

Benefit Highlight Sheet Plummer-Worley School District Effective: September 1, 2022	HSA Blue SM PPO for Idaho School Benefit Trust	
	In-Network	Out-of-Network
Benefit Period* Aggregate Deductible** (Individual/Family, applies to benefits below unless noted.)	\$3,000/\$6,000	
Cost Sharing	You pay 30% of the allowed amount	You pay 50% of the allowed amount
Out-of-Pocket Limit (See Plan for services that do not apply to the limit.) (Includes applicable Deductible, Cost Sharing and Copayments)	\$5,800/\$11,600	
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	
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
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		
Diabetes Self-Management Education Services (Only for accredited providers approved by BCI.)		
Diagnostic Services (Including diagnostic mammograms)		
Durable Medical Equipment, Orthotic Devices and Prosthetic Appliances	Deductible and Cost Sharing	Deductible and Cost Sharing
Emergency Services – Facility Services (Copayment waived if admitted) (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.)		
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		80% of the allowed amount
Hospice Services	No Charge after Deductible	Deductible and Cost Sharing
Hospital Services (Inpatient and outpatient services at a licensed general hospital or ambulatory surgical facility.)	Deductible and Cost Sharing	Deductible and Cost Sharing
Rehabilitation or Habilitation Services		
Maternity Services and/or Involuntary Complications of Pregnancy		
Medical Services (Inpatient and outpatient)		

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 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.

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. <i>This is called balance-billing. Some services may require prior authorization</i>	In-Network	Out-of-Network
	What you pay	
Mental Health and Substance Use Disorder– Inpatient and Outpatient (Facility and Professional Services) (No charge after Deductible for Outpatient Psychotherapy Services, for Participants under the age of eighteen (18).)	Deductible and Cost Sharing	Deductible and Cost Sharing
Outpatient Applied Behavioral Analysis (as part of an approved treatment plan) (No charge after Deductible for Participants under the age of eighteen (18).)		
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 of the Benefits Outline. Visit limits do not apply to Treatments for Autism Spectrum Disorder, and related diagnoses.	
Outpatient Cardiac Rehabilitation Services (Limited to 36 visits per insured, per benefit period.)	Deductible and Cost Sharing	Deductible and Cost Sharing
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.)		
Palliative Care Services	No charge after Deductible	
Pediatric Physician Office Visit (For Participants under the age of eighteen (18).)	Deductible and Cost Sharing	
Physician Office Visit		
Prescribed Contraceptive Services (Includes diaphragms, intrauterine devices (IUDs), implantables, injections and tubal ligation.)	No charge	
Post-Mastectomy/Lumpectomy Reconstructive Surgery	Deductible and Cost Sharing	Deductible and Cost Sharing
Skilled Nursing Facility (Limited to 30 days combined per Participant, per benefit period.)		
Surgical/Medical		
Therapy Services (Including chemotherapy, growth hormone therapy, radiation and renal dialysis.)		
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	
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.	

*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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**One family member will not accumulate more than the individual deductible or out-of-pocket maximum toward the family deductible or out-of-pocket maximum. After one family member has met the individual deductible, benefits begin for that person. After the family deductible has been met, benefits begin for all family members.

PRESCRIPTION DRUG BENEFITS		
Each non Specialty Prescription Drug shall not exceed a 90-day supply at one (1) time (Prescription Drug Services apply to the In-Network Out-of-Pocket Limit.)		
RETAIL OR BCI MAIL ORDER PHARMACIES	In-Network	Out-of-Network
WHAT YOU PAY		
Generic Prescription Drugs Preferred Brand Name Prescription Drugs Non-Preferred Brand Name Prescription Drugs	Deductible and Cost Sharing	
ACA Preventive Prescription Drugs	No charge for ACA Preventive Prescription Drugs as specifically listed on the BCI Formulary on the BCI Website, www.bcidaho.com . Deductible does not apply.	
HSA Preventive Prescription Drugs	No charge for HSA Preventive Prescription Drugs as specifically listed on the BCI Formulary on the BCI Website, www.bcidaho.com . (Deductible does not apply)	Cost Sharing per prescription, after Deductible is met for HSA Preventive Prescription Drugs as specifically listed on the BCI Formulary on the BCI Website, www.bcidaho.com .
Prescribed Contraceptives	No charge for Women's Preventive Prescription Drugs and devices as specifically listed on the BCI Formulary on the BCI Website, 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.	

Note: Certain Prescription Drugs have generic equivalents. If the Participant requests a Brand Name Drug, the Participant 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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