 1% Coinsurance (retail and mail order)	$20 Copay/prescription, 1% Coinsurance (retail and mail order)	Coverage may include limitations and Preauthorization may be required.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% Coinsurance	40% Coinsurance	Preauthorization required.
	Physician/surgeon fees	20% Coinsurance	40% Coinsurance	Preauthorization required.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	Emergency Room Care	20% Coinsurance	40% Coinsurance	Out-of-Network services paid at In-Network if Emergency Medical Condition.
	Emergency Medical Transportation	20% Coinsurance	40% Coinsurance	---------- none ----------
	Urgent Care	$20 Copay/visit	40% Coinsurance	Does not apply to additional services.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% Coinsurance	40% Coinsurance	Preauthorization required.
	Physician/surgeon fee	20% Coinsurance	40% Coinsurance	Preauthorization required.
If you have mental health, behavioral health, or substance abuse services	Outpatient services	$20 Copay/visit, 20% Coinsurance for facility and other services	40% Coinsurance	---------- none ----------
	Inpatient services	20% Coinsurance	40% Coinsurance	Preauthorization required.
If you are pregnant	Office Visits	20% Coinsurance	40% Coinsurance	For pregnancy services, Cost Sharing does not apply to certain Preventive Services. Depending on the type of services, a Copay, Coinsurance or Deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	20% Coinsurance	40% Coinsurance	---------- none ----------
	Childbirth/delivery facility services	20% Coinsurance	40% Coinsurance	---------- none ----------
If you need help recovering or have other special health needs	Home Health Care	20% Coinsurance	40% Coinsurance	Preauthorization required.
	ReHabilitation Services	50% Coinsurance	Not covered	Coverage is limited to 20 visit annual max for Habiltation and ReHabilitation Services.
	Habilitation Services	50% Coinsurance	Not covered	Coverage is limited to 20 visit annual max for Habiltation and ReHabilitation Services.
	Skilled Nursing Care	20% Coinsurance	40% Coinsurance	Coverage is limited to 30 day annual max.
	Durable Medical Equipment	20% Coinsurance	40% Coinsurance	Preauthorization required.
	Hospice Services	No charge. Deductible does not apply.	40% Coinsurance	---------- none ----------

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	---------- none ----------
	Children's glasses	Not covered	Not covered	---------- none ----------
	Children's dental check-up	Not covered	Not covered	---------- none ----------

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of other excluded services.)

- Acupuncture
- Cosmetic surgery
- Dental care (Adult)
- Dental check-up (Child)
- Eye exam (Child)
- Glasses (Child)
- Hearing aids
- Infertility treatment
- Long-term care
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Bariatric surgery
- Chiropractic care
- Non-emergency care when traveling outside the U.S.

Your Rights to Continue Coverage:

**** Group health coverage -**

There are agencies that can help if you want to continue coverage after it ends. The contact information for those agencies is: Department of Labor's Employee Benefits Security Administration at 1-866-4444-EBSA(3272) or www.dol.gov/ebsa/healthreform; or the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance through Your Health Idaho. For more information about Your Health Idaho, visit www.YourHealthIdaho.org or call 1-855-944-3246.

Your Grievance and Appeals Rights:

There are agencies that can help if you have a complaint against your plan for a denial of claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact:

For any initial questions concerning a claim, or to appeal a claim or benefit decision, please contact Customer Service at 1-208-331-7347 or 1-800-627-1188, www.bcidaho.com, or at P.O. Box 7408, Boise, ID 83707.

If your plan is subject to ERISA, you may contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA or www.dol.gov/ebsa/healthreform

If your plan is fully insured or self-funded and subject to the Idaho Insurance Code, you may also receive assistance from the Idaho Department of Insurance at 1-800-721-3272 or www.DOI.Idaho.gov

Does this plan provide Minimum Essential Coverage? **Yes.**

If you don't have Minimum Essential Coverage for a month, you will have to make payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for the month.

Does this plan meet the Minimum Value Standards? **Yes.**

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

----------*To see examples of how this plan might cover costs for a sample medical situation, see the next section.*----------

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and Coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$500
Specialist copay	$20
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care*)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	**$12,731**

In this example, Peg would pay:

Cost Sharing	
Deductible	$500
Copayments	$20
Coinsurance	$1,480
What isn't Covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,060**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$500
Specialist copay	$20
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	**$7,389**

In this example, Joe would pay:

Cost Sharing	
Deductible	$500
Copayments	$1,500
Coinsurance	$0
What isn't Covered	
Limits or exclusions	$55
The total Joe would pay is	**$2,055**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$500
Specialist copay	$20
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	**$1,930**

In this example, Mia would pay:

Cost Sharing	
Deductible	$500
Copayments	$40
Coinsurance	$230
What isn't Covered	
Limits or exclusions	$0
The total Mia would pay is	**$770**

DISCRIMINATION IS AGAINST THE LAW

Blue Cross of Idaho and Blue Cross of Idaho Care Plus, Inc., (collectively referred to as Blue Cross of Idaho) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. Blue Cross of Idaho does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

Blue Cross of Idaho:

- Provides free aids and services to people with disabilities 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 services to people whose primary language is not English, such as:
  - o Qualified interpreters
  - o Information written in other languages

If you need these services, contact Blue Cross of Idaho Customer Service Department. Call 1-800-627-1188 (TTY: 1-800-377-1363), or call the customer service phone number on the back of your card. 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 with Blue Cross of Idaho's Grievances and Appeals Department at:

Manager, Grievances and Appeals 3000 E. Pine Ave., Meridian, ID 83642 Telephone:
1-800-274-4018
Fax: 208-331-7493
Email: grievances&appeals@bcidaho.com TTY: 1-800-377-1363

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our Grievances and Appeals team 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/portal/lobby.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 (TTY). Complaint forms are available at ***<http://www.hhs.gov/ocr/office/file/index.html>***

Glossary of Health Coverage and Medical Terms

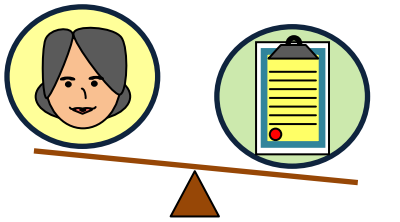
- This glossary has many commonly used terms, but isn't a full list. These glossary terms and definitions are intended to be educational and may be different from the terms and definitions in your plan. Some of these terms also might not have exactly the same meaning when used in your policy or plan, and in any such case, the policy or plan governs. (See your Summary of Benefits and Coverage for information on how to get a copy of your policy or plan document.)
- Bold blue text indicates a term defined in this Glossary.
- See page 4 for an example showing how deductibles, co-insurance and out-of-pocket limits work together in a real life situation.

Allowed Amount
Maximum amount on which payment is based for covered health care services. This may be called "eligible expense," "payment allowance" or "negotiated rate." If your provider charges more than the allowed amount, you may have to pay the difference. (See Balance Billing.)

Appeal
A request for your health insurer or plan to review a decision or a grievance again.

Balance Billing
When a provider bills you for the difference between the provider's charge and the allowed amount. For example, if the provider's charge is $100 and the allowed amount is $70, the provider may bill you for the remaining $30. A preferred provider may ***not*** balance bill you for covered services.

Co-insurance
Your share of the costs of a covered health care service, calculated as a percent (for example, 20%) of the allowed amount for the service. You pay co-insurance ***plus*** any deductibles you owe. For example, if the health insurance or plan's allowed amount for an office visit is $100 and you've met your deductible, your co-insurance payment of 20% would be $20. The health insurance or plan pays the rest of the allowed amount.

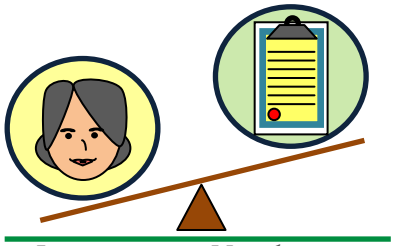


(See page 4 for a detailed example.)

Complications of Pregnancy
Conditions due to pregnancy, labor and delivery that require medical care to prevent serious harm to the health of the mother or the fetus. Morning sickness and a non-emergency caesarean section aren't complications of pregnancy.

Co-payment
A fixed amount (for example, $15) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service.

Deductible
The amount you owe for health care services your health insurance or plan covers before your health insurance or plan begins to pay. For example, if your deductible is $1000, your plan won't pay anything until you've met your $1000 deductible for covered health care services subject to the deductible. The deductible may not apply to all services.



(See page 4 for a detailed example.)

Durable Medical Equipment (DME)
Equipment and supplies ordered by a health care provider for everyday or extended use. Coverage for DME may include: oxygen equipment, wheelchairs, crutches or blood testing strips for diabetics.

Emergency Medical Condition
An illness, injury, symptom or condition so serious that a reasonable person would seek care right away to avoid severe harm.

Emergency Medical Transportation
Ambulance services for an emergency medical condition.

Emergency Room Care
Emergency services you get in an emergency room.

Emergency Services
Evaluation of an emergency medical condition and treatment to keep the condition from getting worse.

OMB Control Numbers 1545-2229, 1210-0147, and 0938-1146

Excluded Services
Health care services that your health insurance or plan doesn't pay for or cover.

Grievance
A complaint that you communicate to your health insurer or plan.

Habilitation Services
Health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Health Insurance
A contract that requires your health insurer to pay some or all of your health care costs in exchange for a premium.

Home Health Care
Health care services a person receives at home.

Hospice Services
Services to provide comfort and support for persons in the last stages of a terminal illness and their families.

Hospitalization
Care in a hospital that requires admission as an inpatient and usually requires an overnight stay. An overnight stay for observation could be outpatient care.

Hospital Outpatient Care
Care in a hospital that usually doesn't require an overnight stay.

In-network Co-insurance
The percent (for example, 20%) you pay of the allowed amount for covered health care services to providers who contract with your health insurance or plan. In-network co-insurance usually costs you less than out-of-network co-insurance.

In-network Co-payment
A fixed amount (for example, $15) you pay for covered health care services to providers who contract with your health insurance or plan. In-network co-payments usually are less than out-of-network co-payments.

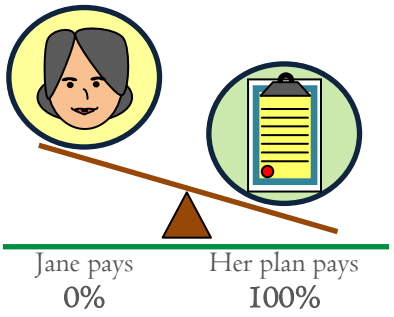
Medically Necessary
Health care services or supplies needed to prevent, diagnose or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards of medicine.

Network
The facilities, providers and suppliers your health insurer or plan has contracted with to provide health care services.

Non-Preferred Provider
A provider who doesn't have a contract with your health insurer or plan to provide services to you. You'll pay more to see a non-preferred provider. Check your policy to see if you can go to all providers who have contracted with your health insurance or plan, or if your health insurance or plan has a "tiered" network and you must pay extra to see some providers.

Out-of-network Co-insurance
The percent (for example, 40%) you pay of the allowed amount for covered health care services to providers who do ***not*** contract with your health insurance or plan. Out-of-network co-insurance usually costs you more than in-network co-insurance.

Out-of-network Co-payment
A fixed amount (for example, $30) you pay for covered health care services from providers who do ***not*** contract with your health insurance or plan. Out-of-network co-payments usually are more than in-network co-payments.

Out-of-Pocket Limit


The most you pay during a policy period (usually a year) before your health insurance or plan begins to pay 100% of the allowed amount. This limit never includes your premium, balance-billed charges or health care your health insurance or plan doesn't cover. Some health insurance or plans don't count all of your co-payments, deductibles, co-insurance payments, out-of-network payments or other expenses toward this limit.

(See page 4 for a detailed example.)

Physician Services
Health care services a licensed medical physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) provides or coordinates.

Plan
A benefit your employer, union or other group sponsor provides to you to pay for your health care services.

Preauthorization
A decision by your health insurer or plan that a health care service, treatment plan, prescription drug or durable medical equipment is medically necessary. Sometimes called prior authorization, prior approval or precertification. Your health insurance or plan may require preauthorization for certain services before you receive them, except in an emergency. Preauthorization isn't a promise your health insurance or plan will cover the cost.

Preferred Provider
A provider who has a contract with your health insurer or plan to provide services to you at a discount. Check your policy to see if you can see all preferred providers or if your health insurance or plan has a "tiered" network and you must pay extra to see some providers. Your health insurance or plan may have preferred providers who are also "participating" providers. Participating providers also contract with your health insurer or plan, but the discount may not be as great, and you may have to pay more.

Premium
The amount that must be paid for your health insurance or plan. You and/or your employer usually pay it monthly, quarterly or yearly.

Prescription Drug Coverage
Health insurance or plan that helps pay for prescription drugs and medications.

Prescription Drugs
Drugs and medications that by law require a prescription.

Primary Care Physician
A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) who directly provides or coordinates a range of health care services for a patient.

Primary Care Provider
A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist or physician assistant, as allowed under state law, who provides, coordinates or helps a patient access a range of health care services.

Provider
A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), health care professional or health care facility licensed, certified or accredited as required by state law.

Reconstructive Surgery
Surgery and follow-up treatment needed to correct or improve a part of the body because of birth defects, accidents, injuries or medical conditions.

Rehabilitation Services
Health care services that help a person keep, get back or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt or disabled. These services may include physical and occupational therapy, speech-language pathology and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

Skilled Nursing Care
Services from licensed nurses in your own home or in a nursing home. Skilled care services are from technicians and therapists in your own home or in a nursing home.

Specialist
A physician specialist focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions. A non-physician specialist is a provider who has more training in a specific area of health care.

UCR (Usual, Customary and Reasonable)
The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the allowed amount.

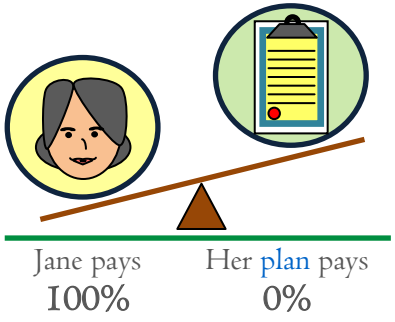
Urgent Care
Care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care.

How You and Your Insurer Share Costs - Example

Jane's Plan Deductible: $1,500 **Co-insurance:** 20% **Out-of-Pocket Limit:** $5,000

January 1st
Beginning of Coverage Period

December 31st
End of Coverage Period

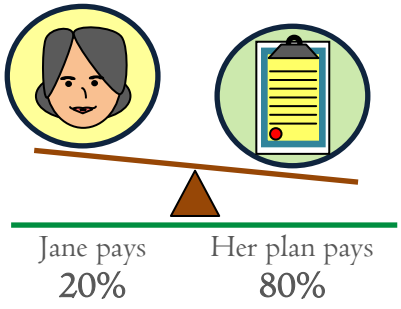


Jane hasn't reached her $1,500 deductible yet

Her plan doesn't pay any of the costs.

Office visit costs: $125
Jane pays: $125
Her plan pays: $0

more costs

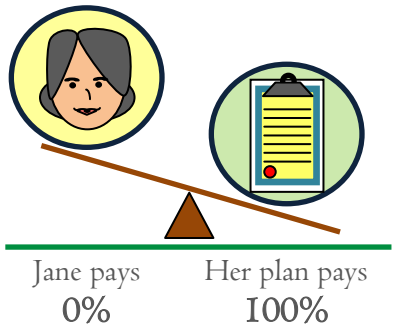


Jane reaches her $1,500 deductible, co-insurance begins

Jane has seen a doctor several times and paid $1,500 in total. Her plan pays some of the costs for her next visit.

Office visit costs: $75
Jane pays: 20% of $75 = $15
Her plan pays: 80% of $75 = $60

more costs



Jane reaches her $5,000 out-of-pocket limit

Jane has seen the doctor often and paid $5,000 in total. Her plan pays the full cost of her covered health care services for the rest of the year.

Office visit costs: $200
Jane pays: $0
Her plan pays: $200

WELLNESS BENEFITS

WELLNESS

- Plan pays 100% for annual flu shots
- Plan pays 100% up to $500 for Wellness/Preventive Services such as office visits, vaccinations or immunizations, then subject to deductible & co-insurance.

Refer to the Schedule of benefits for more details.

MAMMOGRAM

1 Mammogram, wellness or diagnosis, paid at 100% per calendar year.

SMOKING CESSATION

- Plan pays 50% up to $500 lifetime benefit.
- Includes Rx, prescription or over-the-counter.
- Call GemPlan for pre-authorization.
- Give copy of receipts to GemPlan for reimbursement.

DIABETES EDUCATION

Pays up to $500 for Outpatient Diabetes Education. Subject to deductible & co-insurance.

Refer to the Schedule of Benefits for more details.

WEIGHT LOSS

- Plan pays 50% up to $300 maximum per calendar year.
- Can be used for physician or dietician visits.
- Memberships in weight loss programs such as Weight Watchers (food not covered)
- Call GemPlan for pre-authorization.
- Give copy of receipts to GemPlan for reimbursement.

QUESTIONS?

Give GemPlan a call at 800.632.0905

1575 Baldy Ave., Pocatello, ID 83201 | 208.237.9696 | Fax: 208.237.9697

Blue Cross of Idaho

Breast Cancer Screenings

Idaho is in 52nd out of 52 states and U.S. territories for breast cancer screenings, according to the American Cancer Society. We can do better! Here are answers to some frequently asked questions that may help give clarity to our customers about breast cancer screenings.

1. What is the difference between regular mammograms and 3D mammograms?

The difference between 3D mammograms and 2D mammograms is like the difference between a circle and a sphere. Regular mammograms are 2D images and are flat. When the radiologist reviews the 3D mammogram, he or she can, to a certain degree, move the image to see into areas of overlapping tissue, which can reduce the need for more testing.

2. Are regular and 3D mammograms covered by Blue Cross of Idaho insurance?

Yes. One, in-network screening mammogram per year is covered with no copayment, deductible, coinsurance or out-of-pocket costs. A diagnostic mammogram may be subject to deductible, coinsurance and out-of-pocket costs. Out-of-network benefits are subject to deductible, coinsurance and out-of-pocket costs.

The Blue Cross and Blue Shield Association and Blue Cross of Idaho medical policy that considered 3D mammograms investigational for breast cancer screening was archived by Blue Cross of Idaho fall of 2018 and since then considers 3D screening mammogram a covered service.

Form No. 17-245 (09-19)

3. How often should a woman have a mammogram?

Blue Cross of Idaho uses the U.S. Preventive Services Task Force (USPSTF) guidelines for breast cancer screening, which includes:

	USPSTF 2016
Women aged 40 to 49 with average risk	The decision to start screening mammography in women prior to age 50 years should be an individual one. Women who place a higher value on the potential benefit than the potential harms may choose to begin biennial screening between the ages of 40 and 49 years
Women aged 50 to 74 with average risk	Biennial screening (every other year) mammography is recommended.
Women aged 75 or older with average risk	Current evidence is insufficient to assess the balance of benefits and harms of screening mammography in women aged 75 years or older.
Women with dense breasts	Current evidence is insufficient to assess the balance of benefits and harms of adjunctive screening for breast cancer using breast ultrasonography, magnetic resonance imaging (MRI), digital breast tomosynthesis (DBT) or other methods in women identified to have dense breasts on an otherwise negative screening mammogram.

4. What are the cost associated with breast cancer?

The average costs of a patient in the first 12 months following a diagnosis of breast cancer vary widely based on the stage of cancer.

- For members with Stage 0, the average annual cost is $60,637
- For members with Stage I/II, the average annual cost is $82,121
- For members with Stage III, the average annual cost is $129,387
- For members with Stage IV, the average annual cost is $134,682

According to the Comprehensive Care Alliance for Idaho, 35 percent of new cases of invasive breast cancer were diagnosed at a late Stage III/IV, driving costs even higher.

The cost of a screening mammography is significantly lower at an average of $153 for a 2D mammogram and $226 for a 3D mammogram. It's important to remember that the cost of breast cancer is more than monetary, it's also the emotional and physical impact to the patient, their family, friends and coworkers. Encourage your employees and their covered dependents to get screened for breast cancer – early detection saves lives!.

Blue Cross of Idaho

Telehealth Options

Using telehealth to get care keeps you out of a doctor's office and quickly gets you the help you need. Below are telehealth options available to you as a Blue Cross of Idaho member and examples of when you might want to use your telehealth benefits.

Non-emergency care

When you're not sure if you've got the cold, flu, allergies or something more serious, or if your child is sick but your doctor's office is closed for the night, non-emergency telehealth may be the right choice.*

Your Blue Cross of Idaho member benefits covers virtual care through our vendor MDLIVE. If you need care right away, you can connect with a board-certified doctor 24/7 through the MDLIVE mobile app, by phone or by video chat. These doctors can diagnose many common conditions. Visit ***MDLIVE.com/bcidaho*** to learn more and create an account today.

Your primary care provider (PCP) might be able to schedule you for a same-day virtual appointment. Contact the office to learn more. Some urgent care clinics now offer telehealth visits for some conditions. Contact your closest clinic to find out if this is an option for you.

Preventive care

Regular wellness visits are more important than ever, and many offices now offer virtual appointments. Contact your PCP's office about scheduling a telehealth visit. Be sure to ask them about what kind of technology you will need to use and what information they may need from you before your appointment.

PCP and specialist care

Just like wellness visits, you may be able to have regular visits with your PCP or a specialist through a virtual appointment. Contact your PCP or specialist about your options for virtual care.

** During a true emergency, go to the emergency room.*

MD

Form No. 3-1478 (10-20)

Mental healthcare

A virtual visit with a mental health provider can help. You can use MDLIVE to connect with a licensed counselor or therapist to get help for anxiety, depression, relationship issues and more. Many local behavioral health providers also offering virtual appointments. If you don't yet have a provider for behavioral healthcare, you can use the new Blue Cross of Idaho member app to find one.

Find care

If you need help finding a doctor for in-person or telehealth care, you have options:

- **Mobile app:** Download the Blue Cross of Idaho member app for iOS and Android, create an account and log in, and select ***Find Care***.
- **Blue Cross of Idaho website:** Log in to your member account at ***members.bcidaho.com***, select ***Search Tools*** then ***Find a Provider*** to visit our provider search tool.
- **Customer service:** Call the Blue Cross of Idaho Customer Service Department at the number on the back of your member ID card.

HELPING PEOPLE HELP THEMSELVES

Rocky Mountain EAP
Your Employee Assistance Program

Healthy living goes beyond eating a balanced diet and physical exercise. Emotional well-being, strong personal/working relationships, positive attitudes on life, family, and work is critical for a healthy lifestyle. There are times, we may not be able to cope with the stresses of everyday life, or we may feel unable to resolve all the decisions associated with personal, family issues, or career challenges. In such cases, it's a relief to have someone to turn to.

Rocky Mountain EAP (RMEAP) is that someone. RMEAP professional services are designed to help you and your dependent family members cope with a variety of personal, family, or career challenges. These services are provided in collaboration with your County and the GemPlan.

- **Confidential**, professional counseling for you and your dependent family members
- No out-of-pocket expenses
- Toll-free, 24-hour hot line
- Prompt, timely and convenient counseling, with a provider of your choice, in a location of your choosing, within the provider network
- Referral to the community services or programs, when and if necessary

REMEMBER: The decision to use RMEAP is voluntary and most importantly, **confidential**. To schedule an appointment, simply call **1-208-227-0152**, or **1-866-260-9490**.

Your County is offering this benefit at no out-of-pocket expense to employees and dependent family members. Coverage under this benefit is for **8 visits** per incident per fiscal year.

— PROFESSIONAL SERVICES —

RMEAP therapists are caring and experienced individuals who hold a minimum, 5yr's post-masters in counseling. Each one is certified and licensed by your states appropriate agency. The scope of work that RMEAP provides covers a wide range of issues such as:

- Abuse (Mental/Physical/Emotional)
- Marriage
- Depression
- Family Related Issues
- Grief
- Managing Stress
- Alcohol/Drug Abuse
- Relationships
- Work Related Issues
- Anxiety

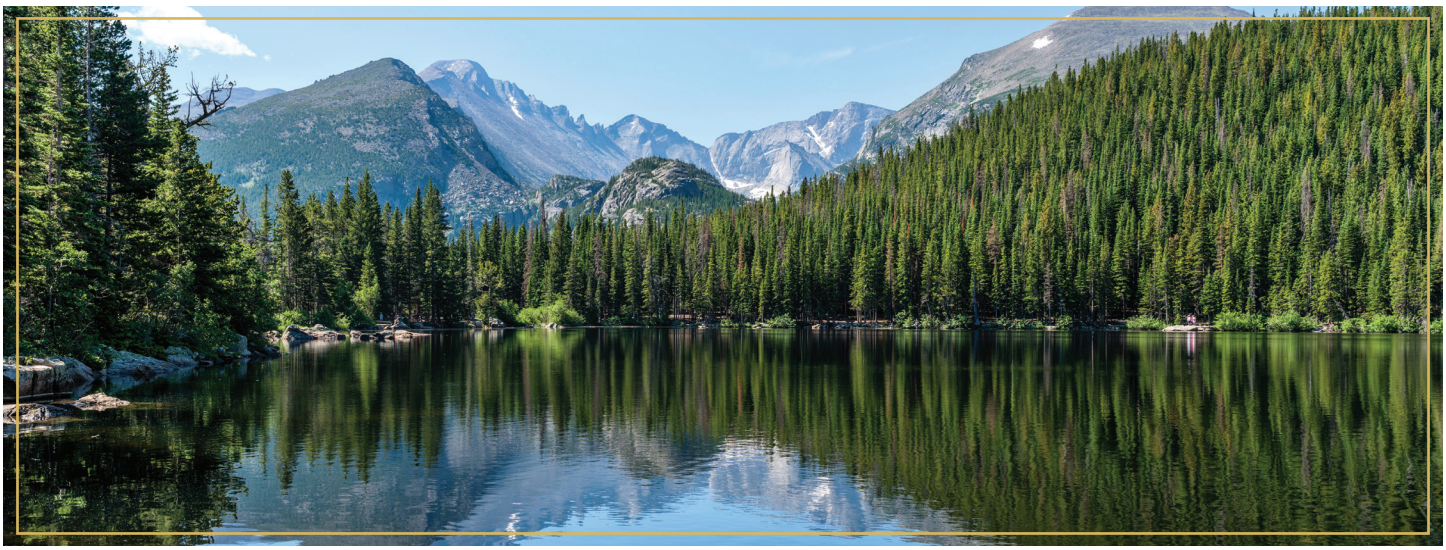
The Cornerstone of RMEAP is Confidentiality

All discussions (during your therapy sessions) between you and your EAP therapist are confidential. RMEAP therapists follow federal laws and regulation regarding confidentiality. Disclosure of any information to third parties is performed only with your written consent, except if you pose an imminent threat or harm to self or others; by court order; or in situations of abuse such as child or elder abuse.

CONFIDENTIAL ASSISTANCE WITH WORK/LIFE ISSUES IS ONLY A CALL AWAY

Please call **1-208-227-0152**, Monday through Friday, during regular business hours, for an appointment. The 24hr hot line is available for crisis situations: **1-866-260-9490**.

Check Out Your Wellness Tools and Resources



At GemPlan, we strive to address what's causing the rising costs of healthcare. This is why we bring you tools and resources to help you improve your health. Better health can mean lower healthcare costs and a happier outlook knowing that you are the best you can be.

GemPlan is offering you access to the Blue Cross of Idaho's WellConnected wellness website to help you live a healthier life. Here you can find helpful online tools and resources such as:

- Health assessment
- Health library
- Wellness workshops
- Mobile app
- Activity devices syncing
- Daily health tip
- Wellness blog
- Health trackers

Don't miss your chance to win great prizes! Visit the WellConnected site between November 1 and December 31 for a chance to win a FitBit Inspire.

REGISTER ON THE BLUE CROSS OF IDAHO WEBSITE

If you don't already have an online member account, registering is easy.

Visit ***members.bcidaho.com***, select ***Register*** and follow the instructions.

ACCESS THE WELLCONNECTED WEBSITE

Once you are logged in, select the ***WellConnected*** link in the middle of your member home page.

Your first time in the WellConnected website, you must set up your profile

GemPlan will roll out many programs throughout 2020, including quarterly challenges you can participate in. Each challenge will give you a chance to win prizes, like FitBits or gift cards.

Blue Cross of Idaho

Additional Services

Effective January 1, 2015, your employer, Bannock County, has purchased the following additional services for your benefit. The following additional services are not administered by Blue Cross of Idaho and are not a part of the Benefit Summary. Please read this information carefully and keep for future reference.

Nurse Advice Line

The Nurse Advice Line provides access to registered nurses 24/7/365. The service helps you determine the most appropriate level of care (emergency room, urgent care center, home care, etc.) based on you or your family members' symptoms. Nurses also provide general health and medication information. You will also have convenient access to the audio health library which provides hundreds of pre-recorded messages, many also in Spanish, on an array of healthcare topics ranging from the common cold to heart disease.. To reach Nurse Advice Line, call (888) 993-7120.

To access the Nurse Advice Chat Line feature log on to the Blue Cross of Idaho website at bcidaho.com and look for the *MyNurse 24/7 Nurse Advice Line* Chat Line button.

Finding A Doctor

Our Find a Doctor tool makes it easy to find in-network providers in your neighborhood and anywhere in the country.

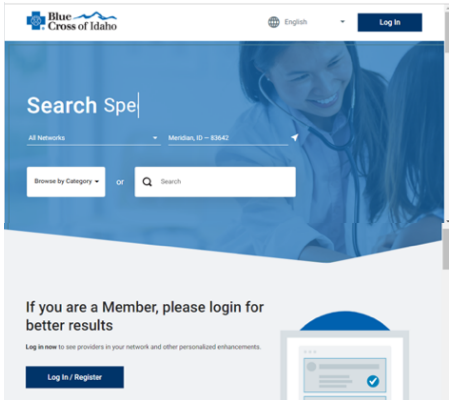
Blue Cross of Idaho works with healthcare providers who agree to provide services at discounted rates to help save you money. When you see an in-network provider, you get the most out of your health benefits. You can visit an out-of-network provider, but you may pay more out-of-pocket. Follow the steps below to find an in-network provider.

STEP 1:

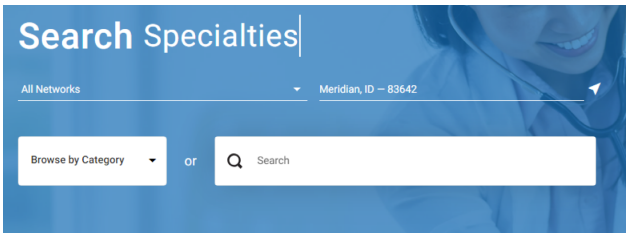
- Visit ***bcidaho.com***. Select ***Find a Doctor*** on the homepage.

STEP 2:

- Select the ***Log In*** button at the top right or the ***Log In / Register*** button and log in to your member account. You'll get better results when you log in.



- If you don't want to log in or don't have an online account (creating one is easy), you can still search for a doctor by selecting your network from the dropdown list.



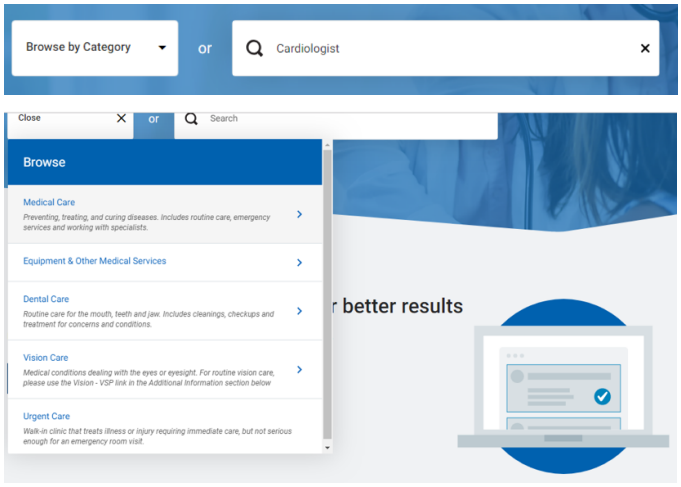
- Choose your network.
  - If you don't know your network, select ***All Networks.***

STEP 3:

- Enter a location to search or use the auto-populated location. You can enter a state, city or zip code.

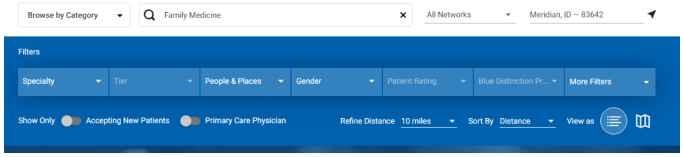
STEP 4:

- Begin your search by either selecting a category from the ***Browse by Category*** dropdown or by entering a name or specialty in the search box.



STEP 5:

- Use the top navigation menu to narrow or expand your search results. You can sort by location, gender, rating, etc.



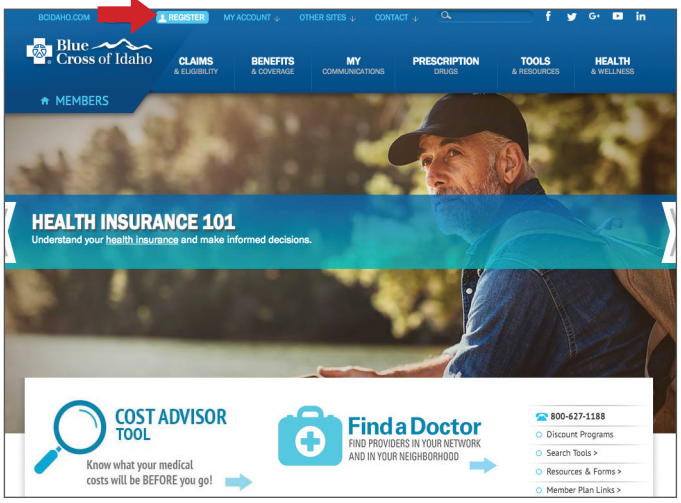
STEP 6:

- Select the name of a healthcare provider from the results displayed to learn more about him or her.
- Once you select a healthcare provider, you can find out more about his or her accepted networks, specialty, education and any practice limitations. You can also read reviews from patients and much more.

Member Registration Instructions

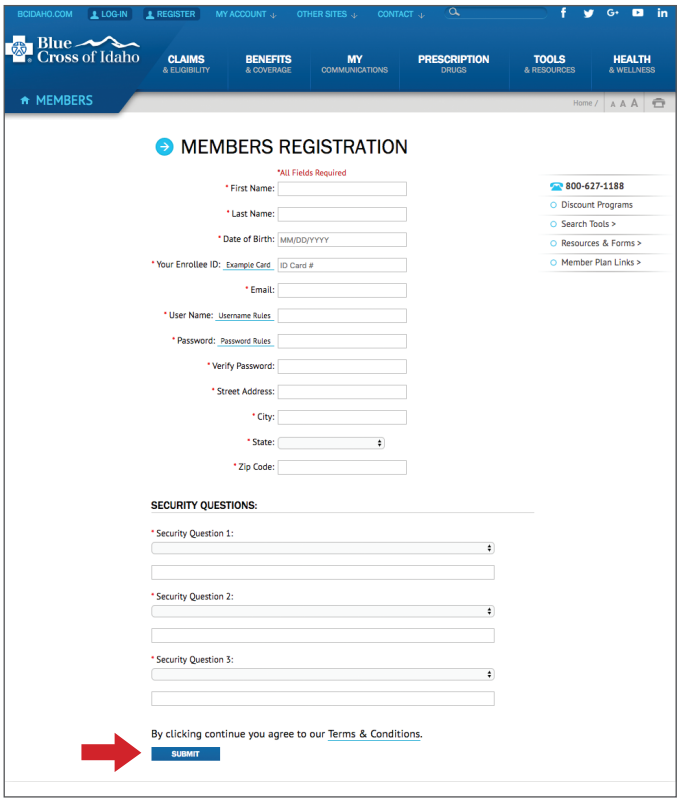
STEP 1:

- Visit ***members.bcidaho.com***. Select ***Register*** from the menu at the top of the page.



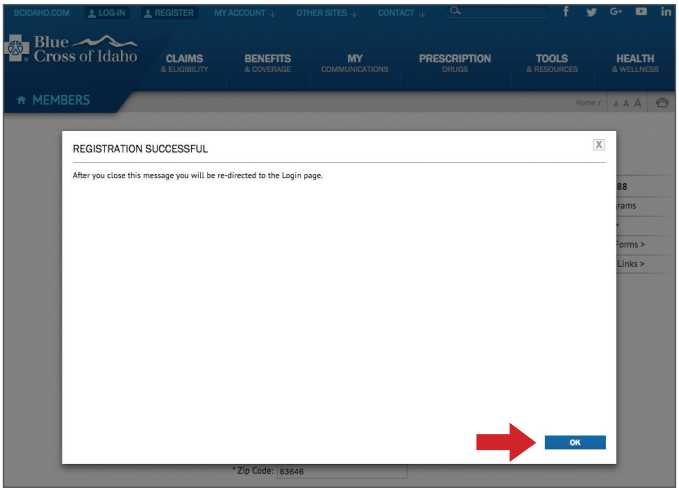
STEP 2:

- Enter your first and last name and email address. Then create a username and password. To help identify you if you forget your password, select three security questions with answers only you know. Click **Submit**.



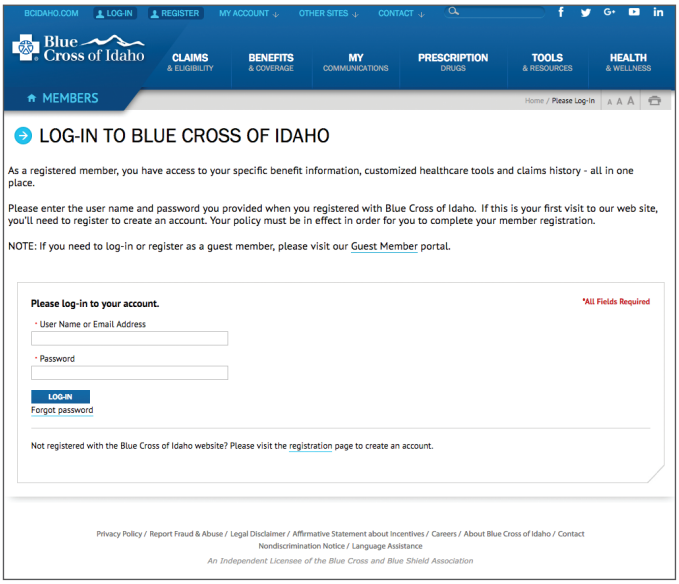
STEP 3:

- A pop-up box will appear once your registration is successful. Select ***OK*** to be redirected to the Login page.



STEP 4:

- You're successfully registered!
- Select **Login** from the top menu to enter your username and password. You can now access your EOBs, benefits, out-of-pocket amounts, ID card and other important plan information anytime.



Blue Cross of Idaho

2019 Blue Cross of Idaho Prior Authorization List

Procedures:

- Stereotactic radiosurgery
- Intensity-modulated radiation therapy (IMRT)
- Proton beam therapy
- Spinal cord stimulator
- Removal of kidney tumors
- Dental surgery related to an accident
- Eyelid surgery
- Invasive treatment of lower extremity veins
- Jaw surgery
- Nasal and sinus surgery
- Reconstructive and cosmetic/plastic surgery, including breast reconstruction after mastectomy
- Surgery for snoring or sleep problems
- Transplants (organ, tissue, etc.)
- Gender reassignment services
- Experimental or investigational procedures

Services:

- Acute inpatient hospitalization
- Long-term acute care hospital (LTACH) admissions
- Rehabilitation and long-term care facility admissions
- Skilled nursing facility admissions
- Sub-acute and transitional care admissions
- Certain inpatient and outpatient surgical procedures
- Certain genetic testing
- Bone stimulation for fracture healing
- Hyperbaric oxygen therapy
- Non-emergency ambulance transport
- Behavioral Health Services
  - Psychological testing/neuropsychological evaluation testing
  - Electroconvulsive therapy (ECT)
  - Intensive outpatient program (IOP)
  - Partial hospitalization program (PHP)
  - Residential treatment center (RTC)

Durable Medical Equipment:

- Equipment with costs of more than $1,000 (including rent-to-purchase items)
- Hospital-grade breast pumps
- Continuous positive airway pressure (CPAP)/ bilevel positive airway pressure (BiPAP)
- Oral appliances for sleep apnea
- Covered orthotics and prosthetics with costs of more than $1,000

AIM Specialty Health:

- Sleep therapy
- Sleep studies
- Nuclear cardiology
- Magnetic resonance imaging (MRI)/magnetic resonance angiography (MRA), computed tomography (CT)/CT angiogram scan (CTA), positron emission tomography (PET) scan
- Pain management (effective April 1, 2019)
- Musculoskeletal procedures
  - Spine
  - Joints (effective April 1, 2019)

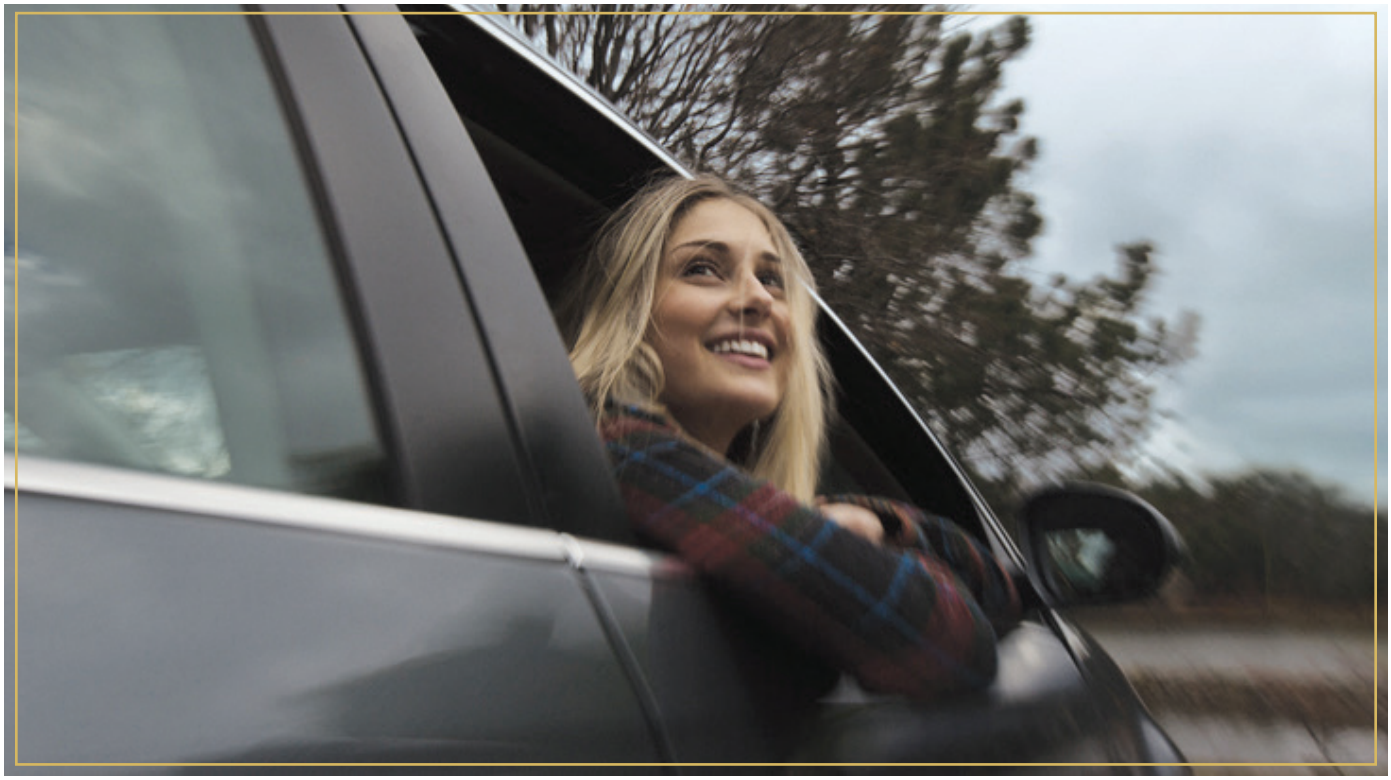
Pharmacy

- Certain prescription drugs (find a full list at ***members.bcidaho.com***)
- Growth hormone therapy
- Outpatient IV therapy for infusion drugs (find a list at ***members.bcidaho.com***)

Form No. 3-1357NI (03-19)

BlueCross BlueShield

Blue Cross of Idaho



Across the country and around the world…we've got you covered.

As a Blue Cross and Blue Shield member, you take your healthcare benefits with you – across the country and around the world. Your membership gives you a world of choices. Within the United States, you're covered whether you need care in urban or rural areas. Outside the United States, you have access to doctors and hospitals around the world through the Blue Cross Blue Shield Global® Core program.

Designed to save you money.

In most cases, when you travel or live outside your Blue Cross and Blue Shield (BCBS) company's service area, you can take advantage of savings the local BCBS company has negotiated with its doctors and hospitals. For covered services, you should not have to pay any amount above these negotiated rates and any applicable out-of-pocket expenses.

To locate doctors and hospitals wherever you or a covered dependent need care (have your member ID card handy):

- Visit the National Doctor & Hospital Finder at www.BCBS.com.
- Use the National Doctor & Hospital Finder app and the Blue Cross Blue Shield Global Core app for Android,* iPhone, iPad and iPod Touch.** (Rates from your wireless provider may apply.)
- Call BlueCard Access® at 1.800.810.BLUE (2583).

Form No. 3-146 (06-19)

Take charge of your health, wherever you are.

In the United States

- Always carry your current member ID card.
- If you're a PPO member, always use a BlueCard PPO doctor or hospital to ensure you receive the highest level of benefits.
- Call your BCBS company for precertification or prior authorization, if necessary. Refer to the phone number on the back of your member ID card.
- When you arrive at the participating doctor's office or hospital, show the provider your ID card. The provider will identify your benefit level through one of these symbols:


Traditional/ Indemnity Benefits

PPO Benefits

After you receive care, you should:

- Not have to complete any claim forms.
- Not have to pay upfront for medical services, except for the out-of-pocket expenses (noncovered services, deductible, copayment and coinsurance) you normally pay.
- Receive an explanation of benefits from your BCBS company.

In an emergency, go directly to the nearest hospital.

Blue Cross of Idaho

Around the world

- Always carry your current member ID card.
- Before you travel, contact your BCBS company for coverage details. Coverage outside the United States may be different.
- If you need medical assistance, call the Service Center for Blue Cross Blue Shield Global Core at 1.800.810.BLUE (2583) or call collect at 1.804.673.1177, 24 hours a day, seven days a week. An assistance coordinator, in conjunction with a medical professional, will arrange a physician appointment or hospitalization, if necessary.

Inpatient claim: Call the Service Center if you need inpatient care. In most cases, you should not need to pay upfront for inpatient care except for the out-of-pocket expenses (noncovered services, deductible, copayment and coinsurance) you normally pay. The hospital should submit the claim on your behalf.

In addition to contacting the Service Center, call your BCBS company for precertification or preauthorization. Refer to the phone number on the back of your member ID card. *Note: this number is different from the Service Center phone numbers listed above.*

Professional claim: You may need to pay upfront for care received from a doctor and/or hospital. Complete a Blue Cross Blue Shield Global Core International claim form and send it with the bill(s) to the Service Center (the address is on the form). You can also submit your claim online or through the Blue Cross Blue Shield Global Core mobile app. The claim form is available from your BCBS company or online at www.bcbsglobalcore.com.

To learn more about the programs described here, call your BCBS company.

TheBlueCard®
Now, Home Is Where The Card Is®

The Blue Cross Blue Shield Global Core program was formerly known as BlueCard Worldwide®.

Blue Cross of Idaho

BlueExtras
A VALUE-ADDED PROGRAM

Balance your budget and healthcare needs with Blue Cross of Idaho's Blue Extras![sm], where you'll find discounts on healthcare services near you.

Blue Extras! offers discounted services, programs and products that will help you with your health, wellness and fitness goals. These extras are provided by independent sources that have agreed to offer discounted rates to you as a Blue Cross of Idaho member.

Blue Extras! provides access to discounts on products and services, that include:

- LASIK surgery
- Hearing aids
- Medical alert services
- Vision services and supplies
- Discounted fitness and wellness products
- Massage therapy
- Fitness club memberships
- Childcare and nursery items, which includes nursing supplies, car seats and infant carriers
- Orthodontic values–program offers a $400 discount off the total cost of treatment from select providers

For more information on Blue Extras!, please visit ***members.bcidaho.com*** and select ***Health & Wellness***, then ***Discount Programs***.

Form No. 3-1266 (10-19)

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No.
1210-0149
(expires 5-31-2022

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution –as well as your employee contribution to employer-offered coverage– is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact _____.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

[1] An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name	4. Employer Identification Number (EIN)
Bannock County	82-6000279
5. Employer address	**6. Employer phone number**
624 E Center	208-236-7217

7. City	8. State	9. ZIP code
Pocatello	ID	83201

10. Who can we contact about employee health coverage at this job?	
GemPlan	
11. Phone number (if different from above)	**12. Email address**
1-800-632-0905 or 208237-9696	lydiep@mutualid.com

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:

☐ All employees. Eligible employees are:

⊡ Some employees. Eligible employees are:

Any full-time permanent employee - refer to employee manual

- With respect to dependents:

☒ We do offer coverage. Eligible dependents are:

Legally married spouse and children

☐ We do not offer coverage.

☒ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, HealthCare.gov will guide you through the process. Here's the employer information you'll enter when you visit HealthCare.gov to find out if you can get a tax credit to lower your monthly premiums.

The information below corresponds to the Marketplace Employer Coverage Tool. Completing this section is optional for employers, but will help ensure employees understand their coverage choices.

13. **Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?**

☒ **Yes** (Continue)
13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage?_____ (mm/dd/yyyy) (Continue)
☐ **No** (STOP and return this form to employee)

14. Does the employer offer a health plan that meets the minimum value standard*?
☒ Yes (Go to question 15) ☐ No (STOP and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard* **offered only to the employee** (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.
a. How much would the employee have to pay in premiums for this plan? $ 22.00
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☒ Monthly ☐ Quarterly ☐ Yearly

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.

16. What change will the employer make for the new plan year?_____
☐ Employer won't offer health coverage
☒ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)
a. How much would the employee have to pay in premiums for this plan? $ 22.00
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☒ Monthly ☐ Quarterly ☐ Yearly

• An employer–sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

Continuation Coverage Rights Under COBRA General Notice

Introduction

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should contact GemPlan.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;

- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after GemPlan has been notified that a qualifying event has occurred. The employer must notify GemPlan of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify GemPlan within 60 days after the qualifying event occurs. You must provide this notice to your spouse &/or dependent child(ren) losing coverage.

How is COBRA continuation coverage provided?

Once GemPlan receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify GemPlan in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage. The qualified beneficiary must provide the Plan documentation of the SSA disability determination. If the qualified beneficiary is determined by SSA to no longer be disabled, you must notify the Plan of that fact within 30 days after that determination.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights, including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

Keep your Plan informed of address changes

To protect your family's rights, let GemPlan know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to GemPlan.

Plan contact information

GemPlan
1575 Baldy Ave.
Pocatello, ID 83201
Phone: 208-237-9696 or 800-632-0905

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2020. Contact your State for more information on eligibility –

ALABAMA – Medicaid	COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 1-855-692-6442
ALASKA – Medicaid	**FLORIDA – Medicaid**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
ARKANSAS – Medicaid	**GEORGIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162 ext 2131

CALIFORNIA – Medicaid

Website:
https://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx
Phone: 916-440-5676

INDIANA – Medicaid

Healthy Indiana Plan for low-income adults 19-64
Website: http://www.in.gov/fssa/hip/
Phone: 1-877-438-4479
All other Medicaid
Website: https://www.in.gov/medicaid/
Phone 1-800-457-4584

IOWA – Medicaid and CHIP (Hawki)

Medicaid Website:
https://dhs.iowa.gov/ime/members
Medicaid Phone: 1-800-338-8366
Hawki Website:
http://dhs.iowa.gov/Hawki
Hawki Phone: 1-800-257-8563

MONTANA – Medicaid

Website:
http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084

KANSAS – Medicaid

Website: http://www.kdheks.gov/hcf/default.htm
Phone: 1-800-792-4884

NEBRASKA – Medicaid

Website: http://www.ACCESSNebraska.ne.gov
Phone: 1-855-632-7633
Lincoln: 402-473-7000
Omaha: 402-595-1178

KENTUCKY – Medicaid

Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website:
https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx
Phone: 1-855-459-6328
Email: KIHIPP.PROGRAM@ky.gov

KCHIP Website:
https://kidshealth.ky.gov/Pages/index.aspx
Phone: 1-877-524-4718

Kentucky Medicaid Website: https://chfs.ky.gov

NEVADA – Medicaid

Medicaid Website: http://dhcfp.nv.gov
Medicaid Phone: 1-800-992-0900

LOUISIANA – Medicaid

Website: www.medicaid.la.gov or
www.ldh.la.gov/lahipp
Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

NEW HAMPSHIRE – Medicaid

Website: https://www.dhhs.nh.gov/oii/hipp.htm
Phone: 603-271-5218
Toll free number for the HIPP program: 1-800-852-3345, ext 5218

MAINE – Medicaid

Enrollment Website:
https://www.maine.gov/dhhs/ofi/applications-forms
Phone: 1-800-442-6003
TTY: Maine relay 711

Private Health Insurance Premium Webpage:
https://www.maine.gov/dhhs/ofi/applications-forms
Phone: -800-977-6740.
TTY: Maine relay 711

NEW JERSEY – Medicaid and CHIP

Medicaid Website:
http://www.state.nj.us/humanservices/dmahs/clients/medicaid/
Medicaid Phone: 609-631-2392
CHIP Website: http://www.njfamilycare.org/index.html
CHIP Phone: 1-800-701-0710

MASSACHUSETTS – Medicaid and CHIP

Website:
http://www.mass.gov/eohhs/gov/departments/masshealth/
Phone: 1-800-862-4840

NEW YORK – Medicaid

Website:
https://www.health.ny.gov/health_care/medicaid/
Phone: 1-800-541-2831

MINNESOTA – Medicaid

Website:
https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp
Phone: 1-800-657-3739

NORTH CAROLINA – Medicaid

Website: https://medicaid.ncdhhs.gov/
Phone: 919-855-4100

MISSOURI – Medicaid	**NORTH DAKOTA – Medicaid**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**UTAH – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
OREGON – Medicaid	**VERMONT– Medicaid**
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
PENNSYLVANIA – Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx Phone: 1-800-692-7462	Website: https://www.coverva.org/hipp/ Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-855-242-8282
RHODE ISLAND – Medicaid and CHIP	**WASHINGTON – Medicaid**
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
SOUTH CAROLINA – Medicaid	**WEST VIRGINIA – Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
SOUTH DAKOTA - Medicaid	**WISCONSIN – Medicaid and CHIP**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
TEXAS – Medicaid	**WYOMING – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2020, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number.

The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

CMS.gov
Centers for Medicare & Medicaid Services

Newborns' and Mothers' Health Protection Act (NMHPA)

The Newborns' and Mothers' Health Protection Act of 1996 (NMHPA) is a federal law that affects the length of time a mother and newborn child are covered for a hospital stay in connection with childbirth. In general, group health plans and health insurance issuers that are subject to NMHPA may NOT restrict benefits for a hospital stay in connection with childbirth to less than 48 hours following a vaginal delivery or 96 hours following a delivery by cesarean section.

If you deliver your baby in the hospital, the 48-hour (or 96-hour) period starts at the time of delivery. If you deliver your baby outside the hospital and you are later admitted to the hospital in connection with childbirth (as determined by the attending provider), the period begins at the time of the hospital admission.

If the attending provider, in consultation with the mother, determines that either the mother or the newborn child can be discharged before the 48-hour (or 96-hour) period, the group health plan or health insurance issuer does not have to continue covering the stay for the one ready for discharge. An attending provider is an individual, licensed under State law, who is directly responsible for providing maternity or pediatric care to the mother or the newborn child. In addition to physicians, an individual such as a nurse midwife, physician assistant, or nurse practitioner may be an attending provider. A health plan, hospital, insurance company, or HMO would NOT be an attending provider.

Blue Cross of Idaho

IMPORTANT NOTICE

In 1998, Congress passed HR 4328, also known as the *Women's Health and Cancer Rights Act of 1998*. This legislation requires group health plans and health insurance issuers of group health insurance to cover reconstructive surgery following a mastectomy/lumpectomy and to notify you of this coverage annually.

Specifically, if health plans and insurers cover mastectomies/lumpectomies, they must also cover, in a manner determined in consultation with the attending physician and the patient:

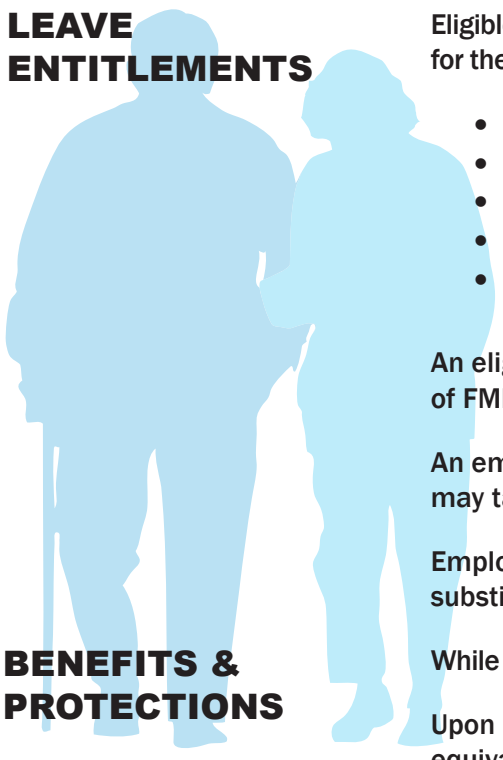
1. Reconstruction of the breast on which the mastectomy/lumpectomy was performed;
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
3. Prostheses and treatment of physical complications at all stages of the mastectomy/ lumpectomy, including lymphedemas.

Benefits are subject to the standard surgical deductibles, copayments and coinsurance amounts of your contract/policy. If you have any questions, please contact our Customer Services Department at 1-800-627-1188.

Originated 9-99 Form No. 3-435 (12-06)

EMPLOYEE RIGHTS
UNDER THE FAMILY AND MEDICAL LEAVE ACT

THE UNITED STATES DEPARTMENT OF LABOR WAGE AND HOUR DIVISION



LEAVE ENTITLEMENTS

Eligible employees who work for a covered employer can take up to 12 weeks of unpaid, job-protected leave in a 12-month period for the following reasons:

- The birth of a child or placement of a child for adoption or foster care;
- To bond with a child (leave must be taken within 1 year of the child's birth or placement);
- To care for the employee's spouse, child, or parent who has a qualifying serious health condition;
- For the employee's own qualifying serious health condition that makes the employee unable to perform the employee's job;
- For qualifying exigencies related to the foreign deployment of a military member who is the employee's spouse, child, or parent.

An eligible employee who is a covered servicemember's spouse, child, parent, or next of kin may also take up to 26 weeks of FMLA leave in a single 12-month period to care for the servicemember with a serious injury or illness.

An employee does not need to use leave in one block. When it is medically necessary or otherwise permitted, employees may take leave intermittently or on a reduced schedule.

Employees may choose, or an employer may require, use of accrued paid leave while taking FMLA leave. If an employee substitutes accrued paid leave for FMLA leave, the employee must comply with the employer's normal paid leave policies.

BENEFITS & PROTECTIONS

While employees are on FMLA leave, employers must continue health insurance coverage as if the employees were not on leave.

Upon return from FMLA leave, most employees must be restored to the same job or one nearly identical to it with equivalent pay, benefits, and other employment terms and conditions.

An employer may not interfere with an individual's FMLA rights or retaliate against someone for using or trying to use FMLA leave, opposing any practice made unlawful by the FMLA, or being involved in any proceeding under or related to the FMLA.

ELIGIBILITY REQUIREMENTS

An employee who works for a covered employer must meet three criteria in order to be eligible for FMLA leave. The employee must:

- Have worked for the employer for at least 12 months;
- Have at least 1,250 hours of service in the 12 months before taking leave;* and
- Work at a location where the employer has at least 50 employees within 75 miles of the employee's worksite.

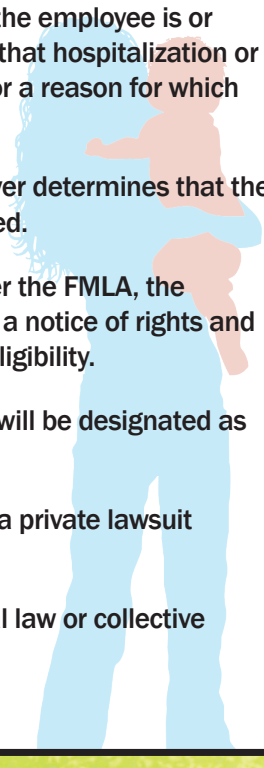
*Special "hours of service" requirements apply to airline flight crew employees.

REQUESTING LEAVE

Generally, employees must give 30-days' advance notice of the need for FMLA leave. If it is not possible to give 30-days' notice, an employee must notify the employer as soon as possible and, generally, follow the employer's usual procedures.

Employees do not have to share a medical diagnosis, but must provide enough information to the employer so it can determine if the leave qualifies for FMLA protection. Sufficient information could include informing an employer that the employee is or will be unable to perform his or her job functions, that a family member cannot perform daily activities, or that hospitalization or continuing medical treatment is necessary. Employees must inform the employer if the need for leave is for a reason for which FMLA leave was previously taken or certified.

Employers can require a certification or periodic recertification supporting the need for leave. If the employer determines that the certification is incomplete, it must provide a written notice indicating what additional information is required.



EMPLOYER RESPONSIBILITIES

Once an employer becomes aware that an employee's need for leave is for a reason that may qualify under the FMLA, the employer must notify the employee if he or she is eligible for FMLA leave and, if eligible, must also provide a notice of rights and responsibilities under the FMLA. If the employee is not eligible, the employer must provide a reason for ineligibility.

Employers must notify its employees if leave will be designated as FMLA leave, and if so, how much leave will be designated as FMLA leave.

ENFORCEMENT

Employees may file a complaint with the U.S. Department of Labor, Wage and Hour Division, or may bring a private lawsuit against an employer.

The FMLA does not affect any federal or state law prohibiting discrimination or supersede any state or local law or collective bargaining agreement that provides greater family or medical leave rights.

For additional information or to file a complaint:

1-866-4-USWAGE

(1-866-487-9243) TTY: 1-877-889-5627

www.dol.gov/whd

U.S. Department of Labor | Wage and Hour Division

WH1420 REV 04/16

YOUR RIGHTS UNDER USERRA

THE UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT

USERRA protects the job rights of individuals who voluntarily or involuntarily leave employment positions to undertake military service or certain types of service in the National Disaster Medical System. USERRA also prohibits employers from discriminating against past and present members of the uniformed services, and applicants to the uniformed services.

REEMPLOYMENT RIGHTS

You have the right to be reemployed in your civilian job if you leave that job to perform service in the uniformed service and:

- ☆ you ensure that your employer receives advance written or verbal notice of your service;
- ☆ you have five years or less of cumulative service in the uniformed services while with that particular employer;
- ☆ you return to work or apply for reemployment in a timely manner after conclusion of service; and
- ☆ you have not been separated from service with a disqualifying discharge or under other than honorable conditions.

If you are eligible to be reemployed, you must be restored to the job and benefits you would have attained if you had not been absent due to military service or, in some cases, a comparable job.

RIGHT TO BE FREE FROM DISCRIMINATION AND RETALIATION

If you:

- ☆ are a past or present member of the uniformed service;
- ☆ have applied for membership in the uniformed service; or
- ☆ are obligated to serve in the uniformed service;

then an employer may not deny you:

- ☆ initial employment;
- ☆ reemployment;
- ☆ retention in employment;
- ☆ promotion; or
- ☆ any benefit of employment

because of this status.

In addition, an employer may not retaliate against anyone assisting in the enforcement of USERRA rights, including testifying or making a statement in connection with a proceeding under USERRA, even if that person has no service connection.

HEALTH INSURANCE PROTECTION

- ☆ If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents for up to 24 months while in the military.

- ☆ Even if you don't elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan when you are reemployed, generally without any waiting periods or exclusions (e.g., pre-existing condition exclusions) except for service-connected illnesses or injuries.

ENFORCEMENT

- ☆ The U.S. Department of Labor, Veterans Employment and Training Service (VETS) is authorized to investigate and resolve complaints of USERRA violations.

- ☆ For assistance in filing a complaint, or for any other information on USERRA, contact VETS at **1-866-4-USA-DOL** or visit its website at **http://www.dol.gov/vets**. An interactive online USERRA Advisor can be viewed at **http://www.dol.gov/elaws/userra.htm**.

- ☆ If you file a complaint with VETS and VETS is unable to resolve it, you may request that your case be referred to the Department of Justice or the Office of Special Counsel, as applicable, for representation.

- ☆ You may also bypass the VETS process and bring a civil action against an employer for violations of USERRA.

The rights listed here may vary depending on the circumstances. The text of this notice was prepared by VETS, and may be viewed on the internet at this address: **http://www.dol.gov/vets/programs/userra/poster.htm**. Federal law requires employers to notify employees of their rights under USERRA, and employers may meet this requirement by displaying the text of this notice where they customarily place notices for employees.

U.S. Department of Labor
1-866-487-2365

U.S. Department of Justice

Office of Special Counsel

1-800-336-4590

Publication Date — April 2017

MHPAEA Enforcement Fact Sheet

United States Department of Labor
Employee Benefits Security Administration

Mental Health Parity and Addiction Equity Act

The Mental Health Parity and Addiction Equity Act ("MHPAEA") provides important protections for individuals with mental health and substance use disorder conditions. The statutory provisions became effective for plan years beginning on or after October 3, 2009. The Department published interim final regulations effective for plan years beginning on or after July 1, 2010 and final regulations became effective for plan years beginning on or after July 1, 2014.

Since October 2010, EBSA has conducted over 1,500 investigations related to MHPAEA and cited over 170 violations for noncompliance with these rules.

Examples of MHPAEA Violations

Insufficient Benefits

- Not offering out-of-network providers or inpatient benefits to treat mental health or substance use disorders even though these benefits are available for medical/surgical benefits.

Higher Financial Requirements

- Charging higher copays to see mental health providers than those charged for medical/surgical providers.

More Restrictive Quantitative Treatment Limitations (QTLs)

- Imposing visit limits on mental health benefits that are more restrictive than those applied to medical/surgical visits.

More Restrictive Non-Quantitative Treatment Limitations (NQTLs)

- Imposing broad preauthorization requirements on all mental health and substance use disorder treatments, even though these same plans only required pre-authorization on a select few medical/surgical treatments.
- Requiring written treatment plans for mental health services while not requiring similar plans to receive medical/surgical treatment.

Lower Annual Dollar Limits on Benefits

- Imposing annual dollar limits on coverage of mental health benefits when such limitations are not imposed on medical/surgical benefits.

Inadequate Disclosures

- Not disclosing the criteria used for determining medical necessity and/or reasons for benefit denials.

EBSA Process for Addressing MHPAEA Violations

Participant complaints

Global Correction

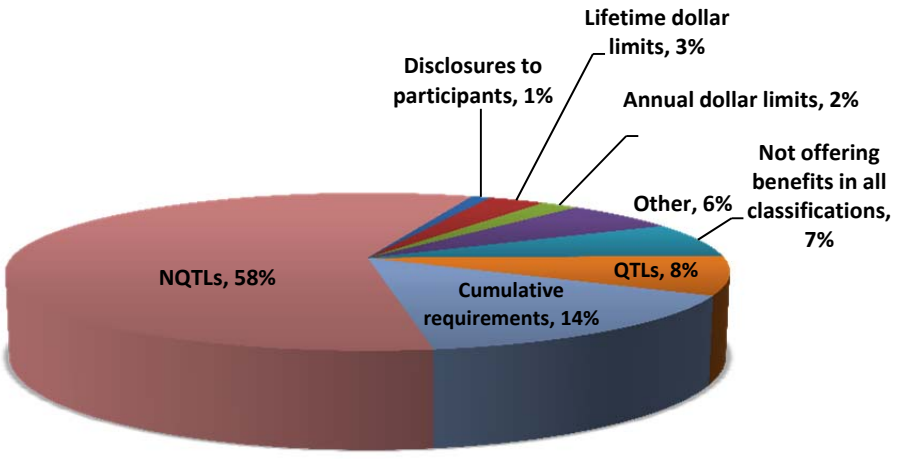
EBSA receives inquiries from participants all over the country who believe their mental health benefits were denied improperly. If the facts suggest the problem affects multiple people, EBSA may refer the issue for investigation.

To achieve the greatest impact, EBSA works with plans and their service providers to find other improperly denied claims and correct the problem for all those affected.

EBSA's New York Regional Office assisted a participant whose plan was not crediting mental health benefit payments towards their annual out-of-pocket maximum. EBSA's Benefit Advisor explained the relevant provisions of the law to plan officials. As a result, the plan reprocessed claims and paid more than $35,000 in wrongfully denied benefits to five plan participants.

EBSA has worked with several large insurance companies to remove impermissible barriers to mental health benefits such as restrictive written treatment plan requirements and overly broad preauthorization requirements. These global changes have impacted hundreds of thousands of group health plans and millions of participants.

FY2010-FY2015 MHPAEA Violations



Need Help with Your Employee Benefits?

Contact EBSA

U.S. Department of Labor
Frances Perkins Building, 200 Constitution Ave., NW, Washington, DC 20210
www.dol.gov
Telephone: 1-866-444-EBSA (3272)

Blue Cross of Idaho | Care Plus

13001040

NOTICE OF PRIVACY PRACTICES

Effective February 18, 2020

THIS NOTICE DESCRIBES HOW YOUR PERSONAL FINANCIAL AND HEALTH INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.
45 CFR 164.520(b)(1)(i)

This notice applies to the privacy practices of Blue Cross of Idaho Health Service, Inc. and Blue Cross of Idaho Care Plus, Inc., affiliated entities. Blue Cross of Idaho maintains the privacy of your protected health information and is required to comply with the terms of this notice currently in effect. We may share your personal financial and health information with each other as needed for our treatment, payment and healthcare operations. We are committed to protecting the privacy of your personal financial and health information in any form, whether oral, written or electronic. We keep your personal information private by maintaining physical, electronic, and procedural safeguards that comply with legal requirements. This notice explains our privacy practices, our legal duties, and your rights concerning your personal information. We reserve the right to change the way your personal information is used or disclosed. Blue Cross of Idaho provides our members notice of its legal duties and privacy practices with respect to protected health information. If we make a material change to the notice, we will post the revised notice on our website and send current members information about the change and how to obtain a revised notice the next time we send out a mailing to all members.

Uses and Disclosures of Personal Financial Information

We use certain financial information to carry out insurance activities as allowed by law. This includes information collected from you when you apply for our products or services, such as your name, address, age, and social security number. We may verify or obtain additional information through others, such as adult family members, employers, other insurers, physicians, hospitals, and other medical providers. We disclose information only to our affiliates and others who perform services within the scope of healthcare operations on our behalf. For example, information is disclosed to our affiliates and others to help us evaluate requests for insurance or benefits, perform general administrative activities, and process claims. In addition, we disclose information to law enforcement and regulatory agencies to help us prevent fraud. We do not make any disclosures of your financial information to other companies who may want to sell their products or services to you.

Uses and Disclosures of Personal Health Information

We use your personal health information for treatment, healthcare payment and operations as allowed or required by law. We must use and disclose your personal health information to provide information:

- To you or someone who has the right to act on your behalf (your legal or personal representative);
- To the Secretary of the Department of Health and Human Services, if necessary, to make sure your privacy is protected; and
- As required by law.

We have the right to use and disclose your personal health information for treatment, to pay for your healthcare, and to carry out our healthcare operations. For example, we may use or disclose your personal health information:

- To pay or deny your claims, to collect your premiums, to share your benefit payment information with your other insurers, and to inform your providers regarding your eligibility for coverage under a health plan;
- To provide customer services to you, or to resolve any complaints you may have;
- To inform the policyholder about determinations made regarding claims submitted for all dependents on the policy;
- To send you a reminder to obtain preventive health services or to inform you about alternative medical treatments or other health-related benefits and services that may interest you (such as our Disease Management Programs);
- To the Idaho Health Data Exchange (IHDE), a collaboration to improve coordination and quality of care, and to other health care entities that provide health care operations on our behalf, and other health improvement or health care cost-reduction programs;
- With others who help us conduct our business operations. However, we will not share your information with these outside groups unless they agree to protect it;
- If you are an enrollee of a group health plan, to share information with the plan sponsor (employer) or the group health plan through which you receive health benefits. However, we will not share detailed health information with your benefit plan unless they agree in writing to protect it;

We may use or disclose personal health information for the following purposes under limited circumstances:

- To meet regulatory requirements of state and federal agencies (such as the Idaho Department of Insurance);
- For public health activities (such as reporting disease outbreaks, child abuse, neglect or domestic violence);
- For government health care oversight activities (such as fraud and abuse investigations);
- For judicial and administrative proceedings (such as in response to a court order);
- For law enforcement purposes (such as providing limited information to locate a missing person);
- For research studies that meet all privacy law requirements (such as research related to the prevention of disease or disability);
- To avoid a serious and imminent threat to health or safety;
- To a coroner, medical examiner, funeral director or organ donation organizations (for reasons such as to identify a deceased person, determine a cause of death, or as authorized by law);
- To a correctional institution or to a law enforcement official (for reasons such as the health and safety of the inmates and for the safety and security of the correctional institution);
- To specialized government functions (such as military and veteran activities, national security and intelligence activities, and the protective services for the President and others);
- To workers compensation carriers or others involved in workers compensation systems (for reasons such as to report information on job-related injuries); and
- To others involved in your health care or payment for health care (for reasons such as to inform your spouse of the status of a claim).

We may not use or disclose any genetic information for our underwriting purposes. We may not sell your personal health information, or use or disclose your personal health information for marketing communications, without your written authorization except where permitted by law.

Other Uses and Disclosures of Your Personal Health Information

By law, we must have your written authorization to use or disclose your personal health information for any purpose that is not set out in this notice (for reasons such as the disclosure of psychotherapy notes). You may revoke your written authorization at any time, except if we have already acted based on your authorization.

Potential Impact of State Law

In some situations, we are required to follow state privacy or other applicable laws that provide greater privacy protections to individuals. If a state law that we follow requires that we not use or disclose protected health information (such as age of majority or parental notification restrictions), then we may not use or disclose that information.

Breach Notification

In the event of a breach of your unsecured health information, we will provide you notification of such a breach as required by law or where we otherwise deem appropriate.

Your Rights

By law, you have the right to:

- Inspect and get a copy of your personal health information held by us upon your written request. An electronic copy may be available in certain circumstances upon request. There may be a fee for copies of this information;
- Have your personal health information amended if you believe (and we agree) that it is wrong or if information is missing. You must make this request in writing and the request must explain why you think the information should be amended;
- Receive, upon written request, a list of instances in which we may have disclosed your personal health information for purposes other than those described in this notice. This list does not include disclosures made for treatment, payment or healthcare operations, certain other activities, and those authorized by you;
- Ask us, upon written request, to communicate with you in a different manner or at a different place (for example, by sending materials to a post office box instead of your home address). Please include in your request if you believe you will be harmed if we sent your information to your current mailing address.
- Ask us to restrict how your personal health information is used and disclosed in order to pay your claims and run our healthcare operations. We are not required to agree to any restriction that you may request; and
- Get a copy of this notice at any time.

Questions and Complaints

If you believe we have violated your privacy rights set out in this notice, you may file a complaint with us at the following address:

Information Privacy Officer
Blue Cross of Idaho
P.O. Box 7408
Boise, ID 83707
1-877-488-7788

You also may file a complaint with the Secretary of the U.S. Department of Health and Human Services. We will not penalize or in any other way retaliate against you for filing a complaint with the Secretary or with us.

Please contact our Information Privacy Officer at 1-877-488-7788 for more information about this notice.

GemPlan℠

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September 1, 2021

GemPlan – Notice of Grandfathered Health Plan

GemPlan believes this plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted.

Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan manager at (208) 237-9696.

Thank you,

GemPlan Staff