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

Preferred Blue® PPO

Summary of Benefits West Ada School District **Effective Date: January 1, 2019**		**Preferred Blue® Large Group**	
		In-Network	**Out-of-Network**
Benefit Period* Deductible (Individual/Family)		$500/$1,000	
Coinsurance		You pay 20% of the allowed amount for covered services	You pay 40% of the allowed amount for covered services
Individual Out-of-Pocket Limit *(See Policy for services that do not apply to the limit.) (Includes applicable Deductible, Coinsurance and Copayments)*		$5,000	$6,500
Family Out-of-Pocket Limit *(See Policy for services that do not apply to the limit.) (Includes applicable Deductible, Coinsurance and Copayments)*		$10,000	$13,000
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 deductible and/or coinsurance payment required before insurance pays?**	**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)	Yes	You pay nothing for the first $100, then you pay 20% of the allowed amount	You pay 40% of the allowed amount
Allergy Injections	No	You pay a $5 copayment (*if this is the only service provided during the visit)*	
Ambulance Transportation Services	Yes	You pay 20% of the allowed amount	
Breastfeeding Support and Supply Services (Limited to one (1) breast pump purchase per benefit period, per insured.)	No	No charges	
Chiropractic Care (Limited to 18 visits combined per insured, per benefit period.)	Yes	You pay 20% of the allowed amount	You pay 50% of the allowed amount
Dental Services Related to Accidental Injury			You pay 40% of the allowed amount
Diabetes Self-Management Education Services (Only for accredited providers approved by BCI.)	No	You pay a $20 copayment per visit	
Diagnostic Services (Including diagnostic mammogram.)	Yes	You pay nothing for the first $100, then you pay 20% of the allowed amount	
Durable Medical Equipment, Orthotic Devices, and Prosthetic Appliances		You pay 20% of the allowed amount	
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.)		You pay $200 copayment for hospital Outpatient emergency room visit, then you pay 20% of allowed amount	You pay $200 copayment for hospital Outpatient emergency room visit, then you pay 40% of allowed amount
Emergency Services – Professional Services (BCI will provide in-network benefits for treatment of Emergency Medical Conditions. Insured may be balance-billed for these services.)		You pay 20% of the allowed amount	You pay 40% of the allowed amount

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.

Revised 10.24.2018 JB

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			What you pay		
Home Health Skilled Nursing		Yes	You pay 20% of the allowed amount		You pay 40% of the allowed amount
Home Intravenous Therapy					You pay 80% of the allowed amount
Hospice Services		No	No charge		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		
Rehabilitation or Habilitation Services					
Maternity Services and/or Involuntary Complications of Pregnancy					
Outpatient Applied Behavioral Analysis (as part of an approved treatment plan)		No	You pay a $20 copayment per visit		
Mental Health– Inpatient (Facility and Professional Services)		Yes	You pay 20% of the allowed amount		
Mental Health– Outpatient	**Psychotherapy Services**	No	You pay a $20 copayment per visit		
	Facility and other Professional Services	Yes	You pay 20% of the allowed amount		
Outpatient Habilitation Therapy Services (Includes physical, speech and occupational therapies. Limited to 20 visits combined per insured, per benefit period.)		Yes	You pay 50% of the allowed amount		You pay 80% of the allowed amount
Outpatient Rehabilitation Therapy Services (Includes physical, speech and occupational therapies. Limited to 20 visits combined per insured, per benefit period.)					
Physician Office Visit (Other services rendered during a physician office visit will be subject to deductible and coinsurance.)		No	**Unity Health Clinic Provider**	**In-Network**	You pay 40% of the allowed amount
			No charge	You pay a $20 copayment per visit	
Post Mastectomy Reconstructive Surgery		Yes	You pay 20% of the allowed amount		
Prescribed Contraceptive Services (Includes diaphragms, intrauterine devices (IUDs), implantables, injections and tubal ligation.)		No	No charge		
Skilled Nursing Facility (Limited to 30 days combined per insured, per benefit period)		Yes	You pay 20% of the allowed amount		
Surgical/Medical (Professional Services)					
Sleep Study Services					
Therapy Services (Including chemotherapy, growth hormone therapy, radiation and renal dialysis.)					
Transplant Services					

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		What you pay	
Preventive Care Benefits (See policy for specifically listed preventive care services)	Yes/No	No charge for services specifically listed For services not specifically listed you pay deductible and coinsurance	You pay 40% of the allowed amount
Immunizations (See policy for specifically listed immunizations)	No	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.

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Prescription Benefits	
	RETAIL
Generic Drugs	Insured pays $10 Copayment + 20% Coinsurance per prescription
Brand Name Drugs	Insured pays $20 Copayment + 20% Coinsurance per prescription Limited to a 30-day supply
BCI Mail Order Participating Pharmacy **Generic Drugs** **Brand Name Drugs**	 Insured pays $10 Copayment per prescription Insured pays $20 Copayment per prescription 90-day supply or 100 unit doses, whichever is less
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)
Out-of-Pocket Limit	**Individual:** You pay $1,500 in Copayments and/or Coinsurance per Benefit Period for a combination of all Prescription Drug charges incurred. **Family:** You pay a combination of $3,000 in Copayments and/or Coinsurance per Benefit Period for a combination of all Prescription Drug charges incurred. *When the Prescription Drug Out-of-Pocket Limit is met, the Prescription Drug Benefits payable will increase to 100% of the Allowed Charge or the Usual Charge for the remainder of the Benefit Period.*
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.

*For brand name drugs that have a corresponding generic substitute your pharmacist should fill your prescription with the generic (unless indicated otherwise by your physician) and you will pay the lowest copayment. If you purchase the brand name drug and it has a corresponding generic equivalent, you will be responsible for the difference in cost between the generic and brand name drug plus the applicable brand name copayment.

To view and print a copy of the Summary of Benefits and Coverage (SBC) for your current coverage options and the uniform glossary, please visit our website, bcidaho.com and log in as a member. If you need help registering on the Blue Cross of Idaho website, have questions about the SBC, need language assistance or would like a paper copy free of charge, please call the Customer Service number on the back of your Blue Cross of Idaho ID cards or call 1-800-627-1188. You can also visit our website at bcidaho.com/SBC for more information.

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