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

Preferred Blue® PPO

Summary of Benefits City of Idaho Falls Effective Date October 1, 2019	Preferred Blue Large	
	In-Network	**Out-of-Network**
Benefit Period* Deductible (Individual/Family)	$1,000/$3,000	
Coinsurance	You pay 50% of the allowed amount	You pay 70% of the allowed amount
Individual Out-of-Pocket Limit *(See Policy for services that do not apply to the limit.) (Includes applicable Deductible, Coinsurance and Copayments)*	$1,750	$2,250
Family Out-of-Pocket Limit *(See Policy for services that do not apply to the limit.) (Includes applicable Deductible, Coinsurance and Copayments)*	$5,250	$6,750
Copayment (*Applies to In-Network only. Other services rendered during an office visit will be subject to deductible and coinsurance.)*	You pay $40 Copayment per visit	Not applicable
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
Allergy Injections	$5 Copayment (*if this is the only service provided during the visit)*	
Ambulance Transportation Services	Deductible and Coinsurance	
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	Deductible and Coinsurance
Dental Services Related to Accidental Injury		
Diabetes Self-Management Education Services (Only for accredited providers approved by BCI.)	Copayment	
Diagnostic Services (Including diagnostic mammograms)	Deductible and Coinsurance	
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	
Hospital Services (Inpatient and outpatient services at a licensed general hospital or ambulatory surgical facility.)	Deductible and Coinsurance	
Rehabilitation or Habilitation Services		

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.

Blue Cross of Idaho

An Independent Licensee of the Blue Cross and Blue Shield Association

Preferred Blue® PPO

<table>
<tr><th colspan="2" rowspan="2">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</th><th>In-Network</th><th>Out-of-Network</th></tr>
<tr><th colspan="2">What you pay</th></tr>
<tr><td colspan="2">Maternity Services and/or Involuntary Complications of Pregnancy</td><td>Deductible and Coinsurance</td><td rowspan="7">Deductible and Coinsurance</td></tr>
<tr><td colspan="2">Outpatient Applied Behavioral Analysis (as part of an approved treatment plan)</td><td>Copayment</td></tr>
<tr><td colspan="2">Mental Health– Inpatient (Facility and Professional Services)</td><td>Deductible and Coinsurance</td></tr>
<tr><td rowspan="2">Mental Health– Outpatient</td><td>Psychotherapy Services</td><td>Copayment</td></tr>
<tr><td>Facility and other Professional Services</td><td>Deductible and Coinsurance</td></tr>
<tr><td colspan="2">Outpatient Habilitation Therapy Services (Includes physical, speech and occupational therapies. Limited to 20 visits combined per insured, per benefit period.)</td><td rowspan="2">Deductible and Coinsurance</td></tr>
<tr><td colspan="2">Outpatient Rehabilitation Therapy Services (Includes physical, speech and occupational therapies. Limited to 20 visits combined per insured, per benefit period.)</td></tr>
<tr><td colspan="2">Physician Office Visit</td><td>Copayment</td><td rowspan="9">Deductible and Coinsurance</td></tr>
<tr><td colspan="2">Prescribed Contraceptive Services (Includes diaphragms, intrauterine devices (IUDs), implantables, injections and tubal ligation.)</td><td>No charge</td></tr>
<tr><td colspan="2">Post-Mastectomy/Lumpectomy Reconstructive Surgery</td><td rowspan="6">Deductible and Coinsurance</td></tr>
<tr><td colspan="2">Skilled Nursing Facility (Limited to 30 days combined per insured, per benefit period.)</td></tr>
<tr><td colspan="2">Sleep Study Services</td></tr>
<tr><td colspan="2">Surgical/Medical (Professional Services)</td></tr>
<tr><td colspan="2">Therapy Services (Including chemotherapy, growth hormone therapy, radiation and renal dialysis.)</td></tr>
<tr><td colspan="2">Transplant Services</td></tr>
<tr><td colspan="2">Preventive Care Benefits (See the BCI Web site, www.bcidaho.com, for specifically listed preventive care services.)</td><td>No charge for services specifically listed

For services not specifically listed deductible and coinsurance</td></tr>
<tr><td colspan="2">Immunizations (See the BCI Web site, www.bcidaho.com, for specifically listed immunizations.)</td><td colspan="2">No charge for listed immunizations</td></tr>
<tr><td colspan="2">Treatment for Autism Spectrum Disorder (Services identified as part of the approved treatment plan)</td><td colspan="2">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.</td></tr>
</table>

*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.

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.