Blue Cross of Idaho
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ISBT HDHP PPO BENEFITS OUTLINE Visit our Website at www.bcidaho.com to locate a Contracting Provider		
Canyon Owyhee : Effective Date: 09/01/2023		
Deductibles (per Benefit Period) *This Plan has a calendar year Deductible* *With the exception of certain Preventive Care services, no payment is due from BCI under this Plan until the Deductible is met.* **Individual** **Family** *(No Participant may contribute more than the Individual Deductible toward the Family Deductible)*	**In-Network** **The Participant is responsible to pay these amounts:** **$3,000** **$6,000**	**Out-of-Network**
Out of Pocket Limits (per Benefit Period) *This Plan has a calendar year Out-of-Pocket Limit. Includes applicable Deductible, Copayments and Cost Sharing.* *(See Plan for services that do not apply to the limit.)* **Individual** **Family** *(No Participant may contribute more than the Individual Out-of-Pocket amount toward the Family Out-of-Pocket Limit)*	**$5,800** **$11,600**	
Cost Sharing *Unless specified otherwise below, the Participant pays the following Cost Sharing amount*	30% of Maximum Allowance after Deductible	50% of Maximum Allowance after Deductible
Frequently used Covered Services - *Some services may require Prior Authorization.*		
Physician Office Visits	Deductible and Cost Sharing	Deductible and Cost Sharing
Pediatric Physician Office Visits (*For Participants under the age of eighteen (18). Includes Urgent Care visits. The following additional services are included in the Pediatric Physician Office Visit: mononucleosis testing, strep A and B testing, development screening(s), ear wax removal, removal of foreign body from ear, urine pregnancy tests, influenza A or B test, rapid RSV test, and pulse oximetry.* *All other additional services, such as laboratory, x-ray, and other Diagnostic Services are not included in the Pediatric Physician Office Visit Copayment.)*	No Charge after Deductible, per visit. No Copayment required	Deductible and Cost Sharing
Preventive Care Covered Services *(Annual adult physical examinations; routine or scheduled well-baby and well-child examinations, including vision, hearing and developmental screenings; Dental fluoride application for Participants age 5 and under; Bone Density; Chemistry Panels; Cholesterol Screening; Colorectal Cancer Screening; Complete Blood Count (CBC); Diabetes Screening; Pap Test; PSA Test; Rubella Screening; Screening EKG; Screening Mammogram; Thyroid Stimulating Hormone (TSH); Transmittable Diseases Screening (Chlamydia, Gonorrhea, Human Immunodeficiency Virus (HIV), Human papillomavirus (HPV); Syphilis, Tuberculosis (TB)); Hepatitis B Virus*	No Charge (Deductible does not apply)	Deductible and Cost Sharing

Screening; Sexually Transmitted Infections assessment; HIV assessment; Screening and assessment for interpersonal and domestic violence; Urinalysis (UA); Abdominal Aortic Aneurysm Screening and Ultrasound; Unhealthy Alcohol and Drug Use Assessment; Breast Cancer (BRCA Risk Assessment and Genetic Counseling and testing for High Risk Family History of Breast or Ovarian Cancer; Newborn Metabolic Screening (PKU, Thyroxine, Sickle Cell); Health Risk Assessment for Depression; Newborn Hearing Test; Lipid Disorder Screening; Nicotine, Smoking and Tobacco-use Cessation Counseling Visit; Dietary Counseling and Physical Activity Behavioral Counseling; Behavioral Counseling for Participants who are overweight or obese; Preventive Lead Screening; Lung Cancer Screening for Participants age 50 and over, Hepatitis C Virus Infection Screening; Urinary Incontinence Screening. Urine Culture for Pregnant Women; Iron Deficiency Screening for Pregnant Women; Rh (D) Incompatibility Screening for Pregnant Women; Diabetes Screening for Pregnant Women; Perinatal Depression Counseling and Intervention; Behavioral Counseling for Healthy Weight and Weight Gain in Pregnancy. *The specifically listed Preventive Care Services may be adjusted accordingly to coincide with federal government changes, updates, and revisions.* **For services not specifically listed**	Deductible and Cost Sharing	Deductible and Cost Sharing
Immunizations Acellular Pertussis, Diphtheria, Haemophilus Influenza B, Hepatitis B, Influenza, Measles, Mumps, Pneumococcal (pneumonia), Poliomyelitis (polio), Rotavirus, Rubella, Tetanus, Varicella (Chicken Pox), *Hepatitis A, Meningococcal, Human papillomavirus (HPV) and Zoster.* *All Immunizations are limited to the extent **recommended** by the Advisory Committee on Immunization Practices (ACIP) and may be adjusted accordingly to coincide with federal government changes, updates and revisions.* Other immunizations not specifically listed may be covered at the discretion of BCI when Medically Necessary.	No Charge (Deductible does not apply) Deductible and Cost Sharing	No Charge (Deductible does not apply) Deductible and Cost Sharing

TELEHEALTH SERVICES	
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. Please see the appropriate section of the Benefits Outline for those terms.

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PRESCRIPTION DRUG BENEFITS	
• The Formulary will be made available to any Participant on request by contacting our Blue Cross of Idaho Customer Service Department at (208) 331-7347 or (800) 627-1188. • Each non-Specialty Prescription Drug shall not exceed a 90 day supply at one (1) time. • Each Specialty Prescription Drug shall not exceed a 30 day supply at one (1) time. • Prescription Drug Services apply to the In-Network Out-of-Pocket Limits.	
RETAIL OR BCI MAIL ORDER PHARMACIES	
Tier 1 - Preferred Generic Drugs **Tier 2 - Non-Preferred Generic Drugs** **Tier 3 - Preferred Brand Name Drugs** **Tier 4 - Non-Preferred Brand Name Drugs** **Tier 5 - Preferred Specialty Drugs, and Generic Specialty Drugs** **Tier 6 - Non-Preferred Specialty Drugs**	No charge, after the Individual/Family Deductible is met
ACA Preventive Prescription Drugs	No Charge
HSA Preventive Prescription Drugs	No Charge
Prescribed Contraceptives	No Charge
Note: Certain Prescription Drugs have generic equivalents. If the Participant requests a Brand Name Drug, the Participant is responsible for the difference between the price of the Generic Drug and the Brand Name Drug, regardless of the Preferred or Non-Preferred status.	

COVERED SERVICES *Some services may require Prior Authorization.*	**In-Network**	**Out-of-Network**
	The Participant is responsible to pay these amounts:	
Ambulance Transportation Service • **Ground Ambulance Services**	Deductible and Cost Sharing	Deductible and Cost Sharing
• **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	In-Network Deductible and In-Network Cost Sharing
Breastfeeding Support and Supply Services *(Includes rental and/or purchase of manual or electric breast pumps. Limited to one (1) breast pump purchase per Benefit Period, per Participant.)*	No Charge (Deductible does not apply)	Deductible and Cost Sharing
Chiropractic Care Services *Up to a combined In-Network and Out of-Network total of 18 visits per Participant, per Benefit Period.*	Deductible and Cost Sharing	Deductible and Cost Sharing
Dental Services Related to Accidental Injury	Deductible and Cost Sharing	Deductible and Cost Sharing
Diabetes Self-Management Education Services - Outpatient	Deductible and Cost Sharing	Deductible and Cost Sharing
Diagnostic Services *(Including diagnostic mammograms)*	Deductible and Cost Sharing	Deductible and Cost Sharing
Durable Medical Equipment, Orthotic Devices and Prosthetic Appliances	Deductible and Cost Sharing	Deductible and Cost Sharing
Emergency Services – Facility Services *(Copayment waived if admitted)* *(Payment for Out-of-Network Emergency Services is based on the Qualifying Payment Amount.)*	$100 Copayment per 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 – 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.	

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COVERED SERVICES *Some services may require Prior Authorization.*	In-Network	Out-of-Network
	The Participant is responsible to pay these amounts:	
Home Health Skilled Nursing Care Services	Deductible and Cost Sharing	Deductible and Cost Sharing
Home Intravenous Therapy	Deductible and Cost Sharing	Deductible and 80% Cost Sharing
Hospice Services	No Charge after Deductible	Deductible and Cost Sharing
Hospital Services	Deductible and Cost Sharing	Deductible and Cost Sharing
Inpatient Rehabilitation or Habilitation Services	Deductible and Cost Sharing	Deductible and Cost Sharing
Maternity Services and/or Involuntary Complications of Pregnancy	Deductible and Cost Sharing	Deductible and Cost Sharing
Mental Health and Substance Use Disorder Inpatient and Outpatient Services • **Facility and Professional Services** • **Pediatric Outpatient Psychotherapy Services** *(For Participants under the age of eighteen (18).)*	Deductible and Cost Sharing No Charge after Deductible, per visit. No Copayment required	Deductible and Cost Sharing
Outpatient Applied Behavioral Analysis (ABA) • **Pediatric Outpatient Applied Behavioral Analysis (ABA)** *(For Participants under the age of eighteen (18).)*	Deductible and Cost Sharing No Charge after Deductible, per visit. No Copayment required	Deductible and Cost Sharing
Treatment for Autism Spectrum Disorder	Covered the same as any other illness, depending on the services rendered. Please see the appropriate section of the Benefits Outline. Visit limits do not apply to Treatments for Autism Spectrum Disorder, and related diagnoses.	
Outpatient Cardiac Rehabilitation Services *Up to a combined In-Network and Out-of-Network total of 36 visits per Participant, per Benefit Period.*	Deductible and Cost Sharing	Deductible and Cost Sharing
Outpatient Habilitation Therapy Services • Outpatient Occupational Therapy • Outpatient Physical Therapy • Outpatient Speech Therapy *Up to a combined In-Network and Out-of-Network total of 20 visits per Participant, per Benefit Period*	Deductible and Cost Sharing	Deductible and Cost Sharing
Outpatient Rehabilitation Therapy Services • Outpatient Occupational Therapy • Outpatient Physical Therapy • Outpatient Speech Therapy *Up to a combined In-Network and Out-of-Network total of 20 visits per Participant, per Benefit Period*	Deductible and Cost Sharing	Deductible and Cost Sharing
Palliative Care Services	No Charge after Deductible	Deductible and Cost Sharing
Post-Mastectomy/Lumpectomy Reconstructive Surgery	Deductible and Cost Sharing	Deductible and Cost Sharing
Prescribed Contraceptive Services *(Includes diaphragms, intrauterine devices (IUDs), implantables, injections and tubal ligation)*	No Charge (Deductible does not apply)	Deductible and Cost Sharing
Skilled Nursing Facility *Up to a combined In-Network and Out-of-Network total of 30 days per Participant, per Benefit Period*	Deductible and Cost Sharing	Deductible and Cost Sharing
Sleep Study Services	Deductible and Cost Sharing	Deductible and Cost Sharing
Surgical/Medical (Professional Services)	Deductible and Cost Sharing	Deductible and Cost Sharing

COVERED SERVICES *Some services may require Prior Authorization.*	In-Network	Out-of-Network
	The Participant is responsible to pay these amounts:	
Therapy Services *(Including Radiation, Chemotherapy, Renal Dialysis and Growth Hormone)*	Deductible and Cost Sharing	Deductible and Cost Sharing
Transplant Services	Deductible and Cost Sharing	Deductible and Cost Sharing
Be aware that your actual costs for services provided by an Out-of-Network Provider may exceed this Plan's Out-of-Pocket Limit for Out-of-Network services. Except as provided by the No Surprises Act, Out-of-Network Providers can bill you for the difference between the amount charged by the Provider and the amount allowed by Blue Cross of Idaho, and that amount is not counted toward the Out-of-Network Out-of-Pocket Limit.		