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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2017 BENEFIT HIGHLIGHTS

MEDICAL SUMMARY OF BENEFITS		*In-Network*	*Out-of-Network*
Individual/Family Deductible		$4,500/$9,000	
Coinsurance		You pay 25% of the allowed amount for covered services	You pay 45% 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)*		$6,500	$13,000
Family Out-of-Pocket Limit *(See Plan for services that do not apply to the limit.) (Includes applicable Deductible, Coinsurance and Copayments)*		$13,000	$26,000
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 45% of the allowed amount
Ambulance Transport Service**	Yes	You pay 25% 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 25% of the allowed amount	
Dental Services Related to Accidental Injury	Yes	You pay 25% 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 25% of the allowed amount	
Durable Medical Equipment, Orthotic Devices, and Prosthetic Appliances	Yes		

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Emergency Services – Facility Services** (Copayment waived if admitted)		Yes	You pay $100 copayment for hospital Outpatient emergency room visit, then you pay 25% of the allowed amount	You pay $100 copayment for hospital Outpatient emergency room visit, then you pay 45% of the allowed amount
Emergency Services – Professional Services**		Yes	You pay 25% of the allowed amount	You pay 45% of the allowed amount
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 45% of the allowed amount
Hospital Facility Services (Inpatient, outpatient, diagnostic, etc.)		Yes	You pay 25% of the allowed amount	
Rehabilitation or Habilitation Services				
Maternity and/or Involuntary Complications of Pregnancy				
Mental Health *Inpatient* (Facility and Professional Services)				
Mental Health *Outpatient*	**Psychotherapy Services**	No	You pay a $30 copayment per visit	
	Facility and other Professional Services	Yes	You pay 25% of the allowed amount	
Outpatient Habilitation Therapy Services (Includes physical, speech and occupational therapies. Limited to 20 visits combined per insured, per benefit period.)				
Outpatient Rehabilitation Therapy Services (Includes physical, speech and occupational therapies. Limited to 20 visits combined per insured, per benefit period.)				
Outpatient Cardiac Rehabilitation Therapy Services				
Outpatient Respiratory Therapy Services				
Post-Mastectomy Reconstructive Surgery				
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 $45 copayment only	
Prescribed Contraceptive Services (Includes diaphragms, intrauterine devices (IUDs), implantables, injections and tubal ligation)		No	You pay nothing of the allowed amount	
Skilled Nursing Facility (Limited to a combined 30 days per benefit period, per participant)		Yes	You pay 25% of the allowed amount	

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Surgical/Medical (Professional Services)	Yes	You pay 25% of the allowed amount	You pay 45% of the allowed amount
Therapy Services (Including chemotherapy, growth hormone therapy, radiation and renal dialysis, respiratory therapy.)			
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	

****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 – COPAY OPTION *(Prescription Drug Services apply to the In-Network Out-of-Pocket Limits)*		
Retail and Mail Order (90-day supply available with multiple copayments)	**Generic**	You pay a $7 copayment
	Preferred Brand Name	You pay 30% coinsurance
	Non-Preferred Brand Name	You pay 50% coinsurance
Prescribed Contraceptives	You pay nothing for Women's Preventive Prescription Drugs and devices as specifically listed 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.*

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Prescription Benefits – DEDUCTIBLE OPTION ***$250 deductible on Preferred Brand Name, Non-Preferred Brand Name and Specialty Drugs*** *(Prescription Drug Services apply to the In-Network Out-of-Pocket Limits)*		
Retail (90 day supply with multiple copays)	**Generic**	You pay a $10 copayment – No Deductible required
	Preferred Brand Name	You pay a $30 copayment after Deductible is met
	Non-Preferred Brand Name	You pay a $50 copayment after Deductible is met
Mail Order (90 day supply with one copay)	**Generic**	You pay a $20 copayment – No Deductible required
	Preferred Brand Name	You pay a $60 copayment after Deductible is met
	Non-Preferred Brand Name	You pay a $100 copayment after Deductible is met
Specialty Prescription Drugs (Limited to a 30 day supply)	You pay a $200 copayment after Deductible is met	
Prescribed Contraceptives	You pay nothing for Women's Preventive Prescription Drugs and devices as specifically listed 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.*

This summary describes the general features of this program; it is not a contract.

All provisions of the Group Master Plan apply to this program.

For Customer Services call (208) 286-3439 or toll-free 1-866-283-6354. Visit us on the web at www.bcidaho.com.