



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 deductible ?	\$5,000 person / \$10,000 family Does not apply to copays, pharmacy, pregnancy, in-network listed preventive and hospice care.	You must pay all the costs up to the <u>deductible</u> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <u>deductible</u> 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 <u>deductible</u> .
Are there other deductibles for specific services?	Yes. \$5,000 for pregnancy services. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this plan begins to pay for these services.
Is there an out-of-pocket limit on my expenses?	Yes. For in-network provider \$2,000 person/ \$4,000 A family, For out-of-network provider \$2,000 person/ \$4,000 A family	The <u>out-of-pocket limit</u> 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, deductibles and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
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 network of providers ?	Yes. For a list of in-network providers, see www.bcidaho.com or call 1-800-627-1188.	If you use an in- <u>network</u> doctor or other health care <u>provider</u> , this plan will pay some of all of the costs of covered services. Be aware, your in- <u>network</u> doctor or hospital may use an out-of- <u>network</u> <u>provider</u> for some services. Plans use the term in- <u>network</u> , <u>preferred</u> , or participating for <u>providers</u> in their <u>network</u> . See the chart starting on page 2 for how this plan pays different kinds of <u>providers</u> .
Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the <u>specialist</u> 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 <u>excluded services</u> .

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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	Not Covered	Not Covered	----- none -----
	Specialist visit	Not Covered	Not Covered	----- none -----
	Other practitioner office visit	Not Covered	Not Covered	----- none -----
	Preventive care/screening/immunization	No charge for listed preventive, screening and immunization services.	No charge for listed immunizations, 50% coinsurance preventive and screening.	----- none -----
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	50% coinsurance	For inpatient and ER services and outpatient mammograms only.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	50% coinsurance	For inpatient and ER services and outpatient mammograms only.

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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
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.bcidaho.com	Generic drugs	Not Covered	Not Covered	Pharmacy discount.
	Preferred brand drugs	Not Covered	Not Covered	Pharmacy discount.
	Non-preferred brand drugs	Not Covered	Not Covered	Pharmacy discount.
	Specialty drugs	Not Covered	Not Covered	Pharmacy discount.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	50% coinsurance	Preauthorization required.
	Physician/surgeon fees	20% coinsurance	50% coinsurance	Preauthorization required.
If you need immediate medical attention	Emergency room services	\$100 copay/visit, 20% coinsurance	\$100 copay/visit, 50% coinsurance	Copay waived if admitted.
	Emergency medical transportation	20% coinsurance	50% coinsurance	----- none -----
	Urgent care	Not Covered	Not Covered	----- none -----
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	50% coinsurance	Preauthorization required.
	Physician/surgeon fee	20% coinsurance	50% coinsurance	Preauthorization required.
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	Not covered	Not covered	----- none -----
	Mental/Behavioral health inpatient services	Not covered	Not covered	----- none -----
	Substance use disorder outpatient services	Not covered	Not covered	----- none -----
	Substance use disorder inpatient services	Not covered	Not covered	----- none -----
If you are pregnant	Prenatal and postnatal care	20% coinsurance	50% coinsurance	No coverage for dependent daughters.
	Delivery and all inpatient services	20% coinsurance	50% coinsurance	No coverage for dependent daughters.

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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
If you need help recovering or have other special health needs	Home health care	Not covered	Not covered	----- none -----
	Rehabilitation services	Not covered	Not covered	----- none -----
	Habilitation services	Not covered	Not covered	----- none -----
	Skilled nursing care	20% coinsurance	50% coinsurance	Coverage is limited to 30 day annual max.
	Durable medical equipment	Not covered	Not covered	----- none -----
	Hospice service	20% coinsurance	50% coinsurance	Preauthorization required. Coverage is limited to \$10,000 lifetime max.
If your child needs dental or eye care	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 | • Habilitation services | • Private-duty nursing |
| • Bariatric surgery | • Hearing aids | • Rehabilitation services |
| • Chiropractic care | • Home health care | • Routine eye care (Adult) |
| • Cosmetic surgery | • Infertility treatment | • Routine foot care |
| • Dental care (Adult) | • Long-term care | • Specialist visit |
| • Dental check-up (Child) | • Mental/Behavioral health inpatient services | • Specialty drugs |
| • Durable medical equipment | • Mental/Behavioral health outpatient services | • Substance use disorder inpatient services |
| • Eye exam (Child) | • Non-preferred brand drugs | • Substance use disorder outpatient services |
| • Generic drugs | • Preferred brand drugs | • Urgent care |
| • Glasses (Child) | • Primary care visit to treat an injury or illness | • 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.)

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

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Your Rights to Continue Coverage:

** Individual health insurance sample -

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your **premium**. There are exceptions, however, such as if:

- You commit fraud
- The insurer stops offering services in the State
- You move outside the coverage area

For more information on your rights to continue coverage, contact the insurer at 1-800-627-1188. You may also contact your state insurance department at 1-800-721-3272.

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, 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 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

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): Dine'ehgo shika at'ohwol ninisingo, kwijigo 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 \$1,320**
- **Patient pays \$6,220**

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
Total	\$7,540

Patient pays:

Deductibles	\$5,000
Co-pays	
Co-insurance	\$320
Limits or exclusions	\$900
Total	\$6,220

Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- **Amount owed to providers: \$5,400**
- **Plan pays \$100**
- **Patient pays \$5,300**

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
Total	\$5,400

Patient pays:

Deductibles	
Co-pays	
Co-insurance	
Limits or exclusions	\$5,300
Total	\$5,300

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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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