Moscow School District
Benefits Summary
2024

Regence BlueShield of Idaho

Medical	Plan 1 *	Plan 2 *	Plan 3 *	Plan 4 *
Plan Type	Innova	Preferred	Innova	Preferred
Network	Preferred	Preferred	Preferred	Preferred
Annual Deductible	$300 per individual $600 per family	$0 per individual $0 per family	$1,000 per individual $2,000 per family	$2,500 per individual $5,000 per family
Annual Out-of-Pocket Maximum	$1,800 per individual $3,600 per family	$6,350 per individual $12,700 per family	$3,500 per individual $7,000 per family	$5,000 per individual $10,000 per family
Coinsurance	20%	50%	20%	25%
Office Visit	$20	50%	$25	$35
MDLive (Telehealth)	$10	$10	$10	$10
Preventive Care	No charge	No charge	No charge	No charge
Emergency Room	$75, then 20% after the deductible	$75, then 50%	$75, then 20% after the deductible	$150, then 25% after the deductible
Urgent Care Copay	$20	50%	$25	$35
Diagnostic Test (x-ray, blood work)	Outpatient: No charge for the first $600 per year, then 20% after the deductible	Outpatient: 50%	Outpatient: No charge for the first $600 per year, then 20% after the deductible	Outpatient: 25% after the deductible
	Inpatient: 20% after the deductible	Inpatient: 50%	Inpatient: 20% after the deductible	Inpatient: 25% after the deductible 50%
Imaging (CT/PET scans, MRIs)	Outpatient: No charge for the first $600 per year, then 20% after the deductible	Outpatient: 50%	Outpatient: No charge for the first $600 per year, then 20% after the deductible	Outpatient: 25% after the deductible
	Inpatient: 20% after the deductible	Inpatient: 50%	Inpatient: 20% after the deductible	Inpatient: 25% after the deductible 50%
Rehabilitation *Limited to 42 inpatient days per year or 30 outpatient visits per year*	20% after the deductible	50%	20% after the deductible	25% after the deductible
Skilled Nursing Facility *Limited to 60 inpatient days per year*	20% after the deductible	50%	20% after the deductible	25% after the deductible
Mental Health, Behavioral Health, or Substance Abuse Services	Outpatient: $20 Inpatient: 20% after the deductible	Outpatient: 50% Inpatient: 50%	Outpatient: $25 Inpatient: 20% after the deductible	Outpatient: $35 Inpatient: 25% after the deductible
Neurodevelopmental Therapy *Limited to 28 visits per year*	20% after the deductible	50%	20% after the deductible	25% after the deductible
Orthotics	20% after the deductible	50%	20% after the deductible	25% after the deductible
Prosthesis	20% after the deductible	50%	20% after the deductible	25% after the deductible
Durable Medical Equipment	20% after the deductible	50%	20% after the deductible	25% after the deductible
TMJ	20% after the deductible	50%	20% after the deductible	25% after the deductible
Transplants	20% after the deductible	50%	20% after the deductible	25% after the deductible
Prescription Drug Deductible	$0	$0	$0	$100 per individual; waived for Tier 1
Prescription Drugs (Tier 1 / Tier 2 / Tier 3)	$10 / $30 / $50	$10 / $30 / $60	$10 / $30 / $50	$10 / $30 / $50
Pharmacy MAC	MAC B	MAC B	MAC B	MAC A
Chiropractic Care *Limited to 12 visits per year*	20%	50%	20%	25%
Employee Assistance Program (EAP) *Limited to 8 counseling sessions per year*	No charge	No charge	No charge	No charge
Included Care Management Programs	Disease Management BabyWise/Bump2Baby MedSavvy Advice24 Physical Medicine - PT/ST/OT, Spine & CAM Physical Medicine - Joint surgery & replacement Physical Medicine - Pain Intervention Advanced Imaging Authorization Site of Care Infusion Sleep Program	Disease Management BabyWise/Bump2Baby MedSavvy Advice24 Physical Medicine - PT/ST/OT, Spine & CAM Physical Medicine - Joint surgery & replacement Physical Medicine - Pain Intervention Advanced Imaging Authorization Site of Care Infusion Sleep Program	Disease Management BabyWise/Bump2Baby MedSavvy Advice24 Physical Medicine - PT/ST/OT, Spine & CAM Physical Medicine - Joint surgery & replacement Physical Medicine - Pain Intervention Advanced Imaging Authorization Site of Care Infusion Sleep Program	Disease Management BabyWise/Bump2Baby MedSavvy Advice24 Physical Medicine - PT/ST/OT, Spine & CAM Physical Medicine - Joint surgery & replacement Physical Medicine - Pain Intervention Advanced Imaging Authorization Site of Care Infusion Sleep Program
Vision Exam Copay	$10	$10	$10	$10

Delta Dental of Idaho & Willamette Dental

Delta Dental of Idaho	Delta Dental		N/A	Delta Dental		Delta Dental	
Annual Deductible	$25 per individual / $75 per family			$25 per individual / $75 per family		$25 per individual / $75 per family	
Network	PPO	Premier		PPO	Premier	PPO	Premier
Preventive	0%	20%		0%	20%	0%	20%
Basic	20%	30%		20%	30%	20%	30%
Major	50%	60%		50%	60%	50%	60%
Annual Benefit Maximum	$1,250	$1,000		$1,250	$1,000	$1,250	$1,000
Rollover Amount	$3,050	$2,500		$3,050	$2,500	$3,050	$2,500

Willamette Dental	Willamette Dental	N/A	Willamette Dental	Willamette Dental
Annual Deductible	None		None	None
Office Visit	$15		$15	$15
Crowns & Bridges	$175		$175	$175
Complete Upper or Lower Denture	$250		$250	$250
Root Canal Therapy	$75 - $125		$75 - $125	$75 - $125
Orthodontics (Adult & Children)	$1,800		$1,800	$1,800
Maximums & Waiting Periods	None		None	None

2024 Rates with Delta Dental of Idaho *Combined Medical / Delta Dental / Vision*	***Effective January 1, 2024***			
Employee	$870.21	$439.80	$773.41	$673.41
Employee & Spouse	$1,562.99	$888.50	$1,389.09	$1,209.59
Employee & 1 Child	$1,144.20	$571.50	$1,018.20	$887.40
Employee & 2 Children	$1,428.86	$703.20	$1,263.66	$1,102.06
Employee & 3+ Children	$1,671.96	$834.90	$1,487.56	$1,295.16
Employee, Spouse & 1 Child	$1,836.98	$1,020.20	$1,633.88	$1,423.58
Employee, Spouse & 2 Children	$2,121.62	$1,151.90	$1,879.32	$1,638.22
Employee, Spouse & 3+ Children	$2,364.72	$1,283.60	$2,103.22	$1,831.32

2024 Rates with Willamette Dental *Combined Medical / Willamette Dental / Vision*	***Effective January 1, 2024***			
Employee	$875.30	$439.80	$778.50	$678.50
Employee & Spouse	$1,573.20	$888.50	$1,399.30	$1,219.80
Employee & 1 Child	$1,152.30	$571.50	$1,026.30	$895.50
Employee & 2 Children	$1,440.10	$703.20	$1,274.90	$1,113.30
Employee & 3+ Children	$1,683.20	$834.90	$1,498.80	$1,306.40
Employee, Spouse & 1 Child	$1,850.20	$1,020.20	$1,647.10	$1,436.80
Employee, Spouse & 2 Children	$2,138.00	$1,151.90	$1,895.70	$1,654.60
Employee, Spouse & 3+ Children	$2,381.10	$1,283.60	$2,119.60	$1,847.70

** The benefits listed assume that you use a Preferred Provider. You may pay more for Participating and Nonparticipating Providers. Please refer to the Summary of Benefits & Coverage (SBC) or medical Booklet for specific plan details.*