



**Idaho AGC Self-Funded  
Benefit Trust  
Preferred Blue® PPO**



<b>2021 BENEFIT HIGHLIGHTS</b>		
<b>MEDICAL SUMMARY OF BENEFITS</b>	<b>In-Network</b>	<b>Out-of-Network</b>
<b>Individual/Family Deductible</b>	\$1,000/\$2,000	
<b>Cost-sharing</b>	You pay 30% of the allowed amount	You pay 50% of the allowed amount
<b>Individual Out-of-Pocket Limit</b> (See Plan for services that do not apply to the limit.) (Includes applicable Deductible, Cost-sharing and Copayments)	\$8,500	\$17,000
<b>Family Out-of-Pocket Limit</b> (See Plan for services that do not apply to the limit.) (Includes applicable Deductible, Cost-sharing and Copayments)	\$17,000	\$34,000
<b>Copayment</b> (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
<b>COVERED SERVICES</b>	<b>In-Network</b>	<b>Out-of-Network</b>
<b>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.</b>	<b>What you pay</b>	
<b>Allergy Injections</b>	\$5 Copayment (if this is the only service provided during the visit)	Deductible and Cost-sharing
<b>Ambulance Transport Service*</b>	Deductible and Cost-sharing	
<b>Breastfeeding Support and Supply Services</b> (Limited to one (1) breast pump purchase per benefit period, per participant)	No charge	
<b>Chiropractic Care</b> (Limited to 20 visits combined per benefit period, per participant)	Deductible and Cost-sharing	

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<b>Dental Services Related to Accidental Injury</b>	Deductible and Cost-sharing	Deductible and Cost-sharing
<b>Diabetes Self-Management Education Services</b> (Only for accredited providers approved by BCI. Limited to 4 visits combined per benefit period, per participant.)	Primary Care Provider Copayment	
<b>Diagnostic Laboratory/X-ray</b> (Includes non-screening mammograms)	Deductible and Cost-sharing	
<b>Durable Medical Equipment, Orthotic Devices, and Prosthetic Appliances</b>	Deductible and Cost-sharing	
<b>Emergency Services* – Facility Services</b> (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
<b>Emergency Services* – Professional Services</b>	Deductible and Cost-sharing	Deductible and Cost-sharing
<b>Hearing Aids</b> (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.)		
<b>Home Health Skilled Nursing</b>		
<b>Home Intravenous Therapy</b>		Deductible and 80% Cost-sharing
<b>Hospice Services</b>	No charge	
<b>Hospital Facility Services</b> (Inpatient, outpatient, diagnostic, etc.)	Deductible and Cost-sharing	Deductible and Cost-sharing
<b>Rehabilitation or Habilitation Services</b>		
<b>Maternity and/or Involuntary Complications of Pregnancy</b>		
<b>Mental Health Inpatient</b> (Facility and Professional Services)		
<b>Outpatient Applied Behavioral Analysis</b> (as part of an approved treatment plan)		

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

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	<b>What you pay</b>	
<b>Transplant Services</b>	Deductible and Cost-sharing	Deductible and Cost-sharing
<b>Preventive Care Benefits</b> (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	
<b>Immunizations</b> (See Plan for specifically listed immunizations.)	No charge for listed immunizations	
<b>Telehealth Virtual Care Services</b>	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.	
<b>Treatment for Autism Spectrum Disorder</b> (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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<b>Prescription Benefits – DEDUCTIBLE OPTION</b>	
<i>(Prescription Drug Services apply to the In-Network Out-of-Pocket Limits)</i>	
<b>RETAIL PHARMACIES:</b> 90-day supply with multiple Copayments <i>(one Copayment for each 30-day supply)</i>	
<b>MAIL ORDER:</b> 90-day supply with two Copayments	
<b>Tier 1 Preferred Generic Prescription Drugs</b>	\$10 Copayment – No Deductible required
<b>Tier 2 Non-Preferred Generic Prescription Drugs</b>	\$10 copayment – No Deductible required
<b>Tier 3 Preferred Brand Name Prescription Drugs</b>	30% Cost-sharing up to \$50 – No Deductible required (mail order 30% Cost-sharing up to \$100 per 90-day supply – No Deductible required)
<b>\$500 Individual Deductible for Non-Preferred Brand Name Drugs, Preferred Specialty Drugs, Generic Specialty Drugs and Non-Preferred Specialty Drugs</b>	
<b>Tier 4 Non-Preferred Brand Name Prescription Drugs</b>	50% Cost-sharing up to \$100 after Deductible (mail order 50% Cost-sharing up to \$200 per 90-day supply after Deductible)
<b>Tier 5 Preferred Specialty Prescription Drugs and Generic Specialty Prescription Drugs</b> (30-day supply limit at one time)	30% Cost-sharing after Deductible
<b>Tier 6 Non-Preferred Specialty Prescription Drugs</b> (30-day supply limit at one time)	50% Cost-sharing after Deductible
<b>ACA Preventive Prescription Drugs</b>	No charge for ACA Preventive Prescription Drugs as specifically listed on the BCI Formulary on the BCI Web site, <a href="http://www.bcidaho.com">www.bcidaho.com</a> . (Deductible does not apply)
<b>Prescribed Contraceptives</b>	No charge for Women’s Preventive Prescription Drugs and devices as specifically listed on the BCI Formulary on the BCI Web site, <a href="http://www.bcidaho.com">www.bcidaho.com</a> ; 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.
<b>Note:</b> 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](http://www.bcidaho.com).

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