Blue Cross of Idaho
An Independent Licensee of the Blue Cross and Blue Shield Association

HSA Blue[sm] PPO for Statewide Schools Economy Option

Summary of Benefits Troy School District 287 **Effective Date September 1, 2017**		**HSA Blue[sm] PPO for Statewide Schools**	
		In-Network	**Out-of-Network**
Benefit Period* Aggregate Deductible (The Individual/Family, applies to benefits below unless noted.)		$3,000/$6,000	
Coinsurance (Applies to benefits below unless noted.)		You pay 30% of the allowed amount	You pay 50% of the allowed amount
Out-of-Pocket Limit *(See Plan for services that do not apply to the limit.) (Includes applicable Deductible, Coinsurance and Copayments)*		$5,800/$11,600	
COVERED SERVICES *By choosing a non-contracting provider you may be responsible for the difference between what Blue Cross allows and what the non-contracting provider charges. Some services may require prior authorization.*	**In-Network deductible and/or coinsurance payment required before insurance pays?**	**In-Network**	**Out-of-Network**
		The amount you pay	
Ambulance Transportation Services	Yes	You pay 30% of the allowed amount	You pay 50% of the allowed amount
Breastfeeding Support and Supply Services (Limited to one (1) breast pump purchase per participant, per benefit period.)	No	You pay nothing of the allowed amount	You pay 50% of the allowed amount
Chiropractic Care (Limited to 18 visits combined per participant, per benefit period.)	Yes	You pay 30% of the allowed amount	You pay 50% of the allowed amount
Dental Services Related to Accidental Injury			
Diabetes Self-Management Education Services (Only for accredited Providers approved by BCI.)			
Diagnostic Services (Including diagnostic mammogram.)			
Durable Medical Equipment, Orthotic Devices, and Prosthetic Appliances			
Emergency Services– Facility Services** (Copayment waived if admitted)	Yes	You pay $100 copayment per hospital Outpatient emergency room visit, then you pay 30% of the allowed amount	You pay $100 copayment per hospital Outpatient emergency room visit, then you pay 50% of the allowed amount
Emergency Services – Professional Services**	Yes	You pay 30% of the allowed amount	You pay 50% of the allowed amount
Home Health Skilled Nursing			
Home Intravenous Therapy			You pay 80% of the allowed amount
Hospice Services	Yes	You pay nothing of allowed amount	You pay 50% of the allowed amount
Hospital Services (Inpatient and outpatient services at a licensed general hospital or ambulatory surgical facility.)	Yes	You pay 30% of the allowed amount	
Immunizations (See Plan for specifically listed immunizations.)	No	You pay nothing for listed immunizations	
Maternity Services and/or Involuntary Complications of Pregnancy	Yes	You pay 30% of the allowed amount	You pay 50% of the allowed amount
Medical Services (Inpatient and outpatient)			
Mental Health– Inpatient and Outpatient (Facility and Professional Services)			

HSA Blue[sm] PPO for Statewide Schools
Economy Option

<table>
<tr><td rowspan="2">COVERED SERVICES
By choosing a non-contracting provider you may be responsible for the difference between what Blue Cross allows and what the non-contracting provider charges. Some services may require prior authorization.</td><td rowspan="2">In-Network deductible and/or coinsurance payment required before insurance pays?</td><td>In-Network</td><td>Out-of-Network</td></tr>
<tr><td colspan="2">The amount you pay</td></tr>
<tr><td>Outpatient Habilitation Therapy Services (Includes physical, speech & occupational therapies. Limited to 20 visits combined per participant, per benefit period.)</td><td rowspan="2">Yes</td><td rowspan="2">You pay 50% of the allowed amount</td><td rowspan="2">You pay 80% of the allowed amount</td></tr>
<tr><td>Outpatient Rehabilitation Therapy Services (Includes physical, speech & occupational therapies. Limited to 20 visits combined per participant, per benefit period.)</td></tr>
<tr><td>Physician Office Visits</td><td rowspan="2">Yes</td><td rowspan="2">You pay 30% of the allowed amount</td><td rowspan="10">You pay 50% of the allowed amount</td></tr>
<tr><td>Post Mastectomy Reconstructive Surgery</td></tr>
<tr><td>Prescribed Contraceptive Services (Includes diaphragms, intrauterine devices (IUDs), implantables, injections and tubal ligation.)</td><td>No</td><td>You pay nothing of the allowed amount</td></tr>
<tr><td>Preventive Care Services (See Plan for specifically listed preventive care services.)</td><td>Yes/No</td><td>You pay nothing for services specifically listed.

For services not specifically listed, you pay deductible and coinsurance</td></tr>
<tr><td>Rehabilitation or Habilitation Services</td><td rowspan="6">Yes</td><td rowspan="6">You pay 30% of the allowed amount</td></tr>
<tr><td>Skilled Nursing Facility (Limited to 30 days combined per participant, per benefit period.)</td></tr>
<tr><td>Surgical Services</td></tr>
<tr><td>Therapy Services (Including chemotherapy, growth hormone therapy, radiation and renal dialysis.)</td></tr>
<tr><td>Transplant Services</td></tr>
</table>

*One family member will not accumulate more than the individual deductible or out-of-pocket maximum toward the family deductible or out-of-pocket maximum. After one family member has met the individual deductible, benefits begin for that person. After the family deductible has been met, benefits begin for all family members.

Emergency Services

For the treatment of Emergency Medical Conditions or Accidental Injuries of sufficient severity to necessitate immediate medical care by, or that require Ambulance Transportation Service to, the nearest appropriate Facility Provider, BCI will provide In-Network benefits for Covered Services provided by either a Contracting or Noncontracting Facility Provider and facility-based Professional Providers only. If the nearest Facility Provider is Noncontracting, once the Participant is stabilized and is no longer receiving emergency care the Participant (at BCI's option) may transfer to the nearest appropriate Contracting Facility Provider for further care in order to continue to receive In-Network benefits for Covered Services. If the Participant is required to transfer, transportation to the Contracting Facility Provider will be a Covered Service under the Ambulance Transportation Service provision of this Plan.

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PRESCRIPTION DRUG BENEFITS *(Prescription Drug Services apply to the Out-of-Pocket Limits.)*		
RETAIL OR BCI MAIL ORDER PHARMACIES		
Generic Prescription Drugs **Preferred Brand Name Prescription Drugs** **Non-Preferred Brand Name Prescription Drugs**	You pay 30% of Maximum Allowance after the In-Network Individual/Family Deductible is met	
Preventive Prescription Drugs	You pay nothing for Preventive Prescription Drugs as specifically listed on the BCI Web site, www.bcidaho.com. (Deductible does not apply)	You pay 30% for Preventive Prescription Drugs as specifically listed on the BCI Web site, www.bcidaho.com.
Prescribed Contraceptives	You pay nothing for Women's Preventive Prescription Drugs and devices as specifically listed on the BCI Web site, www.bcidaho.com; Deductible does not apply. The day supply allowed shall not exceed a 90-day supply at one (1) time, as applicable to the specific contraceptive drug or supply.	

Note: Certain Prescription Drugs have generic equivalents. If the Insured requests a Brand Name Drug, the Insured is responsible for the difference between the price of the Generic Drug and the Brand Name Drug, regardless of the Preferred or Non-Preferred status.

This summary describes the general features of this program; it is not a contract.
All provisions of the Group Master Plan apply to this program.
Noncontracting providers may bill you for amounts over the maximum allowance.

SUMMARY OF GENERAL EXCLUSIONS AND LIMITATIONS

No benefits will be provided for services, supplies, drugs or other charges that are:

- Not medically necessary. If services requiring prior authorization by Blue Cross of Idaho are performed by a contracting provider and benefits are denied as not medically necessary, the cost of said services are not the financial responsibility of the participant. However, the participant could be financially responsible for services found to be not medically necessary when provided by a noncontracting provider.
- In excess of the maximum allowance.
- For hospital inpatient or outpatient care for extraction of teeth or other dental procedures, unless necessary to treat an accidental injury or unless an attending physician certifies in writing that the participant has a non-dental, life-endangering condition which makes hospitalization necessary to safeguard the participant's health and life.
- Not prescribed by or upon the direction of a physician or other professional provider; or which are furnished by any individuals or facilities other than licensed general hospitals, physicians, and other providers.
- Investigational in nature.
- Provided for any condition, disease, illness or accidental injury to the extent that the participant is entitled to benefits under occupational coverage, obtained or provided by or through the employer under state or federal workers' compensation acts, or under employer liability acts, or other laws providing compensation for work-related injuries or conditions. This exclusion applies whether or not the participant claims such benefits or compensation, or recovers losses from a third party.
- Provided or paid for by any federal governmental entity except when payment under the plan is expressly required by federal law, or provided or paid for by any state or local governmental entity where its charges therefore would vary, or would be affected by the existence of coverage under the plan.
- Provided for any condition, accidental injury, disease or illness suffered as a result of any act of war or any war, declared or undeclared.
- Furnished by a provider who is related to the participant by blood or marriage and who ordinarily dwells in the participant's household.
- Received from a dental, vision, or medical department maintained by or on behalf of an employer, a mutual benefit association, labor union, trust or similar person or group.
- For surgery intended mainly to improve appearance or for complications arising from surgery intended mainly to improve appearance, except for:
    - Reconstructive surgery necessary to treat an accidental injury, infection, or other disease of the involved part; or
    - Reconstructive surgery to correct congenital anomalies in a participant who is a dependent child.
    - Benefits for reconstructive surgery to correct an accidental injury are available even though the accident occurred while the participant was covered under a prior insurer's coverage.
- Rendered prior to the participant's effective date.
- For personal hygiene, comfort, beautification (including non-surgical services, drugs, and supplies intended to enhance the appearance), or convenience items or services even if prescribed by a physician, including but not limited to, air conditioners, air purifiers, humidifiers, physical fitness equipment or programs, spas, hot tubs, whirlpool baths, waterbeds or swimming pools and therapies, including but not limited to, educational, recreational, art, aroma, dance, sex, sleep, electro sleep, vitamin, chelation, homeopathic, or naturopathic, massage, or music.
- For telephone consultations; and all computer or internet communications, except as specified as a Covered Service in this Plan.
- For failure to keep a scheduled visit or appointment; for completion of a claim form; or for personal mileage, transportation, food or lodging expenses, or for mileage, transportation, food or lodging expenses billed by a physician or other professional provider.
- For inpatient admissions that are primarily for diagnostic services or therapy services; or for inpatient admissions when the participant is ambulatory and/or confined primarily for bed rest, special diet, behavioral problems, environmental change, or for treatment not requiring continuous bed care.
- For inpatient or outpatient custodial care; or for inpatient or outpatient services consisting mainly of educational therapy, behavioral modification, self-care or self-help training, except as specified as a covered service in the plan.
- For any cosmetic foot care, including but not limited to, treatment of corns, calluses, and toenails (except for surgical care of ingrown or diseased toenails).
- Related to dentistry or dental treatment, even if related to a medical condition; or orthoptics, eyeglasses or contact lenses, or the vision examination for prescribing or fitting eyeglasses or contact lenses, unless specified as a covered service in the plan.
- For hearing aids or examinations for the prescription or fitting of hearing aids.
- For any treatment of either gender leading to or in connection with transsexual surgery, gender transformation, sexual dysfunction, or sexual inadequacy, including erectile dysfunction and/or impotence, even if related to a medical condition.
- Made by a licensed general hospital for the participant's failure to vacate a room on or before the licensed general hospital's established discharge hour.
- Not directly related to the care and treatment of an actual condition, illness, disease or accidental injury.
- Furnished by a facility that is primarily a place for treatment of the aged or that is primarily a nursing home, a convalescent home, or a rest home.
- For acute care, rehabilitative care, diagnostic testing except as specified as a covered service in this Plan; for mental or nervous conditions and substance abuse or addiction services not recognized by the American Psychiatric and American Psychological Associations.
- For any of the following:
    - For appliances, splints or restorations necessary to increase vertical tooth dimensions or restore the occlusion, except as specified as a covered service in this plan;
    - For orthognathic Surgery, including services and supplies to augment or reduce the upper or lower jaw;
    - For implants in the jaw; for pain, treatment, or diagnostic testing or evaluation related to the misalignment or discomfort of the temporomandibular joint (jaw hinge), including splinting services and supplies;
    - For alveolectomy or alveoloplasty when related to tooth extraction
- For weight control or treatment of obesity or morbid obesity, even if medically necessary, including but not limited to surgery for obesity. For reversals or revisions of surgery for obesity, except when required to correct a life-endangering condition, except as specifically listed as a covered service in this Plan.
- For use of operating, cast, examination, or treatment rooms or for equipment located in a contracting or noncontracting provider's office or facility, except for emergency room facility charges in a licensed general hospital, unless specified as a covered service in the plan.
- For the reversal of sterilization procedures, including but not limited to, vasovasostomies or salpingoplasties.
- Treatment for infertility and fertilization procedures, including but not limited to, ovulation induction procedures and pharmaceuticals, artificial insemination, in vitro fertilization, embryo transfer or similar procedures, or procedures that in any way augment or enhance a participant's reproductive ability, including but not limited to laboratory services, radiology services or similar services related to treatment for fertility or fertilization procedures.
- For transplant services and artificial organs, except as specified as a covered service under the plan.
- For acupuncture.
- For surgical procedures that alter the refractive character of the eye, including but not limited to, radial keratotomy, myopic keratomileusis, laser-in-situ keratomileusis (lasik), and other surgical procedures of the refractive-keratoplasty type, to cure or reduce myopia or astigmatism, even if medically necessary, unless specified as a covered service in a vision benefits section of the plan, if any. Additionally, reversals, revisions, and/or complications of such surgical procedures are excluded, except when required to correct an immediately life-endangering condition.
- For hospice, except as specified as a covered service in the plan.
- For pastoral, spiritual, bereavement, or marriage counseling.
- For homemaker and housekeeping services or home-delivered meals.
- For the treatment of injuries sustained while committing a felony, voluntarily taking part in a riot, or while engaging in an illegal act or occupation unless such injuries are a result of a medical condition or domestic violence.
- For treatment or other health care of any participant in connection with an illness, disease, accidental injury or other condition which would otherwise entitle the participant to covered services under the plan, if and to the extent those benefits are payable to or due the participant under any medical payments provision, no fault provision, uninsured motorist provision, underinsured motorist provision, or other first party or no fault provision of any automobile, homeowner's, or other similar plan of insurance, contract, or underwriting plan.
- In the event Blue Cross of Idaho (BCI) for any reason makes payment for or otherwise provides benefits excluded by the above provisions, it shall succeed to the rights of payment or reimbursement of the compensated provider, the participant, and the participant's heirs and personal representative against all insurers, underwriters, self-insurers, or other such obligors contractually liable or obliged to the participant, or his or her estate for such services, supplies, drugs or other charges so provided by BCI in connection with such illness, disease, accidental injury or other condition.
- Any services or supplies for which a participant would have no legal obligation to pay in the absence of coverage under the plan or any similar coverage; or for which no charge or a different charge is usually made in the absence of insurance coverage of for which reimbursement or payment is contemplated under an agreement entered into with a third party.
- For a routine or periodic mental or physical examination that is not connected with the care and treatment of an actual illness, disease or accidental injury or for an examination required on account of employment; or related to an occupational injury; for a marriage license; or for insurance, school or camp application; or for sports participation physicals; or a screening examination including routine hearing examinations, unless specified as a covered service under the plan.
- For immunizations except as provided as a covered service in the plan.
- For breast reduction surgery or surgery for gynecomastia.
- For nutritional supplements.
- For replacements or nutritional formulas except, when administered enterally due to impairment in digestion and absorption of an oral diet and is the sole source of caloric need or nutrition in a participant.
- For vitamins and minerals, unless required through a written prescription and cannot be purchased over the counter.
- For an elective abortion, except to preserve the life of the female upon whom the abortion is performed, unless benefits for an elective abortion are specifically provided by a separate endorsement to the plan.
- For alterations or modifications to a home or vehicle.
- For special clothing, including shoes (unless permanently attached to a brace).
- Provided to a person enrolled as an eligible dependent, but who no longer qualifies as an eligible dependent due to a change in eligibility status that occurred after enrollment.
- Provided outside the United States, which if had been provided in the United States, would not be a covered service under the plan.
- For outpatient pulmonary and/or cardiac rehabilitation.
- For complications arising from the acceptance or utilization of noncovered services.
- For the use of hypnosis, as anesthesia or other treatment, except as specified as a covered service.
- For dental implants, appliances, (with the exception of sleep apnea devices) and/or prosthetics, and/or treatment related to orthodontia, even when medically necessary, unless specified as a covered service in the plan.
- For arch supports, orthopedic shoes, and other foot devices.
- For wigs.
- For cranial molding helmets, unless used to protect post cranial vault surgery.
- For surgical removal of excess skin that is the result of weight loss or gain, including but not limited to association with prior weight reduction (obesity) surgery.
- For the purchase of therapy or service dogs/animals and the cost of training/maintaining said animals.

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, 1-800-627-1188. 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 as 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?	**$3,000** person/**$6,000** family.	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 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?	Services that require copays, immunizations and In-network 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?	**$5,800** person/**$11,600** 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 ?	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 1-800-627-1188** 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)	 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	50% coinsurance	none
	Specialist visit	30% coinsurance	50% coinsurance	none
	Preventive care/screening/immunization	No charge for listed preventive, screening and immunization services.	No charge for listed immunizations, 50% coinsurance 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	50% coinsurance	none
	Imaging (CT/PET scans, MRIs)	30% coinsurance	50% coinsurance	Preauthorization required.
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	30% coinsurance	Covers up to a 90 day supply. Pharmacy discount.
	Preferred brand drugs	30% coinsurance	30% coinsurance	Covers up to a 90 day supply. Pharmacy discount.
	Non-preferred brand drugs	30% coinsurance	30% coinsurance	Covers up to a 90 day supply. Pharmacy discount.
	Specialty drugs	30% coinsurance	30% coinsurance	Coverage may include limitations and Preauthorization may be required. Pharmacy discount.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% coinsurance	50% coinsurance	Preauthorization required.
	Physician/surgeon fees	30% coinsurance	50% coinsurance	Preauthorization required.
If you need immediate medical attention	Emergency room care	$100 copay/visit, 30% coinsurance	$100 copay/visit, 50% coinsurance	Out-of-network services paid at In-network if Emergency medical condition. copay waived if admitted.
	Emergency medical transportation	30% coinsurance	50% coinsurance	none
	Urgent care	30% coinsurance	50% coinsurance	none
If you have a hospital stay	Facility fee (e.g., hospital room)	30% coinsurance	50% coinsurance	Preauthorization required.
	Physician/surgeon fee	30% coinsurance	50% coinsurance	Preauthorization 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 mental health, behavioral health, or substance abuse services	Outpatient services	30% coinsurance	50% coinsurance	none
	Inpatient services	30% coinsurance	50% coinsurance	Preauthorization required.
If you are pregnant	Office Visits	30% coinsurance	50% coinsurance	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	50% coinsurance	none
	Childbirth/delivery facility services	30% coinsurance	50% coinsurance	none
If you need help recovering or have other special health needs	Home health care	30% coinsurance	50% coinsurance	Preauthorization required.
	ReHabilitation services	30% coinsurance	50% coinsurance	Coverage is limited to 20 visit annual max.
	Habilitation services	30% coinsurance	50% coinsurance	Coverage is limited to 20 visit annual max.
	Skilled nursing care	30% coinsurance	50% coinsurance	Coverage is limited to 30 day annual max.
	Durable medical equipment	30% coinsurance	50% coinsurance	Preauthorization required.
	Hospice services	No charge	50% coinsurance	none
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.)

- 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 (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Chiropractic care
- 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 1-800-627-1188, 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 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.

If you don't have Minimum Essential Coverage for a month, you will have to make payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for the month.

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**	$3,000
■ **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	**$12,731**

In this example, Peg would pay:

Cost Sharing	
Deductible	$3,000
Copayments	$0
Coinsurance	$2,800
What isn't Covered	
Limits or exclusions	$60
The total Peg would pay is	**$5,860**

Managing Joe's type 2 Diabetes

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

■ **The plan's overall deductible**	$3,000
■ **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	**$7,389**

In this example, Joe would pay:

Cost Sharing	
Deductible	$3,000
Copayments	$0
Coinsurance	$990
What isn't Covered	
Limits or exclusions	$55
The total Joe would pay is	**$4,045**

Mia's Simple Fracture

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

■ **The plan's overall deductible**	$3,000
■ **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	**$1,930**

In this example, Mia would pay:

Cost Sharing	
Deductible	$1,830
Copayments	$100
Coinsurance	$0
What isn't Covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,930**

Nondiscrimination Statement:
Discrimination is Against the Law

Blue Cross of Idaho complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. Blue Cross of Idaho does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

Blue Cross of Idaho:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Blue Cross of Idaho's Customer Service Department. Call 1-800-627-1188 (TTY: 1-800-377-1363), 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 East Pine Avenue, Meridian, Idaho 83642
Telephone: (800) 274-4018 ext.3838, Fax: (208) 331-7493
Email: grievances&appeals@bcidaho.com
TTY: 1-800-377-1363

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, 1-800-537-7697 (TTY).

Complaint forms are available at ***<http://www.hhs.gov/ocr/office/file/index.html>. Reference: <https://federalregister.gov/a/2016-11458>***

Language Assistance

ATTENTION: If you speak Arabic, Chinese, French, German, Korean, Japanese, Persian (Farsi), Romanian, Russian, Serbo-Croatian, Spanish, Sudanic Fulfulde, Tagalog, Ukrainian, or Vietnamese, language assistance services, free of charge, are available to you. Call 1-800-627-1188 (TTY: 1-800-377-1363).

Arabic

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-627-1188 (رقم هاتف الصم والبكم: 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：1-800-377-1363)。

French ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-627-1188 (ATS : 1-800-377-1363).

German ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-627-1188 (TTY: 1-800-377-1363).

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: 1-800-377-1363）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: 1-800-377-1363)번으로 전화해 주십시오.

Persian-Farsi

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با (TTY: 1-800-377-1363) 1-800-627-1188 تماس بگیرید.

Romanian ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-800-627-1188 (TTY: 1-800-377-1363).

Russian ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-627-1188 (телетайп: 1-800-377-1363).

Serbo-Croation 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: 1-800-377-1363).

Spanish ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-627-1188 (TTY: 1-800-377-1363).

Sudanic Fulfulde MAANDO: To a waawi [Adamawa], e woodi ballooji-ma to ekkitaaki wolde caahu. Noddu 1-800-627-1188 (TTY: 1-800-377-1363).

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: 1-800-377-1363).

Ukrainian УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-800-627-1188 (телетайп: 1-800-377-1363).

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: 1-800-377-1363).