

# Lewiston Independent School District #1

September 1, 2022 - August 31, 2023

## Employee **BENEFITS** *at-a-glance*

Medical Plan Options: Idaho School Benefit Trust	Option 1 Basic Plan \$1,500	Option 2 Optional Plan \$3,000
<b>Network</b>	Blue Cross of Idaho PPO	Blue Cross of Idaho PPO
<b>Deductible:</b> The amount you owe for covered services before your health insurance begins to pay.	<b>\$1,500 Individual</b> <b>\$3,000 Family</b>	<b>\$3,000 Individual</b> <b>\$6,000 Family</b>
<b>Coinsurance:</b> The percentage your insurance will pay after you meet your deductible.	<b>Plan pays 70% / You pay 30%</b>	<b>Plan pays 70% / You pay 30%</b>
<b>Out-of-Pocket Maximum:</b> The maximum amount the member pays in a calendar year for in-network covered services, which includes the Deductible, Coinsurance, & physician copays.	<b>\$5,500 Individual</b> <b>\$11,000 Family</b>	<b>\$5,500 Individual</b> <b>\$11,000 Family</b>
<b>Office Visit Copays: (Per Visit)</b>	<b>ChoiceDocs</b>   <b>All other PPO</b>	<b>ChoiceDocs</b>   <b>All other PPO</b>
<b>Primary Care Physician</b>	<b>\$0 Copay</b>	<b>\$20 Copay</b>
<b>Specialist</b>	<b>\$20 Copay</b>	<b>\$40 Copay</b>
<b>Preventive Care</b>	<b>Covered 100%</b>	<b>Covered 100%</b>
<b>Diagnostic Laboratory &amp; X-Ray</b>	First \$100 covered in full, then Ded + Coins	First \$100 covered in full, then Ded+Coins
<b>Maternity</b>	<b>Ded+Coins</b>	<b>Ded+Coins</b>
<b>Hospital (Inpatient / Outpatient)</b>	<b>Ded+Coins</b>	<b>Ded+Coins</b>
<b>Prescription: (Six-Tier Formulary)</b>		
Tier 1: Preferred Generic	<b>\$10 Copay</b>	<b>\$10 Copay</b>
Tier 2: Non-Preferred Generic	<b>\$20 Copay</b>	<b>\$20 Copay</b>
<b>Brand Name Deductible Per Member:</b>	<b>\$250 Rx Deductible</b>	<b>\$250 Rx Deductible</b>
Tier 3: Preferred Brand-Name	\$30 copay after Rx Deductible	\$30 copay after Rx Deductible
Tier 4: Non-Preferred Brand-Name	\$50 Copay after Rx Deductible	\$50 Copay after Rx Deductible
Tier 5: Generic & Preferred Specialty	20% after Rx Deductible	20% after Rx Deductible
Tier 6: Non-Preferred Specialty	30% after Rx Deductible	30% after Rx Deductible
<b>Rx Out-of-Pocket Maximum</b>	<b>\$1,000 Individual / \$2,000 Family</b>	<b>\$1,000 Individual / \$2,000 Family</b>

Dental Plan Options: (choose one)			
Delta Dental of Idaho		Dental Blue Connect (Willamette)	
Network	PPO / Premier	Network	Willamette Clinic Only
Deductible	\$25 Ind. / \$75 Fam	Office Visit Copay	\$20 Copay Per Visit
Annual Plan Maximum	\$1,250 / \$1,000	Annual Plan Maximum	None
Preventive Services	100% / 80%	Exam/Cleaning/X-Rays/Sealants	Covered 100% after Office Visit Copay
Basic Services	80% / 70%	Fillings / Simple Extractions	\$20 Copay
Major Services	60% / 40%	Crowns/Bridge	\$250 Copay (per tooth)
Orthodontia	Discount program only	Root Canal	\$100 - \$175 Copay
		Surgical Extraction	\$100 Copay
		Complete Orthodontia	\$2,000 Copay

United Heritage Vision	
Network	VSP
<b>Eye Exam</b>	<b>\$10 Copay</b> Covered in full - every 12 months
<b>Materials</b>	<b>\$25 Copay</b>
Lenses	Covered in full - every 12 months (Single, bifocal, trifocal)
<b>Frames</b>	<b>\$130 Allowance - every 24 months</b> \$70 Allowance (Costco, Walmart, Sam's Club)
Contacts Lenses (instead of frames)	\$130 Allowance - every 12 months

Employee Assistance Program (EAP)
<b>RBH</b>
In-Person Counseling
Up to 4 face-to-face sessions per issue / per member
Call RBH for referral to local provider:
<b>866.750.1327</b>
Online Work/Life Resources: MyRBH.com
Access Code: <b>ISD1</b>