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

Preferred Blue® PPO

Benefit Highlight Sheet Canyon Owyhee School District **September 01,2020**	**Preferred Blue for Idaho School Benefit Trust**		
	In-Network		**Out-of-Network**
Benefit Period* Deductible (Individual/Family)	$3,000/$6,000		
Cost Sharing	You pay 20% of the allowed amount		You pay Choose an item. of the allowed amount
Individual Out-of-Pocket Limit *(See Plan for services that do not apply to the limit.) (Includes applicable Deductible, Cost Sharing and Copayments)*	$5,500		$8,000
Family Out-of-Pocket Limit *(See Plan for services that do not apply to the limit.) (Includes applicable Deductible, Cost Sharing and Copayments)*	$11,000		$16,000
Copayment (*Applies to In-Network only. Other services rendered during an office visit will be subject to Deductible and Cost Sharing.)*	**ChoiceDocs** In-Network Providers**	**All other In-Network Providers**	Not applicable
	You pay $10 Copayment per visit for Primary Care Provider You pay $30 Copayment per visit for Specialist Provider (non-Primary Care Provider	You pay $30 Copayment per visit for Primary Care Provider You pay $50 Copayment per visit for Specialist Provider (non-Primary Care Provider	
COVERED SERVICES *By choosing a non-contracting provider you may be responsible for the difference between what Blue Cross allows and what the non-contracting provider* charges*. This is called balance-billing. Some services may require prior authorization.*	**In-Network**		**Out-of-Network**
	What you pay		
Allergy Injections	$5 Copayment (*if this is the only service provided during the visit)*		Deductible and Cost Sharing
Ambulance Transportation Services	Deductible and Cost Sharing		
Breastfeeding Support and Supply Services (Limited to one (1) breast pump purchase per benefit period, per Participant)	No charge		
Chiropractic Care (Limited to 18 visits combined per Participant, per benefit period)	Deductible and Cost Sharing		50% Cost Sharing after Deductible
Dental Services Related to Accidental Injury	Deductible and Cost Sharing		Deductible and Cost Sharing
Diabetes Self-Management Education Services (Only for accredited providers approved by BCI.)	Primary Care Provider** Copayment		
Diagnostic Services (Including diagnostic mammograms)	No charge up to $100, then Deductible and Cost Sharing		

The information in this Highlight Sheet is for informational and comparison purposes only. It is not a complete summary or description of benefits Coverage is subject to the provisions of the corresponding Plan Documents and Summary Plan Description, which contains l the detailed terms and conditions of coverage. Certain services not specifically noted may be excluded. Please refer to the Plan Document and Summary Plan Description issued for a more complete description of benefits, exclusions limitations and conditions of coverage. If there is a difference or conflict between this Highlight Sheet and its corresponding Plan Documents and Summary Plan Description, the Plan Documents and Summary Plan Description will control. This Highlight Sheet is subject to annual update.

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COVERED SERVICES *By choosing a non-contracting provider you may be responsible for the difference between what Blue Cross allows and what the non-contracting provider* charges*. This is called balance-billing. Some services may require prior authorization*		**In-Network** **What you pay**	**Out-of-Network**
Durable Medical Equipment, Orthotic Devices and Prosthetic Appliances		Deductible and Cost Sharing	Deductible and Cost Sharing
Emergency Services – Facility Services (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
Emergency Services – Professional Services (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
Home Health Skilled Nursing			
Home Intravenous Therapy		Deductible and Cost Sharing	80% Cost Sharing after Deductible
Hospice Services		No charge	Deductible and Cost Sharing
Hospital Services (Inpatient and outpatient services at a licensed general hospital or ambulatory surgical facility.)		Deductible and Cost Sharing	
Rehabilitation or Habilitation Services			
Maternity Services and/or Involuntary Complications of Pregnancy			
Outpatient Applied Behavioral Analysis (as part of an approved treatment plan)		Primary Care Provider** Copayment	
Mental Health– Inpatient (Facility and Professional Services)		Deductible and Cost Sharing	
Mental Health– Outpatient	**Psychotherapy Services** *(No charge for Participants under the age of eighteen (18).)*	Primary Care Provider** Copayment	
	Facility and other Professional Services	Deductible and Cost Sharing	
Morbid Obesity ($5,000 combined lifetime benefit limit, per Participant)			
Outpatient Habilitation Therapy Services (Includes physical, speech and occupational therapies. Limited to 20 visits combined per Participant, per benefit period.)			
Outpatient Rehabilitation Therapy Services (Includes physical, speech and occupational therapies. Limited to 20 visits combined per Participant, per benefit period.)			
Physician Office Visit (Other services rendered during a physician office visit will be subject to Deductible and Cost Sharing)		Primary Care Provider Copayment/Non-Primary Care Provider Copayment	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 and tubal ligation.)			
Post-Mastectomy/Lumpectomy Reconstructive Surgery		Deductible and Cost Sharing	
Skilled Nursing Facility (Limited to 30 days combined per Participant, per benefit period.)			
Surgical/Medical (Professional Services)			
Therapy Services (Including chemotherapy, growth hormone therapy, radiation and renal dialysis.)		Deductible and Cost Sharing	
Transplant Services			

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Preventive Care Benefits (See plan for specifically listed services)	No charge for services specifically listed For services not specifically listed Deductible and Cost Sharing	
Immunizations (See Plan for specifically listed immunizations)	No charge for listed immunizations	
Telehealth Services (Services provided by MDLIVE for Medical Consult, Psychotherapy Treatment, Outpatient Medication Management and Psychiatric Evaluation/Medical Service covered services)	No charge To request a consultation, call 1-888-920-2975 or visit the website at www.mdlive.com/bcidaho [mdlive.com].	
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.

**Participant may be eligible to receive lower copayment amounts when selecting a ChoiceDocs Primary Care Provider.