



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 [contribution](#)) 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](#), [cost sharing](#), [copayment](#), [deductible](#), [provider](#), or other [underlined](#) terms see the Glossary. You can view the Glossary at [www.healthcare.gov/sbc-glossary](http://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 <a href="#">Deductible</a> ?	<a href="#">In-Network</a> \$500 person/family is a max of 3.	See the Common Medical Events chart below for your costs for services this <a href="#">Plan</a> covers.
Are there services covered before you meet your <a href="#">Deductible</a> ?	Yes. Pharmacy, services that require <a href="#">Copays</a> , emergency room or listed immunizations and <a href="#">Preventive Care</a> are covered before you meet your <a href="#">Deductible</a> .	This <a href="#">Plan</a> covers some items and services even if you haven't yet met the <a href="#">Deductible</a> amount. But a <a href="#">Copayment</a> or <a href="#">Cost Sharing</a> may apply. For example, this <a href="#">Plan</a> covers certain <a href="#">Preventive Services</a> without cost-sharing and before you meet your <a href="#">Deductible</a> . See a list of covered <a href="#">Preventive Services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <a href="#">Deductibles</a> for specific services ?	There are no other specific <a href="#">Deductibles</a> .	You don't have to meet <a href="#">Deductibles</a> for specific services.
What is the <a href="#">Out-of-pocket Limit</a> for this <a href="#">Plan</a> ?	For <a href="#">In-Network Provider</a> \$3,500 person /\$7,000 family	The <a href="#">Out-of-pocket Limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">Plan</a> , they have to meet their own <a href="#">Out-of-pocket Limits</a> until the overall family <a href="#">Out-of-pocket Limit</a> has been met.
What is not included in the <a href="#">Out-of-pocket Limit</a> ?	Contributions, <a href="#">Balance-Billing</a> charges and health care this <a href="#">Plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">Out-of-pocket Limit</a> .
Will you pay less if you use a <a href="#">Network Provider</a> ?	Yes. See <a href="http://www.bcidaho.com">www.bcidaho.com</a> or call 1-855-854-1412 or 208-985-1968 for a list of <a href="#">Network Providers</a> .	This <a href="#">Plan</a> uses a <a href="#">Provider Network</a> . You will pay less if you use a <a href="#">Provider</a> in the <a href="#">Plan's Network</a> . You will pay the most if you use an <a href="#">Out-of-Network Provider</a> , and you might receive a bill from a <a href="#">Provider</a> for the difference between the <a href="#">Provider's</a> charge and what your <a href="#">Plan</a> pays ( <a href="#">Balance Billing</a> ). Be aware your <a href="#">Network Provider</a> might use an <a href="#">Out-of-Network Provider</a> for some services (such as lab work). Check with your <a href="#">Provider</a> before you get services.
Do you need a <a href="#">Referral</a> to see a <a href="#">Specialist</a> ?	No.	You can see the <a href="#">Specialist</a> you choose without a <a href="#">Referral</a> .



All [copayments](#) and [cost sharing](#) 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 <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	\$20 <a href="#">Copay</a> /visit, <a href="#">Deductible</a> does not apply	Not covered	<a href="#">Copay</a> does not apply to additional services. Additional telehealth services may be provided by your <a href="#">Provider</a> .
	<a href="#">Specialist</a> visit	\$40 <a href="#">Copay</a> /visit, <a href="#">Deductible</a> does not apply	Not covered	<a href="#">Copay</a> does not apply to additional services.
	<a href="#">Preventive Care/Screening</a> /immunization	No charge for listed preventive, <a href="#">Screening</a> and immunization services. <a href="#">Deductible</a> does not apply.	Not covered	You may have to pay for services that aren't preventive. Ask your <a href="#">Provider</a> if the services needed are preventive. Then check what your <a href="#">Plan</a> will pay for.
If you have a test	<a href="#">Diagnostic Test</a> (x-ray, blood work)	20% <a href="#">Cost Sharing</a> after <a href="#">Deductible</a>	Not covered	----- none -----
	Imaging (CT/PET scans, MRIs)	20% <a href="#">Cost Sharing</a> after <a href="#">Deductible</a>	Not covered	<a href="#">Preauthorization</a> required.
If you need drugs to treat your illness or condition  More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.medimpact.com">www.medimpact.com</a> or 1-888-402-1984	Generic drugs	20% <a href="#">Cost Sharing</a> (\$4 min, \$100 max <a href="#">Copay</a> per 30 day supply)	Not covered	Covers up to a 90-day supply at <a href="#">In-Network</a> pharmacies, if applicable, with multiple <a href="#">Copays</a> .
	Preferred brand drugs	20% <a href="#">Cost Sharing</a> (\$20 min, \$100 max <a href="#">Copay</a> per 30 day supply)	Not covered	Covers up to a 90-day supply at <a href="#">In-Network</a> pharmacies, if applicable, with multiple <a href="#">Copays</a> .
	Non-preferred brand drugs	30% <a href="#">Cost Sharing</a> (\$40 min, \$150 max <a href="#">Copay</a> per 30 day supply)	Not covered	Covers up to a 90-day supply at <a href="#">In-Network</a> pharmacies, if applicable, with multiple <a href="#">Copays</a> .
	<a href="#">Specialty Drugs</a>	Covered as listed above	Not covered	Coverage may include limitations and <a href="#">Preauthorization</a> may be required.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <a href="#">Cost Sharing</a> after <a href="#">Deductible</a>	Not covered	<a href="#">Preauthorization</a> required.
	Physician/surgeon fees	20% <a href="#">Cost Sharing</a> after <a href="#">Deductible</a>	Not covered	<a href="#">Preauthorization</a> 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	<a href="#">Emergency Room Care</a>	\$200 <a href="#">Copay</a> /visit, 20% <a href="#">Cost Sharing</a> , <a href="#">Deductible</a> does not apply	\$200 <a href="#">Copay</a> /visit, 20% <a href="#">Cost Sharing</a> , <a href="#">Deductible</a> does not apply	<a href="#">In-Network Cost Sharing</a> applies to both <a href="#">In-Network</a> and <a href="#">Out-of-Network</a> services. <a href="#">Copay</a> waived if admitted.
	<a href="#">Emergency Medical Transportation</a>	\$100 <a href="#">Copay</a> /occurrence, 20% <a href="#">Cost Sharing</a> after <a href="#">Deductible</a>	\$100 <a href="#">Copay</a> /occurrence, 20% <a href="#">Cost Sharing</a> after <a href="#">In-Network Deductible</a>	<a href="#">In-Network Cost Sharing</a> applies for air ambulance services.
	<a href="#">Urgent Care</a>	\$20 <a href="#">Copay</a> /visit; <a href="#">Specialist</a> : \$40 <a href="#">Copay</a> /visit; <a href="#">Deductible</a> does not apply	\$20 <a href="#">Copay</a> /visit; <a href="#">Specialist</a> : \$40 <a href="#">Copay</a> /visit; <a href="#">Deductible</a> does not apply	<a href="#">Copay</a> does not apply to additional services. <a href="#">Cost Sharing</a> may vary based on physician.
If you have a hospital stay	Facility fee (e.g., hospital room)	\$100 <a href="#">Copay</a> /admission, 20% <a href="#">Cost Sharing</a> after <a href="#">Deductible</a>	Not covered	<a href="#">Preauthorization</a> required.
	Physician/surgeon fee	20% <a href="#">Cost Sharing</a> after <a href="#">Deductible</a>	Not covered	<a href="#">Preauthorization</a> required.
If you have mental health, behavioral health, or substance abuse services	Outpatient services	\$20 <a href="#">Copay</a> /visit, 20% <a href="#">Cost Sharing</a> after <a href="#">Deductible</a> for facility and other services	Not covered	Additional telehealth services may be provided by your <a href="#">Provider</a> . Contact ComPsych at 1-877-294-3271 for EAP 1-3 visits.
	Inpatient services	\$100 <a href="#">Copay</a> /admission, 20% <a href="#">Cost Sharing</a> after <a href="#">Deductible</a>	Not covered	<a href="#">Preauthorization</a> required.
If you are pregnant	Office Visits	\$20 /visit primary care, \$40 /visit <a href="#">Specialist</a>	Not covered	For pregnancy services, <a href="#">Cost Sharing</a> does not apply to certain <a href="#">Preventive Services</a> . Depending on the type of services, a <a href="#">Copay</a> , <a href="#">Cost Sharing</a> or <a href="#">Deductible</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	\$20 /visit primary care, \$40 /visit <a href="#">Specialist</a>	Not covered	----- none -----
	Childbirth/delivery facility services	\$100 <a href="#">Copay</a> /admission, 20% <a href="#">Cost Sharing</a> after <a href="#">Deductible</a>	Not covered	----- 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	<a href="#">Home Health Care</a>	20% <a href="#">Cost Sharing</a> after <a href="#">Deductible</a>	Not covered	----- none -----
	<a href="#">Rehabilitation Services</a>	\$40 <a href="#">Copay</a> /visit, <a href="#">Deductible</a> does not apply	Not covered	Limitations may apply for <a href="#">Rehabilitation Services</a> .
	<a href="#">Habilitation Services</a>	\$40 <a href="#">Copay</a> /visit, <a href="#">Deductible</a> does not apply	Not covered	Limitations may apply for <a href="#">Habilitation Services</a> .
	<a href="#">Skilled Nursing Care</a>	\$100 <a href="#">Copay</a> /admission, 20% <a href="#">Cost Sharing</a> after <a href="#">Deductible</a>	Not covered	<a href="#">Preauthorization</a> required. Coverage is limited to 100 day annual max.
	<a href="#">Durable Medical Equipment</a>	20% <a href="#">Cost Sharing</a> after <a href="#">Deductible</a>	Not covered	<a href="#">Preauthorization</a> required.
	<a href="#">Hospice Services</a>	20% <a href="#">Cost Sharing</a> after <a href="#">Deductible</a>	Not covered	----- 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](#).)

- Cosmetic surgery
- Dental care (Adult)
- Dental check-up (Child)
- Eye exam (Child)
- Glasses (Child)
- Long-term care
- 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.)

- Acupuncture
- Bariatric surgery through Transcarent
- Chiropractic care
- Hearing aids
- Infertility treatment
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing

## 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](http://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](http://www.cciio.cms.gov). Other coverage options may be available to you too, including buying individual insurance through the Health Insurance [Marketplace](#). For more information about the [Marketplace](#), visit [www.HealthCare.gov](http://www.HealthCare.gov) 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](http://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](http://www.dol.gov/ebsa/healthreform).

## 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 [cost sharing](#)) 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 cost sharing](#) \$40
- Hospital (facility) [cost sharing](#) 20%
- Other [cost sharing](#) 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 \$12,690

**In this example, Peg would pay:**

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$500
<a href="#">Copayments</a>	\$10
<a href="#">cost sharing</a>	\$2,410
<i>What isn't Covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$2,980</b>

**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 cost sharing](#) \$40
- Hospital (facility) [cost sharing](#) 20%
- Other [cost sharing](#) 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 \$5,830

**In this example, Joe would pay:**

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$120
<a href="#">Copayments</a>	\$620
<a href="#">cost sharing</a>	\$0
<i>What isn't Covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$760</b>

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

- The [plan's](#) overall [deductible](#) \$500
- [Specialist cost sharing](#) \$40
- Hospital (facility) [cost sharing](#) 20%
- Other [cost sharing](#) 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 \$2,800

**In this example, Mia would pay:**

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$500
<a href="#">Copayments</a>	\$380
<a href="#">cost sharing</a>	\$300
<i>What isn't Covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,180</b>

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