



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/coverage>. 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 ?	\$1,500 person/ \$3,000 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 , immunizations or In-Network hospice care and Preventive Care 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 Cost Sharing may apply. For example, this Plan covers certain Preventive Services without Cost Sharing and before you meet your Deductible . See a list of covered Preventive Services at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other Deductibles for specific services?	Yes. \$250 person for Prescription Drugs . There are no other specific Deductibles .	You must pay all of the costs for these services up to the specific Deductible amount before this Plan begins to pay for these services.
What is the Out-of-pocket Limit for this Plan ?	For In-Network Provider \$5,500 person / \$11,000 family, For Out-of-Network Provider \$7,500 person / \$15,000 family For Prescription Drugs \$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 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 https://bcidaho.com/findaProvider 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 Providers 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, Deductible does not apply	40% Coinsurance after Deductible	Copay does not apply to additional services. Cost Sharing may not apply for pediatric physician office visit. Additional telehealth services may be provided by your Provider .
	Specialist visit	\$40 Copay /visit, Deductible does not apply	40% Coinsurance after Deductible	Copay does not apply to additional services. Cost Sharing may not apply for pediatric physician office visit.
	Preventive care / Screening /immunization	No charge for listed preventive, Screening and immunization services. Deductible does not apply.	No charge for listed immunizations, 40% Coinsurance after Deductible for 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. No charge for In-Network supplemental breast Screenings .
If you have a test	Diagnostic test (x-ray, blood work)	20% Coinsurance after Deductible	40% Coinsurance after Deductible	-----none-----
	Imaging (CT/PET scans, MRIs)	20% Coinsurance after Deductible	40% Coinsurance after Deductible	Preauthorization required.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.bcidaho.com	Generic drugs	Preferred=\$10 Copay /prescription Non-preferred=\$20 Copay /prescription (retail and mail order)	Preferred=\$10 Copay /prescription Non-preferred=\$20 Copay /prescription (retail and mail order)	Covers up to a 90 day supply with multiple Copays . Additional Out-of-Network charges may apply.
	Preferred brand drugs	\$30 Copay /prescription (retail and mail order)	\$30 Copay /prescription (retail and mail order)	Subject to prescription Deductible . Covers up to a 90 day supply with multiple Copays . Additional Out-of-Network charges may apply.
	Non-preferred brand drugs	\$50 Copay /prescription (retail and mail order)	\$50 Copay /prescription (retail and mail order)	Subject to prescription Deductible . Covers up to a 90 day supply with multiple Copays . Additional Out-of-Network charges may apply.
	Specialty Drugs	Preferred=20% Coinsurance Non-preferred=30% Coinsurance (retail and mail order)	Preferred=20% Coinsurance Non-preferred=30% Coinsurance (retail and mail order)	Subject to prescription Deductible . Limitations, Preauthorization , and Out-of-Network charges may apply. If eligible for Cost Relief, there is no Cost Sharing if you enroll. If you opt out, Cost Sharing will increase and may not apply to your Deductible .

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 have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% Coinsurance after Deductible	40% Coinsurance after Deductible	Preauthorization required.
	Physician/surgeon fees	20% Coinsurance after Deductible	40% Coinsurance after Deductible	Preauthorization required.
If you need immediate medical attention	Emergency Room Care	\$100 Copay /visit, 20% Coinsurance after Deductible	\$100 Copay /visit, 20% Coinsurance after Deductible	In-Network Cost Sharing applies to both In-Network and Out-of-Network services. Copay waived if admitted.
	Emergency Medical Transportation	20% Coinsurance after Deductible	40% Coinsurance after Deductible	In-Network Cost Sharing applies for air ambulance services.
	Urgent Care	\$40 Copay /visit, Deductible does not apply	40% Coinsurance after Deductible	Copay does not apply to additional services. Cost Sharing may not apply to pediatric physician office visit.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% Coinsurance after Deductible	40% Coinsurance after Deductible	Preauthorization required.
	Physician/surgeon fee	20% Coinsurance after Deductible	40% Coinsurance after Deductible	Preauthorization required.
If you have mental health, behavioral health, or substance abuse services	Outpatient services	\$20 Copay /visit, 20% Coinsurance after Deductible for facility and other services	40% Coinsurance after Deductible	Cost Sharing may not apply for pediatric outpatient psychotherapy. Additional telehealth services may be provided by your Provider .
	Inpatient services	20% Coinsurance after Deductible	40% Coinsurance after Deductible	Preauthorization required.
If you are pregnant	Office Visits	20% Coinsurance after Deductible	40% Coinsurance after Deductible	For pregnancy services, Cost Sharing does not apply to certain Preventive Services . Depending on the type of services, a Copay , Cost Sharing 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 after Deductible	40% Coinsurance after Deductible	-----none-----
	Childbirth/delivery facility services	20% Coinsurance after Deductible	40% Coinsurance after Deductible	-----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 you need help recovering or have other special health needs	Home Health Care	20% Coinsurance after Deductible	40% Coinsurance after Deductible	-----none-----
	ReHabilitation Services	\$60 Copay /visit physical, speech and occupational, \$10 Copay /visit for cardiac therapy; Deductible does not apply.	40% Coinsurance after Deductible	Coverage is limited to 30 visit annual max for outpatient physical, speech and occupational.
	Habilitation Services	\$60 Copay /visit physical, speech and occupational, Deductible does not apply.	40% Coinsurance after Deductible	Coverage is limited to 30 visit annual max for outpatient physical, speech and occupational.
	Skilled Nursing Care	20% Coinsurance after Deductible	40% Coinsurance after Deductible	Preauthorization required. Coverage is limited to 30 day annual max.
	Durable Medical Equipment	20% Coinsurance after Deductible	40% Coinsurance after Deductible	Preauthorization required.
	Hospice Services	No charge. Deductible does not apply.	40% Coinsurance after Deductible	-----none-----
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](#))

- | | | |
|---|--|--|
| <ul style="list-style-type: none">• Acupuncture• Bariatric surgery• Cosmetic surgery• Dental care (Adult)• Dental check-up (Child)• Eye exam (Child) | <ul style="list-style-type: none">• Glasses (Child)• Infertility treatment• Long-term care• Private-duty nursing• Routine eye care (Adult)• Routine foot care | <ul style="list-style-type: none">• Weight loss programs |
|---|--|--|

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

- Chiropractic care
- Hearing aids (Child)
- 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 1-866-444-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.ccio.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.

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

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)		Managing Joe's type 2 Diabetes (a year of routine in-network care of a well-controlled condition)		Mia's Simple Fracture (in-network emergency room visit and follow up care)	
■ The plan's overall deductible	\$1,500	■ The plan's overall deductible :	\$1,500	■ The plan's overall deductible :	\$1,500
■ Specialist copay :	\$40	■ Specialist copay :	\$40	■ Specialist copay :	\$40
■ Hospital (facility) coinsurance :	20%	■ Hospital (facility) coinsurance :	20%	■ Hospital (facility) coinsurance :	20%
■ Other coinsurance :	20%	■ Other 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)		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)		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	\$12,690	Total Example Cost	\$5,830	Total Example Cost	\$2,800
In this example, Peg would pay:		In this example, Joe would pay:		In this example, Mia would pay:	
<i>Cost Sharing</i>		<i>Cost Sharing</i>		<i>Cost Sharing</i>	
Deductibles	\$1,500	Deductibles	\$370	Deductibles	\$1,500
Copayments	\$10	Copayments	\$930	Copayments	\$470
Coinsurance	\$2,210	Coinsurance	\$0	Coinsurance	\$100
<i>What isn't Covered</i>		<i>What isn't Covered</i>		<i>What isn't Covered</i>	
Limits or Exclusions	\$60	Limits or Exclusions	\$20	Limits or Exclusions	\$0
The total Peg would pay is	\$3,780	The total Joe would pay is	\$1,320	The total Mia would pay is	\$2,070

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.

DISCRIMINATION IS AGAINST THE LAW

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

Blue Cross of Idaho:

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

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

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

Civil Rights Coordinator

3000 E. Pine Ave., Meridian, ID 83642

Telephone: 1-800-274-4018

Fax: 208-331-7493

Email: ***grievancesandappeals@bcidaho.com***

TTY: 711

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at ***<https://ocrportal.hhs.gov/ocr/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 (TDD). Complaint forms are available at ***<http://www.hhs.gov/ocr/office/file/index.html>***

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

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

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

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

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

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

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

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

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

Nepali: ध्यान दनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंको नमिता भाषा सहायता सेवाहरू नि:शुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् 1-800-627-1188 (टिटी: 711) ।

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

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

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

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

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

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