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

Preferred Blue® PPO

Benefit Highlight Sheet [Participating School District Name] [Effective Date:]	**Preferred Blue for Idaho School Benefit Trust**		
	In-Network		**Out-of-Network**
Benefit Period* Deductible (Individual/Family)	$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)*	$2,500		$5,000
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.)*	**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 • **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

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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	What you pay	
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 eighteen (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	
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.)	$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	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		
Mental Health and Substance Use Disorder – **Inpatient** (Facility and Professional Services)	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	
Mental Health and Substance Use Disorder – **Outpatient** — **Facility and other Professional Services**	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 of the Benefits Outline. Visit limits do not apply to Treatments for Autism Spectrum Disorder, and related diagnoses.	
Morbid Obesity ($5,000 combined lifetime benefit limit, per Participant)	Deductible and Cost Sharing	Deductible and Cost Sharing
Outpatient Cardiac Rehabilitation Services (Limited to thirty-six (36) visits per Participant, per benefit period.)		

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	What you pay	
Outpatient Habilitation Therapy Services (Includes physical, speech and occupational therapies. Limited to twenty (20) visits combined per Participant, per benefit period.)	Deductible and Cost Sharing	Deductible and Cost Sharing
Outpatient Rehabilitation Therapy Services (Includes physical, speech and occupational therapies. Limited to twenty (20) visits combined per Participant, per benefit period.)		
Palliative Care Services	No charge	
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 thirty (30) days combined per Participant, per benefit period.)		
Surgical/Medical (Professional Services)	Deductible and Cost Sharing	Deductible and Cost Sharing
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	
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.

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