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

Idaho AGC Self-Funded Benefit Trust

Preferred Blue® PPO HDHP 4000

Idaho AGC
A PROUD CHAPTER OF AGC OF AMERICA

HDHP 4000 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**	$4,000	
Family *(No Participant may contribute more than the Individual Deductible amount toward the Family Deductible.)*	$8,000	
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.)*	$4,000 $8,000	$8,000 $16,000
Cost Sharing *Unless specified otherwise below, the Participant pays the following Cost Sharing amount.*	No Charge	50% of Maximum Allowance after Deductible
FREQUENTLY USED COVERED SERVICES - *Some services may require Prior Authorization.*		
Physician Office Visits	Deductible	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; 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	Deductible and Cost Sharing Deductible and Cost Sharing
Immunizations *Acellular Pertussis, Anthrax, COVID-19, Cholera, Dengue, Diphtheria, Haemophilus Hepatitis A, Hepatitis B, Human papillomavirus (HPV), Inactivated Poliovirus, Influenza, Influenza B, Japanese Encephalitis, Measles, Meningococcal, 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.* Other immunizations not specifically listed may be covered at the discretion of the Contract Administrator when Medically Necessary.	No Charge (Deductible does not apply) Deductible	No Charge (Deductible does not apply) Deductible and Cost Sharing

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COVERED SERVICES *Some services may require Prior Authorization.*	**In-Network**	**Out-of-Network**
	The Participant is responsible to pay these amounts:	
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.)*	Deductible	Deductible and Cost Sharing
Dental Services Related to Accidental Injury	Deductible	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.)*	Deductible	Deductible and Cost Sharing
Diagnostic Services *(Includes diagnostic mammograms.)*	Deductible	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	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	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	Deductible and Cost Sharing
Home Health Skilled Nursing Care Services	Deductible	Deductible and Cost Sharing
Home Intravenous Therapy	Deductible	Deductible and 80% Cost Sharing
Hospice Services	Deductible	Deductible and Cost Sharing
Hospital Services	Deductible	Deductible and Cost Sharing
Inpatient Rehabilitation or Habilitation Services	Deductible	Deductible and Cost Sharing
Maternity Services and/or Involuntary Complications of Pregnancy	Deductible	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:	
Mental Health and Substance Use Disorder Inpatient and Outpatient Services (Facility and Professional Services)	Deductible	Deductible and Cost Sharing
Outpatient Applied Behavioral Analysis (ABA)	Deductible	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	Deductible	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	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	Deductible and Cost Sharing
Outpatient Respiratory Therapy Services	Deductible	Deductible and Cost Sharing
Palliative Care Services	Deductible	Deductible and Cost Sharing
Post-Mastectomy/Lumpectomy Reconstructive Surgery	Deductible	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	Deductible and Cost Sharing
Surgical/Medical (Professional Services)	Deductible	Deductible and Cost Sharing
Therapy Services *(Including Radiation, Chemotherapy and Renal Dialysis.)*	Deductible	Deductible and Cost Sharing
Temporomandibular Joint (TMJ) Syndrome Services *(Limited to a combined $2,000 lifetime benefit limit, per participant.)*	Deductible	Deductible and Cost Sharing
Transplant Services	Deductible	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.		

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. • Prescription Drug Services apply to the In-Network Out-of-Pocket Limit.	
Tier 1 **Tier 2** **Tier 3** **Tier 4** **Tier 5** **Tier 6**	In-Network Cost Sharing, after the Individual/Family Deductible is met
ACA Preventive 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.	