Blue Cross of Idaho
An Independent Licensee of the Blue Cross and Blue Shield Association

HSA Blue℠ PPO

Summary of Benefits City of Idaho Falls Effective Date: October 1, 2016		HSA Blue℠ PPO	
		In-Network	Out-of-Network
Benefit Period* Aggregate Deductible (The Individual/Family, applies to benefits below unless noted.)		$2,500/$5,000	
Coinsurance		You pay 20% of the allowed amount	You pay 40% of the allowed amount
Out-of-Pocket Limit *(See Policy for services that do not apply to the limit.) (Includes applicable Deductible, Coinsurance and Copayments)*		$4,000/$8,000	
COVERED SERVICES *By choosing a non-contracting provider you may be responsible for the difference between what Blue Cross allows and what the non-contracting provider charges. Some services may require prior authorization.*	**In-Network deductible and/or coinsurance payment required before insurance pays?**	**In-Network** **The amount you pay**	**Out-of-Network**
Advanced Imaging Services (Outpatient services only) (Magnetic Resonance Imaging (MRI), Magnetic Resonance Angiography (MRA), Computed Tomography Scan (CT Scan), Positron Emission Tomography (PET), Nuclear Cardiology)	Yes	You pay 20% of the allowed amount	You pay 40% of the allowed amount
Ambulance Transportation Services			
Breastfeeding Support and Supply Services (Limited to one (1) breast pump purchase per benefit period per insured)	No	You pay nothing of the allowed amount	
Chiropractic Care (Limited to 18 visits combined per insured, per benefit period.)	Yes	You pay 20% of the allowed amount	You pay 40% of the allowed amount
Dental Services Related to Accidental Injury	Yes		You pay 40% of the allowed amount
Diabetes Self-Management Education Services (Only for accredited providers approved by BCI.)			
Diagnostic Services (Including diagnostic mammograms)			
Durable Medical Equipment, Orthotic Devices, and Prosthetic Appliances			
Emergency Services – Facility Services** (Copayment waived if admitted)	Yes	You pay $500 copayment for hospital Outpatient emergency room visit, then you pay 20% of the allowed amount	You pay $500 copayment for hospital Outpatient emergency room visit, then you pay 40% of the allowed amount
Emergency Services – Professional Services**	Yes	You pay 20% of the allowed amount	You pay 40% of the allowed amount
Hearing Services (Routine hearing exams)			
Home Health Skilled Nursing (Limited to a combined 17 visits per insured, per benefit period.)			
Home Intravenous Therapy	Yes		You pay 40% of the allowed amount
Hospice Services	Yes	You pay nothing of the allowed amount	You pay 40% of the allowed amount
Hospital Services (Inpatient and outpatient services at a licensed general hospital or ambulatory surgical facility.)	Yes	You pay 20% of the allowed amount	
Maternity Services			
Medical Services (Inpatient and outpatient)			
Mental Health– Inpatient and Outpatient (Facility and Professional Services)			

COVERED SERVICES *By choosing a non-contracting provider you may be responsible for the difference between what Blue Cross allows and what the non-contracting provider charges. Some services may require prior authorization.*	**In-Network deductible and/or coinsurance payment required before insurance pays?**	**In-Network**	**Out-of-Network**
		The amount you pay	
Physician Office Visits	Yes	You pay 20% of the allowed amount	You pay 40% of the allowed amount
Post Mastectomy Reconstructive Surgery			
Prescribed Contraceptive Services (Includes diaphragms, intrauterine devices (IUDs), implantables, injections and tubal ligation.)	No	You pay nothing of the allowed amount	
Skilled Nursing Facility (Limited to 30 days combined per insured, per benefit period.)	Yes	You pay 20% of the allowed amount	
Sleep Study Services			
Surgical Services			
Therapy Services (Including chemotherapy, enterostomal therapy, growth hormone therapy, radiation, renal dialysis and respiratory therapy.)			
Transplant Services			
Outpatient Rehabilitation and Habilitation Therapy Services (Includes physical, speech & occupational therapies. Limited to 20 visits combined per insured, per benefit period.)	Yes	You pay 20% of the allowed amount	You pay 40% of the allowed amount
Outpatient Cardiac and Pulmonary Rehabilitation Therapy Services	Yes	You pay 20% of the allowed amount	You pay 40% of the allowed amount
Inpatient Physical Rehabilitation	Yes	You pay 20% of the allowed amount	You pay 40% of the allowed amount
Preventive Care Services (See Policy for specifically listed preventive care services.)	Yes/No	You pay nothing for services specifically listed For services not specifically listed, you pay deductible and coinsurance	
Immunizations (See the Policy for specifically listed immunizations.)	No	You pay nothing for listed immunizations	

*One family member will not accumulate more than the individual deductible or out-of-pocket maximum toward the family deductible or out-of-pocket maximum. After one family member has met the individual deductible, benefits begin for that person. After the family deductible has been met, benefits begin for all family members.

****Emergency Services**

For the treatment of Emergency Medical Conditions or Accidental Injuries of sufficient severity to necessitate immediate medical care by, or that require Ambulance Transportation Service to, the nearest appropriate Facility Provider, BCI will provide In-Network benefits for Covered Services provided by either a Contracting or Noncontracting Facility Provider and facility-based Professional Providers only. If the nearest Facility Provider is Noncontracting, once the Insured is stabilized and is no longer receiving emergency care the Insured (at BCI's option) may transfer to the nearest appropriate Contracting Facility Provider for further care in order to continue to receive In-Network benefits for Covered Services. If the Insured is required to transfer, transportation to the Contracting Facility Provider will be a Covered Service under the Ambulance Transportation Service provision of this Policy.

PRESCRIPTION DRUG BENEFITS *(Prescription Drug Services apply to the Out-of-Pocket Limits.)*		
RETAIL OR BCI PARTICIPATING MAIL ORDER PHARMACIES		
Generic Prescription Drugs **Formulary Brand Name Prescription Drugs** **Non-Preferred Brand Name Prescription Drugs**	You pay 20% of Maximum Allowance after the Individual/Family Deductible is met	
Preventive Prescription Drugs	You pay nothing for Preventive Prescription Drugs as specifically listed on the BCI Web site, www.bcidaho.com. (Deductible does not apply)	You pay 20% after the Individual/Family Deductible is met for Preventive Prescription Drugs as specifically listed on the BCI Web site, www.bcidaho.com.
Prescribed Contraceptives	You pay nothing for Women's Preventive Prescription Drugs and devices as specifically listed on the BCI Web site, www.bcidaho.com; Deductible does not apply. The day supply allowed shall not exceed a 90-day supply at one (1) time, as applicable to the specific contraceptive drug or supply.	

Note: Certain Prescription Drugs have generic equivalents. If the Insured requests a Brand Name Drug, the Insured is responsible for the difference between the price of the Generic Drug and the Brand Name Drug, regardless of the Formulary or Non-Formulary status.

This summary describes the general features of this program; it is not a contract.
All provisions of the Group Master Policy apply to this program.
Noncontracting providers may bill you for amounts over the maximum allowance.