Medical	Blue Cross PPO $1000		Blue Cross PPO $2000		Blue Cross HSA $3000	
	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network
Deductible - Individual	$1,000		$2,000		$3,000	
Deductible - Family	$2,000		$4,000		$6,000	
Coinsurance Percentage	80%	60%	80%	60%	70%	50%
Out Of Pocket - Individual	$2,500	$5,000	$3,500	$5,000	$5,800	
Out Of Pocket Maximum - Family	$4,000	$8,000	$7,000	$10,000	$11,600	
Physician Office Visits:	Choice Docs -$10 Primary-$30	subject to deduct & Co-ins	Choice Docs -$10 Primary-$30	subject to deduct & Co-ins	Subject to Deductible & Co-Ins	
Specialty Office Visits:	Choice Docs-$30 Specialty-$50	subject to deduct & Co-ins	Choice Docs-$30 Specialty-$50	subject to deduct & Co-ins	Subject to Deductible & Co-Ins	
Telehealth	included in network services***		included in network services***		$45 Copay; $0 after deductible is met	Subject to Deductible & Co-Ins
Emergency Room Services	$100 Copay-then Ded & Co-Ins		$100 Copay-then Ded & Co-Ins		$100 Copay-then Ded & Co-Ins	
Chiropractic Care	Subject to Deductible 18 Visits		Subject to Deductible 18 Visits		Subject to Deductible 18 Visits	
Prescription Drug Coverage: **						
Preferred Generic	$10	50% co-ins	$10	50% co-ins	30% Co-Ins after ded, $0 prev	
Non-Preferred Generic	$20	50% co-ins	$20	50% co-ins	30% Co-Ins after ded, $0 prev	
Preferred Brand	deduct then $30	50% co-ins	deduct then $30	50% co-ins	30% Co-Ins after ded, $0 prev	
Non-Preferred Brand	deduct then $50	50% co-ins	deduct then $50	50% co-ins	30% Co-Ins after ded, $0 prev	
Preferred Specialty	deduct then 20%	50% co-ins	deduct then 20%	50% co-ins	30% Co-Ins after ded, $0 prev	
Non-Preferred Specialty	deduct then 30%	50% co-ins	deduct then 30%	50% co-ins	30% Co-Ins after ded, $0 prev	
Prescription Deductible	$250		$250		Medical Deductible*	
Prescription Individual Out of Pocket Max	$3000 Individual/$6000 Family		$3000 Individual/$6000 Family		Combined with Medical	
Mental Health / Chemical Dependency:						
Outpatient - Office Visits	$30 Copay	Ded & Co-Ins	$30 Copay	Ded & Co-Ins	Ded & Co-Ins	Ded & Co-Ins
Outpatient - Other Professional Services	Ded & Co-Ins	Ded & Co-Ins	Ded & Co-Ins	Ded & Co-Ins	Ded & Co-Ins	Ded & Co-Ins
Inpatient - Facility & Professional Services	Ded & Co-Ins	Ded & Co-Ins	Ded & Co-Ins	Ded & Co-Ins	Ded & Co-Ins	Ded & Co-Ins
Covered Preventive Care & Immunizations	100%	Ded & Co-Ins	100%	Ded & Co-Ins	100%	Ded & Co-Ins
Employee Assistance Program (EAP)	4 Visits		4 Visits		4 Visits	
COBRA Administration	Blue Cross of Idaho		Blue Cross of Idaho		Blue Cross of Idaho	

**** Enhanced Rx For Preventive Drugs***

***** Walgreens is NOT In Network for Prescriptions***

******BC is not longer using MD Live for telehealth services. You can access the telehealth service through your provider at the copayment cost.***

SPECIAL ENROLLMENT RIGHTS

If you are declining enrollment for yourself or your dependents because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan (with qualifying event), provided that you request enrollment within 30 days after your other coverage ends. In addition, if you are enrolled and have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll your newly acquired dependents, provided that you request enrollment within 60 days after the marriage, birth, adoption, or placement for adoption.

THINKING ABOUT RETIRING?

If you want to utilitze medical, vision, and/or dental insurance coverage after you retire - you and/or dependents must be covered on the district's medical, vision, and/or dental plan for at least 12 months prior to your retirement date.

OPTIONAL VISION Blue Cross VSP Option
Exam Co-Pay $10 every 12 months
Lenses/Frames Co-Pay $25.00
Frames: $130 Allowance Every 24 months
Contact Lenses: $130 Every 12 months

OPTIONAL DENTAL Blue Cross Dental
Traditional PPO $50
Deductible $50
Preventive 100%
Basic 80%
Major 50%
Implants 50%
Annual Max $1250
No Orthodontics

OPTIONAL DENTAL Dental Blue Connect
Willamette
No Deductible/No Annual Maximum
$15 Office Visit covers: Routine & Emergency Exams, Xrays, Teeth Cleaning, Fluoride Treatment, Sealants, Head & Neck Cancer Screening, Oral Hygiene Instruction, Periodontal Charting & Evaluation
$15 Filling copayment
$150 Porcelain-Metal Crown
$200 Complete Upper or Lower Denture
$150 Bridge/per tooth
$50 copay for Root Canal Therapy $75 copay for Osseous Surgery $25 copay for Root Planing
$15 copay - Routine Extraction $75 copay - Surgical Extraction
Orthodontia: Pre-Treatment $150 Comprehensive Treatment $1500
Must use Willamette Dental Providers