



**This is only a summary.** If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan by calling 1-800-627-1188.

Important Questions	Answers	Why This Matters:
What is the overall <b>deductible</b> ?	For in-network provider <b>\$250</b> person/ <b>\$750</b> family For out-of-network provider <b>\$500</b> person/ <b>\$1,500</b> family. Does not apply to pharmacy, copays, or in-network hospice care and listed preventive care.	You must pay all the costs up to the <b>deductible</b> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <b>deductible</b> starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the <b>deductible</b> .
Are there other <b>deductibles</b> for specific services?	No. There are no other specific deductibles.	You don't have to meet <b>deductibles</b> for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses?	Yes. For in-network provider <b>\$3,250</b> person/ <b>\$6,750</b> family For out-of-network provider <b>\$6,500</b> person/ <b>\$13,500</b> family	The <b>out-of-pocket limit</b> is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Copays, premiums, balance-billed charges, pharmacy and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <b>out-of-pocket limit</b> .
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits.
Does this plan use a <b>network of providers</b> ?	Yes. For a list of in-network providers, see <b>www.bcidaho.com</b> or call <b>1-800-627-1188</b> .	If you use an <b>in-network</b> doctor or other health care <b>provider</b> , this plan will pay some of all of the costs of covered services. Be aware, your <b>in-network</b> doctor or hospital may use an <b>out-of-network provider</b> for some services. Plans use the term <b>in-network, preferred,</b> or participating for <b>providers</b> in their <b>network</b> . See the chart starting on page 2 for how this plan pays different kinds of <b>providers</b> .
Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the <b>specialist</b> you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about <b>excluded services</b> .

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- **Copayments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **coinsurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use in-network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-Of-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$20 copay/visit	30% coinsurance	Does not apply to additional services.
	Specialist visit	\$20 copay/visit	30% coinsurance	Does not apply to additional services.
	Other practitioner office visit	\$20 copay/visit	30% coinsurance	Does not apply to additional services.
	Preventive care/screening/immunization	No charge for listed preventive, screening and immunization services.	30% coinsurance for listed preventive, screening and immunization services.	----- none -----
If you have a test	Diagnostic test (x-ray, blood work)	15% coinsurance	30% coinsurance	----- none -----
	Imaging (CT/PET scans, MRIs)	15% coinsurance	30% coinsurance	Preauthorization required.

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Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-Of-Network Provider	Limitations & Exceptions
<b>If you need drugs to treat your illness or condition</b>  More information about <u>prescription drug coverage</u> is available at <a href="http://www.bcidaho.com">www.bcidaho.com</a>	Generic drugs	\$10 copay/prescription (retail only)	\$10 copay/prescription (retail only)	Covers up to a 30 day supply (non-maintenance drugs), or up to a 90 day supply with multiple copays (maintenance drugs).
	Preferred brand drugs	\$25 copay/prescription (retail only)	\$25 copay/prescription (retail only)	Covers up to a 30 day supply (non-maintenance drugs), or up to a 90 day supply with multiple copays (maintenance drugs).
	Non-preferred brand drugs	\$50 copay/prescription (retail only)	\$50 copay/prescription (retail only)	Covers up to a 30 day supply (non-maintenance drugs), or up to a 90 day supply with multiple copays (maintenance drugs).
	Specialty drugs	\$50 copay/prescription (retail only)	\$50 copay/prescription (retail only)	Coverage may include limitations and preauthorization may be required.
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	15% coinsurance	30% coinsurance	Preauthorization required.
	Physician/surgeon fees	15% coinsurance	30% coinsurance	Preauthorization required.
<b>If you need immediate medical attention</b>	Emergency room services	15% coinsurance	30% coinsurance	----- none -----
	Emergency medical transportation	15% coinsurance	30% coinsurance	----- none -----
	Urgent care	\$20 copay/visit	30% coinsurance	Does not apply to additional services.
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	15% coinsurance	30% coinsurance	Preauthorization required.
	Physician/surgeon fee	15% coinsurance	30% coinsurance	Preauthorization required.
<b>If you have mental health, behavioral health, or substance abuse needs</b>	Mental/Behavioral health outpatient services	\$20/visit, 15% facility and other services / EAP 1-5 visits at no charge	30% coinsurance	Preauthorization required. Contact ComPsych at 1-877-427-2327 for contracting in-network EAP providers and for Preauthorization of EAP visits.
	Mental/Behavioral health inpatient services	15% coinsurance	30% coinsurance	Preauthorization required.
	Substance use disorder outpatient services	\$20/visit, 15% facility and other services / EAP 1-5 visits at no charge	30% coinsurance	Preauthorization required. Contact ComPsych at 1-877-427-2327 for contracting in-network EAP providers and for Preauthorization of EAP visits.
	Substance use disorder inpatient services	15% coinsurance	30% coinsurance	Preauthorization required.

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Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-Of-Network Provider	Limitations & Exceptions
<b>If you are pregnant</b>	Prenatal and postnatal care	15% coinsurance	30% coinsurance	No coverage for dependent daughters.
	Delivery and all inpatient services	15% coinsurance	30% coinsurance	No coverage for dependent daughters.
<b>If you need help recovering or have other special health needs</b>	Home health care	15% coinsurance	30% coinsurance	Preauthorization required.
	Rehabilitation services	15% coinsurance	30% coinsurance	Coverage is limited to 20 visit annual max for habilitation and rehabilitation services.
	Habilitation services	15% coinsurance	30% coinsurance	Coverage is limited to 20 visit annual max for habilitation and rehabilitation services.
	Skilled nursing care	15% coinsurance	30% coinsurance	Coverage is limited to 30 day annual max.
	Durable medical equipment	15% coinsurance	30% coinsurance	Preauthorization required.
	Hospice service	No charge	30% coinsurance	Preauthorization required.
<b>If your child needs dental or eye care</b>	Eye exam	Not covered	Not covered	----- none -----
	Glasses	Not covered	Not covered	----- none -----
	Dental check-up	Not covered	Not covered	----- none -----

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**Excluded Services & Other Covered Services:**

**Services Your Plan Does NOT Cover** (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Dental check-up (Child)
- Eye exam (Child)
- Glasses (Child)
- Hearing aids
- Infertility treatment
- Long-term care
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

**Other Covered Services** (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Chiropractic care
- Non-emergency care when traveling outside the U.S.

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## Your Rights to Continue Coverage:

### \*\* Group health coverage -

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-208-331-7347 or 1-800-627-1188. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa](http://www.dol.gov/ebsa), or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov).

## Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as “minimum essential coverage.” **This plan or policy does provide minimum essential coverage.**

## Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

## Your Grievance and Appeals Rights:

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)

If your plan is fully insured or a self-funded subject to the Idaho Insurance Code, you may also receive assistance from the Idaho Department of Insurance at 1-800-721-3272 or [www.DOIIdaho.gov](http://www.DOIIdaho.gov)

## Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-208-331-7347 or 1-800-627-1188.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-208-331-7347 or 1-800-627-1188.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-208-331-7347 or 1-800-627-1188.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijjigo holne' 1-208-331-7347 or 1-800-627-1188.

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## About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



**This is not a cost estimator.**

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

### Having a baby

(normal delivery)

- **Amount owed to providers: \$7,540**
- **Plan pays \$6,162**
- **Patient pays \$1,378**

#### Sample care costs:

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
<b>Total</b>	<b>\$7,540</b>

#### Patient pays:

Deductibles	\$250
Co-pays	\$70
Co-insurance	\$1,058
Limits or exclusions	
<b>Total</b>	<b>\$1,378</b>

### Managing type 2 diabetes

(routine maintenance of a well-controlled condition)

- **Amount owed to providers: \$5,400**
- **Plan pays \$4,412**
- **Patient pays \$988**

#### Sample care costs:

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
<b>Total</b>	<b>\$5,400</b>

#### Patient pays:

Deductibles	\$250
Co-pays	\$520
Co-insurance	\$218
Limits or exclusions	
<b>Total</b>	<b>\$988</b>

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## Questions and answers about the Coverage Examples:

### What are some of the assumptions behind the Coverage Examples?

- Costs don't include premiums.
- Sample care costs are based on a national averages supplied by the US Department of Health and Human Services; and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network providers. If the patient had received care from out-of-network providers, costs would have been higher.

### What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how deductibles, copayments, and coinsurance can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

### Does the Coverage Example predict my own care needs?

✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

### Does the Coverage Example predict my future expenses?

✗ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.

### Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

### Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the premium you pay. Generally, the lower your premium, the more you'll pay in out-of-pocket costs, such as copayments, deductibles, and coinsurance. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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