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

Coverage for: Enrollee + Eligible Dependents | Plan Type: EPO



The Summary of Benefits and Coverage (SBC) document will help you choose a health <u>plan</u>. The SBC shows you how you and the <u>plan</u> would share the cost for covered health care services. Note: Information about the cost of the <u>plan</u> (called the <u>contribution</u>) 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-accoun

Important Questions	Answers	Why This Matters
What is the overall <u>Deductible</u> ?	<u>In-Network</u> \$1,500 person/\$4,500 family	Generally, you must pay all of the costs from <u>Provider</u> s up to the <u>Deductible</u> amount before this <u>Plan</u> begins to pay. If you have other family members on the <u>Plan</u> , each family member must meet their own individual <u>Deductible</u> until the total amount of <u>Deductible</u> expenses paid by all family members meets the overall family <u>Deductible</u> .
Are there services covered before you meet your <u>Deductible</u> ?	Yes. Pharmacy, services that require <u>Copays</u> , hospice care and listed <u>Preventive</u> <u>Care</u> are covered before you meet your <u>Deductible</u> .	This <u>Plan</u> covers some items and services even if you haven't yet met the <u>Deductible</u> amount. But a <u>Copayment</u> or <u>Cost Sharing</u> may apply. For example, this <u>Plan</u> covers certain <u>Preventive Services</u> without cost-sharing and before you meet your <u>Deductible</u> . See a list of covered <u>Preventive Services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other <u>Deductibles</u> for specific services ?	No. There are no other specific <u>Deductibles</u> .	You don't have to meet <u>Deductibles</u> for specific services.
What is the <u>Out-of-pocket Limit</u> for this <u>Plan</u> ?	<u>In-Network</u> \$5,000 person/\$15,000 family	The <u>Out-of-pocket Limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>Plan</u> , they have to meet their own <u>Out-of-pocket Limits</u> until the overall family <u>Out-of-pocket Limit</u> has been met.
What is not included in the <u>Out-of-pocket Limit</u> ?	Contributions, <u>Balance-Billing</u> charges and health care this <u>Plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>Out-of-pocket Limit</u> .
Will you pay less if you use a <u>Network</u> <u>Provider</u> ?	Yes. See <u>www.bcidaho.com</u> or call 1- 855-854-1412 or 208-985-1968 for a list of <u>Network Provider</u> s.	This <u>Plan</u> uses a <u>Provider Network</u> . You will pay less if you use a <u>Provider</u> in the <u>Plan</u> 's <u>Network</u> . You will pay the most if you use an <u>Out-of-Network Provider</u> , and you might receive a bill from a <u>Provider</u> for the difference between the <u>Provider</u> 's charge and what your <u>Plan</u> pays (<u>Balance Billing</u>). Be aware your <u>Network Provider</u> might use an <u>Out-of-Network Provider</u> for some services (such as lab work). Check with your <u>Provider</u> before you get services.
Do you need a <u>Referral</u> to see a <u>Specialist</u> ?	No.	You can see the <u>Specialist</u> you choose without a <u>Referral</u> .





		What You Will Pay		
Common Medical Event	Services You May Need	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you visit a health care <u>Provider</u> 's office or clinic	Primary care visit to treat an injury or illness	\$20 <u>Copay</u> /visit, <u>Deductible</u> does not apply	Not covered	Additional telehealth services may be provided by your <u>Provider</u> .
	Specialist visit	\$40 <u>Copay</u> /visit, <u>Deductible</u> does not apply	Not covered	none
	Preventive care/Screening/immunization	No charge for listed preventive, <u>Screening</u> and immunization services. <u>Deductible</u> does not apply.	Not covered	You may have to pay for services that aren't preventive. Ask your <u>Provider</u> if the services needed are preventive. Then check what your <u>Plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	Listed services and performed in office: PCP: \$20 Copay/visit; Specialist: \$40 Copay/visit, Deductible does not apply. 30% Cost Sharing after Deductible for services not listed or peformed in office.	Not covered	none
	Imaging (CT/PET scans, MRIs)	30% <u>Cost Sharing</u> after <u>Deductible</u>	Not covered	Preauthorization required.
If you need drugs to treat your illness or	Generic drugs	\$10 <u>Copay</u> per 30 day supply	Not covered	Covers up to a 90-day supply at In-Network pharmacies, if applicable, with multiple Copays .
condition	Preferred brand drugs	20% <u>Coinsurance</u> (\$30 min, \$90 max <u>Copay</u> per 30 day supply)	Not covered	Covers up to a 90-day supply at <u>In-Network</u> pharmacies, if applicable, with multiple <u>Copays</u> .
More information about prescription drug coverage is available at	Non-preferred brand drugs	30% <u>Coinsurance</u> (\$60 min, \$120 max <u>Copay</u> per 30 day supply)	Not covered	Covers up to a 90-day supply at <u>In-Network</u> pharmacies, if applicable, with multiple <u>Copays</u> .
www.medimpact. com or 1-888-402-1984	Specialty Drugs	Covered as listed above	Not covered	Coverage may include limitations and <u>Preauthorization</u> may be required.

		What You Will Pay		
Common Medical Event	Services You May Need	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% <u>Cost Sharing</u> after <u>Deductible</u>	Not covered	<u>Preauthorization</u> required.
	Physician/surgeon fees	30% <u>Cost Sharing</u> after <u>Deductible</u>	Not covered	<u>Preauthorization</u> required.
If you need immediate medical attention	Emergency Room Care	\$200 <u>Copay</u> /visit, 30% <u>Cost</u> <u>Sharing</u> after <u>Deductible</u>	\$200 <u>Copay</u> /visit, 30% <u>Cost</u> <u>Sharing after In-Network</u> <u>Deductible</u>	<u>In-Network Cost Sharing</u> applies to both <u>In-Network</u> and <u>Out-of-Network</u> services. <u>Copay</u> waived if admitted.
	Emergency Medical Transportation	30% <u>Cost Sharing</u> after <u>Deductible</u>	30% <u>Cost Sharing</u> after <u>In-</u> <u>Network</u> <u>Deductible</u>	<u>In-Network</u> <u>Cost Sharing</u> applies for air ambulance services.
	<u>Urgent Care</u>	\$20 <u>Copay</u> /visit; <u>Specialist</u> : \$40 <u>Copay</u> /visit; <u>Deductible</u> does not apply	\$20 <u>Copay</u> /visit; <u>Specialist</u> : \$40 <u>Copay</u> /visit; <u>Deductible</u> does not apply	Cost Sharing may vary based on physician.
If you have a hospital stay	Facility fee (e.g., hospital room)	30% <u>Cost Sharing</u> after <u>Deductible</u>	Not covered	<u>Preauthorization</u> required.
	Physician/surgeon fee	30% <u>Cost Sharing</u> after <u>Deductible</u>	Not covered	<u>Preauthorization</u> required.
If you have mental health, behavioral health, or substance abuse services	Outpatient services	\$20 <u>Copay</u> /visit; <u>Deductible</u> does not apply; 30% <u>Cost</u> <u>Sharing</u> after <u>Deductible</u> for facility and other services	Not covered	Additional telehealth services may be provided by your <u>Provider</u> . Contact ComPsych at 1-877-294-3271 for EAP 1-3 visits.
	Inpatient services	30% <u>Cost Sharing</u> after <u>Deductible</u>	Not covered	<u>Preauthorization</u> required.
If you are pregnant	Office Visits	30% <u>Cost Sharing</u> after <u>Deductible</u>	Not covered	For pregnancy services, <u>Cost Sharing</u> does not apply to certain <u>Preventive Services</u> . Depending on the type of services, a <u>Copay</u> , <u>Cost Sharing</u> or <u>Deductible</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	30% <u>Cost Sharing</u> after <u>Deductible</u>	Not covered	none
	Childbirth/delivery facility services	30% <u>Cost Sharing</u> after <u>Deductible</u>	Not covered	none

		What You Will Pay		
Common Medical Event	Services You May Need	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need help recovering or have other special health needs	Home Health Care	30% <u>Cost Sharing</u> after <u>Deductible</u>	Not covered	none
	ReHabilitation Services	\$40 <u>Copay</u> /visit, <u>Deductible</u> does not apply	Not covered	Coverage is limited to 30 visit annual max combined for outpatient physical, speech and occupational; 36 visit annual max for outpatient cardiac therapy.
	Habilitation Services	\$40 <u>Copay</u> /visit, <u>Deductible</u> does not apply	Not covered	Coverage is limited to 30 visit annual max combined for outpatient physical, speech and occupational.
	Skilled Nursing Care	30% <u>Cost Sharing</u> after <u>Deductible</u>	Not covered	Limited to 100 day annual max. <u>Preauthorization</u> required.
	Durable Medical Equipment	30% <u>Cost Sharing</u> after <u>Deductible</u>	Not covered	<u>Preauthorization</u> required.
	Hospice Services	No charge. <u>Deductible</u> does not apply.	Not covered	Includes Bereavement Counseling.
If your child needs	Children's eye exam	Not covered	Not covered	none
dental or eye care	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)
- Infertility treatment

- 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
- 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 1-866-4444-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 the Health Insurance Marketplace. For more information about the Marketplace, visit 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 <u>plan</u> for a denial of <u>claim</u>. This complaint is called a <u>grievance</u> or <u>appeal</u>. For more information about your rights, look at the explanation of benefits you will receive for that medical <u>claim</u>. Your <u>plan</u> documents also provide complete information to submit a <u>claim</u>, <u>appeal</u>, or a <u>grievance</u> for any reason to your <u>plan</u>. For more information about your rights, this notice, or assistance, contact:

For any inital 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.

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:

Questions: Call 1-855-854-1412 or 208-985-1968 or visit us at www.bcidaho.com/SBC.



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)		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 <u>plan's</u> overall <u>deductible</u>	\$1,500	■ The <u>plan's</u> overall <u>deductible</u> :	\$1,500	■ The <u>plan's</u> overall <u>deductible</u> :	\$1,500
Specialist cost sharing:	\$40	■ Specialist cost sharing:	\$40	■ Specialist cost sharing:	\$40
Hospital (facility) cost sharing:	30%	■ Hospital (facility) <u>cost sharing</u> :	30%	■ Hospital (facility) <u>cost sharing</u> :	30%
Other cost sharing:	30%	■ Other <u>cost sharing</u> :	30%	Other cost sharing:	30%
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 dis 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:	
Cost Sharing		Cost Sharing		Cost Sharing	
Deductibles				D. J. 1911	\$1,500
	\$1,500	<u>Deductibles</u>	\$120	<u>Deductibles</u>	J1,J00
<u>Copayments</u>	\$1,500 \$10	<u>Copayments</u>	\$120 \$900	Copayments	\$490
	<u> </u>		<u> </u>		
<u>Copayments</u>	\$10	<u>Copayments</u>	\$900	Copayments	\$490
Copayments Cost Sharing	\$10	Copayments Cost Sharing	\$900	Cost Sharing	\$490

The <u>plan</u> would be responsible for the other costs of these EXAMPLE covered services.