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?	For in-network $400 person/$1,200 family For out-of-network $600 person. Does not apply to pharmacy, copays or listed preventive care.	You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the deductible 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 deductible.
Are there other deductibles for specific services?	Yes, $1,500 for bariatric surgery and $125 person/$250 family for prescription drugs	You must pay all of the costs for these services up to the specific deductible 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 $3,600 person/$10,800 family For out-of-network provider $5,200 person.	The out-of-pocket limit 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, pharmacy and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
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 *specific* 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-network doctor or other health care provider, this plan will pay some of all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred, or participating for providers in their network. See the chart starting on page 2 for how this plan pays different kinds of providers.
Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the specialist 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 6. See your policy or plan document for additional information about excluded services.

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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	$25 copay/visit	35% coinsurance	Does not apply to additional services.
	Specialist visit	$25 copay/visit	35% coinsurance	Does not apply to additional services.
	Other practitioner office visit	$25 copay/visit	35% coinsurance	Does not apply to additional services.
	Preventive care/screening/immunization	No charge for listed preventive, screening and immunization services.	Not covered	---------- none ----------
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	35% coinsurance	---------- none ----------
	Imaging (CT/PET scans, MRIs)	20% coinsurance	35% coinsurance	Preauthorization required.

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 prescription drug coverage is available at www.bcidaho.com	Generic drugs	Retail 25% with min/max amounts. Mail order $36 copay.	Retail 25% with min/max amounts. Mail order $36 copay.	Prescription drug deductible applies
	Preferred brand drugs	Retail 25% with min/max amounts. Mail order $75 copay.	Retail 25% with min/max amounts. Mail order $75 copay.	Prescription drug deductible applies
	Non-preferred brand drugs	Retail 25% with min/max amounts. Mail order $120 copay.	Retail 25% with min/max amounts. Mail order $120 copay.	Prescription drug deductible applies
	Specialty drugs	As any other drug	As any other drug	Prescription drug deductible applies
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	35% coinsurance	Preauthorization required.
	Physician/surgeon fees	20% coinsurance	35% coinsurance	Preauthorization required.
If you need immediate medical attention	Emergency room services	20% coinsurance	20% coinsurance	---------- none ----------
	Emergency medical transportation	$50 copay/transport	35% coinsurance	---------- none ----------
	Urgent care	$25 copay/visit	35% coinsurance	Does not apply to additional services.
If you have a hospital stay	Facility fee (e.g., hospital room)	$100 copay/day, up to 3 days, and 20% coinsurance	$100 copay/day, up to 3 days, and 35% coinsurance	Preauthorization required.
	Physician/surgeon fee	20% coinsurance	35% coinsurance	Preauthorization required.

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 have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$25 copay/visit, 20% coinsurance for facility and other services	35% coinsurance	Preauthorization required.
	Mental/Behavioral health inpatient services	$100 copay/day, up to 3 days, and 20% coinsurance for facility. Professional 20% coinsurance	$100 copay/day, up to 3 days, and 35% coinsurance for facility. Professional 35% coinsurance	Preauthorization required.
	Substance use disorder outpatient services	$25 copay/visit, 20% coinsurance for facility and other services	35% coinsurance	Preauthorization required.
	Substance use disorder inpatient services	$100 copay/day, up to 3 days, and 20% coinsurance for facility. Professional 20% coinsurance	$100 copay/day, up to 3 days, and 35% coinsurance for facility. Professional 35% coinsurance	Preauthorization required.
If you are pregnant	Prenatal and postnatal care	$250 copay for physician services. $100 copay/day, up to 3 days, and 20% coinsurance for facility services	$250 copay for physician services. $100 copay/day, up to 3 days, and 35% coinsurance for facility services	---------- none ----------
	Delivery and all inpatient services	$250 copay for physician services. $100 copay/day, up to 3 days, and 20% coinsurance for facility services	$250 copay for physician services. $100 copay/day, up to 3 days, and 35% coinsurance for facility services	---------- none ----------

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	No charge	35% coinsurance	Preauthorization required.
	Rehabilitation services	$25 copay/visit	35% coinsurance	---------- none ----------
	Habilitation services	$25 copay/visit	35% coinsurance	---------- none ----------
	Skilled nursing care	$100 copay/day, up to 3 days, and 20% coinsurance	$100 copay/day, up to 3 days, and 35% coinsurance	Coverage is limited to 30 day annual max.
	Durable medical equipment	20% coinsurance	35% coinsurance	Preauthorization required.
	Hospice service	No charge	35% coinsurance	Preauthorization required.
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 ----------

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
- Cosmetic surgery
- Dental care (Adult)
- Glasses (Child)
- Infertility treatment
- Long-term care
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

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

- Bariatric surgery
- Chiropractic care
- Hearing aids
- Non-emergency care when traveling outside the U.S.

Your Rights to Continue Coverage:

**** Group health coverage sample -**

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

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

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, you may also receive assistance from the Idaho Department of Insurance at 1-800-721-3272 or www.DOI.Idaho.gov

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-208-331-7347 or 1-800-627-1188.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-208-331-7347 or 1-800-627-1188.
Chinese (中文): 如果需要中文的帮助， 请拨打这个号码 1-208-331-7347 or 1-800-627-1188.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-208-331-7347 or 1-800-627-1188.

Questions: Call **1-800-627-1188** or visit us at **www.bcidaho.com/SBC.**
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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** $5,546
- **Patient pays** $1,994

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	$525
Co-pays	$550
Co-insurance	$769
Limits or exclusions	$150
Total	**$1,994**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $3,731
- **Patient pays** $1,669

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	$525
Co-pays	$250
Co-insurance	$814
Limits or exclusions	$80
Total	**$1,669**

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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