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

Idaho AGC Self-Funded Benefit Trust Preferred Blue® PPO

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A PROUD CHAPTER OF AGC OF AMERICA

2020 BENEFIT HIGHLIGHTS

MEDICAL SUMMARY OF BENEFITS		*In-Network*	*Out-of-Network*
Individual/Family Deductible		$1,000/$2,000	
Coinsurance		You pay 30% of the allowed amount for covered services	You pay 50% of the allowed amount for covered services
Individual Out-of-Pocket Limit *(See Plan for services that do not apply to the limit.) (Includes applicable Deductible, Coinsurance and Copayments)*		$7,350	$14,700
Family Out-of-Pocket Limit *(See Plan for services that do not apply to the limit.) (Includes applicable Deductible, Coinsurance and Copayments)*		$14,700	$29,400
COVERED SERVICES	**Deductible and/or coinsurance payment required before insurance pays?**	***In-Network*** *By choosing an in-network provider you pay only coinsurance and/or copayment amounts for allowed charges.*	***Out-of-Network*** *By choosing an out-of-network provider you pay more coinsurance and you may also be responsible for the difference between what Blue Cross allows and what the out-of-network provider charges.*
Allergy Injections	No	You pay a $5 copayment per visit if allergy injection is the only service provided during the visit	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.)	No	You pay a $30 copayment only	
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		No	You pay nothing 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* (Facility and Professional Services)				
Outpatient Applied Behavioral Analysis (as part of an approved treatment plan)		No	You pay a $30 copayment per visit	
Mental Health *Outpatient*	**Psychotherapy Services**	No	You pay a $30 copayment per visit	
	Facility and other Professional Services	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.)				
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 (Primary Care Provider) **Specialist Provider Office Visit** (Non-Primary Care Provider) (Other services rendered during a physician office visit will be subject to deductible and coinsurance)	No	You pay a $30 copayment only You pay a $50 copayment only	You pay 50% of the allowed amount
Prescribed Contraceptive Services (Includes diaphragms, intrauterine devices (IUDs), implantables, injections and tubal ligation)		You pay nothing 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, growth hormone, radiation 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 coinsurance	
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 Benefits – DEDUCTIBLE OPTION ***$500 Individual deductible on Non-Preferred Brand Name, Preferred Specialty, Generic Specialty and Non-Preferred Specialty Drugs*** *(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	You pay a $10 copayment per prescription – No Deductible required
Tier 2 Non-Preferred Generic Prescription Drugs	You pay a $10 copayment per prescription – No Deductible required
Tier 3 Preferred Brand Name Prescription Drugs	Participant pays 30% Cost-sharing up to $50 per prescription – No Deductible required (mail order 30% cost sharing up to $100 per 90 day supply – No Deductible required)
$500 Individual Deductible for Non-Preferred Brand Name Drugs, Preferred Specialty Drugs, Generic Specialty Drugs and Non-Preferred Specialty Drugs	
Tier 4 Non-Preferred Brand Name Prescription Drugs	Participant pays 50% Cost-sharing up to $100 per prescription after Deductible is met (mail order 50% cost sharing up to $200 per 90 day supply after deductible is met)
Tier 5 Preferred Specialty Prescription Drugs and Generic Specialty Prescription Drugs (30 day supply limit at one time)	Participant pays 30% Cost-sharing per prescription after Deductible is met
Tier 6 Non-Preferred Specialty Prescription Drugs (30 day supply limit at one time)	Participant pays 50% Cost-sharing per prescription after Deductible is met
ACA Preventive Prescription Drugs	Plan pays100% for 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.

**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.*

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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