Blue Cross of Idaho

An Independent Licensee of the Blue Cross and Blue Shield Association

# Large Group PPO

**Summary of Benefits and Coverage:**
What this Plan Covers & What You Pay For Covered Services

**Coverage Period: 9/1/2026 - 8/31/2027**

**Coverage for:** Enrollee + Eligible Dependents | **Plan Type:** PPO

**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/coverage.. 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 at 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? | **$1,000** person/**$2,000** 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? | Yes. Pharmacy, services that require Copays, immunizations or In-Network hospice care and 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 Cost Sharing 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? | For In-Network Provider **$4,000** person / **$8,000** family, For Out-of-Network Provider **$6,000** person /**$12,000** family For Prescription Drugs **$3,000** person/**$6,000** 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 **https://bcidaho.com/findaProvider 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 Providers 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 | | 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 Provider's office or clinic** | Primary care visit to treat an injury or illness | $20 Copay/visit, Deductible does not apply | 40% Coinsurance after Deductible | Copay does not apply to additional services. Cost Sharing may not apply for pediatric physician office visit. Additional telehealth services may be provided by your Provider. |
| | Specialist visit | $40 Copay/visit, Deductible does not apply | 40% Coinsurance after Deductible | Copay does not apply to additional services. Cost Sharing may not apply for pediatric physician office visit. |
| | Preventive care/Screening/immunization | No charge for listed preventive, Screening and immunization services. Deductible does not apply. | No charge for listed immunizations, 40% Coinsurance after Deductible for 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. No charge In-Network for one supplemental breast Screening if you have heightened risk of breast cancer. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | 20% Coinsurance after Deductible | 40% Coinsurance after Deductible | -------none------- |
| | Imaging (CT/PET scans, MRIs) | 20% Coinsurance after Deductible | 40% Coinsurance after Deductible | Preauthorization required. |
| **If you need drugs to treat your illness or condition**<br><br>More information about prescription drug coverage is available at www.bcidaho.com | Generic drugs | Preferred=$10 Copay/prescription Non-preferred=$20 Copay/prescription (retail and mail order) | Preferred=$10 Copay/prescription Non-preferred=$20 Copay/prescription (retail and mail order) | Covers up to a 90 day supply with multiple Copays. Additional Out-of-Network charges may apply. |
| | Preferred brand drugs | $30 Copay/prescription (retail and mail order) | $30 Copay/prescription (retail and mail order) | Covers up to a 90 day supply with multiple Copays. Additional Out-of-Network charges may apply. |
| | Non-preferred brand drugs | $50 Copay/prescription (retail and mail order) | $50 Copay/prescription (retail and mail order) | Covers up to a 90 day supply with multiple Copays. Additional Out-of-Network charges may apply. |
| | Specialty Drugs | Preferred=20% Coinsurance Non-preferred=30% Coinsurance (retail and mail order) | Preferred=20% Coinsurance Non-preferred=30% Coinsurance (retail and mail order) | Limitations, Preauthorization, and Out-of-Network charges may apply. If eligible for Cost Relief, there is no Cost Sharing if you enroll. If you opt out, Cost Sharing will increase and may not apply to your Deductible. |

| 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 outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 20% Coinsurance after Deductible | 40% Coinsurance after Deductible | Preauthorization required. |
| | Physician/surgeon fees | 20% Coinsurance after Deductible | 40% Coinsurance after Deductible | Preauthorization required. |
| **If you need immediate medical attention** | Emergency Room Care | $100 Copay/visit, 20% Coinsurance after Deductible | $100 Copay/visit, 20% Coinsurance after Deductible | In-Network Cost Sharing applies to both In-Network and Out-of-Network services. Copay waived if admitted. |
| | Emergency Medical Transportation | 20% Coinsurance after Deductible | 40% Coinsurance after Deductible | In-Network Cost Sharing applies for air ambulance services. |
| | Urgent Care | $40 Copay/visit, Deductible does not apply | 40% Coinsurance after Deductible | Copay does not apply to additional services. Cost Sharing may not apply to pediatric physician office visit. |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 20% Coinsurance after Deductible | 40% Coinsurance after Deductible | Preauthorization required. |
| | Physician/surgeon fee | 20% Coinsurance after Deductible | 40% Coinsurance after Deductible | Preauthorization required. |
| **If you have mental health, behavioral health, or substance abuse services** | Outpatient services | $20 Copay/visit, 20% Coinsurance after Deductible for facility and other services | 40% Coinsurance after Deductible | Cost Sharing may not apply for pediatric outpatient psychotherapy. Additional telehealth services may be provided by your Provider. Contact BPA at 1-800-726-0003 for EAP 1-4 Visits. |
| | Inpatient services | 20% Coinsurance after Deductible | 40% Coinsurance after Deductible | Preauthorization required. |
| **If you are pregnant** | Office Visits | 20% Coinsurance after Deductible | 40% Coinsurance after Deductible | For pregnancy services, Cost Sharing does not apply to certain Preventive Services. Depending on the type of services, a Copay, Cost Sharing or Deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). |
| | Childbirth/delivery professional services | 20% Coinsurance after Deductible | 40% Coinsurance after Deductible | -------none------- |
| | Childbirth/delivery facility services | 20% Coinsurance after Deductible | 40% Coinsurance after Deductible | -------none------- |

| 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 need help recovering or have other special health needs** | Home Health Care | 20% Coinsurance after Deductible | 40% Coinsurance after Deductible | -------none------- |
| | ReHabilitation Services | $60 Copay/visit physical, speech and occupational, $10 Copay/visit for cardiac therapy; Deductible does not apply. | 40% Coinsurance after Deductible | Coverage is limited to 30 visit annual max for outpatient physical, speech and occupational. |
| | Habilitation Services | $60 Copay/visit physical, speech and occupational, Deductible does not apply. | 40% Coinsurance after Deductible | Coverage is limited to 30 visit annual max for outpatient physical, speech and occupational. |
| | Skilled Nursing Care | 20% Coinsurance after Deductible | 40% Coinsurance after Deductible | Preauthorization required. Coverage is limited to 30 day annual max. |
| | Durable Medical Equipment | 20% Coinsurance after Deductible | 40% Coinsurance after Deductible | Preauthorization required. |
| | Hospice Services | No charge. Deductible does not apply. | 40% Coinsurance after Deductible | -------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)
- 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
- Hearing aids (Child)
- 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.

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

## 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 | $1,000 |
| Specialist copay: | $40 |
| 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** | **$12,690** |
| **In this example, Peg would pay:** | |
| ***Cost Sharing*** | |
| Deductibles | $1,000 |
| Copayments | $10 |
| Coinsurance | $2,310 |
| ***What isn't Covered*** | |
| Limits or Exclusions | $60 |
| **The total Peg would pay is** | **$3,380** |

### Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

| | |
|---|---|
| The plan's overall deductible: | $1,000 |
| Specialist copay: | $40 |
| 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** | **$5,830** |
| **In this example, Joe would pay:** | |
| ***Cost Sharing*** | |
| Deductibles | $120 |
| Copayments | $960 |
| Coinsurance | $0 |
| ***What isn't Covered*** | |
| Limits or Exclusions | $20 |
| **The total Joe would pay is** | **$1,100** |

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

| | |
|---|---|
| The plan's overall deductible: | $1,000 |
| Specialist copay: | $40 |
| 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** | **$2,800** |
| **In this example, Mia would pay:** | |
| ***Cost Sharing*** | |
| Deductibles | $1,000 |
| Copayments | $470 |
| Coinsurance | $200 |
| ***What isn't Covered*** | |
| Limits or Exclusions | $0 |
| **The total Mia would pay is** | **$1,670** |

The plan would be responsible for the other costs of these EXAMPLE covered services.

## DISCRIMINATION IS AGAINST THE LAW

Blue Cross of Idaho complies with applicable Federal civil rights laws and does not discriminate, exclude or treat less favorably on the basis of race, color, national origin (including limited English proficiency and primary language), age, disability or sex.

Blue Cross of Idaho:

- Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services 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 assistance services to people whose primary language is not English, which may include:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Blue Cross of Idaho Civil Rights Coordinator at 1-800-627-1188 (TTY: 711).

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 at:

Civil Rights Coordinator
3000 E. Pine Ave., Meridian, ID 83642
Telephone: 1-800-274-4018
Fax: 208-331-7493
Email: ***grievancesandappeals@bcidaho.com***
TTY: 711

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our Civil Rights Coordinator 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, 800-537-7697 (TDD). Complaint forms are available at ***http://www.hhs.gov/ocr/office/file/index.html***

**ATTENTION:** If you speak Arabic, Bantu, Chinese, Farsi, French, German, Japanese, Korean, Nepali, Romanian, Russian, Serbo-Croatian, Spanish, Tagalog, or Vietnamese, language assistance services, free of charge, are available to you. Call 1-800-627-1188 (TTY:711).

**Arabic** انتبه: إذا كنت تتحدث اللغة العربية ، فإن خدمات المساعدة اللغوية متاحة لك مجانًا اتصل على 1-800-627-1188 (للصم والبكم: 711).

**Bantu:** ICITONDERWA: Nimba uvuga Ikirundi, uzohabwa serivisi zo gufasha mu ndimi, ku buntu. Woterefona 1-800-627-1188 (TTY: 711).

**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：711)。

**Farsi** توجه: اگر به زبان فارسی صحبت می کنید، خدمات رایگان پشتیبانی زبان، در دسترس شما است. شماره تماس 1-800-627-1188 (711:TTY).

**French:** ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-627-1188 (ATS : 711).

**German:** ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-627-1188 (TTY: 711).

**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:711）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: 711)번으로 전화해 주십시오.

**Nepali:** ध्यान दिनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् 1-800-627-1188 (टटिविाइ: 711) ।

**Romanian:** ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-800-627-1188 (TTY: 711).

**Russian:** ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-627-1188 (телетайп: 711).

**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: 711).

**Spanish:** ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-627-1188 (TTY: 711).

**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: 711.

**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: 711).