Blue Cross of Idaho

An Independent Licensee of the Blue Cross and Blue Shield Association

Preferred Blue®PPO

Benefit Highlight Sheet Syringa Mountain School *September 1, 2019*	**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)*	$4,000	$8,000
Family Out-of-Pocket Limit *(See Plan for services that do not apply to the limit.) (Includes applicable Deductible, Cost Sharing and Copayments)*	$6,000	$12,000
Copayment (*Applies to In-Network only. Other services rendered during an office visit will be subject to Deductible and Cost Sharing.)*	You pay $30	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	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	50% Cost Sharing after Deductible
Dental Services Related to Accidental Injury	Deductible and Cost Sharing	Deductible and Cost Sharing
Diabetes Self-Management Education Services (Only for accredited providers approved by BCI.)	Copayment	Deductible and Cost Sharing
Diagnostic Services (Including diagnostic mammograms)	No charge up to $100, then Deductible and Cost Sharing	Deductible and Cost Sharing
Durable Medical Equipment, Orthotic Devices and Prosthetic Appliances	Deductible and Cost Sharing	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	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	Deductible and Cost Sharing

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<table>
<tr><th colspan="2" rowspan="2">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</th><th>In-Network</th><th>Out-of-Network</th></tr>
<tr><th colspan="2">What you pay</th></tr>
<tr><td colspan="2">Rehabilitation or Habilitation Services</td><td rowspan="2">Deductible and Cost Sharing</td><td rowspan="18">Deductible and Cost Sharing</td></tr>
<tr><td colspan="2">Maternity Services and/or Involuntary Complications of Pregnancy</td></tr>
<tr><td colspan="2">Outpatient Applied Behavioral Analysis (as part of an approved treatment plan)</td><td>Copayment</td></tr>
<tr><td colspan="2">Mental Health– Inpatient (Facility and Professional Services)</td><td>Deductible and Cost Sharing</td></tr>
<tr><td rowspan="2">Mental Health– Outpatient</td><td>Psychotherapy Services</td><td>Copayment</td></tr>
<tr><td>Facility and other Professional Services</td><td rowspan="4">Deductible and Cost Sharing</td></tr>
<tr><td colspan="2">Morbid Obesity ($5,000 combined lifetime benefit limit, per Participant)</td></tr>
<tr><td colspan="2">Outpatient Habilitation Therapy Services (Includes physical, speech and occupational therapies. Limited to 20 visits combined per Participant, per benefit period.)</td></tr>
<tr><td colspan="2">Outpatient Rehabilitation Therapy Services (Includes physical, speech and occupational therapies. Limited to 20 visits combined per Participant, per benefit period.)</td></tr>
<tr><td colspan="2">Physician Office Visit (Other services rendered during a physician office visit will be subject to Deductible and Cost Sharing)</td><td>Copayment</td></tr>
<tr><td colspan="2">Prescribed Contraceptive Services (Includes diaphragms, intrauterine devices (IUDs), implantables, injections and tubal ligation.)</td><td>No charge</td></tr>
<tr><td colspan="2">Post-Mastectomy/Lumpectomy Reconstructive Surgery</td><td rowspan="3">Deductible and Cost Sharing</td></tr>
<tr><td colspan="2">Skilled Nursing Facility (Limited to 30 days combined per Participant, per benefit period.)</td></tr>
<tr><td colspan="2">Surgical/Medical (Professional Services)</td></tr>
<tr><td colspan="2">Telehealth Services (Provided by MDLIVE)</td><td>No charge</td></tr>
<tr><td colspan="2">Therapy Services (Including chemotherapy, growth hormone therapy, radiation and renal dialysis.)</td><td rowspan="2">Deductible and Cost Sharing</td></tr>
<tr><td colspan="2">Transplant Services</td></tr>
<tr><td colspan="2">Preventive Care Benefits (See plan for specifically listed services)</td><td>No charge for services specifically listed

For services not specifically listed Deductible and Cost Sharing</td></tr>
<tr><td colspan="2">Immunizations (See Plan for specifically listed immunizations)</td><td colspan="2">No charge for listed immunizations</td></tr>
<tr><td colspan="2">Treatment for Autism Spectrum Disorder (Services identified as part of the approved treatment plan)</td><td colspan="2">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.</td></tr>
</table>

*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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