



Shared Strength • Trusted Care

Northern Lakes Fire District  
**Employee Benefits Book**  
Effective: October 1, 2020

## **Contact Information**

**III-A Benefits: (208) 938-8199**

**Fax: (208) 575-6423**

**iii-a.org**

PO Box 190477

Boise, ID 83719

### **III-A Staff**

III-A staff is available 24/7, including all holidays, to assist our members, answer benefit questions and help with any issues that arise. If you have a question that is not an immediate benefit issue, please contact the appropriate staff member below:

#### **Executive Director**

Amy Manning  
(208) 317-2814  
amymanning@iii-a.org

- Annual reports
- New agency rate proposal

#### **Health Coach & Data Analyst**

Megan Smith  
(208) 860-1979  
megansmith@iii-a.org

- Health coaching
- Onsite wellness clinics & programs

#### **Benefits Manager**

Lisa Fritz  
(208) 938-8199 or (208) 850-0545  
lisafrtiz@iii-a.org

- Member benefits
- Prescription drug issues
- Claims/EOB questions
- Prior authorizations

#### **Operations Manager**

Susan Lasuen  
(208) 869-3572  
susanlasuen@iii-a.org

- COBRA administration
- III-A internal claims payments

**Like us on Facebook! @IIIATrust**

#### **Blue Cross of Idaho**

(986) 224-4152 or (833) 623-7993  
bcidaho.com

- ID cards
- Help finding an in-network provider
- Deductible reports

#### **ProAct Rx**

(877) 635-9545  
Mail Order Pharmacy: (866) 287-9885  
proactrx.com

- ID cards
- Formularies look up





Shared Strength · Trusted Care

Dear Member,

We are excited to have you as part of the III-A family! The III-A team is dedicated to helping you with your benefits and wellness. Please do not hesitate to reach out to us at any time.

Members of the III-A enjoy several enhanced benefits. Each year, the Trustees review new benefit options and, after careful consideration, choose which enhancements are added to the plans.

**List of the new 2020-21 benefits that will be effective October 1, 2020:**

**Physical Therapy:**

- Increase physical therapy benefit to 30 visits per benefit period on all III-A standard plans

**Vasectomy:**

- Cover initial Vasectomy procedures at 100% (including consultation, procedure, and post semen analysis)

**Allergy Serum:**

- Allergy serum is a \$20 copay (and \$5 for injections)

**Hearing Protection Benefit:**

- Cover protective hearing devices for all subscribers up to \$150 every five benefit periods (administered internally)

**Diabetic Test Strips Benefit:**

- Cover diabetic test strips at 100% for diabetic members on all III-A plans

**Zero-Dollar Pediatric Copay:**

- Medical and behavioral health visits for members under age 18 will be covered at 100% with a \$0 copay

This booklet will help explain the benefits available to you as a member of the III-A. We look forward to assisting you!

Sincerely,

Amy, Lisa, Susan, and Megan

**Board of Trustees**

Rick Watkins, Chairman  
City of Fruitland

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Power County Highway District

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Lori Yarbrough  
City of Athol

## III-A Internally Administered Benefits

*\*\*Please contact III-A Benefits Manager with any questions on III-A Internal Benefits*

### MEDICAL TELEHEALTH: \*\*\*NEW\*\*\*

This is a no-cost Medical Telehealth program for all III-A members that is replacing MDLive.

**Hours of Operation:** 24 hours a day, 7 days a week

**Dustin Reno, NP – Pocatello Wellness Clinic**      **Phone: (208) 203-0783**

or

**Velma Seabolt, NP – Wellness Associates**      **Phone: (208) 271-4460**

\*You may call either Provider. Please leave a message if you receive the answering service and you will receive a call back within 2 hours. If you leave a message do not call the other provider, you will receive a call back.

*COVID-19 testing is available if deemed medically necessary.*

### HEALTH COACHING:

Personalized health coaching is available to all members covered on a III-A medical plan. 1-on-1 coaching is available over the phone, or via email.

**Areas of focus include:** Nutrition, Physical activity & exercise, Stress management, Sleep, Weight loss/maintenance, Diabetes prevention, Blood pressure and/or cholesterol management, and Tobacco cessation.

*Please contact III-A Health Coach, Megan Smith at [megansmith@iii-a.org](mailto:megansmith@iii-a.org) or 208-860-1979 to get enrolled or learn more information on this program.*

### ACUPUNCTURE:

100 Acupuncture visits (up to \$80 per visit), per calendar year for each member covered under a III-A medical plan. Acupuncturist must be state licensed, and not “certified”.

- **Direct-Pay Acupuncturist (Best Option):** By choosing to see a “III-A Direct-Pay” Acupuncturist, no upfront payment is required, and the provider will invoice the III-A directly. The list of Direct-Pay Acupuncturists is on our website: [iii-a.org](http://iii-a.org)
  - Any amount charged over \$80 is the patient's responsibility to pay.
- **Blue Cross In-Network Acupuncturist:** Provider will submit claims on your behalf and will bill you for any amount over \$80 per visit. Use the “Provider Search” tool on the [bcidaho.com](http://bcidaho.com) website to locate a list of In-Network Acupuncturists.
- **Blue Cross Out-of-Network Acupuncturist:** The provider typically collects payment at the time of service. You will need to submit a claim form to Blue Cross for reimbursement. *Claims forms are available on [bcidaho.com](http://bcidaho.com).*





## HEARING-AIDS:

100% coverage for all members covered under the III-A medical plan, up to \$3,000 every other calendar year.

Payment options:

- Reimbursement to the member upon submission of a detailed receipt showing payment and an internal claim form
- Payment to the Hearing-Aid provider upon submission of an invoice and an internal claim form

*Please visit [iii-a.org](http://iii-a.org) and download the "Internal Claim Form". Submit the completed form, along with an invoice or receipt, via fax: (208) 575-6423, scan and email to: [claims@iii-a.org](mailto:claims@iii-a.org) or mail to PO Box 190477 Boise, ID 83719*

## HEARING PROTECTION DEVICES: \*\*\*NEW\*\*\*

Protective hearing devices are covered for all members up to \$150, every five calendar years.

Payment options:

- Reimbursement to the member upon submission of a detailed receipt showing payment and an internal claim form
- Payment to the provider upon submission of an invoice and an internal claim form

*Please visit [iii-a.org](http://iii-a.org) and download the "Internal Claim Form". Submit the completed form, along with a paid receipt, via fax: (208) 575-6423, scan and email to: [claims@iii-a.org](mailto:claims@iii-a.org) or mail to PO Box 190477 Boise, ID 83719*

## AIR AMBULANCE:

III-A covers medically necessary air ambulance transports.

**III-A members:** Claim will be submitted and processed through Blue Cross of Idaho. III-A will pay the member's remaining balance upon receipt of the member's Explanation of Benefits (EOB).

**Dependents NOT enrolled in the III-A Plan:** Claim will be processed through dependents medical insurance and III-A will reimburse the remaining balance upon receipt of the Explanation of Benefits (EOB).

**Eligible dependents without any insurance coverage:** III-A will pay a maximum of \$2,000 of the medically necessary air ambulance claim upon receipt of air ambulance invoice.

*Please visit [iii-a.org](http://iii-a.org) and download the "Internal Claim Form". Submit the completed form, along with an invoice or EOB, via fax: (208) 575-6423, scan and email to: [claims@iii-a.org](mailto:claims@iii-a.org) or mail to PO Box 190477 Boise, ID 83719*

## CASE MANAGEMENT:

This is a voluntary program through Blue Cross of Idaho at no cost to III-A members.

Case Managers are specially trained registered nurses and licensed social workers that bring skill, experience, and compassion to help with physical or behavioral health issues. Case Managers work in collaboration with your healthcare providers to coordinate care for optimal health outcomes. They provide extra guidance, advocacy and support to any member who has encountered a serious health situation, medical trauma, or illness.

*Please contact III-A Benefits Manager to get enrolled or learn more information on this program.*



Summary of Benefits III-A Trust First Responder Medical Plan 500 Effective Date: October 1, 2020	Preferred Blue Large	
	In-Network	Out-of-Network
<b>Benefit Period* Deductible</b> (Individual/Family)	\$500 Individual / \$1,000 Family	
<b>Cost Sharing</b>	<b>You pay 20% of the allowed amount</b>	<b>You pay 40% of the allowed amount</b>
<b>Individual Out-of-Pocket Limit</b> (See Plan for services that do not apply to the limit.) (Includes applicable Deductible, Cost Sharing and Copayments)	\$2,500	\$4,000
<b>Family Out-of-Pocket Limit</b> (See Plan for services that do not apply to the limit.) (Includes applicable Deductible, Cost Sharing and Copayments)	\$5,000	\$8,000
<b>Copayment</b> (Applies to In-Network only. Other services rendered during an Office Visit will be subject to Deductible and Cost Sharing.)	You pay a \$20 Copayment	Not applicable
<b>COVERED SERVICES</b> By choosing a Noncontracting Provider you may be responsible for the difference between what Blue Cross allows and what the Noncontracting Provider charges. This is called balance-billing. Some services may require Prior Authorization.	In-Network	Out-of-Network
	What you pay	
<b>Acupuncture</b> (Only for a licensed acupuncturist) (Limited to 100 visits combined In- and Out-of-Network per member, per Benefit Period)	No charge up to \$80 of the allowed amount per day	No charge up to \$80 of the billed charge per day
<b>Advanced Imaging Services</b> (Outpatient services only) (Magnetic Resonance Imaging (MRI), Magnetic Resonance Angiography (MRA), Computed Tomography Scan (CT Scan), Positron Emission Tomography (PET), Nuclear Cardiology)	Deductible and Cost Sharing	Deductible and Cost Sharing
<b>Allergy Injections</b> <ul style="list-style-type: none"><li>Administration Only</li><li>Allergy Serum</li></ul>	\$5 Copayment (if this is the only service provided during the visit)  \$20 Copayment	Deductible and Cost Sharing
<b>Ambulance Transportation Services</b>	Deductible and Cost Sharing	
<b>Breastfeeding Support and Supply Services</b> (Limited to one (1) breast pump purchase per Benefit Period, per Participant)	No charge	Deductible and Cost Sharing
<b>Cardiac Rehabilitation Therapy Services – Outpatient</b> (Limited to 36 visits combined per Participant, per Benefit Period)	Deductible and Cost Sharing	

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.

## Preferred Blue®PPO

COVERED SERVICES <i>By choosing a Noncontracting Provider you may be responsible for the difference between what Blue Cross allows and what the Noncontracting Provider charges. This is called balance-billing. Some services may require Prior Authorization</i>	In-Network	Out-of-Network
	What you pay	
<b>Chiropractic Care</b> Additional services, such as laboratory, x-ray, and other Diagnostic Services are not included in the Office Visit. <i>(Limited to 24 visits combined per Participant, per Benefit Period)</i>	Copayment  Deductible and Cost Sharing	Deductible and Cost Sharing
<b>Colonoscopies and Sigmoidoscopies</b> (Preventive and Diagnostic)	No charge	Deductible and Cost Sharing
<b>Dental Services Related to Accidental Injury</b>	Deductible and Cost Sharing	
<b>Diabetes Self-Management Education Services</b> (Only for accredited Providers approved by BCI.)	Copayment	
<b>Diagnostic Services</b>	Deductible and Cost Sharing	Deductible and Cost Sharing
<b>Durable Medical Equipment, Orthotic Devices and Prosthetic Appliances</b> <i>(Includes wigs required due to a medical condition up to a limit of \$300 combined per Participant, per Benefit Period.)</i>		
<b>Emergency Services – Facility Services</b> (Copayment waived if admitted) (Additional services, such as laboratory, x-ray, and other Diagnostic Services are subject to applicable Deductible, Cost Sharing and/or Copayment.) (BCI will provide In-Network benefits for treatment of Emergency Medical Conditions. Participant may be balance-billed for these services.)	\$100 Copayment for hospital Outpatient emergency room visit, then Deductible and Cost Sharing	\$100 Copayment for hospital Outpatient emergency room visit, then Deductible and Cost Sharing
<b>Emergency Services – Professional Services</b> (BCI will provide In-Network benefits for treatment of Emergency Medical Conditions. Participant may be balance-billed for these services.)	Deductible and Cost sharing	Deductible and Cost Sharing
<b>Hearing and Hearing Aid Exams</b>	Copayment	
<b>Home Health Skilled Nursing</b>	Deductible and Cost Sharing	
<b>Home Intravenous Therapy</b>	Deductible and Cost sharing	Deductible and 80% Cost Sharing (Member pays)
<b>Hospice Services</b>	No charge	Deductible and Cost Sharing
<b>Hospital Services</b> (Inpatient and Outpatient services at a licensed general hospital or ambulatory surgical facility.)	Deductible and Cost Sharing	
<b>Mammograms</b> (Preventive and Diagnostic)	No charge	
<b>Maternity Services and/or Involuntary Complications of Pregnancy</b>	Deductible and Cost Sharing	
<b>Morbid Obesity</b> (Includes the surgical treatment of morbid obesity, complications resulting from the surgical treatment of morbid obesity or for reversals or revisions of surgery for morbid obesity when required to correct an immediately life-threatening condition. <i>Lifetime maximum benefit of \$20,000 combined per Participant.</i> )	Deductible and Cost Sharing	
<b>Outpatient Habilitation Physical Therapy Services</b> <i>(Limited to 40 visits combined per Participant, per Benefit Period.)</i>	Copayment	
<b>Outpatient Habilitation Therapy Services</b> (Includes speech and occupational therapies. <i>Limited to 40 visits combined per Participant, per Benefit Period.</i> )	Deductible and Cost Sharing	
<b>Outpatient Rehabilitation Physical Therapy Services</b> <i>(Limited to 40 visits combined per Participant, per Benefit Period.)</i>	Copayment	
<b>Outpatient Rehabilitation Therapy Services</b> (Includes speech and occupational therapies. <i>Limited to 40 visits combined per Participant, per Benefit Period.</i> )	Deductible and Cost Sharing	

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## Preferred Blue®PPO

COVERED SERVICES <i>By choosing a Noncontracting Provider you may be responsible for the difference between what Blue Cross allows and what the Noncontracting Provider charges. This is called balance-billing. Some services may require Prior Authorization</i>		In-Network	Out-of-Network
		What you pay	
Physician Office Visit (Other services rendered during a Physician Office Visit will be subject to Deductible and Cost Sharing.)		Copayment	Deductible and Cost Sharing
Post-Mastectomy/Lumpectomy Reconstructive Surgery		Deductible and Cost Sharing	
Pediatric Physician Office Visit (For Participants under the age of eighteen (18).)		No charge	
Prescribed Contraceptive Services (Includes diaphragms, intrauterine devices (IUDs), implantables, injections, tubal ligation and vasectomy.)			
PSA Tests and Pap Smears			
Psychiatric Services – Inpatient (Facility and Professional Services)		Deductible and Cost Sharing	
Psychiatric Services – Outpatient	Psychotherapy Services	Copayment	
	Pediatric Outpatient Psychotherapy Services (For Participants under the age of eighteen (18).)	No charge	
	Facility and other Professional Services	Deductible and Cost Sharing	
Outpatient Applied Behavioral Analysis (as part of an approved treatment plan)		Copayment	
Rehabilitation or Habilitation Services		Deductible and Cost Sharing	
Skilled Nursing Facility (Limited to 30 days combined per Participant, per Benefit Period.)			
Sleep Study Services			
Surgical/Medical (Professional Services)			
Therapy Services (Including chemotherapy, growth hormone therapy, radiation and renal dialysis.)			
Transplant Services		No charge for services specifically listed  For services not specifically listed Deductible and Cost Sharing	Deductible and Cost Sharing
Preventive Care Benefits (See Plan for specifically listed preventive care services.)			
Immunizations (See Plan for specifically listed immunizations.)		No charge for listed immunizations	
Treatment for Autism Spectrum Disorder (Services identified as part of the approved treatment plan)		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.	

\*The specified period of time during which charges for Covered Services must be incurred in order to accumulate toward annual benefit limits, Deductible amounts and Out-of-Pocket Limits.

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## Highlights of Your Preventive Care Benefits

Preventive care is when you see a doctor or have a screening when you do not have any signs of a medical problem.

- You pay nothing; no coinsurance, copayment or deductible, for covered preventive care services when you visit in-network providers.
- Preventive care benefits for services from out-of-network providers are subject to your out-of-network benefit.

Covered Preventive Care Services	In-Network	Out-of-Network
<b>Specifically Listed Services</b> 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 younger; Bone density; Chemistry panels; Cholesterol screening; Colorectal cancer screening (colonoscopy, sigmoidoscopy, fecal occult blood test); Complete Blood Count; HIV screening; Sexually transmitted infections assessment; HIV assessment; Screening and assessment for interpersonal and domestic violence; Urinalysis (UA); Aortic aneurysm ultrasound; Alcohol misuse 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; Newborn hearing test; Lipid disorder screening; Smoking cessation counseling visit; Dietary counseling (limited to 3 visits per participant, per benefit period); Behavioral counseling for participants who are overweight or obese; Preventive lead screening; Lung cancer screening for participants age 55 and older; Hepatitis C virus infection screening; Gestational diabetes screening for pregnant women; Iron deficiency screening for pregnant women; Rh (D) incompatibility screening for pregnant women; and Urine culture for pregnant women.	<p>You pay nothing of the allowed amount for specifically listed preventive care services per person, per benefit period.</p> <p>No copayment, deductible or coinsurance required.</p>	<p>You pay costs subject to your out-of-network benefit.</p>
Women's Preventive Health Services	In-Network	Out-of-Network
Well Woman visits (for recommended age-appropriate preventive services); breastfeeding support, supplies and counseling.	<p>You pay nothing of the allowed amount for specifically listed preventive care services per person, per benefit period.</p> <p>No copayment, deductible or coinsurance required.</p>	<p>You pay costs subject to your out-of-network benefit.</p>
Blue Cross of Idaho pays 100 percent for women's preventive prescription drugs and devices as specifically listed on the Blue Cross of Idaho website, <b>bcidaho.com</b> ; 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.		
<b>Prescribed Contraceptive Services</b> Includes diaphragms, intrauterine devices (IUDs), implantables, injections and tubal ligation		
Immunizations	In-Network	Out-of-Network
Accellular Pertussis, Diphtheria, Hemophilus Influenza B, Hepatitis B, Influenza, Measles, Mumps, Pneumococcal (pneumonia), Poliomyelitis (polio), Rotavirus, Rubella, Tetanus, Varicella (Chicken Pox), Hepatitis A, Meningococcal, Human Papillomavirus (HPV) and Zoster.	<p>You pay nothing for specifically listed immunizations.</p> <p>No copayment, deductible or coinsurance required.</p>	
All Immunizations are limited to the extent recommended by the Advisory Committee on Immunization Practices and may be adjusted to coincide with federal government changes, updates, and revisions. Other immunizations not specifically listed may be covered when medically necessary and approved by the Blue Cross of Idaho Pharmacy & Therapeutics Committee.		

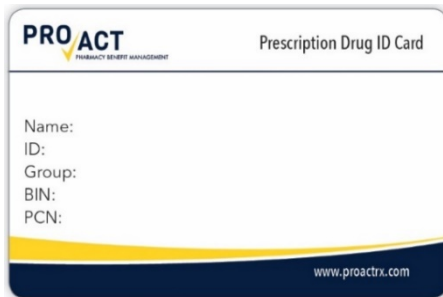
**Please Note:** Your provider must bill these services as preventive/wellness services. For complete descriptions of your policy and please contact the Ill-A Benefits Manager.



## III-A PROACT PRESCRIPTION DRUG BENEFIT

Below is a sample copy of your ProAct Prescription Drug ID Card. This is what you will present to your pharmacy to process your prescription(s).

**IMPORTANT:** Please make sure your medical provider(s) also receive a copy of your ProAct Prescription Drug ID card and understand that any prescription prior authorization requests *must* be submitted to ProAct, NOT Blue Cross of Idaho.



### Why ProAct?

All Pharmacies across the U.S. are in-network, including Walgreens.

24/7 Customer Service  
(877) 635-9545



## Your III-A Pharmacy Benefit Copays:

### Retail Pharmacy

#### Per 30-day Supply

Generic Drugs (Tier 1): Copay up to \$10  
Brand Name Drugs (Tier 2): Copay up to \$25  
Non-Preferred Drugs (Tier 3): Copay up to \$40

Contact: (877) 635-9545  
Fax: (315) 287-7864  
Web: [ProActRx.com](http://ProActRx.com)  
Email: [Support@ProActRx.com](mailto:Support@ProActRx.com)

### Specialty Pharmacy

#### 30-Day Supply Limit

*Requires a new/separate prescription to be submitted*  
\*Copays are same as Retail

Contact: (888) 843-2040  
Fax: (888) 842-3977  
Email: [ContactUs@NobleHealthServices.com](mailto:ContactUs@NobleHealthServices.com)

### Mail Order Pharmacy

You receive a 90-day supply for the price of a 60-day supply

#### Per 90-day Supply

*Requires a new/separate prescription to be submitted*  
Generic Drugs (Tier 1): Copay up to \$20  
Brand Name Drugs (Tier 2): Copay up to \$50  
Non-Preferred Drugs (Tier 3): Copay up to \$80

Contact: (866) 287-9885 to set up home delivery & payment profile  
Fax: (315) 287-3330  
Web: [ProActRx.com](http://ProActRx.com)  
Email: [MailOrder@ProActPharmacyServices.com](mailto:MailOrder@ProActPharmacyServices.com)

## DIABETIC MEMBERS

**DexCom G6 Program** - Members may purchase the DexCom G6 through ProAct via their local retail pharmacy or through ProAct mail order with a prescription from their provider.

### **To purchase via Retail:**

You must present your prescription to the pharmacy, along with your **ProAct ID** card.  
Copays are as follows: Transmitter: \$25 / Reader: \$25 / Sensors: \$25 for a 30-day supply (3 sensors per month)

**To purchase through the ProAct mail-order program (and receive a 90-day supply for the price of a 60-day supply) call: (866) 287-9885.**

Visit [ProActRx.com](http://ProActRx.com) to register as a member and view your pharmacy claims.

**NEVER LEAVE THE PHARMACY WITHOUT YOUR PRESCRIBED MEDICATIONS**  
If you encounter any issues, please contact the III-A Benefits Manager



**VISION CARE BENEFITS – C – 25**

**Effective October 1, 2020**

**For Covered Providers and Services**

**Copayment**

Participant pays \$0 per eye exam and/or \$25 per Frame and Lenses or Medically Necessary Contact Lenses.

**Service Frequency Limitations**

**Elective**—includes basic eye exam and an allowance of \$150 in place of benefits for Prescribed Lenses and Frames

Participant may receive one (1) eye exam and/or one (1) pair of Lenses or one (1) pair of Medically Necessary Contact Lenses (in lieu of eyeglasses) and/or one (1) Frame every twelve (12) months.

**Payment for Services Rendered**

**Participating Provider**

Plan pays 100% of Maximum Allowance after Copayment

**Nonparticipating Provider**

**Professional Fees**

Eye Exam

\$45

**Materials—lenses per pair**

Single Vision

\$30

Bifocals, up to

\$50

Trifocals, up to

\$65

Frame, up to

\$70

**Contact Lenses— per pair**

(evaluation, materials, and fittings only)

\$105

**Medically Necessary, up to**

\$210

The VCSV Participating Provider is responsible for verifying benefits with VSP prior to rendering services. A Participant must provide the VCSV Participating Provider sufficient information to verify eligibility. Failure of the Participant to provide sufficient information may delay services and may affect benefit payment under the Plan.

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# Mental Health Resource Directory

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*If this is an Emergency, please call 911*

**BPA HEALTH:** For immediate crisis counseling assistance or ongoing counseling, contact BPA Health, your Employee Assistance Program (EAP):



**Call:** # (800) 726-0003

**Or visit:** [bpahealth.com/eap-home/](http://bpahealth.com/eap-home/)

**Employer Name/Login:** III-A

**Toll Free Number/Password:** 8007260003

EAP is a benefit provided by III-A to help you successfully address work and personal problems that impact your life. They provide counseling services – either face-to-face, or virtual, with licensed mental health professionals.

**All III-A members receive 10 sessions per incident/per calendar year.** Services are provided at no cost to employee and family and are strictly confidential. *\*\*\*Call BPA to request an authorization prior to seeing a Provider.*

**If you or someone you care about is in a crisis, seek help immediately: Call 911, visit a nearby emergency department or your health care provider's office. Or call a toll-free, 24-hour hotline:**

**Idaho Suicide Prevention Hotline:**

- **Text or Call:** (208) 398-4357 or dial 211

**National Suicide Prevention Lifeline:**

- **Call:** (800) 273-TALK (8255) or TTY: (800) 799-4TTY (4889)
- **Text:** HELLO to 741741 to talk to a trained counselor

**Safe Call Now:** A 24/7 crisis line for public safety employees, emergency services personnel and their families to speak confidentially with officers, former law enforcement officers, public safety professionals and/or mental healthcare providers

- **Call:** (206) 456-3020

**III-A Blue Cross of Idaho Counseling Benefits:**

**Outpatient Mental Health Services:** Office visit copayment (same as medical). Additional testing or services may be subject to in or out of network deductible/out of pocket.

**Inpatient Mental Health Services:** Subject to in or out of network deductible/out of pocket. Prior authorization is required.

*To find a Blue Cross of Idaho provider either visit online at [www.bcidaho.com](http://www.bcidaho.com), or call the customer service phone number listed on the back of your ID card: (986) 224-4152 or (833) 623-7993*





## Employee Assistance Program (EAP)

**BPA Health:** In addition to your 10 EAP counseling sessions per incident/per year (see *Mental Health Resource* page) for the entire family, our members also have access to the following services provided by BPA:



- **Legal/Financial Assistance:** All members receive one annual free 30-minute session with a legal attorney on most issues. In most cases discounted rates are available if further legal representation is required.
- **Financial Guidance:** Free telephonic consultation with a financial professional on common topics such as: Avoiding, responding to, and correcting identity theft. Budgeting, buying a home, managing credit. Easy access to vital legal and financial information.
- **Free Legal downloadable and customizable forms & online resources:**
  - Quicken Will Maker & Trust
  - Monthly Budget worksheet
  - Landlord/Tenant Checklist

Additional articles are available on the BPA website to provide a range of assistance on various topics, such as: Work & Personal Relationships, Aging, Parenting, Medical and Mental Health Issues and more.

**Use the below username and password to review this information:**

**Employer Name Login/Username: III-A**  
**Toll Free Number/Password: 8007260003**

Toll Free: (800) 726-0003  
Website: [bpahealth.com/eap-home/](http://bpahealth.com/eap-home/)

## Life Insurance

**Life, Accidental Death & Dismemberment (AD&D) Insurance:**

**As of 10/1/2020, OneAmerica has replaced Unum as the III-A life insurance carrier.**

**IMPORTANT: Fill out and submit your Beneficiary Designation form to your Employer. This form is available at [iii-a.org](http://iii-a.org) (or the last pages of this booklet). \*\*\*Keep this form updated\*\*\***

**Eligibility:** Active fulltime Employees and Elected Officials

**Benefit Amount:** \$20,000

**Accelerated Death Benefit:** 25%, 50%, or 75% of face value with remainder paid at time of death

**Portability:** If you retire, reduce your hours to less than fulltime, or leave your Employer, you can take this coverage with you.

**Life Benefit Reduction:** 50% at age 75



**Other services included with this life insurance benefit:**

- Life Planning Financial & Legal Resources
- Employee Assistance Program (3-visits at no cost per incident/per year)
- Travel Assistance Program

Please visit the OneAmerica website for more details: [oneamerica.com](http://oneamerica.com)



# Beneficiary Designation Under Group Life Insurance Policy

Submit your completed form to your Employer

\*\*\*Reminder to keep this form updated\*\*\*

Products and financial services provided by  
American United Life Insurance Company®  
a ONEAMERICA® company  
One American Square, P.O. Box 6123  
Indianapolis, IN 46206-6123  
1-800-553-5318 Fax: 1-888-285-1565  
www.employeebenefits.aul.com



**IMPORTANT:** PLEASE READ INSTRUCTIONS AND SAMPLE DESIGNATIONS ON REVERSE SIDE BEFORE COMPLETING FORM.

CHECK IF BENEFICIARY FOR: ☐ All Policies or ☐ Basic Life ☐ Supplemental ☐ Voluntary Term Life ☐ AD&D  
☐ List Other \_\_\_\_\_

Group Policy/Participating Unit Number			
Name of Group Policyholder/Participating Unit			
Name of Insured Person			
Insured Person's SSN		Insured Person's Date of Birth	

Subject to the provisions of the policy, applicable laws, and the rights of any valid assignee of record with American United Life Insurance Company® (AUL), it is requested the beneficiary of any policy proceeds payable at the death of the Insured Person be as follows:

## PRIMARY BENEFICIARY(S)

Name	Relationship	Address	DOB	SSN	Percentage
Total <sup>1</sup>					0

## CONTINGENT BENEFICIARY(S) IF THE PRIMARY BENEFICIARY(S) PREDECEASES YOU

Name	Relationship	Address	DOB	SSN	Percentage
Total <sup>2</sup>					0

It is understood and agreed upon receipt of this beneficiary designation by AUL at its principal office, such beneficiary designation will become effective and shall relate back to the date this beneficiary designation is signed, but without prejudice to AUL on account of any payment made prior to the receipt of and acknowledgement of the validity of the beneficiary designation by AUL. AUL shall not be obligated to honor this beneficiary designation unless and until it has been received by AUL, acknowledged by the appropriate officer of AUL, and determined by AUL to comply with applicable law at the time a claim is made. This beneficiary designation supersedes and cancels all prior beneficiary designations by the Insured Person for the policy(s) indicated. If no beneficiary designation is named on any additional AUL coverage, the undersigned understands that this beneficiary designation will be used by AUL for any additional coverage.

The undersigned hereby declares that he/she has not been declared incompetent and no court order or laws prevent naming the above designee(s). It is agreed that AUL assumes no responsibility for the validity or effect of any purported beneficiary designation or transfer of rights under the policy.

**The undersigned represents and warrants any information or documents provided to AUL by the undersigned prior to and after the date of the application for insurance and the facts and other matters contained in the foregoing are true and accurate to the best of the undersigned's knowledge and belief.** The undersigned understands and agrees: 1) any insurance coverage or benefits is contingent upon any statements made to AUL as being complete and correct and 2) benefits under any policy will be paid only if AUL decides the applicant is entitled to them under the policy.

Signature of Insured	Signature of Witness (The Witness must have no interest in the policy/contract or be a named beneficiary)
Printed Name	Printed Name
Date	Date

**Lack of Notice of Community Property Interest:** If AUL has not previously received written notice of a community property interest and if the space for consent below is not signed by a person having such an interest, then AUL shall be entitled to rely upon its good faith that no such interest exists. AUL assumes no responsibility of inquiry regarding such interest and, in consideration of acknowledgement of this designation, the insured person listed above, for himself/herself and his/her estate, heirs, successors and assigns, agrees to indemnify AUL and hold it harmless from the consequences of acknowledging this beneficiary designation.

Spouse's signature and consent (if applicable):<sup>3</sup> \_\_\_\_\_ Date \_\_\_\_\_

1 Total percentage must equal 100%. If percentages do not equal 100%, then benefits will be paid on a pro-rata basis, according to the percentages shown. If no percentages are shown, benefits will be distributed equally.

2 Total percentage must equal 100%. If percentages do not equal 100%, then benefits will be paid on a pro-rata basis, according to the percentages shown. If no percentages are shown, benefits will be distributed equally.

3 Spouse's signature is needed only if Insured/Beneficiary lives in a community property state which currently include AZ, CA, ID, LA, NM, NV, TX, WA and WI.

## SAMPLE BENEFICIARY DESIGNATIONS

The beneficiary wording should be absolutely clear and without question as to whom the proceeds are to be paid. Listed below are sample beneficiary designations. Please note state laws may prohibit naming certain entities and individuals as a beneficiary. If you live in a community property state, you should obtain the signature of your spouse if your spouse will not be named as a primary beneficiary. Community property states currently include: AZ, CA, ID, LA, NM, NV, TX, WA and WI.

To ensure the correct individual or entity receives the benefits and the intended benefit amount, please provide the following:

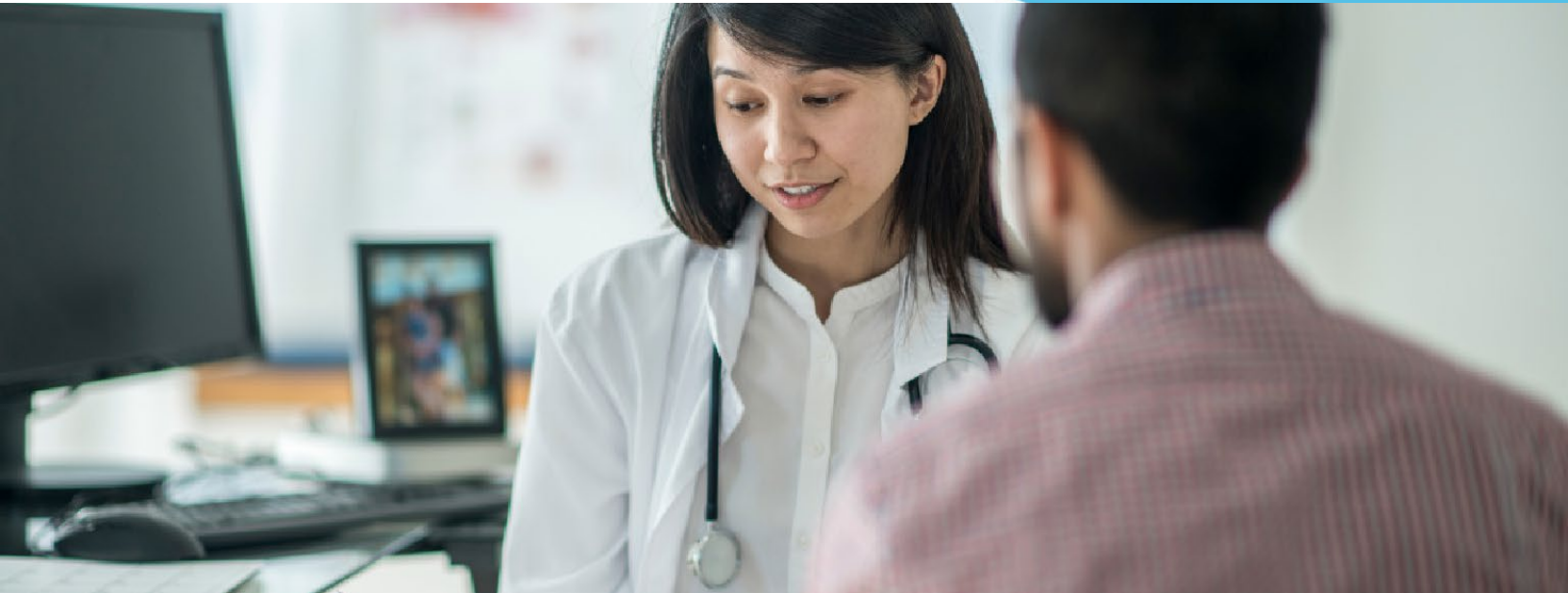
- The beneficiary's social security number, tax identification number and date of birth.
- Distribution of proceeds should be shown in fractions or percentages if multiple beneficiaries are designated. Do not list dollar amounts as the amount of the insured's life benefit may change. If no distribution is shown, benefits will be divided equally among the living beneficiaries.

## ACCEPTABLE BENEFICIARY DESIGNATIONS

- 1) **One Beneficiary** – State the full name and relationship to the insured.  
Sample: John Doe, husband
- 2) **Two Beneficiaries in Equal Shares** –  
Sample: Jane Doe and Mary Doe, cousins, in equal shares, or their survivors.
- 3) **Three or More Beneficiaries in Equal Shares** –  
Sample: Jane Doe, Mary Doe, and Richard Doe, cousins, in equal shares, or their survivors.
- 4) **Two Beneficiaries in Succession** – If the primary beneficiary dies, the second person named will receive the proceeds and is known as the contingent beneficiary.  
Sample: Martha Doe, wife, or, in the event of her death, Richard Doe, cousin.
- 5) **Three or More Beneficiaries in succession** – If the primary and secondary beneficiaries die, the third person named will receive the proceeds.  
Sample: Martha Doe, wife, or, in the event of her death, Richard Doe, cousin, or in the event of his death, Jane Doe, niece.
- 6) **One Beneficiary Followed by Two Beneficiaries in Equal Shares** –  
Sample: Martha Doe, wife, or, in the event of her death, Jane Doe and Mary Doe, cousins, in equal shares, or their survivors.
- 7) **One Beneficiary Followed by Three or More Beneficiaries in Equal Shares** –  
Sample: John Doe, husband, or, in the event of his death, Jane Doe, Mary Doe, and Richard Doe, cousins, in equal shares, or their survivors.
- 8) **Two Beneficiaries Shown in Percentages** –  
Sample: John Smith, cousin 40%, Sally Smith, aunt 60%.
- 9) **Two or More Beneficiaries Shown in Percentages** –  
Sample: Mary Doe, wife 50%, Jane Doe, cousin 25%, John Doe, cousin 25%.
- 10) **Estate** – Do not identify the name of the executor of executrix since this name may change as wills are updated.  
Sample: Estate of John Doe
- 11) **Custodian for Minor Children** – Please note any minor child beneficiary designation should nominate a custodian (i.e. bank, adult, trustee) followed by the words "as custodian for (*minor child's name*) under the (*child's residential state*) uniform transfers to minors act." This designation may avoid a court appointed guardianship for the payment of the death benefit.  
Sample: John Doe as custodian for Jimmy Smith under the Indiana Uniform Transfers to Minors act.
- 12) **Trust Agreement** – State the name of the trust and the date of the trust agreement.  
Sample: John Doe Trust dated \_\_\_\_\_. Payment to trustee shall discharge the company.
- 13) **Wife or Unnamed Children** –  
Sample: Martha Doe, wife, or in the event of her death, our children, if any, or their survivors.
- 14) **Unnamed Children** –  
Sample: Children, if any, in equal shares, or their survivors.
- 15) **Beneficiary - No Relationship** –  
Sample: Mary Doe, friend
- 16) **To a Church or Organization** – It is preferable to indicate both the name and address and the wording "or its successors or assigns."  
Sample: Christ Lutheran Church or its successors or assigns
- 17) **Irrevocable Beneficiary** – This is acceptable, but not preferable, as the beneficiary must then approve any future beneficiary change.  
Sample: John Smith, husband, irrevocable beneficiary.
- 18) **Employee Unable to Sign** – This designation must contain the person's mark and be signed by two disinterested witnesses.

## UNACCEPTABLE BENEFICIARY DESIGNATIONS

- 1) **Collateral assignments**, e.g. to banks, finance companies, etc. as creditors on a loan.
- 2) **The Employer**
- 3) **Funeral Homes**



## Preventive Schedule

Make a Plan for Your Health

✓ CHECK WHEN COMPLETED	FREQUENCY	DATE SCHEDULED
<input type="checkbox"/> Annual Wellness Exam	Every 12 months	
<input type="checkbox"/> Blood Pressure	At least annually*	
<input type="checkbox"/> Cholesterol	Every 5 years*	
<input type="checkbox"/> Body Mass Index	Annually	
<input type="checkbox"/> Bone Mass Measurement	Every 1-2 years	
<input type="checkbox"/> Breast Cancer	Annually	
<input type="checkbox"/> Colon Cancer	Ask my doctor	
<input type="checkbox"/> Diabetes Screening (A1C)	At least annually*	
<input type="checkbox"/> Flu Vaccine	Annually	
<input type="checkbox"/> Immunizations	As needed*	
<input type="checkbox"/> Pneumonia Vaccine	Once after age 65	
<input type="checkbox"/> Well Baby/Well Child Exam	As recommended in Well Child Schedule	
<input type="checkbox"/> Well Woman Exam	Annually	

*\*Your primary care provider (PCP) will help determine frequency.*

Depending on your health and personal risk factors, your preventive care schedule may differ from the standard recommendations. Talk with your Primary Care Provider (PCP) about a schedule that is best for you. If you have particular risk factors like a chronic disease, obesity, or a family history of a disease, your PCP may recommend additional screenings.



# Well Child Immunization and Visit Schedule

## Giving Your Kids a Healthy Start

Getting your child vaccinated is one of the best steps you can take for a healthy start in life. Not too long ago, diseases like measles, whooping cough and polio affected thousands of children, sometimes leading to lifelong disability or even death. Now, vaccines can help prevent children from ever suffering from these diseases.

Vaccines are administered during Well Child visits with your child's healthcare provider. These visits include a complete physical exam, developmental milestones, immunization schedules and more. The American Academy of Pediatrics Bright Futures suggest the following schedule for Well Child visits unless otherwise suggested by your pediatrician.

Age	Activity	Immunization/ Test
2 weeks	Exam, Health Education	None
2 months	Exam, Health Education	DTaP-Polio-Hib, Hepatitis B, Pneumococcal, Rotavirus
4 months	Exam, Health Education	DTaP-Polio-Hib, Hepatitis B (if birth dose not given), Pneumococcal, Rotavirus
6 months	Exam, Health Education	DTaP-Polio-Hib, Pneumococcal, Hepatitis B, Rotavirus
9 months	Exam, Health Education	None
12 months	Exam, Health Education	MMR, VZV, Hepatitis A, Anemia test, Lead test, TB test as needed
15 months	Exam, Health Education	DTaP-Polio-Hib, Pneumococcal
18 months	Exam, Health Education	Hepatitis A
24 months	Exam, Health Education	Lead test, TB test as needed
30 months	Exam, Health Education	None
3 years	Exam, Health Education	Blood Pressure (at each exam 3 years & older)
4 years	Exam, Health Education	MMR, VZV, DTaP, Polio
5 years	Exam, School Readiness	Vision and Hearing Screens (MMR, VZV, DTaP, Polio if not given at 4 year WCC)
6-10 years	Exam, Health Education Physical Exam Yearly	Catch-up Immunizations
11-18 years	Annual Sports/Adolescent Exam Yearly	Tdap, Meningococcal, HPV Catch-up Immunizations Anemia Test (menstruating females)

**Your Pediatrician will review immunizations on each visit for the needs of your child.**

**[www.completechildrenshealth.com/education-resources/immunization-schedule.php](http://www.completechildrenshealth.com/education-resources/immunization-schedule.php)**

