

Benefit Highlight Sheet Plummer-Worley School District Effective: September 1, 2022	Blue Value® for Idaho School Benefit Trust	
	In-Network	Out-of-Network
Benefit Period* Deductible (Individual/Family)	\$500/\$1,000	\$1,000/\$2,000
Cost Sharing	You pay 10% of the allowed amount	You pay 30% 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)	\$2,000	\$4,000
Family Out-of-Pocket Limit (See Plan for services that do not apply to the limit.) (Includes applicable Deductible, Cost Sharing and Copayments)	\$4,000	\$8,000
Copayment (Applies to In-Network only. Other services rendered during an office visit will be subject to Deductible and Cost Sharing.)	You pay \$30 Copayment per visit for Primary Care Provider (PCP)/ You pay \$50 Copayment per visit for Non-Primary Care Provider (non-PCP)	Not applicable
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 <ul style="list-style-type: none"> • Ground Ambulance Services • Air Ambulance Services (Payment for Out-of-Network Air Ambulance Services is based on the Qualifying Payment Amount. Out-of-Network Air Ambulance Services accumulate towards the In-Network Out-of-Pocket Limit.) 	Deductible and Cost Sharing	Deductible and Cost Sharing In-Network Deductible and In-Network Cost Sharing
Breastfeeding Support and Supply Services (Limited to one (1) breast pump purchase per benefit period, per Participant)	No charge	Deductible and Cost Sharing
Chiropractic Care (Limited to 18 visits combined per Participant, per benefit period)	Deductible and Cost Sharing	
Dental Services Related to Accidental Injury	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	
Durable Medical Equipment, Orthotic Devices and Prosthetic Appliances	Deductible and Cost Sharing	

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COVERED SERVICES <i>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</i>	In-Network	Out-of-Network	
	What you pay		
Emergency Services – Facility Services (Payment for Out-of-Network Emergency Services is based on the Qualifying Payment Amount. Additional services, such as laboratory, x-ray, and other Diagnostic Services are subject to applicable Deductible, Cost Sharing and/or Copayment.)	\$100 Copayment for hospital Outpatient emergency room visit, then In-Network 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.)	In-Network Deductible and In-Network Cost Sharing Emergency Services accumulate towards the In-Network Out-of-Pocket Limit.		
Home Health Skilled Nursing	Deductible and Cost Sharing	Deductible and Cost Sharing	
Home Intravenous Therapy			
Hospice Services	No charge		
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 (Physician Services including prenatal, delivery, and postnatal care.)	Deductible and Cost Sharing		
Outpatient Applied Behavioral Analysis (as part of an approved treatment plan) (No charge for Participants under the age of eighteen (18).)	Primary Care Provider Copayment		
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.		
Mental Health and Substance Use Disorder – Inpatient (Facility and Professional Services)	Deductible and Cost Sharing	Deductible and Cost Sharing	
Mental Health and Substance Use Disorder – 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 Cardiac Rehabilitation Services (Limited to 36 visits per Participant, per benefit period.)			
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.)	No charge		
Palliative Care Services			
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		
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)			

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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 – see appropriate Covered Services section.	
Therapy Services (Including chemotherapy, growth hormone therapy, radiation and renal dialysis.)	Deductible and Cost Sharing	Deductible and Cost Sharing
Transplant Services		
Preventive Care Benefits (See plan for specifically listed services)	No charge for services specifically listed For services not specifically listed deductible and Cost sharing	Deductible and Cost Sharing
Immunizations (See Plan for specifically listed immunizations)	No charge for listed immunizations	

*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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