Silver Copay CarePoint 2500

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: QHP**

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 at www.healthcare.gov/sbc-glossary or call 1-855-230-6862 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall Deductible?	In-Network **$0**; Out-of-Network **$18,900** person /**$37,800** family.	See the Common Medical Events chart below for your costs for services this Plan covers.
Are there services covered before you meet your Deductible?	Yes. In-Network covered services 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 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 https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other Deductibles for specific services ?	Yes. **$300** person for Prescription Drugs. Does not apply to generic drugs. There are no other specific Deductibles.	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.
What is the Out-of-pocket Limit for this Plan?	For In-Network Provider **$2,950** person/**$5,900** family For Out-of-Network Provider **$94,500** person/**$189,000** 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, this Plan uses the St. Lukes Health Partners. For a list of In-Network Providers, see **www.bcidaho.com or call 1-855-230-6862**.	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?	Yes.	This Plan will pay some or all of the costs to see a Specialist for covered services but only if you have a Referral before you see the Specialist.

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: Network Provider (You will pay the least)	What You Will Pay: 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	No charge, Deductible does not apply	60% Coinsurance after Deductible	Primary Care Physician (PCP) must be selected from St. Lukes Health Partners. All services must be coordinated/referred by PCP. $10 Copay/visit for qualifying non-emergency telehealth services provided by MDLIVE. Additional telehealth services may be provided by your Provider.
	Specialist visit	$35 Copay/visit, Deductible does not apply.	60% Coinsurance after Deductible	The Copay does not apply to additional services.
	Preventive Care/Screening/immunization	No charge for listed preventive, Screening and immunization services. Deductible does not apply.	No charge for listed immunizations, 60% 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 for.
If you have a test	Diagnostic Test (x-ray, blood work)	$35 Copay/service for lab work; $70 Copay/procedure for X-rays and diagnostic imaging; Deductible does not apply	60% Coinsurance after Deductible	-- none --
	Imaging (CT/PET scans, MRIs)	$200 Copay/procedure, Deductible does not apply.	$200 Copay/procedure, 60% Coinsurance after Deductible	Preauthorization required.

Common Medical Event	Services You May Need	What You Will Pay Network Provider (You will pay the least)	 Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at https://members.bcidaho.com/resources/pdfs/pharmacy/2023/2023-Blue-Cross-of-Idaho-QHP-Formulary.pdf	Generic drugs	Preferred=$10 Copay/prescription Non-preferred=$15 Copay/prescription (retail and mail order)	Preferred=$10 Copay/prescription Non-preferred=$15 Copay/prescription (retail and mail order)	Deductible does not apply. 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)	Subject to prescription Deductible. 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)	Subject to prescription Deductible. Covers up to a 90 day supply with multiple Copays. Additional Out-of-Network charges may apply.
	Specialty Drugs	Preferred=30% Coinsurance Non-preferred=50% Coinsurance (retail and mail order)	Preferred=30% Coinsurance Non-preferred=50% Coinsurance (retail and mail order)	Subject to prescription Deductible. Coverage may include limitations and Preauthorization may be required. Additional Out-of-Network charges may apply.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	40% Coinsurance, Deductible does not apply.	60% Coinsurance after Deductible	Preauthorization required.
	Physician/surgeon fees	40% Coinsurance, Deductible does not apply.	60% Coinsurance after Deductible	Preauthorization required.
If you need immediate medical attention	Emergency Room Care	$300 facility Copay/visit; other services 40% Coinsurance. Deductible does not apply.	$300 facility Copay/visit; other services 40% Coinsurance. Deductible does not apply.	In-Network Cost Sharing applies to both In-Network and Out-of-Network services. Copay waived if admitted.
	Emergency Medical Transportation	40% Coinsurance, Deductible does not apply.	60% Coinsurance after Deductible	In-Network Cost Sharing applies for air ambulance services.
	Urgent Care	$0 Copay/visit, Deductible does not apply.	60% Coinsurance after Deductible	The Copay does not apply to additional services.

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 a hospital stay	Facility fee (e.g., hospital room)	40% Coinsurance, Deductible does not apply.	60% Coinsurance after Deductible	Preauthorization required.
	Physician/surgeon fee	40% Coinsurance, Deductible does not apply.	60% Coinsurance after Deductible	Preauthorization required.
If you have mental health, behavioral health, or substance abuse services	Outpatient services	No charge for office visit, 40% Coinsurance for facility and other services, Deductible does not apply	60% Coinsurance after Deductible	$10 Copay/visit for qualifying non-emergency telehealth services provided by MDLIVE. Additional telehealth services may be provided by your Provider.
	Inpatient services	40% Coinsurance, Deductible does not apply.	60% Coinsurance after Deductible	Preauthorization required.
If you are pregnant	Office Visits	40% Coinsurance, Deductible does not apply.	60% Coinsurance after Deductible	For pregnancy services, Cost Sharing does not apply to certain Preventive Services. Depending on the type of services, a Copay, Coinsurance or Deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	40% Coinsurance, Deductible does not apply.	60% Coinsurance after Deductible	--------------------------------------- none -----------------------------------
	Childbirth/delivery facility services	40% Coinsurance, Deductible does not apply.	60% 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	40% Coinsurance, Deductible does not apply.	60% Coinsurance after Deductible	---------- none ----------
	ReHabilitation Services	$35 Copay/visit, Deductible does not apply.	60% Cost Sharing after Deductible	Coverage is limited to 20 visit annual max. The Copay does not apply to additional services.
	Habilitation Services	$35 Copay/visit, Deductible does not apply.	60% Cost Sharing after Deductible	Coverage is limited to 20 visit annual max. The Copay does not apply to additional services.
	Skilled Nursing Care	40% Coinsurance, Deductible does not apply.	60% Coinsurance after Deductible	Coverage is limited to 30 day annual max.
	Durable Medical Equipment	40% Coinsurance, Deductible does not apply.	60% Coinsurance after Deductible	Preauthorization required.
	Hospice Services	No charge, Deductible does not apply.	60% Coinsurance after Deductible	---------- none ----------
If your child needs dental or eye care	Children's eye exam	No charge, Deductible does not apply.	50% Coinsurance, Deductible does not apply.	Under the age of 19 only. VSP limits will apply.
	Children's glasses	No charge, Deductible does not apply.	50% Coinsurance, Deductible does not apply.	Under the age of 19 only. VSP limits will apply.
	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.)

- Abortion, except in cases of rape, incest or when the life of the mother is endangered.
- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Dental check-up (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
- Eye exam (Child)
- Glasses (Child)
- Hearing aids (Child)
- Non-emergency care when traveling outside the U.S.

Your Rights to Continue Coverage:

**** Individual health insurance -**

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your **premium**. There are exceptions, however, such as if:

- You commit fraud
- The insurer stops offering services in the State
- You move outside the coverage area

For more information on your rights to continue coverage, contact the insurer at 1-855-230-6862. You may also contact your state insurance department at 1-800-721-3272.

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 1-208-286-3828 or 1-855-230-6862, 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? **Not Applicable.**

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** $0
- **Specialist copay** $35
- **Hospital (facility) coinsurance** 40%
- **Other coinsurance** 40%

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	$0
Copayments	$890
Coinsurance	$2,060
What isn't Covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,010**

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible** $0
- **Specialist copay** $35
- **Hospital (facility) coinsurance** 40%
- **Other coinsurance** 40%

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	$300
Copayments	$960
Coinsurance	$0
What isn't Covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,280**

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

- **The plan's overall deductible** $0
- **Specialist copay** $35
- **Hospital (facility) coinsurance** 40%
- **Other coinsurance** 40%

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	$0
Copayments	$660
Coinsurance	$670
What isn't Covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,330**

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

*Note: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.

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Blue Cross of Idaho:

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  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
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  - Qualified interpreters
  - 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).

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: 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 1-800-627-1188 (TTY:711).

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.

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

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

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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).