Blue Cross of Idaho

An Independent Licensee of the Blue Cross and Blue Shield Association

Form No. LGNGFPPO (01/22)

LARGE GROUP PPO
BENEFITS OUTLINE
Visit our Website at www.bcidaho.com to locate a Contracting Provider

	In-Network	Out-of-Network
	The Insured is responsible to pay these amounts:	
Deductibles (per Benefit Period) **Individual**	**$500**	
Family *(No Insured may contribute more than the Individual Deductible amount toward the Family Deductible)*	**$1,000**	
Out-of-Pocket Limits (per Benefit Period) Includes applicable Deductible, Coinsurance and Copayments. *(See Policy for services that do not apply to the limit)*		
Individual	**$5,000**	**$6,500**
Family *(No Insured may contribute more than the Individual Out-of-Pocket Limit amount toward the Family Out-of-Pocket Limit)*	**$10,000**	**$13,000**
Coinsurance *Unless specified otherwise below, the Insured pays the following Coinsurance amount*	20% of Maximum Allowance after Deductible	40% 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.*	**Unity Health Clinic Provider:** No Charge **All other In-Network Providers:** $20 Copayment per visit	Deductible and Coinsurance
Pediatric Physician Office Visits *(For Insureds under the age of eighteen (18). Includes Urgent Care visits. Includes mononucleosis testing, strep A and B testing, development screening(s), ear wax removal, removal of foreign body from ear, urine pregnancy tests, influenza A or B test, rapid RSV test, and pulse oximetry.* *All other additional services not listed above, such as laboratory, x-ray, and other Diagnostic Services are not included in the Pediatric Physician Office Visit Copayment.)*	No Charge (Deductible does not apply)	Deductible and Coinsurance
Preventive Care Covered Services *(Includes services, screenings and tests that have received a rating of A or B to the extent recommended by the U.S. Preventive Services Task Force and Health Resources and Services Administration. Further information and specifically listed Preventive Care Covered Services are available on the BCI Website, www.bcidaho.com)*	No Charge (Deductible does not apply)	Deductible and Coinsurance
Immunizations Specifically listed on the BCI Website, www.bcidaho.com.	No Charge (Deductible does not apply)	No Charge (Deductible does not apply)

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TELEHEALTH SERVICES	
Telehealth Services provided by MDLIVE	MDLIVE provides access to the following non-emergency categories of telehealth services: Medical Consultation, Psychotherapy Treatment, Outpatient Medication Management and Psychiatric Evaluation/Medical Service. All MDLIVE services are In-Network and require a $10 Copayment, per visit. To request a visit, call (888) 920-2975 or visit the Website at www.mdlive.com/bcidaho.
Telehealth Virtual Care Services (Providers other than MDLIVE)	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.

COVERED SERVICES *Some services may require Prior Authorization.*	**In-Network**	**Out-of-Network**
	The Insured is responsible to pay these amounts:	
Allergy Injections	$5 Copayment per visit if this is the only service provided during the visit	Deductible and Coinsurance
Ambulance Transportation Service	Deductible and Coinsurance	Deductible and Coinsurance
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 Insured. Hospital Grade Breast Pumps require Prior Authorization)*	No Charge (Deductible does not apply)	Deductible and Coinsurance
Chiropractic Care Services *Up to a combined In-Network and Out of-Network total of 18 visits per Insured, 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 Coinsurance
Dental Services Related to Accidental Injury	Deductible and Coinsurance	Deductible and Coinsurance
Diabetes Self-Management Education Services	$20 Copayment per visit	Deductible and Coinsurance
Diagnostic Services - Laboratory and X-ray *(Including diagnostic mammograms)*	No charge up to $100, then Deductible and Coinsurance	Deductible and Coinsurance
Durable Medical Equipment, Orthotic Devices and Prosthetic Appliances	Deductible and Coinsurance	Deductible and Coinsurance
Emergency Services – Facility Services *(Copayment waived if admitted)* *(Additional services, such as laboratory, x-ray, and other Diagnostic Services are subject to applicable Deductible, Coinsurance and/or Copayment. For Out-of-Network treatment of Emergency Medical Conditions as defined in the Policy, BCI will provide In-Network benefits for Covered Services. Insured may be balance-billed for these services.)*	$200 Copayment per hospital Outpatient emergency room visit, then Deductible and Coinsurance	$200 Copayment per hospital Outpatient emergency room visit, then Deductible and Coinsurance
Emergency Services – Professional Services *(For Out-of-Network treatment of Emergency Medical Conditions as defined in the Policy, BCI will provide In-Network benefits for Covered Services. Insured may be balance-billed for these services.)*	Deductible and Coinsurance	Deductible and Coinsurance
Hearing Aids *(For 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.)*	Deductible and Coinsurance	Deductible and Coinsurance

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COVERED SERVICES *Some services may require Prior Authorization.*	In-Network	Out-of-Network
	The Insured is responsible to pay these amounts:	
Home Health Skilled Nursing Care Services	Deductible and Coinsurance	Deductible and Coinsurance
Home Intravenous Therapy	Deductible and Coinsurance	Deductible and Coinsurance
Hospice Services	No Charge (Deductible does not apply)	Deductible and Coinsurance
Hospital Services	Deductible and Coinsurance	Deductible and Coinsurance
Maternity Services and/or Involuntary Complications of Pregnancy	Deductible and Coinsurance	Deductible and Coinsurance
Mental Health and Substance Use Disorder Inpatient Services • **Inpatient Facility and Professional Services**	Deductible and Coinsurance	Deductible and Coinsurance
Mental Health and Substance Use Disorder Outpatient Services • **Outpatient Psychotherapy Services** • **Pediatric Outpatient Psychotherapy Services** *(For Insureds under the age of eighteen (18).)* • **Facility and other Professional Services**	 $20 Copayment per visit No Charge (Deductible does not apply) Deductible and Coinsurance	Deductible and Coinsurance
Outpatient Applied Behavioral Analysis (ABA) *(as part of an approved treatment plan)* • **Pediatric Outpatient Applied Behavioral Analysis (ABA)** *(For Insureds under the age of eighteen (18).)*	$20 Copayment per visit No Charge (Deductible does not apply)	Deductible and Coinsurance
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. 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 *Up to a combined In-Network and Out-of-Network total of 36 visits per Insured, per Benefit Period. An additional 36 visits may be available with Prior Authorization.*	Deductible and Coinsurance	Deductible and Coinsurance
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 30 visits per Insured, per Benefit Period* *(Additional services, such as, x-ray and other Diagnostic Services are not included in the Therapy Services Copayment)*	$60 Copayment per visit	Deductible and Coinsurance
Outpatient Pulmonary Rehabilitation Services	Deductible and Coinsurance	Deductible and Coinsurance
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 30 visits per Insured, per Benefit Period* *(Additional services, such as, x-ray and other Diagnostic Services are not included in the Therapy Services Copayment)*	$60 Copayment per visit	Deductible and Coinsurance
Palliative Care Services	No Charge (Deductible does not apply)	Deductible and Coinsurance
Post-Mastectomy/Lumpectomy Reconstructive Surgery	Deductible and Coinsurance	Deductible and Coinsurance

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COVERED SERVICES *Some services may require Prior Authorization.*	**In-Network**	**Out-of-Network**
	The Insured is responsible to pay these amounts:	
Prescribed Contraceptive Services *(Includes diaphragms, intrauterine devices (IUDs), implantables, injections and tubal ligation)*	No Charge (Deductible does not apply)	Deductible and Coinsurance
Rehabilitation or Habilitation Services	Deductible and Coinsurance	Deductible and Coinsurance
Skilled Nursing Facility *Up to a combined In-Network and Out-of-Network total of 30 days per Insured, per Benefit Period*	Deductible and Coinsurance	Deductible and Coinsurance
Sleep Study Services	Deductible and Coinsurance	Deductible and Coinsurance
Surgical/Medical (Professional Services)	Deductible and Coinsurance	Deductible and Coinsurance
Therapy Services *(Including Radiation, Chemotherapy, Renal Dialysis and Growth Hormone)*	Deductible and Coinsurance	Deductible and Coinsurance
Transplant Services	Deductible and Coinsurance	Deductible and Coinsurance
NOTE: Be aware that your actual costs for services provided by an Out-of-Network Provider may exceed this Policy's Out-of-Pocket Limit for Out-of-Network services. In addition, Out-of-Network Providers can bill you for the difference between the amount charged by the Provider and the amount allowed by Blue Cross of Idaho and that amount is not counted toward the Out-of-Network Out-of-Pocket Limit. By choosing a Noncontracting Provider you may be responsible for the difference between the BCI Allowed Amount and what the Noncontracting Provider charges. This is called balance-billing.		

PRESCRIPTION DRUG BENEFITS

- The Formulary will be made available to any Insured on request by contacting our Blue Cross of Idaho Customer Service Department at (208) 331-7347 or (800) 627-1188.
- 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 day supply at one (1) time.
- Retail - One Copayment for each 30-day supply
- Mail Order – 90-day supply or 100-unit doses, whichever is less

RETAIL OR BCI MAIL ORDER PHARMACIES

OUT-OF-POCKET LIMIT (PER BENEFIT PERIOD)

Individual: $1,500 in Copayments for a combination of all Prescription Drug charges incurred.

Family: $3,000 in Copayments and/or Coinsurance for a combination of all Prescription Drug charges incurred. (*No Insured may contribute more than the Individual Prescription Drug Out-of-Pocket Limit amount toward the Family Prescription Drug Out-of-Pocket Limit.)*

When the Prescription Drug Out-of-Pocket Limit is met, the Prescription Drug Benefits payable will increase to 100% of the Allowed Charge or the Usual Charge for the remainder of the Benefit Period.

Retail **Tier 1 – Generic Drugs**	$10 Copayment + 20% Coinsurance per prescription
Tier 2 –Brand Name Drugs	$20 Copayment + 20% Coinsurance per prescription
Mail Order **Tier 1 – Generic Drugs**	$10 Copayment per prescription
Tier 2 –Brand Name Drugs	$20 Copayment per prescription
ACA Preventive Prescription Drugs	No Charge
Prescribed Contraceptives	No Charge
Note: Certain Prescription Drugs have generic equivalents. If the Insured requests a Brand Name Drug, the Insured 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.	

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