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

Idaho AGC Self-Funded Benefit Trust HDHP

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2020 BENEFIT HIGHLIGHTS

MEDICAL SUMMARY OF BENEFITS		*In-Network*	*Out-of-Network*
Benefit Period* Aggregate Deductible (The Individual/Family, applies to benefits below unless noted.)		$3,000/$6,000	
Cost-Sharing		You pay 30% of the allowed amount for covered services	You pay 50% of the allowed amount for covered services
Out-of-Pocket Limit *(See Plan for services that do not apply to the limit.) (Includes applicable Deductible, Cost-Sharing and Copayments)*		$6,750/$13,500	$13,500/$27,000
COVERED SERVICES	**Deductible and/or Cost-Sharing payment required before insurance pays?**	***In-Network*** *By choosing an in-network provider you pay only Cost-Sharing and/or copayment amounts for allowed charges.*	***Out-of-Network*** *By choosing an out-of-network provider you pay more Cost-Sharing and you may also be responsible for the difference between what Blue Cross allows and what the out-of-network provider charges.*
Allergy Injections	Yes	You pay 30% of the allowed amount	You pay 50% of the allowed amount
Ambulance Transport Service**	Yes	You pay 30% of the allowed amount	
Breastfeeding Support and Supply Services (Limited to one (1) breast pump purchase per benefit period per participant)	No	You pay nothing of the allowed amount	
Chiropractic Care (Limited to 20 visits combined per benefit period, per participant)	Yes	You pay 30% of the allowed amount	
Dental Services Related to Accidental Injury	Yes	You pay 30% of the allowed amount	
Diabetes Self-Management Education Services (Only for accredited providers approved by BCI. Limited to 4 visits combined per benefit period, per participant.)	Yes	You pay 30% of the allowed amount	
Diagnostic Laboratory/X-ray (Includes non-screening mammograms)	Yes	You pay 30% of the allowed amount	
Durable Medical Equipment, Orthotic Devices, and Prosthetic Appliances	Yes		

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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Emergency Services – Facility Services** (Copayment waived if admitted)	Yes	You pay $350 copayment for hospital Outpatient emergency room visit, then you pay 30% of the allowed amount	You pay $350 copayment for hospital Outpatient emergency room visit, then you pay 50% of the allowed amount
Emergency Services – Professional Services**	Yes	You pay 30% of the allowed amount	You pay 50% of the allowed amount
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			You pay 80% of the allowed amount
Hospice Services	Yes	You pay 30% of the allowed amount	You pay 50% of the allowed amount
Hospital Facility Services (Inpatient, outpatient, diagnostic, etc.)	Yes	You pay 30% of the allowed amount	
Rehabilitation or Habilitation Services			
Maternity and/or Involuntary Complications of Pregnancy			
Mental Health – **Inpatient and Outpatient** (Facility and Professional Services)			
Outpatient Applied Behavioral Analysis (as part of an approved treatment plan)	Yes	You pay 30% of the allowed amount	
Outpatient Habilitation Therapy Services (Includes physical, speech and occupational therapies. Limited to 20 visits combined per participant, per benefit period.)	Yes	You pay 30% of the allowed amount	
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			
Post-Mastectomy Reconstructive Surgery			

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Physician Office Visit	Yes	You pay 30% of the allowed amount	
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Prescribed Contraceptive Services (Includes diaphragms, intrauterine devices (IUDs), implantables, injections and tubal ligation)	No	You pay nothing of the allowed amount	You pay 50% of the allowed amount
Skilled Nursing Facility (Limited to a combined 30 days per benefit period, per participant)	Yes	You pay 30% of the allowed amount	
Surgical/Medical (Professional Services)	Yes	You pay 30% of the allowed amount	
Therapy Services (Including chemotherapy, radiation, growth hormone and renal dialysis.)			
Temporomandibular Joint (TMJ) Syndrome Services (Limited to a combined $2,000 lifetime benefit limit, per participant)			
Transplant Services			
Preventive Care Benefits (See Plan for specifically listed preventive care services.)	Yes/No	You pay nothing for services specifically listed. For services not specifically listed, you pay deductible and Cost-Sharing	
Immunizations (See Plan for specifically listed immunizations.)	No	You pay nothing for listed immunizations	
Treatment for Autism Spectrum Disorder (Services identified as part of the approved treatment plan)	Yes	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 DRUG BENEFITS *(Prescription Drug Services apply to the Out-of-Pocket Limits.)*	
RETAIL OR BCI MAIL ORDER PHARMACIES	
Generic Prescription Drugs **Preferred Brand Name Prescription Drugs** **Non-Preferred Brand Name Prescription Drugs**	You pay 30% of Maximum Allowance after the Individual/Family Deductible is met
ACA Preventive Prescription Drugs	You pay nothing 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	You pay nothing 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.