

| Benefit Highlight Sheet for Syringa Mountain School Sept: 2022 | 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 | \$6,000 |
| Family Out-of-Pocket Limit (See Plan for services that do not apply to the limit.) (Includes applicable Deductible, Cost Sharing and Copayments) | \$8,000 | \$12,000 |
| 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 |
| | 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) |
| | | Not applicable |
| COVERED SERVICES <i>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.</i> | 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 <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 In-Network Deductible and In-Network Cost Sharing |

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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 | \$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 – 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 | Deductible and Cost Sharing | 80% Cost Sharing after Deductible |
| Hospice Services | No charge | |
| 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 | | |
| 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).) | |
| | 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.) | Deductible and Cost Sharing | Deductible and Cost Sharing |
| Surgical/Medical (Professional Services) | | |
| Therapy Services (Including chemotherapy, growth hormone therapy, radiation and renal dialysis.) | | |
| Transplant Services | No charge for services specifically listed For services not specifically listed Deductible and Cost Sharing | Deductible and Cost Sharing |
| Preventive Care Benefits (See plan for specifically listed services) | | |
| 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.

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