

Summary of Benefits Troy School District 287 Effective Date September 1, 2017		Preferred Blue® PPO for Statewide Schools	
		In-Network	Out-of-Network
Benefit Period* Deductible (Individual/Family)		\$2,000/\$4,000	
Coinsurance		You pay 10% of the allowed amount	You pay 30% of the allowed amount
Individual Out-of-Pocket Limit (See Plan for services that do not apply to the limit.) (Includes applicable Deductible, Coinsurance and Copayments)		\$3,500	\$5,000
Family Out-of-Pocket Limit (See Plan for services that do not apply to the limit.) (Includes applicable Deductible, Coinsurance and Copayments)		\$7,000	\$10,000
<b>COVERED SERVICES</b> <i>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.</i>	<b>In-Network deductible and/or coinsurance payment required before insurance pays?</b>	<b>In-Network</b>	<b>Out-of-Network</b>
		<b>The amount you pay</b>	
Allergy Injections	No	You pay a \$5 copayment (if this is the only service provided during the visit)	You pay 30% of the allowed amount
Ambulance Transportation Services	Yes	You pay 10% 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 10% of the allowed amount	
Dental Services Related to Accidental Injury	No	You pay a \$20 copayment per visit	
Diabetes Self-Management Education Services (Only for accredited Providers approved by BCI.)	No	You pay nothing up to \$100 for services in excess of the \$100 you pay deductible and coinsurance	You pay 30% of the allowed amount
Diagnostic Services (Including diagnostic mammogram.)	Yes/No	You pay 10% of the allowed amount	
Durable Medical Equipment/ Prosthetic Appliances/ Orthotic Devices	Yes	You pay \$100 copayment per hospital outpatient emergency room visit, then you pay 10% of the allowed amount	You pay 30% of the allowed amount
Emergency Services** – Facility Services (Copayment waived if admitted)	Yes	You pay 10% of the allowed amount	
Emergency Services** – Professional Services	Yes	You pay 10% of the allowed amount	You pay 80% of the allowed amount
Home Health Skilled Nursing	Yes		You pay 30% of the allowed amount
Home Intravenous Therapy	Yes	You pay 10% of the allowed amount	You pay 80% of the allowed amount

COVERED SERVICES <i>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.</i>	In-Network deductible and/or coinsurance payment required before insurance pays?	In-Network	Out-of-Network	
		The amount you pay		
<b>Hospice Services</b>	No	You pay nothing of the allowed amount	You pay 30% of the allowed amount	
<b>Hospital Services</b> (Inpatient and outpatient services at a licensed general hospital or ambulatory surgical facility.)	Yes	You pay 10% of the allowed amount		
<b>Immunizations</b> (See Plan for specifically listed immunizations)	No	You pay nothing for listed immunizations		
<b>Maternity Services and/or Involuntary Complications of Pregnancy</b>	Yes	You pay 10% of the allowed amount	You pay 30% of the allowed amount	
<b>Mental Health— Inpatient</b> (Facility and Professional Services)				
<b>Mental Health— Outpatient</b>	<b>Psychotherapy Services</b>	No		You pay a \$20 copayment per visit
	<b>Facility and other Professional Services</b>	Yes		You pay 10% of the allowed amount
<b>Morbid Obesity</b> (\$5,000 combined lifetime benefit limit, per participant.)	Yes			
<b>Outpatient Habilitation Therapy Services</b> (Includes physical, speech and occupational therapies. Limited to 20 visits combined per participant, per benefit period.)	Yes			
<b>Outpatient Rehabilitation Therapy Services</b> (Includes physical, speech and occupational therapies. Limited to 20 visits combined per participant, per benefit period.)				
<b>Physician Office Visit</b> (Other services rendered during a physician office visit will be subject to deductible and coinsurance.)	No	You pay a \$20 copayment per visit		
<b>Post Mastectomy Reconstructive Surgery</b>	Yes	You pay 10% of the allowed amount		
<b>Prescribed Contraceptive Services</b> (Includes diaphragms, intrauterine devices (IUDs), implantables, injections and tubal ligation.)	No	You pay nothing of the allowed amount		
<b>Preventive Care Benefits</b> (See Plan for specifically listed preventive care services)	Yes/No	You pay nothing for services specifically listed.  For services not specifically listed, you pay deductible and coinsurance		
<b>Rehabilitation or Habilitation Services</b>	Yes	You pay 10% of the allowed amount		
<b>Skilled Nursing Facility</b> (Limited to 30 days combined per participant, per benefit period)				
<b>Surgical/Medical</b> (Professional Services)				
<b>Therapy Services</b> (Including chemotherapy, growth hormone therapy, radiation and renal dialysis.)				
<b>Transplant Services</b>				

\*The specified period of time during which charges for covered services must be incurred in order to accumulate toward annual benefit limits, deductible amounts and out-of-pocket limits.

**\*\*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.



## *Preferred Blue<sup>®</sup> PPO for Statewide Schools*

**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, except as specifically provided 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.

## *Prescription Benefits for Statewide Schools*

Prescription Drug Option Troy School District 287 Effective Date September 1, 2017		Prescription Benefits for Statewide Schools
<b>Retail</b> (90 day supply with multiple copays)	<b>Generic</b>	You pay a \$15 copayment
	<b>Preferred Brand Name</b>	You pay a \$30 copayment
	<b>Non-Preferred Brand Name</b>	You pay a \$45 copayment
<b>Mail Order</b> (90 day supply with multiple copays)	<b>Copayment</b>	Matches Retail
<b>Prescribed Contraceptives</b>	<p>You pay nothing for Women's Preventive Prescription Drugs and devices as specifically listed on the BCI Web site, <a href="http://www.bcidaho.com">www.bcidaho.com</a>; 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.</p>	
<b>Out-of-Pocket Limit</b>	<p><b>Individual:</b> You pay \$3,000 in Copayments and/or Coinsurance per Benefit Period for a combination of all Prescription Drug charges incurred.</p> <p><b>Family:</b> You pay a combination of \$6,000 in Copayments and/or Coinsurance per Benefit Period for a combination of all Prescription Drug charges incurred.</p> <p><i>When the Prescription Drug Out-of-Pocket Limit is met, the Prescription Drug Benefits payable will increase to 100% of the Allowed Charge or the Usual Charge for the remainder of the Benefit Period.</i></p>	



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 as [www.healthcare.gov/sbc-glossary](http://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 <a href="#">deductible</a> ?	<b>\$2,000</b> person/ <b>\$4,000</b> family.	Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
Are there services covered before you meet your <a href="#">deductible</a> ?	Pharmacy, services that require <a href="#">copays</a> , immunizations or <a href="#">In-network</a> hospice care and <a href="#">Preventive care</a> are covered before you meet your <a href="#">deductible</a> .	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without cost-sharing and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <a href="#">deductibles</a> for specific services ?	No. There are no other specific <a href="#">deductibles</a> .	You don't have to meet <a href="#">deductibles</a> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	For <a href="#">In-network provider</a> <b>\$3,500</b> person / <b>\$7,000</b> family, For <a href="#">Out-of-network provider</a> <b>\$5,000</b> person / <b>\$10,000</b> family For <a href="#">prescription drugs</a> <b>\$3,000</b> person/ <b>\$6,000</b> family	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
What is not included in the <a href="#">out-of-pocket limit</a> ?	<a href="#">Premiums</a> , <a href="#">balance-billing</a> charges and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="http://www.bcidaho.com">www.bcidaho.com</a> or call <b>1-800-627-1188</b> for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">Out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware your <a href="#">network provider</a> might use an <a href="#">Out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">Specialist</a> ?	No.	You can see the <a href="#">Specialist</a> you choose without a <a href="#">referral</a> .



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		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 <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	\$20 <a href="#">copay</a> /visit	30% <a href="#">coinsurance</a>	Does not apply to additional services.
	<a href="#">Specialist</a> visit	\$20 <a href="#">copay</a> /visit	30% <a href="#">coinsurance</a>	Does not apply to additional services.
	<a href="#">Preventive care/screening</a> /immunization	No charge for listed preventive, <a href="#">screening</a> and immunization services. <a href="#">deductible</a> does not apply.	No charge for listed immunizations, 30% <a href="#">coinsurance</a> preventive and <a href="#">screening</a> .	You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services needed are preventive. Then check what your <a href="#">plan</a> will pay for.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	No charge up to \$100, then 10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	----- none -----
	Imaging (CT/PET scans, MRIs)	No charge up to \$100, then 10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> required.
If you need drugs to treat your illness or condition  More information about <a href="#">prescription drug coverage</a> is available at <a href="#">www.bcidaho.com</a>	Generic drugs	\$15 <a href="#">copay</a> /prescription (retail and mail order)	\$15 <a href="#">copay</a> /prescription (retail and mail order)	Covers up to a 90 day supply with multiple <a href="#">copays</a> .
	Preferred brand drugs	\$30 <a href="#">copay</a> /prescription (retail and mail order)	\$30 <a href="#">copay</a> /prescription (retail and mail order)	Covers up to a 90 day supply with multiple <a href="#">copays</a> .
	Non-preferred brand drugs	\$45 <a href="#">copay</a> /prescription (retail and mail order)	\$45 <a href="#">copay</a> /prescription (retail and mail order)	Covers up to a 90 day supply with multiple <a href="#">copays</a> .
	<a href="#">Specialty drugs</a>	\$45 <a href="#">copay</a> /prescription (retail and mail order)	\$45 <a href="#">copay</a> /prescription (retail and mail order)	Coverage may include limitations and <a href="#">Preauthorization</a> may be required.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> required.
	Physician/surgeon fees	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> required.
If you need immediate medical attention	<a href="#">Emergency room care</a>	\$100 <a href="#">copay</a> /visit, 10% <a href="#">coinsurance</a>	\$100 <a href="#">copay</a> /visit, 30% <a href="#">coinsurance</a>	<a href="#">Out-of-network</a> services paid at <a href="#">In-network</a> if <a href="#">Emergency medical condition</a> . <a href="#">copay</a> waived if admitted.
	<a href="#">Emergency medical transportation</a>	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	----- none -----
	<a href="#">Urgent care</a>	\$20 <a href="#">copay</a> /visit	30% <a href="#">coinsurance</a>	Does not apply to additional services.
If you have a hospital stay	Facility fee (e.g., hospital room)	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> required.
	Physician/surgeon fee	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> 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	\$20 <a href="#">copay</a> /visit, 10% <a href="#">coinsurance</a> for facility and other services	30% <a href="#">coinsurance</a>	Contact BPA at 1-800-726-0003 for EAP 1-4 Visits.
	Inpatient services	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> required.
If you are pregnant	Office Visits	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	For pregnancy services, <a href="#">cost sharing</a> does not apply to certain <a href="#">preventive services</a> . Depending on the type of services, a <a href="#">copay</a> , <a href="#">coinsurance</a> or <a href="#">deductible</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	----- none -----
	Childbirth/delivery facility services	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	----- none -----
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> required.
	<a href="#">Rehabilitation services</a>	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	Coverage is limited to 20 visit annual max.
	<a href="#">Habilitation services</a>	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	Coverage is limited to 20 visit annual max.
	<a href="#">Skilled nursing care</a>	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	Coverage is limited to 30 day annual max.
	<a href="#">Durable medical equipment</a>	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> required.
	<a href="#">Hospice services</a>	No charge. <a href="#">deductible</a> does not apply.	30% <a href="#">coinsurance</a>	----- 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
- 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.)

- Bariatric surgery
- 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](http://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](http://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](http://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](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 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](http://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](#) \$2,000
- [Specialist copay](#) \$20
- Hospital (facility) [coinsurance](#) 10%
- Other [coinsurance](#) 10%

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	\$2,000
Copayments	\$40
Coinsurance	\$1,060

*What isn't Covered*

Limits or exclusions	\$60
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**The total Peg would pay is \$3,160**

**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 copay](#) \$20
- Hospital (facility) [coinsurance](#) 10%
- Other [coinsurance](#) 10%

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	\$130
Copayments	\$1,260
Coinsurance	\$0

*What isn't Covered*

Limits or exclusions	\$55
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**The total Joe would pay is \$1,445**

**Mia's Simple Fracture**  
(in-network emergency room visit and follow up care)

- The [plan's](#) overall [deductible](#) \$2,000
- [Specialist copay](#) \$20
- Hospital (facility) [coinsurance](#) 10%
- Other [coinsurance](#) 10%

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	\$1,240
Copayments	\$140
Coinsurance	\$0

*What isn't Covered*

Limits or exclusions	\$0
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**The total Mia would pay is \$1,380**

# 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](mailto: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

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

**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

فرا مه می دشار. با 1-800-627-1188 تماس بگیرد. توجه: گار به ایزن فارسی گفتگو می دینک، تسهیلات ی نابز و صیرت اگیارن بریا شما

**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-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: 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).

**Sudanese 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).