Blue Cross of Idaho
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J.R. Simplot Company - ASC HSA

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

Coverage Period: 1/1/2026 - 12/31/2026

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 contribution) 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, cost sharing, 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?	In-Network **$3,400** family; Out-of-Network **$6,400** 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 policy, the overall family Deductible must be met before the Plan begins to pay.
Are there services covered before you meet your Deductible?	Yes. In-Network Preventive Care and immunizations 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 **$6,850** person / **$8,400** family. For Out-of-Network Provider **$16,400** 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 ?	Contributions, Balance-Billing charges and health care this Plan doesn't cover.	Even though you pay these expenses, they don't count toward the Out-of-pocket Limit.
Will you pay less if you use a Network Provider?	Yes. See **www.bcidaho.com or call 1-855-216-6850** 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 cost sharing 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% Cost Sharing after Deductible	40% Cost Sharing after Deductible	For additional telehealth services contact Teledoc at 1-800-TELADOC.
	Specialist visit	20% Cost Sharing after Deductible	40% Cost Sharing after Deductible	-------none-------
	Preventive care/Screening/immunization	No charge for listed preventive, Screening and immunization services. Deductible does not apply.	40% Cost Sharing after Deductible	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. 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% Cost Sharing after Deductible	40% Cost Sharing after Deductible	-------none-------
	Imaging (CT/PET scans, MRIs)	20% Cost Sharing after Deductible	40% Cost Sharing after Deductible	Preauthorization required.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.bcidaho.com	Generic drugs	20% Cost Sharing after Deductible	Not covered	Covers up to a 90 day supply.
	Preferred brand drugs	20% Cost Sharing after Deductible	Not covered	Covers up to a 90 day supply.
	Non-preferred brand drugs	30% Cost Sharing after Deductible	Not covered	Covers up to a 90 day supply.
	Specialty Drugs	30% Cost Sharing after Deductible	Not covered	Coverage may include limitations and Preauthorization may be required.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% Cost Sharing after Deductible	40% Cost Sharing after Deductible	Preauthorization required.
	Physician/surgeon fees	20% Cost Sharing after Deductible	40% Cost Sharing after Deductible	Preauthorization required.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	Emergency Room Care	20% Cost Sharing after Deductible	20% Cost Sharing after Deductible	In-Network Cost Sharing applies to both In-Network and Out-of-Network services.
	Emergency Medical Transportation	20% Cost Sharing after Deductible	40% Cost Sharing after Deductible	In-Network Cost Sharing applies for air ambulance services.
	Urgent Care	20% Cost Sharing after Deductible	40% Cost Sharing after Deductible	-------none-------
If you have a hospital stay	Facility fee (e.g., hospital room)	20% Cost Sharing after Deductible	40% Cost Sharing after Deductible	Preauthorization required.
	Physician/surgeon fee	20% Cost Sharing after Deductible	40% Cost Sharing after Deductible	Preauthorization required.
If you have mental health, behavioral health, or substance abuse services	Outpatient services	20% Cost Sharing after Deductible	40% Cost Sharing after Deductible	For additional telehealth services contact Teledoc at 1-800-TELADOC.
	Inpatient services	20% Cost Sharing after Deductible	40% Cost Sharing after Deductible	Preauthorization required.
If you are pregnant	Office Visits	20% Cost Sharing after Deductible	40% Cost Sharing 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% Cost Sharing after Deductible	40% Cost Sharing after Deductible	-------none-------
	Childbirth/delivery facility services	20% Cost Sharing after Deductible	40% Cost Sharing 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% Cost Sharing after Deductible	40% Cost Sharing after Deductible	Coverage is limited to 100 day annual max.
	ReHabilitation Services	20% Cost Sharing after Deductible	40% Cost Sharing after Deductible	Coverage is limited to 40 visit annual max for outpatient physical, speech and occupational.
	Habilitation Services	20% Cost Sharing after Deductible	40% Cost Sharing after Deductible	Coverage is limited to 40 visit annual max for outpatient physical, speech and occupational.
	Skilled Nursing Care	20% Cost Sharing after Deductible	40% Cost Sharing after Deductible	Coverage is limited to 120 day annual max.
	Durable Medical Equipment	20% Cost Sharing after Deductible	40% Cost Sharing after Deductible	Preauthorization required.
	Hospice Services	20% Cost Sharing after Deductible	40% Cost Sharing 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)

- Cosmetic surgery
- Dental care (Adult)
- Dental check-up (Child)
- Eye exam (Child)
- Glasses (Child)
- 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.)

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Hearing aids (Child)
- Infertility treatment
- 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 the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov 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 inital 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.

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 cost sharing) 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)		**Managing Joe's type 2 Diabetes** (a year of routine in-network care of a well-controlled condition)		**Mia's Simple Fracture** (in-network emergency room visit and follow up care)	
The plan's overall deductible	$3,400	**The plan's overall deductible:**	$3,400	**The plan's overall deductible:**	$3,400
Specialist cost sharing:	20%	**Specialist cost sharing:**	20%	**Specialist cost sharing:**	20%
Hospital (facility) cost sharing:	20%	**Hospital (facility) cost sharing:**	20%	**Hospital (facility) cost sharing:**	20%
Other cost sharing:	20%	**Other cost sharing:**	20%	**Other cost sharing:**	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)		**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)		**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	**$12,690**	**Total Example Cost**	**$5,830**	**Total Example Cost**	**$2,800**
In this example, Peg would pay:		**In this example, Joe would pay:**		**In this example, Mia would pay:**	
Cost Sharing		***Cost Sharing***		***Cost Sharing***	
Deductibles	$3,400	Deductibles	$3,400	Deductibles	$2,800
Copayments	$0	Copayments	$0	Copayments	$0
cost sharing	$1,840	cost sharing	$280	cost sharing	$0
What isn't Covered		***What isn't Covered***		***What isn't Covered***	
Limits or Exclusions	$60	Limits or Exclusions	$20	Limits or Exclusions	$0
The total Peg would pay is	**$5,300**	**The total Joe would pay is**	**$3,700**	**The total Mia would pay is**	**$2,800**

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

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 (टटिविइ: 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).