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

HSA Blue℠PPO

Benefit Highlight Sheet, Canyon-Owyhee SD ***September 01,2020***	**HSA Blue℠ PPO for Idaho School Benefit Trust**	
	In-Network	**Out-of-Network**
Benefit Period* Aggregate Deductible** (Individual/Family, applies to benefits below unless noted.)	$3,000/$6,000	
Cost Sharing	You pay 30% of the allowed amount	You pay 50% of the allowed amount
Out-of-Pocket Limit *(See Plan for services that do not apply to the limit.) (Includes applicable Deductible, Cost Sharing and Copayments)*	$5,800/$11,600	
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	
Ambulance Transportation Services	Deductible and Cost Sharing	Deductible and Cost Sharing
Breastfeeding Support and Supply Services (Limited to one (1) breast pump purchase per benefit period, per Participant)	No charge	
Chiropractic Care (Limited to 18 visits combined per Participant, per benefit period)	Deductible and Cost Sharing	
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, Cost Sharing and/or Copayment.) (BCI will provide in-network benefits for treatment of Emergency Medical Conditions. Participant may be balance-billed for these services.)	$100 Copayment for hospital Outpatient emergency room visit, then Deductible and Cost Sharing	$100 Copayment for hospital Outpatient emergency room visit, then Deductible and Cost Sharing
Emergency Services – Professional Services (BCI will provide in-network benefits for treatment of Emergency Medical Conditions. Participant may be balance-billed for these services.)	Deductible and Cost Sharing	Deductible and Cost Sharing
Home Health Skilled Nursing		
Home Intravenous Therapy		80% Cost Sharing after Deductible
Hospice Services	No Charge after Deductible	Deductible and Cost Sharing
Hospital Services (Inpatient and outpatient services at a licensed general hospital or ambulatory surgical facility.)	Deductible and Cost Sharing	
Rehabilitation or Habilitation Services		
Maternity Services and/or Involuntary Complications of Pregnancy		
Medical Services (Inpatient and outpatient)		
Mental Health– Inpatient and Outpatient (Facility and Professional Services) (No charge after Deductible for Outpatient Psychotherapy Services, for Participants under the age of eighteen (18).)		
Outpatient Applied Behavioral Analysis (as part of an approved treatment plan)		

The information in this Highlight Sheet is for informational and comparison purposes only. It is not a complete summary or description of benefits Coverage is subject to the provisions of the corresponding Plan Documents and Summary Plan Description, which contains the detailed terms and conditions of coverage. Certain services not specifically noted may be excluded. Please refer to the Plan Document and Summary Plan Description issued for a more complete description of benefits, exclusions limitations and conditions of coverage. If there is a difference or conflict between this Highlight Sheet and its corresponding Plan Documents and Summary Plan Description, the Plan Documents and Summary Plan Description will control. This Highlight Sheet is subject to annual update.

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	What you pay	
Outpatient Habilitation Therapy Services (Includes physical, speech and occupational therapies. Limited to 20 visits combined per Participant, per benefit period.)	50% Cost Sharing after Deductible	80% Cost Sharing after Deductible
Outpatient Rehabilitation Therapy Services (Includes physical, speech and occupational therapies. Limited to 20 visits combined per Participant, per benefit period.)		
Pediatric Physician Office Visit (For Participants under the age of eighteen (18).)	No charge after Deductible	Deductible and Cost Sharing
Physician Office Visit	Deductible and Cost Sharing	
Prescribed Contraceptive Services (Includes diaphragms, intrauterine devices (IUDs), implantables, injections and tubal ligation.)	No charge	Deductible and Cost Sharing
Post-Mastectomy/Lumpectomy Reconstructive Surgery	Deductible and Cost Sharing	
Skilled Nursing Facility (Limited to 30 days combined per Participant, per benefit period.)		
Surgical/Medical		
Therapy Services (Including chemotherapy, growth hormone therapy, radiation and renal dialysis.)		
Transplant Services		
Preventive Care Benefits (See plan for specifically listed services)	No charge for services specifically listed For services not specifically listed Deductible and Cost Sharing	
Immunizations (See Plan for specifically listed immunizations)	No charge for listed immunizations	
Telehealth Services (Services provided by MDLIVE for Medical Consult, Psychotherapy Treatment, Outpatient Medication Management and Psychiatric Evaluation/Medical Service covered services)	Deductible and Cost Sharing To request a consultation, call 1-888-920-2975 or visit the website at www.mdlive.com/bcidaho [mdlive.com].	
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, and related diagnoses.	

*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.

**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.

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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**	**Out-of-Network**
	WHAT YOU PAY	
Generic Prescription Drugs **Preferred Brand Name Prescription Drugs** **Non-Preferred Brand Name Prescription Drugs**	Deductible and Cost Sharing	
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.	
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.	

Note: Certain Prescription Drugs have generic equivalents. If the Participant requests a Brand Name Drug, the Participant 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.