

ASC PPO Idaho

Summary of Benefits and Coverage: What this Plan Covers & What You

Pay For Covered Services

Coverage Period: 1/1/2024 - 12/31/2024

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 1-866-588-6176 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall Deductible?	For In-Network Provider \$200 person/\$400 family. For Out-of-Network Provider \$1,000 person/\$2,000 family.	Generally, you must pay all of the costs from <u>Providers</u> up to the <u>Deductible</u> amount before this <u>Plan</u> begins to pay. If you have other family members on the <u>Plan</u> , each family member must meet their own individual <u>Deductible</u> until the total amount of <u>Deductible</u> expenses paid by all family members meets the overall family <u>Deductible</u> .
Are there services covered before you meet your <u>Deductible</u> ?	Yes. Pharmacy, services that require <u>Copays</u> , immunizations or <u>In-Network</u> hospice care and <u>Preventive Care</u> are covered before you meet your <u>Deductible</u> .	This <u>Plan</u> covers some items and services even if you haven't yet met the <u>Deductible</u> amount. But a <u>Copayment</u> or <u>Cost Sharing</u> may apply. For example, this <u>Plan</u> covers certain <u>Preventive Services</u> without cost-sharing and before you meet your <u>Deductible</u> . See a list of covered <u>Preventive Services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other Deductibles for specific services?	No. There are no other specific <u>Deductibles</u> .	You don't have to meet <u>Deductibles</u> for specific services.
What is the Out-of-pocket Limit for this Plan?	For <u>In-Network Provider</u> \$2,000 person /\$4,000 family For <u>Out-of-Network Provider</u> \$6,000 person /\$12,000 family	The <u>Out-of-pocket Limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>Plan</u> , they have to meet their own <u>Out-of-pocket Limits</u> until the overall family <u>Out-of-pocket Limit</u> has been met.
What is not included in the Out-of-pocket Limit?	Contributions, <u>Balance-Billing</u> charges and health care this <u>Plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>Out-of-pocket Limit</u> .
Will you pay less if you use a Network Provider?	Yes. See <u>www.bcidaho.com</u> or call 1-800-358-5527 for a list of <u>Network</u> <u>Provider</u> s.	This <u>Plan</u> uses a <u>Provider Network</u> . You will pay less if you use a <u>Provider</u> in the <u>Plan</u> 's <u>Network</u> . You will pay the most if you use an <u>Out-of-Network Provider</u> , and you might receive a bill from a <u>Provider</u> for the difference between the <u>Provider</u> 's charge and what your <u>Plan</u> pays (<u>Balance Billing</u>). Be aware your <u>Network Provider</u> might use an <u>Out-of-Network Provider</u> for some services (such as lab work). Check with your <u>Provider</u> before you get services.
Do you need a Referral to see a Specialist?	No.	You can see the <u>Specialist</u> you choose without a <u>Referral</u> .

Questions: Call 1-800-358-5527 or visit us at www.bcidaho.com/SBC.

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		What You Will Pay		
Common Medical Event	Services You May Need	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$35 <u>Copay</u> /visit; <u>Deductible</u> does not apply	40% <u>Cost Sharing</u> after <u>Deductible</u>	<u>Copay</u> does not apply to additional services. \$20 <u>Copay</u> /visit for qualifying non-emergency telehealth services provided by MDLIVE. Additional telehealth services may be provided by your <u>Provider</u> .
	<u>Specialist</u> visit	\$50 <u>Copay</u> /visit; <u>Deductible</u> does not apply	40% <u>Cost Sharing</u> after <u>Deductible</u>	Copay does not apply to additional services.
	Preventive Care/Screening/immunization	No charge for listed preventive, <u>Screening</u> and immunization services. <u>Deductible</u> does not apply.	No charge for listed immunizations, 40% <u>Cost</u> <u>Sharing</u> after <u>Deductible</u> preventive and <u>Screening</u> .	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.
If you have a test	Diagnostic Test (x-ray, blood work)	20% <u>Cost Sharing</u> after <u>Deductible</u>	40% <u>Cost Sharing</u> after <u>Deductible</u>	none
	Imaging (CT/PET scans, MRIs)	20% <u>Cost Sharing</u> after <u>Deductible</u>	40% <u>Cost Sharing</u> after <u>Deductible</u>	<u>Preauthorization</u> required.
If you need drugs to treat your illness or condition	Generic drugs	\$10 <u>Copay</u> /prescription (retail and mail order)	\$10 <u>Copay</u> /prescription (retail and mail order)	Retail: covers up to a 90 day supply with one <u>Copay</u> per 30-day supply. Mail order: covers up to a 90 day supply with two <u>Copays</u> . Additional <u>Out-of-Network</u> charges may apply.
More information about prescription drug coverage is	Preferred brand drugs	15% <u>Cost Sharing</u> up to a \$75 max (retail and mail order)	15% <u>Cost Sharing</u> up to a \$75 max (retail and mail order)	Retail: covers up to a 90 day supply with one <u>Cost Sharing</u> applied per 30-day supply. Mail order: covers up to a 90 day supply with 2.5 <u>Cost Sharing</u> applied. Additional <u>Out-of-Network</u> charges may apply.
available at www.bcidaho.com	Non-preferred brand drugs	35% <u>Cost Sharing</u> up to a \$125 max (retail and mail order)	35% <u>Cost Sharing</u> up to a \$125 max (retail and mail order)	Retail: covers up to a 90 day supply with one <u>Cost Sharing</u> applied per 30-day supply. Mail order: covers up to a 90 day supply with 2.5 <u>Cost Sharing</u> applied. Additional <u>Out-of-Network</u> charges may apply.
	Specialty Drugs	20% <u>Cost Sharing</u> up to a \$250 max (retail and mail order)	Not covered	Limitations, <u>Preauthorization</u> , and <u>Out-of-Network</u> charges may apply. If eligible for Cost Relief, there is no <u>Cost Sharina</u> if you enroll. If you opt out, <u>Cost Sharina</u> will increase and may not apply to your <u>Deductible</u> .

		What You Will Pay		
Common Medical Event	Services You May Need	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center) Physician/surgeon fees	20% <u>Cost Sharing</u> after <u>Deductible</u> 20% <u>Cost Sharing</u> after <u>Deductible</u>	40% Cost Sharing after Deductible 40% Cost Sharing after Deductible	Preauthorization required. Preauthorization required.
If you need immediate medical attention	Emergency Room Care Emergency Medical Transportation	\$100 Copay/visit, 20% Cost Sharing after Deductible 20% Cost Sharing after Deductible	\$100 Copay/visit, 20% Cost Sharing after Deductible 40% Cost Sharing after Deductible	In-Network Cost Sharing applies to both In-Network and Out-of-Network services. Copay waived if admitted. In-Network Cost Sharing applies for air ambulance services.
	<u>Urgent Care</u>	\$35 <u>Copay</u> /visit; <u>Specialist</u> : \$50 <u>Copay</u> /visit; <u>Deductible</u> does not apply	40% <u>Cost Sharing</u> after <u>Deductible</u>	Cost Sharing may vary based on physician. Copay does not apply to additional services.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>Cost Sharing</u> after <u>Deductible</u>	40% <u>Cost Sharing</u> after <u>Deductible</u>	<u>Preauthorization</u> required.
	Physician/surgeon fee	20% <u>Cost Sharing</u> after <u>Deductible</u>	40% <u>Cost Sharing</u> after <u>Deductible</u>	<u>Preauthorization</u> required.
If you have mental health, behavioral health, or substance abuse services	Outpatient services	\$35 <u>Copay</u> /visit, <u>Deductible</u> does not apply; 20% <u>Cost Sharing</u> after <u>Deductible</u> for facility and other services	40% <u>Cost Sharing</u> after <u>Deductible</u>	\$20 <u>Copay</u> /visit for qualifying non-emergency telehealth services provided by MDLIVE. Additional telehealth services may be provided by your <u>Provider</u> .
	Inpatient services	20% <u>Cost Sharing</u> after <u>Deductible</u>	40% <u>Cost Sharing</u> after <u>Deductible</u>	<u>Preauthorization</u> required.

		What You Will Pay			
Common Medical Event	Services You May Need	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information	
If you are pregnant	Office Visits	20% <u>Cost Sharing</u> after <u>Deductible</u>	40% <u>Cost Sharing</u> after <u>Deductible</u>	For pregnancy services, <u>Cost Sharing</u> does not apply to certain <u>Preventive Services</u> . Depending on the type of services, a <u>Copay</u> , <u>Cost</u> <u>Sharing</u> or <u>Deductible</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). No coverage for dependent daughters.	
	Childbirth/delivery professional services	20% <u>Cost Sharing</u> after <u>Deductible</u>	40% <u>Cost Sharing</u> after <u>Deductible</u>	No coverage for dependent daughters.	
	Childbirth/delivery facility services	20% <u>Cost Sharing</u> after <u>Deductible</u>	40% <u>Cost Sharing</u> after <u>Deductible</u>	No coverage for dependent daughters.	
If you need help recovering or have	Home Health Care	20% <u>Cost Sharing</u> after <u>Deductible</u>	40% <u>Cost Sharing</u> after <u>Deductible</u>	none	
other special health needs	ReHabilitation Services	\$35 <u>Copay</u> /visit physical, speech and occupational, <u>Deductible</u> does not apply; 20% <u>Cost Sharing</u> after <u>Deductible</u> for cardiac therapy	40% <u>Cost Sharing</u> after <u>Deductible</u>	Coverage is limited to 60 combined visit annual max for outpatient physical, speech and occupational therapy.	
	Habilitation Services	\$35 <u>Copay</u> /visit physical, speech and occupational, <u>Deductible</u> does not apply	40% <u>Cost Sharing</u> after <u>Deductible</u>	Coverage is limited to 60 combined visit annual max.	
	Skilled Nursing Care	20% <u>Cost Sharing</u> after <u>Deductible</u>	40% <u>Cost Sharing</u> after <u>Deductible</u>	Coverage is limited to 30 day annual max. <u>Preauthorization</u> required.	
	Durable Medical Equipment	20% <u>Cost Sharing</u> after <u>Deductible</u>	40% <u>Cost Sharing</u> after <u>Deductible</u>	Preauthorization required.	
	Hospice Services	No charge. <u>Deductible</u> does not apply.	40% <u>Cost Sharing</u> after <u>Deductible</u>	none	
If your child needs	Children's eye exam	Not covered	Not covered	none	
dental or eye care	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 <u>Plan</u> Generally Does NOT Cover (Check your policy or <u>plan</u> document for more information and a list of other <u>excluded</u>
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 <u>plan</u> document.)

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Hearing aids
- 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 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 <u>plan</u> for a denial of <u>claim</u>. This complaint is called a <u>grievance</u> or <u>appeal</u>. For more information about your rights, look at the explanation of benefits you will receive for that medical <u>claim</u>. Your <u>plan</u> documents also provide complete information. To submit a <u>claim</u>, <u>appeal</u>, or a <u>grievance</u> for any reason to your <u>plan</u>. 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 1-208-286-3687 Or 1-866-588-6176, 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 <u>plans</u>, <u>health insurance</u> available through the <u>Marketplace</u> or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of <u>Minimum Essential Coverage</u>, 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 <u>plan</u> 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 <u>plan</u> might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your <u>providers</u> charge, and many other factors. Focus on the <u>cost sharing</u> amounts (<u>deductibles</u>, <u>copayments</u> and <u>Cost Sharing</u>) and <u>excluded services</u> under the <u>plan</u>. Use this information to compare the portion of costs you might pay under different health <u>plans</u>. 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 <u>plan's</u> overall <u>deductible</u>	\$200
■ Specialist cost sharing	\$50
■ Hospital (facility) 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)

Total Example Cost	\$12,690
In this example. Peg would pay:	

Cost Sharing		
<u>Deductibles</u>	\$200	
<u>Copayments</u>	\$10	
Cost Sharing	\$1, 790	
What isn't Covered		
Limits or exclusions	\$60	
The total Peg would pay is	\$2,060	

Managing Joe's type 2 Diabetes	
(a year of routine in-network care of a well-	
controlled condition)	
■ The <u>plan's</u> overall <u>deductible</u>	\$200
■ Specialist cost sharing	\$50
■ Hospital (facility) <u>cost sharing</u>	20%
Other cost sharing	20%

This EXAMPLE event includes services like:

<u>Primary care physician</u> office visits (including disease education)

Diagnostic tests (blood work)

Prescription drugs

Total Example Cost

Durable medical equipment (glucose meter)

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in this example, soe would pay.		
Cost Sharing		
<u>Deductibles</u>	\$200	
<u>Copayments</u>	\$620	
Cost Sharing	\$650	
What isn't Covered		
Limits or exclusions	\$20	
The total Joe would pay is	\$1,490	

Mia's Simple Fracture		
(in-network emergency room visit and follow up		
care)		
■ The <u>plan's</u> overall <u>deductible</u>	\$200	
■ Specialist cost sharing	\$50	
■ Hospital (facility) cost sharing	20%	
■ Other cost sharing 20%		

This EXAMPLE event includes services like:

Emergency room care (including medical supplies)

Diagnostic test (x-ray)

Total Example Cost

\$5,830

Durable medical equipment (crutches)

Rehabilitation services (physical therapy)

In this example Mia would nav:

\$200
\$110
\$500
\$0
\$810

The <u>plan</u> would be responsible for the other costs of these EXAMPLE covered services.

\$2,800

DISCRIMINATION IS AGAINST THE LAW

Blue Cross of Idaho and Blue Cross of Idaho Care Plus, Inc., (collectively referred to as 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:
 - o Qualified interpreters
 - o Information written in other languages

If you need these services, contact Blue Cross of Idaho Customer Service Department. Call

1-800-627-1188 (TTY: 711), 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 E. Pine Ave., Meridian, ID 83642 Telephone:

1-800-274-4018 Fax: 208-331-7493

Email: grievances&appeals@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 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, 800-537-7697 (TTY). 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).

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

Bantu: ICITONDERWA: Nimba uvuga Ikirundi, uzohabwa serivisi zo gufasha mu ndimi, ku buntu. Woterefona 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:711)。

Farsi توجه: اگر به زبان فارسی صحبت می کنید، خدمات رایگان پشتیبانی زبان، در دسترس شما است. شماره تماس 1188-627-800-1 (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 दनिहोस: तपार्इले नेपाली बोल्नुहुन्छ भने तपार्इको निमृति भाषा सहायता सेवाहर् निःशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् 1-800-627-1188 (टटिवाइ: 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).