

Benefit Highlight Sheet Coeur d'Alene School District #271 Effective Date: September 1, 2021	Blue Value® for Idaho School Benefit Trust	
	In-Network	Out-of-Network
Benefit Period* Deductible (Individual/Family)	\$400/\$800	\$750/\$1,500
Cost Sharing	You pay 20% of the allowed amount	You pay 50% 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)	\$2,900	\$4,250
Family Out-of-Pocket Limit (See Plan for services that do not apply to the limit.) (Includes applicable Deductible, Cost Sharing and Copayments)	\$4,300	\$8,500
Copayment (Applies to In-Network only. Other services rendered during an office visit will be subject to Deductible and Cost Sharing.)	You pay \$25 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	Out-of-Network
	What you pay	
Ambulance Transportation Services	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	
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.)	Non-Primary Care Provider Copayment	
Diagnostic Services (except for mammograms)	No charge up to \$250, 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) (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		

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.

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		What you pay	
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		Deductible and Cost Sharing	
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	
Mammogram Services (Preventive screening, routine and diagnostic.)		No charge	
Mental Health– Inpatient (Facility and Professional Services)		Deductible and Cost Sharing	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		
Morbid Obesity (\$5,000 combined lifetime benefit limit, per participant)		Deductible and Cost Sharing	
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.)			
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.)			
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)			
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	
Telehealth Virtual Care Services (Providers other than MDLIVE)		To request a visit, call 1-888-920-2975 or visit the website at www.mdlive.com/bcidaho 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.	

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Therapy Services (Including chemotherapy, growth hormone therapy, radiation and renal dialysis.) Transplant Services	Deductible and Cost Sharing	Deductible and Cost Sharing
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	
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.

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