

Summary of Benefits City of Rexburg Effective: January 1, 2016		Preferred Blue® Large Group	
		In-Network	Out-of-Network
Benefit Period* Deductible (Individual/Family)		\$2,500/\$5,000	
Coinsurance		You pay 10% of the allowed amount for covered services	You pay 30% 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)		\$4,500	\$6,500
Family Out-of-Pocket Limit (See Policy for services that do not apply to the limit.) (Includes applicable Deductible, Coinsurance and Copayments)		\$9,000	\$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. 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	
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 10% of the allowed amount	You pay 30% 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 10% of the allowed amount	
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	You pay 50% of the allowed amount
Chiropractic Care (Limited to 18 visits combined per insured, per benefit period. Services are not subject to Deductible)	No	You pay 10% of the allowed amount	
Dental Services Related to Accidental Injury	Yes	You pay a \$30 copayment per visit	You pay 30% of the allowed amount
Diabetes Self-Management Education Services (Only for accredited providers approved by BCI.)	No		
Diagnostic Services (Including diagnostic mammograms)	Yes		
Durable Medical Equipment, Orthotic Devices, and Prosthetic Appliances	Yes	You pay 10% of the allowed amount	You pay \$100 copayment for hospital Outpatient emergency room visit, then you pay 30% of the allowed amount
Emergency Services** – Facility Services (Copayment waived if admitted)	Yes	You pay \$100 copayment for hospital Outpatient emergency room visit, then you pay 10% of the allowed amount	
Emergency Services** – Professional Services	Yes	You pay 10% of the allowed amount	You pay 30% of the allowed amount
Home Health Skilled Nursing			You pay 80% of the allowed amount
Home Intravenous Therapy	Yes	You pay nothing of the allowed amount	You pay 30% of the allowed amount
Hospice Services	No	You pay 10% of the allowed amount	
Hospital Services (Inpatient and outpatient services at a licensed general hospital or ambulatory surgical facility.)	Yes	You pay 10% of the allowed amount	

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		The amount you pay	
Inpatient Physical Rehabilitation	Yes	You pay 10% of the allowed amount	You pay 30% of the allowed amount
Maternity Services and/or Involuntary Complications of Pregnancy			
Mental Health— Inpatient (Facility and Professional Services)			
Mental Health— Outpatient	Psychotherapy Services	No	You pay a \$30 copayment per visit
	Facility and other Professional Services	Yes	
Outpatient Rehabilitation and 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
Physician Office Visit (Other services rendered during a physician office visit will be subject to deductible and coinsurance.)	No	You pay a \$30 copayment per visit	You pay 30% of the allowed amount
Prescribed Contraceptive Services (Includes diaphragms, intrauterine devices (IUDs), implantables, injections and tubal ligation.)	No	You pay nothing of the allowed amount	
Post Mastectomy Reconstructive Surgery	Yes	You pay 10% of the allowed amount	
Skilled Nursing Facility (Limited to 30 days combined per insured, per benefit period)			
Sleep Study Services			
Surgical/Medical (Professional Services)			
Therapy Services (Including chemotherapy, enterostomal therapy, growth hormone therapy, radiation, renal dialysis, respiratory therapy, and inpatient occupational therapy.)			
Transplant Services	Yes/No	You pay nothing for services specifically listed For services not specifically listed you pay deductible and coinsurance	
Preventive Care Benefits (See the BCI Web site, www.bcidaho.com for specifically listed preventive care services.)			
Immunizations (See the BCI Web site, www.bcidaho.com for specifically listed immunizations.)	No	You pay nothing for listed immunizations	

*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.

****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.

VISION CARE BENEFITS (VSP) Exam + Materials	
For Covered Providers and Services	
Vision Exam	
Participating VSP Doctors	You pay nothing up to the Maximum Allowance per eye exam
Nonparticipating VSP Doctors	You pay nothing up to \$45 per eye exam
Materials	
For Participating VSP Doctors ¹	You pay nothing up to \$150
Nonparticipating VSP Doctors	You pay nothing up to \$150
Service Frequency Limitations	
Insured may receive one (1) eye exam and/or one (1) pair of Lenses and/or one (1) Frame or one (1) pair of Medically Necessary Contact Lenses (in lieu of eyeglasses) every twelve (12) months.	

*The Participating VSP Doctor is responsible for verifying benefits with VSP prior to rendering services. An Insured must provide the VCSV Participating Provider sufficient information to verify eligibility. Failure of the Insured to provide sufficient information may delay services and may affect benefit payment under the policy.

Prescription Benefits		
Retail and Mail Order (90 day supply with multiple copays)	Generic	You pay a \$10 Copayment – No Deductible required
	\$250 deductible per insured on Preferred and Non-Preferred Brand Name Drugs.*	
	Preferred Brand Name	You pay a \$30 Copayment after Deductible is met
	Non-Preferred Brand Name	You pay a \$50 Copayment after Deductible is met
Out-of-Pocket Limit	<p>Individual: You pay \$2,000 in Copayments and/or Coinsurance per Benefit Period for a combination of all Prescription Drug charges incurred.</p> <p>Family: You pay a combination of \$4,000 in Copayments and/or Coinsurance per Benefit Period for a combination of all Prescription Drug charges incurred.</p> <p><i>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.</i></p>	
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.

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.