Idaho AGC Self-Funded Benefit Trust Preferred Blue® PPO 1750

PPO 1750 BENEFITS OUTLINE Visit our Website at www.bcidaho.com to locate a Contracting Provider		
	In-Network	**Out-of-Network**
	The Participant is responsible to pay these amounts:	
Deductibles (per Benefit Period) **Individual**	$1,750	
Family *(No Participant may contribute more than the Individual Deductible amount toward the Family Deductible.)*	$3,500	
Out-of-Pocket Limits (per Benefit Period) *(See Plan for services that do not apply to the limit.)* *(Includes applicable Deductible, Cost Sharing and Copayments.)* **Individual** **Family** *(No Participant may contribute more than the Individual Out-of-Pocket Limit amount toward the Family Out-of-Pocket Limit.)*	$5,500 $11,000	$11,000 $22,000
Cost Sharing *Unless specified otherwise below, the Participant pays the following Cost Sharing amount*	30% of Maximum Allowance after Deductible	50% of Maximum Allowance after Deductible
FREQUENTLY USED COVERED SERVICES - *Some services may require Prior Authorization.*		
Physician Office Visits *(Additional services, such as laboratory, x-ray, and other Diagnostic Services are not included in the Office Visit.)*	$30 Copayment per visit for Primary Care Provider. $50 Copayment per visit for Specialist Provider (non-Primary Care Provider)	Deductible and Cost Sharing
TELEHEALTH SERVICES		
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. Please see the appropriate section of the Benefits Outline for those terms.	

Preventive Care Covered Services **For specifically listed Covered Services** *Annual adult physical examinations; routine or scheduled well-baby and well-child examinations, including vision, hearing and developmental screenings; Dental fluoride application for Participants age 5 and under; Bone Density; Chemistry Panels; Cholesterol Screening; Colorectal Cancer Screening; Complete Blood Count (CBC); Diabetes Screening; Pap Test; PSA Test; Rubella Screening; Screening EKG; Screening Mammogram; Thyroid Stimulating Hormone (TSH); Transmittable Diseases Screening (Chlamydia, Gonorrhea, Human Immunodeficiency Virus (HIV); Human papillomavirus (HPV), Syphilis, Tuberculosis (TB); Hepatitis B Virus Screening; Sexually Transmitted Infections assessment; HIV assessment; Screening and assessment for interpersonal and domestic violence; Urinalysis (UA); Abdominal Aortic Aneurysm Screening and Ultrasound; Unhealthy Alcohol and Drug Use Assessment; Breast Cancer (BRCA) Risk Assessment and Genetic Counseling and Testing for High Risk Family History of Breast or Ovarian Cancer; Newborn Metabolic Screening (PKU, Thyroxine, Sickle Cell); Health Risk Assessment for Depression and/or self-harm; Anxiety Screening; Newborn Hearing Test; Lipid Disorder Screening; Nicotine, Smoking and Tobacco-use Cessation Counseling Visit; Dietary Counseling and Physical Activity Behavioral Counseling; Behavioral Counseling for Participants who are overweight or obese; Preventive Lead Screening; Lung Cancer Screening for Participants age 50 and over; Hepatitis C Virus Infection Screening; Urinary Incontinence Screening; For Participating Employee or the Enrolled Eligible Dependent spouse: Urine Culture for Pregnant Women; Iron Deficiency Screening for Pregnant Women; Rh (D) Incompatibility Screening for Pregnant Women; Diabetes Screening for Pregnant Women; Perinatal Depression Counseling and Intervention; Behavioral Counseling for Healthy Weight and Weight Gain in Pregnancy.* *The specifically listed Preventive Care Services may be adjusted accordingly to coincide with federal government changes, updates, and revisions.* **For services not specifically listed**	No Charge (Deductible does not apply) Deductible and Cost Sharing	Deductible and Cost Sharing Deductible and Cost Sharing
Supplemental Breast Screening *(For Participants at heightened risk of breast cancer. Includes breast exam using standard or abbreviated MRI, contrast mammogram imaging or ultrasound.)* *One supplemental breast screening per Participant, per Benefit Period combined In-Network and Out of-Network.* *For additional exams, Diagnostic or Preventive Care Services apply as listed in the Benefits Outline)*	No Charge (Deductible does not apply)	Deductible and Cost Sharing

Immunizations *Acellular Pertussis, Anthrax, COVID-19, Cholera, Dengue, Diphtheria, Haemophilus Influenza B, Hepatitis A, Hepatitis B, Human papillomavirus (HPV), Inactivated Poliovirus, Influenza, Japanese Encephalitis, Measles, Meningococcal, Mpox, Mumps, Pneumococcal (pneumonia), Rabies, Rotavirus, RSV, Rubella, Tetanus, Typhoid, Varicella (Chicken Pox), Yellow Fever and Zoster.* *All Immunizations are limited to the extent **recommended** by the Advisory Committee on Immunization Practices (ACIP) and may be adjusted accordingly to coincide with federal government changes, updates and revisions.*	No Charge (Deductible does not apply)	No Charge (Deductible does not apply)
Other immunizations not specifically listed may be covered at the discretion of the Contract Administrator when Medically Necessary.	Deductible and Cost Sharing	Deductible and Cost Sharing

PRESCRIPTION DRUG BENEFITS

- The Standard Formulary is available at www.bcidaho.com, and is available to any Participant on request by contacting the Contract Administrator's Customer Service Department at (208) 286-3439 or (866) 283-6354.
- Each Non-Specialty Prescription Drug shall not exceed a 90 day supply at one (1) time.
- Each Specialty Prescription Drug shall not exceed a 30 day supply at one (1) time.
- **Retail Pharmacies:** One Copayment for each 30 day supply.
- **Mail Order:** 2.5x retail Copayments for a 90 day supply.
- Prescription Drug Services apply to the In-Network Out-of-Pocket Limits.

SPECIALTY PRESCRIPTION DRUGS

The Plan may increase the Cost Sharing listed below to take full advantage of any available drug cost share assistance program offered by drug manufacturers (either directly or indirectly through third parties). This feature, known as the Cost Relief Program, can lower overall costs to the Plan for certain Specialty Prescription Drugs. If a Participant enrolls in the Cost Relief Program, they will not be responsible for the additional Cost Sharing. If a Participant does not enroll, their Cost Sharing may increase, and may not count towards, their Deductible or Out-of-Pocket Limit.

Tier 1*	$10 Copayment per prescription
Tier 2*	$10 Copayment per prescription
Tier 3*	$35 Copayment per prescription
Tier 4*	$70 Copayment per prescription
Tier 5*	20% Cost Sharing per prescription
Tier 6*	50% Cost Sharing per prescription

***Specialty Prescription Drug Cost Relief Program**
Please note that certain Specialty Prescription Drugs are only available from an In-Network Specialty Pharmacy, and a Participant will not be able to get them at a Retail Pharmacy. For more information about applicable Cost Sharing amounts available to Specialty Drugs that are eligible for the Cost Relief Program, please see the "Drug Cost Relief Program" section in the Prescription Drug Benefits Section.

ACA Preventive Prescription Drugs	No Charge
Prescribed Contraceptives	No Charge

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.

COVERED SERVICES *Some services may require Prior Authorization.*	**In-Network**	**Out-of-Network**
	The Participant is responsible to pay these amounts:	
Allergy Injections	$5 Copayment per visit if this is the only service provided during the visit	Deductible and Cost Sharing
Ambulance Transportation Services • Ground Ambulance Services • Air Ambulance Services *(Payment for Out-of-Network Air Ambulance Services is based on the Qualifying Payment Amount.)*	Deductible and In-Network Cost Sharing. Cost Sharing accumulates towards the In-Network Out-of-Pocket Limit.	
Breastfeeding Support and Supply Services *(Includes rental and/or purchase of manual or electric breast pumps. Limited to one (1) breast pump purchase per Benefit Period, per Participant.)*	No Charge (Deductible does not apply)	Deductible and Cost Sharing
Chiropractic Care Services *(Up to a combined In-Network and Out of-Network total of 24 visits per Participant, per Benefit Period.)* *(Additional services, such as laboratory, x-ray and other Diagnostic Services are not included in the Office Visit.)*	$30 Copayment per visit	Deductible and Cost Sharing
Dental Services Related to Accidental Injury	Deductible and Cost Sharing	Deductible and Cost Sharing
Diabetes Self-Management Education Services *(Up to a combined In-Network and Out of-Network total of 4 visits per Participant, per Benefit Period.)*	$30 Copayment per visit	Deductible and Cost Sharing
Diagnostic Services - Laboratory and X-ray *(Including diagnostic mammograms)*	Deductible and Cost Sharing	Deductible and Cost Sharing
Durable Medical Equipment, Orthotic Devices and Prosthetic Appliances *(For wigs required due to a covered medical condition: One (1) wig per Participant, per Benefit Period, up to a combined annual benefit limit of $500.)*	Deductible and Cost Sharing	Deductible and Cost Sharing
Emergency Services – Facility Services *(Copayment waived if admitted.)* *(Payment for Out-of-Network Emergency Services is based on the Qualifying Payment Amount.)*	$150 Copayment per hospital Outpatient emergency room visit, then Deductible and In-Network Cost Sharing. Emergency Services accumulate towards the In-Network Out-of-Pocket Limit.	
Emergency Services – Professional Services *(Payment for Out-of-Network Emergency Services is based on the Qualifying Payment Amount.)*	Deductible and In-Network Cost Sharing. Emergency Services accumulate towards the In-Network Out-of-Pocket Limit.	
Growth Hormone Therapy	Deductible and Cost Sharing	Deductible and Cost Sharing
Hearing Aids *(Benefits are limited to one (1) device per ear, every three (3) years, per Participant, per Benefit Period. Benefits for Eligible Dependent Children also includes forty-five (45) speech therapy visits during the first twelve (12) months after delivery of the covered device. Refer to Outpatient Speech Therapy section for benefit details.)*	Deductible and Cost Sharing	Deductible and Cost Sharing
Home Health Skilled Nursing Care Services	Deductible and Cost Sharing	Deductible and Cost Sharing
Home Intravenous Therapy	Deductible and Cost Sharing	Deductible and 80% Cost Sharing
Hospice Services	No Charge (Deductible does not apply)	Deductible and Cost Sharing
Hospital Services	Deductible and Cost Sharing	Deductible and Cost Sharing

COVERED SERVICES *Some services may require Prior Authorization.*	**In-Network**	**Out-of-Network**
	The Participant is responsible to pay these amounts:	
Inpatient Rehabilitation or Habilitation Services	Deductible and Cost Sharing	Deductible and Cost Sharing
Maternity Services and/or Involuntary Complications of Pregnancy	Deductible and Cost Sharing	Deductible and Cost Sharing
Mental Health and Substance Use Disorder Inpatient Services • **Inpatient Facility and Professional Services**	Deductible and Cost Sharing	Deductible and Cost Sharing
Mental Health and Substance Use Disorder Outpatient Services • **Outpatient Psychotherapy Services** • **Facility and other Professional Services**	$30 Copayment per visit Deductible and Cost Sharing	Deductible and Cost Sharing
Outpatient Applied Behavioral Analysis (ABA)	$30 Copayment per visit	Deductible and Cost Sharing
Treatment for Autism Spectrum Disorder	Covered the same as any other illness, depending on the services rendered. Please see the appropriate section of the Benefits Outline. Visit limits do not apply to Treatments for Autism Spectrum Disorder, and related diagnoses.	
Outpatient Cardiac Rehabilitation Services *(Additional services, such as, x-ray and other Diagnostic Services are not included in the Therapy Services Copayment)*	$10 Copayment per visit	Deductible and Cost Sharing
Outpatient Habilitation Therapy Services • Outpatient Occupational Therapy • Outpatient Physical Therapy • Outpatient Speech Therapy *(Up to a combined In-Network and Out-of-Network total of 20 visits per Participant, per Benefit Period.)*	Deductible and Cost Sharing	Deductible and Cost Sharing
Outpatient Pulmonary Rehabilitation Services *(Additional services, such as, x-ray and other Diagnostic Services are not included in the Therapy Services Copayment)*	$10 Copayment per visit	Deductible and Cost Sharing
Outpatient Rehabilitation Therapy Services • Outpatient Occupational Therapy • Outpatient Physical Therapy • Outpatient Speech Therapy *(Up to a combined In-Network and Out-of-Network total of 20 visits per Participant, per Benefit Period.)*	Deductible and Cost Sharing	Deductible and Cost Sharing
Outpatient Respiratory Therapy Services	Deductible and Cost Sharing	Deductible and Cost Sharing
Palliative Care Services	No Charge (Deductible does not apply)	Deductible and Cost Sharing
Post-Mastectomy/Lumpectomy Reconstructive Surgery	Deductible and Cost Sharing	Deductible and Cost Sharing
Prescribed Contraceptive Services *(Includes diaphragms, intrauterine devices (IUDs), implantables, injections and tubal ligation.)*	No Charge (Deductible does not apply)	Deductible and Cost Sharing
Skilled Nursing Facility *(Up to a combined In-Network and Out-of-Network total of 30 days per Participant, per Benefit Period.)*	Deductible and Cost Sharing	Deductible and Cost Sharing

COVERED SERVICES *Some services may require Prior Authorization.*	In-Network	Out-of-Network
	The Participant is responsible to pay these amounts:	
Sleep Study Services	Deductible and Cost Sharing	Deductible and Cost Sharing
Surgical/Medical (Professional Services)	Deductible and Cost Sharing	Deductible and Cost Sharing
Therapy Services *(Including Radiation, Chemotherapy and Renal Dialysis.)*	Deductible and Cost Sharing	Deductible and Cost Sharing
Temporomandibular Joint (TMJ) Syndrome Services *(Limited to a combined $2,000 lifetime benefit limit, per Participant.)*	Deductible and Cost Sharing	Deductible and Cost Sharing
Transplant Services	Deductible and Cost Sharing	Deductible and Cost Sharing
Be aware that your actual costs for services provided by an Out-of-Network Provider may exceed the Plan's Out-of-Pocket Limit for Out-of-Network services. Except as provided by the No Surprises Act, Out-of-Network Providers can bill you for the difference between the amount charged by the Provider and the amount allowed by the Contract Administrator, and that amount is not counted toward the Out-of-Network Out-of-Pocket Limit.		

DISCRIMINATION IS AGAINST THE LAW

Blue Cross of Idaho complies with applicable Federal civil rights laws and does not discriminate, exclude or treat less favorably on the basis of race, color, national origin (including limited English proficiency and primary language), age, disability or sex.

Blue Cross of Idaho:

- Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language assistance services to people whose primary language is not English, which may include:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Blue Cross of Idaho Civil Rights Coordinator at 1-800-627-1188 (TTY: 711).

If you believe that Blue Cross of Idaho has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance at:

Civil Rights Coordinator
3000 E. Pine Ave., Meridian, ID 83642
Telephone: 1-800-274-4018
Fax: 208-331-7493
Email: ***grievancesandappeals@bcidaho.com***
TTY: 711

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at ***https://ocrportal.hhs.gov/ocr/portal/lobby.jsf***, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at ***https://www.hhs.gov/ocr/complaints/index.html.***

ATTENTION: If you speak Arabic, Bantu, Chinese, Farsi, French, German, Japanese, Korean, Nepali, Romanian, Russian, Serbo-Croatian, Spanish, Tagalog, or Vietnamese, language assistance services, free of charge, are available to you. Call 1-800-627-1188 (TTY: 711).

Arabic انتبه: إذا كنت تتحدث اللغة العربية ، فإن خدمات المساعدة اللغوية متاحة لك مجانًا اتصل على 1-800-627-1188 (للصم والبكم: 711).

Bantu: ICITONDERWA: Nimba uvuga Ikirundi, uzohabwa serivisi zo gufasha mu ndimi, ku buntu. Woterefona 1-800-627-1188 (TTY: 711).

Chinese: 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-627-1188 (TTY：711)。

Farsi توجه: اگر به زبان فارسی صحبت می کنید، خدمات رایگان پشتیبانی زبان، در دسترس شما است. شماره تماس 1-800-627-1188 (TTY:711).

French: ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-627-1188 (ATS : 711).

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-627-1188 (TTY: 711).

Japanese: 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-627-1188（TTY:711）まで、お電話にてご連絡ください。

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-627-1188 (TTY: 711)번으로 전화해 주십시오.

Nepali: ध्यान दनिुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंको नमिर्ता भाषा सहायता सेवाहरू नःिशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् 1-800-627-1188 (टटिवाइ: 711) ।

Romanian: ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-800-627-1188 (TTY: 711).

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-627-1188 (телетайп: 711).

Serbo-Croatian: OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-800-627-1188 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 711).

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-627-1188 (TTY: 711).

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-627-1188 (TTY: 711.

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-627-1188 (TTY: 711).

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Form No. 3-1187 (08-25)

Attachment A:
NON-EMERGENCY SERVICES REQUIRING PRIOR AUTHORIZATION ANNUAL NOTICE

NOTICE: ***Prior Authorization is required to determine if the specified services listed below are Medically Necessary and a Covered Service. If Prior Authorization has not been obtained to determine Medical Necessity, services may be subject to denial. Any dispute involved in the Contract Administrator's Medical Necessity decision must be resolved by use of the appeal process described in this Benefit Trust Plan.***

If Non-Medically Necessary services are performed by Contracting Providers, without the Prior Authorization, and benefits are denied, the cost of said services are not the financial responsibility of the Participant. The Participant is financially responsible for Non-Medically Necessary services performed by a Provider who does not have a Provider contract with the Contract Administrator.

The Contract Administrator will respond to a request for Prior Authorization for the services listed below received from either the Provider or the Participant within seventy-two (72) hours for an expedited request or fourteen (14) days for a standard request of the receipt of the medical information necessary to make a determination. For additional information, please check with your Provider, call Customer Service at the telephone number listed on the back of the Participant's Identification Card or check the Contract Administrator's Website at www.bcidaho.com.

Prior Authorization is not a guarantee of payment. It is a pre-service determination of Medical Necessity based on information provided to the Contract Administrator at the time the Prior Authorization request is made. The Contract Administrator retains the right to review the Medical Necessity of services, eligibility of services and benefit limitations and exclusions after services are received.

The following listing includes specific Procedures and Services, as well as a few general categories or examples of Procedures and Services, that require Prior Authorization. In the case of general categories or examples, call Customer Service at the telephone number listed on the back of the Participant's Identification Card to confirm if a specific Procedure or Service requires Prior Authorization.

Procedures:

- Radiation therapy Dental Surgery related to an accident
- Treatment of veins
- Reconstructive and plastic Surgery, including breast, eyelid, jaw and sinus
- Surgery for snoring or sleep problems
- Transplants (organ, tissue, etc.)
- Gender affirming services
- Other Inpatient and Outpatient surgical procedures
- Certain genetic and laboratory testing
- Certain cardiology procedures and testing
- Wound Care and Hyperbaric Oxygen (HCO)

Services:

- Acute Inpatient hospitalization
- Long-term acute care hospital (LTACH) admissions
- Rehabilitation and long-term care facility admissions
- Skilled nursing facility admissions
- Sub-acute and transitional care admissions
- Non-emergency ambulance transport

Durable Medical Equipment:

- Certain equipment with costs of more than one thousand dollars ($1,000) (including rent-to-purchase items)
- Certain Orthotic Devices and Prosthetic Appliances with costs of more than one thousand dollars ($1,000)

Pharmacy

- Certain Prescription Drugs (find a full list at ***members.bcidaho.com***)
- Chimeric antigen receptor (CAR) T-cell Therapy
- Growth hormone therapy
- Outpatient intravenous (IV) therapy for infusion drugs (find a list at ***members.bcidaho.com***)