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 2019		HSA Blue℠ PPO	
		In-Network	**Out-of-Network**
Benefit Period* Aggregate Deductible (Individual/Family, applies to benefits below unless noted.)		$2,700/$5,400	
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*. This is called balance-billing. Some services may require prior authorization.*		**In-Network**	**Out-of-Network**
		What you pay	
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)		Deductible and Coinsurance	Deductible and Coinsurance
Ambulance Transportation Services			
Breastfeeding Support and Supply Services (Limited to one (1) breast pump purchase per benefit period, per insured)		No charge	
Chiropractic Care (Limited to 18 visits combined per insured, per benefit period)		Deductible and Coinsurance	
Dental Services Related to Accidental Injury			
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) (Additional services, such as laboratory, x-ray, and other Diagnostic Services are subject to applicable Deductible, Coinsurance and/or Copayment.) (BCI will provide in-network benefits for treatment of Emergency Medical Conditions. Insured may be balance-billed for these services.)		$500 Copayment for hospital Outpatient emergency room visit, then Deductible and Coinsurance	$500 Copayment for hospital Outpatient emergency room visit, then Deductible and Coinsurance
Emergency Services – Professional Services (BCI will provide in-network benefits for treatment of Emergency Medical Conditions. Insured may be balance-billed for these services.)		Deductible and Coinsurance	Deductible and Coinsurance
Home Health Skilled Nursing			
Home Intravenous Therapy			
Hospice Services		No charge after Deductible	
Hospital Services (Inpatient and outpatient services at a licensed general hospital or ambulatory surgical facility.)		Deductible and Coinsurance	
Rehabilitation or Habilitation Services			
Maternity Services and/or Involuntary Complications of Pregnancy			
Outpatient Applied Behavioral Analysis (as part of an approved treatment plan)			
Mental Health– Inpatient (Facility and Professional Services)			
Mental Health– Outpatient	**Psychotherapy Services**		
	Facility and other Professional Services		
Outpatient Habilitation Therapy Services (Includes physical, speech and occupational therapies. Limited to 20 visits combined per insured, per benefit period.)		Deductible and Coinsurance	
Outpatient Rehabilitation Therapy Services (Includes physical, speech and occupational therapies. Limited to 20 visits combined per insured, per benefit period.)			

This information is for comparison purposes only and not a complete description of benefits. All descriptions of coverage are subject to the provisions of the corresponding policy, which contains all the terms and conditions of coverage. Certain services not specifically noted may be excluded. Please refer to the policy issued for a complete description of benefits, exclusions limitations and conditions of coverage. If there is a difference between this comparison and its corresponding policy, the policy will control. This comparison is subject to annual update and may not reflect the information contained in the corresponding policy.

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Physician Office Visit	Deductible and Coinsurance	Deductible and Coinsurance
Prescribed Contraceptive Services(Includes diaphragms, intrauterine devices (IUDs), implantables, injections and tubal ligation.)	No charge	
Post-Mastectomy/Lumpectomy Reconstructive Surgery	Deductible and Coinsurance	
Skilled Nursing Facility (Limited to 30 days combined per insured, per benefit period.)		
Sleep Study Services		
Surgical/Medical (Professional Services)		
Therapy Services (Including chemotherapy, growth hormone therapy, radiation and renal dialysis.)		
Transplant Services		
Preventive Care Benefits (See the20 BCI Web site, www.bcidaho.com, for specifically listed preventive care services.)	No charge for services specifically listed For services not specifically listed deductible and coinsurance	
Immunizations (See the BCI Web site, www.bcidaho.com, for specifically listed immunizations.)	No charge for listed immunizations	
Treatment for Autism Spectrum Disorder (Services identified as part of the approved treatment plan)	Covered the same as any other illness, depending on the services rendered, see appropriate Covered Services section. Visit limits do not apply to Treatments for Autism Spectrum Disorder.	

*The specified period of time during which charges for covered services must be incurred in order to accumulate toward annual benefit limits, deductible amounts and out-of-pocket limits.

PRESCRIPTION DRUG BENEFITS Each non Specialty Prescription Drug shall not exceed a 90-day supply at one (1) time (Prescription Drug Services apply to the In-Network Out-of-Pocket Limit.)		
RETAIL OR BCI MAIL ORDER PHARMACIES	**In-Network** **WHAT YOU PAY**	**Out-of-Network**
Generic Prescription Drugs **Preferred Brand Name Prescription Drugs** **Non-Preferred Brand Name Prescription Drugs**	20% Coinsurance per prescription, after Deductible is met	
ACA Preventive Prescription Drugs	No charge for ACA Preventive Prescription Drugs as specifically listed on the BCI Formulary on the BCI Web site, www.bcidaho.com. Deductible does not apply.	
HSA Preventive Prescription Drugs	No charge for HSA Preventive Prescription Drugs as specifically listed on the BCI Formulary on the BCI Web site, www.bcidaho.com. (Deductible does not apply)	20% Coinsurance per prescription, after Deductible is met for HSA Preventive Prescription Drugs as specifically listed on the BCI Formulary on the BCI Web site, www.bcidaho.com.
Prescribed Contraceptives	No charge for Women's Preventive Prescription Drugs and devices as specifically listed on the BCI Formulary 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.	

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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 Preferred or Non-Preferred status.

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