HDHP Single Retiree

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

Coverage Period: 7/1/2023 - 6/30/2024

Coverage for: Enrollee | **Plan Type: Trad**

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 1-866-804-2253 or 208-331-8897 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall Deductible?	**$2,000** person	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 policy, the overall family Deductible must be met before the Plan begins to pay.
Are there services covered before you meet your Deductible?	Yes. Immunizations 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 Coinsurance 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 **$5,000** person For Out-of-Network Provider **$6,500** person	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 **www.bcidaho.com or call 1-866-804-2253** 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: Network Provider (You will pay the least)	What You Will Pay: Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	30% Coinsurance after Deductible	50% Coinsurance after Deductible	No charge for qualifying non-emergency telehealth services provided by MDLIVE. Additional telehealth services may be provided by your Provider.
	Specialist visit	30% Coinsurance after Deductible	50% Coinsurance after Deductible	-- none --
	Preventive Care/Screening/immunization	No charge for listed preventive, Screening and immunization services. Deductible does not apply.	No charge for listed immunizations, 50% 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.
If you have a test	Diagnostic Test (x-ray, blood work)	30% Coinsurance after Deductible	50% Coinsurance after Deductible	No charge after Deductible for COVID-19 testing.
	Imaging (CT/PET scans, MRIs)	30% Coinsurance after Deductible	50% Coinsurance after Deductible	Preauthorization required.

Common Medical Event	Services You May Need	What You Will Pay: Network Provider (You will pay the least)	What You Will Pay: Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.bcidaho.com	Generic drugs	30% Coinsurance after Deductible (retail and mail order)	30% Coinsurance after Deductible (retail and mail order)	Covers up to a 30 day supply for retail non-maintenance drugs, or up to a 90 day supply for retail and mail order maintenance drugs. Additional Out-of-Network charges may apply. No charge after Deductible for certain medical services available at Albertsons and Safeway Pharmacy locations.
	Preferred brand drugs	30% Coinsurance after Deductible (retail and mail order)	30% Coinsurance after Deductible (retail and mail order)	Covers up to a 30 day supply for retail non-maintenance drugs, or up to a 90 day supply for retail and mail order maintenance drugs. Additional Out-of-Network charges may apply. No charge after Deductible for certain medical services available at Albertsons and Safeway Pharmacy locations.
	Non-preferred brand drugs	30% Coinsurance after Deductible (retail and mail order)	30% Coinsurance after Deductible (retail and mail order)	Covers up to a 30 day supply for retail non-maintenance drugs, or up to a 90 day supply for retail and mail order maintenance drugs. Additional Out-of-Network charges may apply. No charge after Deductible for certain medical services available at Albertsons and Safeway Pharmacy locations.
	Specialty Drugs	30% Coinsurance after Deductible (retail and mail order)	30% Coinsurance after Deductible (retail and mail order)	Covers up to a 30 day supply. Coverage may include limitations and Preauthorization may be required. Additional Out-of-Network charges may apply. No charge after Deductible for certain medical services available at Albertsons and Safeway Pharmacy locations.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% Coinsurance after Deductible	50% Coinsurance after Deductible	Preauthorization required.
	Physician/surgeon fees	30% Coinsurance after Deductible	50% Coinsurance after Deductible	Preauthorization required.
If you need immediate medical attention	Emergency Room Care	$100 Copay, then 30% Coinsurance after Deductible	$100 Copay, then 50% Coinsurance after Deductible	Copay waived if admitted.
	Emergency Medical Transportation	30% Coinsurance after Deductible	50% Coinsurance after Deductible	---------- none ----------
	Urgent Care	30% Coinsurance after Deductible	50% 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 have a hospital stay	Facility fee (e.g., hospital room)	30% Coinsurance after Deductible	50% Coinsurance after Deductible	Preauthorization required.
	Physician/surgeon fee	30% Coinsurance after Deductible	50% Coinsurance after Deductible	Preauthorization required.
If you have mental health, behavioral health, or substance abuse services	Outpatient services	30% Coinsurance after Deductible	50% Coinsurance after Deductible	No charge for qualifying non-emergency telehealth services provided by MDLIVE. Additional telehealth services may be provided by your Provider.
	Inpatient services	30% Coinsurance after Deductible	50% Coinsurance after Deductible	Preauthorization required.
If you are pregnant	Office Visits	30% Coinsurance after Deductible	50% Coinsurance after Deductible	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	30% Coinsurance after Deductible	50% Coinsurance after Deductible	-- none --
	Childbirth/delivery facility services	30% Coinsurance after Deductible	50% Coinsurance after Deductible	-- none --
If you need help recovering or have other special health needs	Home Health Care	30% Coinsurance after Deductible	50% Coinsurance after Deductible	Preauthorization required.
	ReHabilitation Services	30% Coinsurance after Deductible	50% Coinsurance after Deductible	Coverage is limited to 20 visit annual max for occupational and speech therapies. Physical therapy is limited to 40 visit annual max.
	Habilitation Services	30% Coinsurance after Deductible	50% Coinsurance after Deductible	Coverage is limited to 20 visit annual max for occupational and speech therapies. Physical therapy is limited to 40 visit annual max.
	Skilled Nursing Care	30% Coinsurance after Deductible	50% Coinsurance after Deductible	Coverage is limited to 30 day annual max.
	Durable Medical Equipment	30% Coinsurance after Deductible	50% Coinsurance after Deductible	Preauthorization required.
	Hospice Services	No charge after Deductible	50% Coinsurance after Deductible	-- none --

Common Medical Event	Services You May Need	What You Will Pay: Network Provider (You will pay the least)	What You Will Pay: Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
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.)	
• Bariatric surgery • Cosmetic surgery • Dental care (Adult) • Dental check-up (Child) • Eye exam (Child) • Glasses (Child) • 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.)
• Acupuncture • Chiropractic care • Hearing aids • 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 1-866-804-2253 or 208-331-8897, 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)

■ **The plan's overall deductible**	$2,000
■ **Specialist coinsurance**	30%
■ **Hospital (facility) coinsurance**	30%
■ **Other coinsurance**	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)*

Total Example Cost	$12,690

In this example, Peg would pay:

Cost Sharing	
Deductibles	$2,000
Copayments	$0
Coinsurance	$3,000
What isn't Covered	
Limits or exclusions	$60
The total Peg would pay is	**$5,060**

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ **The plan's overall deductible**	$2,000
■ **Specialist coinsurance**	30%
■ **Hospital (facility) coinsurance**	30%
■ **Other coinsurance**	30%

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:

Cost Sharing	
Deductibles	$2,000
Copayments	$0
Coinsurance	$840
What isn't Covered	
Limits or exclusions	$20
The total Joe would pay is	**$2,860**

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ **The plan's overall deductible**	$2,000
■ **Specialist coinsurance**	30%
■ **Hospital (facility) coinsurance**	30%
■ **Other coinsurance**	30%

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:

Cost Sharing	
Deductibles	$2,000
Copayments	$100
Coinsurance	$170
What isn't Covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,270**

The plan would be responsible for the other costs of these EXAMPLE covered services.

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  - o Qualified sign language interpreters
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- Provides free language services to people whose primary language is not English, such as:
  - o Qualified interpreters
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If you need these services, contact Blue Cross of Idaho Customer Service Department. Call 1-800-627-1188 (TTY: 711), 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: 711

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>***

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 مجانًا 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: 1-800-377-1363).

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.

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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).