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 or call 1-800-627-1188 to request a copy.

<table>
<thead>
<tr>
<th>Important Questions</th>
<th>Answers</th>
<th>Why This Matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the overall deductible?</td>
<td>$500 person/$1,500 family</td>
<td>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.</td>
</tr>
<tr>
<td>Are there services covered before you meet your deductible?</td>
<td>Yes. Pharmacy, services that require copays, dental, vision, diabetes education, hearing aid services or in-network listed Preventive care are covered before you meet your deductible.</td>
<td>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 <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a></td>
</tr>
<tr>
<td>Are there other deductibles for specific services?</td>
<td>Yes. $75 for dental services. There are no other specific deductibles.</td>
<td>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.</td>
</tr>
<tr>
<td>What is the out-of-pocket limit for this plan?</td>
<td>For in-network provider $3,720 person / $7,440 family. For out-of-network provider $7,500 person / $2,880 person / $5,760 family.</td>
<td>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.</td>
</tr>
<tr>
<td>What is not included in the out-of-pocket limit?</td>
<td>Premiums, hearing aid services, adult dental, vision, balance-billing charges and health care this plan doesn’t cover, and Out-of-network deductibles and copays.</td>
<td>Even though you pay these expenses, they don’t count toward the out-of-pocket limit.</td>
</tr>
<tr>
<td>Will you pay less if you use a network provider?</td>
<td>Yes. See <a href="http://www.bcidaho.com">www.bcidaho.com</a> or call 1-800-627-1188 for a list of network providers.</td>
<td>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.</td>
</tr>
<tr>
<td>Do you need a referral to see a Specialist?</td>
<td>No.</td>
<td>You can see the Specialist you choose without a referral.</td>
</tr>
</tbody>
</table>

Questions: Call 1-800-627-1188 or visit us at www.bcidaho.com/SBC.
All copayments and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you visit a health care provider's office or clinic</td>
<td>Primary care visit to treat an injury or illness</td>
<td>Network Provider (You will pay the least)</td>
<td>Out-of-Network Provider (You will pay the most)</td>
</tr>
<tr>
<td></td>
<td>$25 copay/visit, 20% coinsurance</td>
<td>$25 copay/visit, 30% coinsurance</td>
<td>Does not apply to additional services.</td>
</tr>
<tr>
<td></td>
<td>$25 copay/visit, 30% coinsurance</td>
<td>$25 copay/visit, 30% coinsurance</td>
<td>Does not apply to additional services.</td>
</tr>
<tr>
<td></td>
<td>Preventive care/screening/immunization</td>
<td>No charge for listed preventive, screening and immunization services. deductible does not apply.</td>
<td>30% coinsurance immunizations, 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.</td>
</tr>
<tr>
<td>If you have a test</td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>20% coinsurance</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>20% coinsurance</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td>If you need drugs to treat your illness or condition</td>
<td>Generic drugs</td>
<td>$20</td>
<td>The difference between the Contracted Rate (rate of In-network provider) and the provider charge plus copay.</td>
</tr>
<tr>
<td></td>
<td>Preferred brand drugs</td>
<td>$40</td>
<td>OptumRx Mail Service Pharmacy has a $40 copay for a 90 day supply. Special provisions apply to maintenance drugs.</td>
</tr>
<tr>
<td></td>
<td>Non-preferred brand drugs</td>
<td>$70</td>
<td>OptumRx Mail Service Pharmacy has a $80 copay for a 90 day supply. Special provisions apply to maintenance drugs.</td>
</tr>
<tr>
<td></td>
<td>Specialty drugs</td>
<td>10% or $120 max copay (One 30 day supply at retail)</td>
<td>One fill allowed at retail for a specialty medication; after that must be filled through OptumRx Specialty Mail Service Pharmacy.</td>
</tr>
</tbody>
</table>

More information about prescription drug coverage is available at www.OptumRx.com

Questions: Call 1-800-627-1188 or visit us at www.bcidaho.com/SBC.
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<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>Network Provider (You will pay the least): 20% coinsurance</td>
<td>Out-of-Network Provider (You will pay the most): 30% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>20% coinsurance</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room care</td>
<td>$100 copay/visit; 20% coinsurance</td>
<td>$100 copay/visit; 20% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>20% coinsurance</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>$25 copay/visit; 20% coinsurance</td>
<td>$25 copay/visit; 30% coinsurance</td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>20% coinsurance</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fee</td>
<td>20% coinsurance</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td>If you have mental health, behavioral health, or substance abuse services</td>
<td>Outpatient services</td>
<td>$25 copay visit; 20% coinsurance</td>
<td>$25 copay visit; 30% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>20% coinsurance</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Office Visits</td>
<td>20% coinsurance</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>20% coinsurance</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>20% coinsurance</td>
<td>30% coinsurance</td>
</tr>
</tbody>
</table>

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<tr>
<td>If you need help recovering or have other special health needs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Home health care</strong></td>
<td></td>
<td><strong>Network Provider</strong> (You will pay the least): 20% coinsurance</td>
<td>Coverage is limited to 70 days/illness (combined with Skilled Nursing).</td>
</tr>
<tr>
<td><strong>ReHabilitation services</strong></td>
<td></td>
<td><strong>Out-of-Network Provider</strong> (You will pay the most): 30% coinsurance</td>
<td></td>
</tr>
<tr>
<td><strong>Habilitation services</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Skilled nursing care</strong></td>
<td></td>
<td><strong>Network Provider</strong> (You will pay the least): 20% coinsurance</td>
<td></td>
</tr>
<tr>
<td><strong>Durable medical equipment</strong></td>
<td></td>
<td><strong>Out-of-Network Provider</strong> (You will pay the most): 30% coinsurance</td>
<td></td>
</tr>
<tr>
<td><strong>Hospice services</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>If your child needs dental or eye care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Children’s eye exam</strong></td>
<td></td>
<td><strong>Network Provider</strong> (You will pay the least): No charge</td>
<td></td>
</tr>
<tr>
<td><strong>Children’s glasses</strong></td>
<td></td>
<td><strong>Out-of-Network Provider</strong> (You will pay the most): 50% coinsurance</td>
<td></td>
</tr>
<tr>
<td><strong>Children’s dental check-up</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Questions: Call 1-800-627-1188 or visit us at www.bcidaho.com/SBC.
### 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
- Infertility treatment
- Long-term care
- Private-duty nursing
- 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
- Dental care (Adult)
- Hearing aids (employee only)
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)
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 1-855-944-3426.

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.bcidadaho.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 1-866-4444-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.-----------------------------------------

Questions: Call 1-800-627-1188 or visit us at www.bcidadaho.com/SBC.
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 $500
- Specialist copay $25
- Hospital (facility) coinsurance 20%
- Other coinsurance 20%

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

What isn't Covered
- Limits or exclusions $60

In this example, Peg would pay:
- Deductible $500
- Copayments $40
- Coinsurance $2,620
- Limits or exclusions $60
- The total Peg would pay is $3,220

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)
- The plan's overall deductible $500
- Specialist copay $25
- Hospital (facility) coinsurance 20%
- Other coinsurance 20%

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

What isn't Covered
- Limits or exclusions $55

In this example, Joe would pay:
- Deductible $130
- Copayments $1,620
- Coinsurance $0
- Limits or exclusions $55
- The total Joe would pay is $1,805

Mia's Simple Fracture
(in-network emergency room visit and follow up care)
- The plan's overall deductible $500
- Specialist copay $25
- Hospital (facility) coinsurance 20%
- Other coinsurance 20%

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

What isn't Covered
- Limits or exclusions $0

In this example, Mia would pay:
- Deductible $130
- Copayments $140
- Coinsurance $320
- Limits or exclusions $0
- The total Mia would pay is $960

Questions: Call 1-800-627-1188 or visit us at www.bcidaho.com/SBC.
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).


Questions: Call 1-800-627-1188 or visit us at www.bcidaho.com/SBC.
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).

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）。


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 گواهی می‌دهم: با (1363-377-1363) تماس بگیرید. جهت کسب جهت‌گیری کننده، شماره تلفن تایپ‌ساز 1-800-377-1363 است.

Romanian ATENŢIE: Dacă vorbiţi limba română, vă stau la dispoziţie servicii de asistenţă lingvistică, gratuit. Sunaţi 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).


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


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