Blue Cross of Idaho
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Idaho AGC Self-Funded Benefit Trust Preferred Blue® PPO

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2021 BENEFIT HIGHLIGHTS

MEDICAL SUMMARY OF BENEFITS	***In-Network***	***Out-of-Network***
Individual/Family Deductible	$1,000/$2,000	
Cost-sharing	You pay 30% of the allowed amount	You pay 50% of the allowed amount
Individual Out-of-Pocket Limit *(See Plan for services that do not apply to the limit.) (Includes applicable Deductible, Cost-sharing and Copayments)*	$8,500	$17,000
Family Out-of-Pocket Limit *(See Plan for services that do not apply to the limit.) (Includes applicable Deductible, Cost-sharing and Copayments)*	$17,000	$34,000
Copayment *(Applies to In-Network only. Other services rendered during an office visit will be subject to Deductible and Cost-sharing.)*	You pay $30 Copayment per visit for Primary Care Provider/ You pay $50 Copayment per visit for Non-Primary Care Provider	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	
Allergy Injections	$5 Copayment *(if this is the only service provided during the visit)*	Deductible and Cost-sharing
Ambulance Transport Service*	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 20 visits combined per benefit period, per participant)	Deductible and Cost-sharing	

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

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	What you pay	
Dental Services Related to Accidental Injury	Deductible and Cost-sharing	Deductible and Cost-sharing
Diabetes Self-Management Education Services (Only for accredited providers approved by BCI. Limited to 4 visits combined per benefit period, per participant.)	Primary Care Provider Copayment	
Diagnostic Laboratory/X-ray (Includes non-screening mammograms)	Deductible and Cost-sharing	
Durable Medical Equipment, Orthotic Devices, and Prosthetic Appliances		
Emergency Services* – Facility Services (Copayment waived if admitted)	$350 Copayment for hospital Outpatient emergency room visit, then Deductible and Cost-sharing	$350 Copayment for hospital Outpatient emergency room visit, then Deductible and Cost-sharing
Emergency Services* – Professional Services	Deductible and Cost-sharing	Deductible and Cost-sharing
Hearing Aids (Eligible Dependent Children Only) (Benefits are limited to one (1) device per ear, every three (3) years, and includes forty-five (45) speech therapy visits during the first twelve (12) months after delivery of the covered device.)		
Home Health Skilled Nursing		
Home Intravenous Therapy		Deductible and 80% Cost-sharing
Hospice Services	No charge	Deductible and Cost-sharing
Hospital Facility Services (Inpatient, outpatient, diagnostic, etc.)	Deductible and Cost-sharing	
Rehabilitation or Habilitation Services		
Maternity and/or Involuntary Complications of Pregnancy		
Mental Health Inpatient (Facility and Professional Services)		
Outpatient Applied Behavioral Analysis (as part of an approved treatment plan)	Primary Care Provider Copayment	

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		What you pay	
Mental Health Outpatient	**Psychotherapy Services**	Primary Care Provider Copayment	Deductible and Cost-sharing
	Facility and other Professional Services	Deductible and Cost-sharing	
Outpatient Habilitation Therapy Services (Includes physical, speech and occupational therapies. Limited to 20 visits combined per participant, per benefit period.)		Deductible and Cost-sharing	
Outpatient Rehabilitation Therapy Services (Includes physical, speech and occupational therapies. Limited to 20 visits combined per participant, per benefit period.)			
Outpatient Cardiac Rehabilitation Therapy Services			
Outpatient Respiratory Therapy Services			
Palliative Care Services		No charge	
Post-Mastectomy Reconstructive Surgery		Deductible and Cost-sharing	
Physician Office Visit (Other services rendered during a physician office visit will be subject to Deductible and Cost-sharing)		Primary Care Provider Copayment / Non-Primary Care Provider Copayment	
Prescribed Contraceptive Services (Includes diaphragms, intrauterine devices (IUDs), implantables, injections and tubal ligation)		No charge	
Skilled Nursing Facility (Limited to a combined 30 days per benefit period, per participant)		Deductible and Cost-sharing	
Surgical/Medical (Professional Services)			
Temporomandibular Joint (TMJ) Syndrome Services (Limited to a combined $2,000 lifetime benefit limit, per participant)			
Therapy Services (Including chemotherapy, growth hormone, radiation and renal dialysis.)			

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		What you pay	
Transplant Services		Deductible and Cost-sharing	Deductible and Cost-sharing
Preventive Care Benefits (See Plan for specifically listed preventive care services.)		No charge for services specifically listed For services not specifically listed, you pay Deductible and Cost-sharing	
Immunizations (See Plan for specifically listed immunizations.)		No charge for listed immunizations	
Telehealth Virtual Care Services		Telehealth Virtual Care Services are available for any category of covered outpatient services. The amount of payment and other conditions for in-person services will apply to Telehealth Virtual Care Services – see appropriate Covered Services section.	
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.	

***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, on behalf of the Plan Administrator, 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 Participant is stabilized and is no longer receiving emergency care, the Participant (at BCI's option, on behalf of the Plan Administrator,) 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 Participant is required to transfer, transportation to the Contracting Facility Provider will be a Covered Service under the Ambulance Transportation Service provision of this Plan.

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Prescription Benefits – COPAY OPTION *(Prescription Drug Services apply to the In-Network Out-of-Pocket Limits)*	
RETAIL PHARMACIES: 90-day supply with multiple Copayments *(one Copayment for each 30-day supply)* **MAIL ORDER:** 90-day supply with two Copayments	
Tier 1 Preferred Generic Prescription Drugs	$7 Copayment
Tier 2 Non-Preferred Generic Prescription Drugs	$7 Copayment
Tier 3 Preferred Brand Name Prescription Drugs	30% Cost-sharing
Tier 4 Non-Preferred Brand Name Prescription Drugs	50% Cost-sharing
Tier 5 Preferred Specialty Prescription Drugs and Generic Specialty Prescription Drugs *(30-day supply limit at one time)*	30% Cost-sharing
Tier 6 Non-Preferred Specialty Prescription Drugs *(30-day supply limit at one time)*	50% 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.	

For Customer Services call (208) 286-3439 or toll-free 1-866-283-6354. Visit us on the web at www.bcidaho.com.

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