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

HMOBlue®

Benefit Highlight Sheet Coeur d' Alene School District #271 **Effective Date: September 1, 2021**		**HMO*Blue*® for Idaho School Benefit Trust**	
		In-Network	**Out-of-Network**
Benefit Period* Deductible (Individual/Family)		No charge	$750/$1,500
Cost Sharing		No charge	You pay 50% of the allowed amount
Out-of-Pocket Limit (Individual**/**Family) *(See Plan for services that do not apply to the limit.) (Includes applicable Deductible, Cost Sharing and Copayments)*		$2,500/$3,500	$3,500/$7,000
Copayment (*Applies to In-Network only. Other services rendered during an office visit will be subject to Deductible and Cost Sharing.)*		You pay $20 Copayment per visit for Primary Care Provider (PCP)/ You pay $40 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** **What you pay**	**Out-of-Network**
Ambulance Transportation Services	**Ground**	$50 copayment	Deductible and Cost Sharing
	Air	$100 copayment	
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)		Non-Primary Care Provider Copayment	
Dental Services Related to Accidental Injury		No charge	
Diabetes Self-Management Education Services (Only for accredited providers approved by BCI.)		Non-Primary Care Provider Copayment	
Diagnostic Mammogram Services		No charge	
Diagnostic Services (Except for mammogram)		No charge	Deductible and Cost Sharing
Durable Medical Equipment, Orthotic Devices and Prosthetic Appliances		20% copayment	
Emergency 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.)		$75 copayment	Deductible and Cost Sharing *(For treatment of Emergency Medical Conditions as defined in the Plan, Plan will provide In-Network benefits for Covered Services)*
Home Health Skilled Nursing Care Services		Non-Primary Care Provider Copayment	Deductible and Cost Sharing
Home Intravenous Therapy		No charge	
Hospice Services			
Inpatient Hospital Facility Services (No copayment required for properly enrolled newborn Participant.)		$500 copayment per admission	Deductible and Cost Sharing

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		What you pay	
Injections		Primary Care Provider Copayment/ Non-Primary Care Provider Copayment	Deductible and Cost Sharing
Immunizations (See plan for specifically listed immunizations.)		No charge for listed immunizations	
Maternity Services and/or Involuntary Complications of Pregnancy (Physician Services including prenatal, delivery, and postnatal care.)		$200 copayment	Deductible and Cost Sharing
Mental Health– Inpatient	**Facility**	$500 copayment	
	Professional Services	No charge	
Mental Health– Outpatient	**Psychotherapy Services** *(No charge for Participants under the age of eighteen (18).)*	Primary Care Provider Copayment	Deductible and Cost Sharing
	Facility and other Professional Services	$100 copayment	
Morbid Obesity ($5,000 combined lifetime benefit limit, per participant.)		20% copayment	
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	
Outpatient Facility Services • *Hospital* • *Ambulatory Surgical Facility* • *Licensed Birthing Center* • *Observation Room/area*		$100 Copayment	
Outpatient Cardiac Rehabilitation Services (Limited to 36 visits per Participant, per benefit period.)		Non-Primary Care Provider Copayment	
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	
Palliative Care Services		No charge	
Pediatric Physician Office Visit (For Participants under the age of eighteen (18).			
Prescribed Contraceptive Services (Includes diaphragms, intrauterine devices (IUDs), implantables, injections and tubal ligation.)			
Preventive Care Benefits (See plan for specifically listed preventive care services)		No charge for services specifically listed For services not specifically listed Deductible and Cost Sharing (See benefits section for services not specifically listed)	Deductible and Cost Sharing

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	What you pay	
Rehabilitation or Habilitation Services	$500 copayment	Deductible and Cost Sharing
Skilled Nursing Facility (Limited to 30 days combined per participant, per benefit period.)	$500 copayment per admission	
Telehealth Services provided by MDLIVE (Non-emergency services for Medical Consultation, Psychotherapy Treatment, Outpatient Medication Management and Psychiatric Evaluation/Medical Service covered services)	No charge To request a visit, call 1-888-920-2975 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 – see appropriate Covered Services section.	
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.	Deductible and Cost Sharing
Therapy Services *(including Radiation, Chemotherapy, Renal Dialysis and Growth Hormone)* *(Requires Inpatient Facility Admission and/or Outpatient Facility Copayment. See Benefits Outline for services listed.)*	No copayment	

*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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