



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 or call 1-800-627-1188 to request a copy.

Important Questions	Answers	Why This Matters
What is the overall Deductible ?	In-Network \$1,500 person/family is a max of 3. Out-of-Network \$1,500 person/family is a max of 3.	Generally, you must pay all of the costs from Provider s 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. Rx drugs, Copay , non-covered and ambulance services or In-Network home health, hospice 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?	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 \$5,300 person / \$10,600 family For Out-of-Network Provider \$5,300 person / \$10,600 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 ?	Contributions, 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 www.bcidaho.com or call 1-855-854-1412 or 208-985-1968 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 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 <u>Provider's</u> office or clinic	Primary care visit to treat an injury or illness	20% <u>Cost Sharing</u> after <u>Deductible</u>	40% <u>Cost Sharing</u> after <u>Deductible</u>	Additional telehealth services may be provided by your <u>Provider</u> .
	<u>Specialist</u> visit	20% <u>Cost Sharing</u> after <u>Deductible</u>	40% <u>Cost Sharing</u> after <u>Deductible</u>	-----none-----
	<u>Preventive care/Screening</u> /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)	20% <u>Cost Sharing</u> after <u>Deductible</u>	40% <u>Cost Sharing</u> after <u>Deductible</u>	-----none-----
	Imaging (CT/PET scans, MRIs)	20% <u>Cost Sharing</u> after <u>Deductible</u>	40% <u>Cost Sharing</u> after <u>Deductible</u>	<u>Preauthorization</u> required.
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.medimpact.com or 1-888-402-1984	Generic drugs	20% <u>Cost Sharing</u>	Not covered	\$4 min/\$20 max per prescription up to a 30 day supply. \$8 min/\$40 max per prescription 31-60 day supply. \$12 min/\$60 max per prescription 61-90 day supply. Max amounts do not apply to <u>Out-of-Network Providers</u> .
	Preferred brand drugs	30% <u>Cost Sharing</u>	Not covered	\$40 min/\$100 max per prescription up to a 30 day supply. \$80 min/\$200 max per prescription 31-60 day supply. \$100 min/\$250 max per prescription 61-90 day supply. Max amounts do not apply to <u>Out-of-Network Providers</u> .
	Non-preferred brand drugs	50% <u>Cost Sharing</u>	Not covered	\$70 min/\$160 max per prescription up to a 30 day supply. \$140 min/\$320 max per prescription 31-60 day supply. \$175 min/\$380 max per prescription 61-90 day supply. Max amounts do not apply to <u>Out-of-Network Providers</u> .
	<u>Specialty Drugs</u>	50% <u>Cost Sharing</u>	Not covered	Coverage may include limitations and <u>Preauthorization</u> may be 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 have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% Cost Sharing after Deductible	40% Cost Sharing after Deductible	Preauthorization required.
	Physician/surgeon fees	20% Cost Sharing after Deductible	40% Cost Sharing after Deductible	Preauthorization required.
If you need immediate medical attention	Emergency Room Care	\$200 Copay /visit, 20% Cost Sharing after Deductible	\$200 Copay /visit, 20% Cost Sharing after In-Network Deductible	In-Network Cost Sharing applies to both In-Network and Out-of-Network services. Copay waived if admitted.
	Emergency Medical Transportation	\$100 Copay /occurrence, 20% Cost Sharing . Deductible does not apply.	\$100 Copay /occurrence, 20% Cost Sharing . Deductible does not apply.	In-Network Cost Sharing applies for air ambulance services.
	Urgent Care	20% Cost Sharing after Deductible	20% Cost Sharing after In-Network Deductible	-----none-----
If you have a hospital stay	Facility fee (e.g., hospital room)	\$100 Copay /admission, 20% Cost Sharing after Deductible	\$200 Copay /admission, 40% Cost Sharing after Deductible	Preauthorization required.
	Physician/surgeon fee	20% Cost Sharing after Deductible	40% Cost Sharing after Deductible	Preauthorization required.
If you have mental health, behavioral health, or substance abuse services	Outpatient services	20% Cost Sharing after Deductible	40% Cost Sharing after Deductible	Additional telehealth services may be provided by your Provider . Contact ComPsych at 1-877-294-3271 for EAP 1-5 visits.
	Inpatient services	\$100 Copay /admission, 20% Cost Sharing after Deductible	\$200 Copay /admission, 40% Cost Sharing after Deductible	Preauthorization required.
If you are pregnant	Office Visits	20% Cost Sharing after Deductible	40% Cost Sharing 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% Cost Sharing after Deductible	40% Cost Sharing after Deductible	-----none-----
	Childbirth/delivery facility services	\$100 Copay /admission, 20% Cost Sharing after Deductible	\$200 Copay /admission, 40% Cost Sharing after Deductible	Preauthorization required if inpatient stay exceeds 48 hours for normal delivery and 96 hours after cesarean delivery.

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	No charge	40% Cost Sharing after Deductible	Coverage is limited to 90 visits annual max.
	ReHabilitation Services	20% Cost Sharing after Deductible	40% Cost Sharing after Deductible	Coverage is limited to 45 visit annual max for physical, speech and occupational services. Cardiac services are limited to 45 visit annual max.
	Habilitation Services	20% Cost Sharing after Deductible	40% Cost Sharing after Deductible	Coverage is limited to 45 visit annual max for physical, speech and occupational services.
	Skilled Nursing Care	20% Cost Sharing after Deductible	40% Cost Sharing after Deductible	Coverage is limited to 120 day annual max. Preauthorization required.
	Durable Medical Equipment	20% Cost Sharing after Deductible	40% Cost Sharing after Deductible	Preauthorization required.
	Hospice Services	No charge. Deductible does not apply.	40% Cost Sharing after Deductible	Includes Bereavement Counseling.
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)

- Abortion, except in the cases of rape, incest or when the life of the mother is endangered.
- Cosmetic surgery
- Dental care (Adult)
- Dental check-up (Child)
- Eye exam (Child)
- Glasses (Child)
- 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.)

- Acupuncture
- Bariatric surgery through Transcarent
- Chiropractic care
- Hearing aids
- Infertility treatment
- 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.ccio.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 [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.

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)	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 cost sharing : 20%	■ Specialist cost sharing : 20%	■ Specialist cost sharing : 20%
■ Hospital (facility) cost sharing : 20%	■ Hospital (facility) cost sharing : 20%	■ Hospital (facility) cost sharing : 20%
■ Other cost sharing : 20%	■ Other 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)	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:
Cost Sharing	Cost Sharing	Cost Sharing
Deductibles \$1,500	Deductibles \$1,500	Deductibles \$1,500
Copayments \$100	Copayments \$0	Copayments \$300
cost sharing \$2,200	cost sharing \$1,270	cost sharing \$200
What isn't Covered	What isn't Covered	What isn't Covered
Limits or Exclusions \$60	Limits or Exclusions \$20	Limits or Exclusions \$0
The total Peg would pay is \$3,860	The total Joe would pay is \$2,790	The total Mia would pay is \$2,000

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