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

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)
		Root Canal	$100 - $175 Copay
Orthodontia	Discount program only	Surgical Extraction	$100 Copay
		Complete Orthodontia	$2,000 Copay

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

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