Blue Cross of Idaho
An Independent Licensee of the Blue Cross and Blue Shield Association

ISBT PPO BENEFITS OUTLINE Visit our Website at www.bcidaho.com to locate a Contracting Provider		
Canyon Owyhee: Effective Date: 9/01/2023		
Deductibles (per Benefit Period)	**In-Network**	**Out-of-Network**
	The Participant is responsible to pay these amounts:	
Individual	**$1,000**	
Family *(No Participant may contribute more than the Individual Deductible amount toward the Family Deductible)*	**$2,000**	
Out-of-Pocket Limits (per Benefit Period) *(See Plan for services that do not apply to the limit)* *(Includes applicable Deductible, Cost Sharing and Copayments)* **Individual** **Family** *(No Participant may contribute more than the Individual Out-of-Pocket Limit amount toward the Family Out-of-Pocket Limit)*	***$4,000*** ***$8,000***	***$6,000*** ***$12,000***
Cost Sharing *Unless specified otherwise below, the Participant pays the following Cost Sharing amount*	10% of Maximum Allowance after Deductible	30% of Maximum Allowance after Deductible
Frequently used Covered Services - *Some services may require Prior Authorization.*		
Physician Office Visits • **ChoiceDocs In-Network Providers** *Additional services, such as laboratory, x-ray, and other Diagnostic Services are not included in the Office Visit.* • **All Other In-Network Providers** *Additional services, such as laboratory, x-ray, and other Diagnostic Services are not included in the Office Visit.*	$0 Copayment per visit for ChoiceDocs Primary Care Provider. $20 Copayment per visit for ChoiceDocs Specialist Provider (non-Primary Care Provider) $20 Copayment per visit for In-Network Primary Care Provider. $40 Copayment per visit for In-Network Specialist Provider (non-Primary Care Provider)	Deductible and Cost Sharing
Pediatric Physician Office Visits (*For Participants under the age of eighteen (18). Includes Urgent Care visits. Includes 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 not listed above, such as laboratory, x-ray, and other Diagnostic Services are not included in the Pediatric Physician Office Visit Copayment.)*	No Charge (Deductible does not apply)	Deductible and Cost Sharing

This information is for comparison purposes only and not a complete description of benefits. All descriptions of coverage are subject to the provisions of the corresponding plan, which contains all the terms and conditions of coverage and exclusions and limitations. Certain services not specifically noted may be excluded. Please refer to the plan issued for a complete description of benefits, exclusions limitations and conditions of coverage. If there is a difference between this comparison and its corresponding plan, the plan will control.

Blue Cross of Idaho
An Independent Licensee of the Blue Cross and Blue Shield Association

Frequently used Covered Services - *Some services may require Prior Authorization.*		
Preventive Care Covered Services **For specifically listed 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 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.*	No Charge (Deductible does not apply)	Deductible and Cost Sharing
For services not specifically listed	Deductible and Cost Sharing	Deductible and Cost Sharing

This information is for comparison purposes only and not a complete description of benefits. All descriptions of coverage are subject to the provisions of the corresponding plan, which contains all the terms and conditions of coverage and exclusions and limitations. Certain services not specifically noted may be excluded. Please refer to the plan issued for a complete description of benefits, exclusions limitations and conditions of coverage. If there is a difference between this comparison and its corresponding plan, the plan will control.

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.

COVERED SERVICES *Some services may require Prior Authorization.*	**In-Network**	**Out-of-Network**
	The Participant is responsible to pay these amounts:	
Allergy Injections	$5 Copayment per visit if this is the only service provided during the visit	Deductible and Cost Sharing
Ambulance Transportation Service • **Ground Ambulance Services** • **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 Deductible and Cost Sharing	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	Primary Care Provider Copayment per visit	Deductible and Cost Sharing
Diagnostic Services (Outpatient services only) *(Including diagnostic mammograms)*	No charge up to $100 per Participant per Benefit Period (No Deductible required) Covered Services over the annual limit above Deductible and Cost Sharing	Deductible and Cost Sharing
Durable Medical Equipment / Prosthetic Appliances / Orthotics Devices	Deductible and Cost Sharing	Deductible and Cost Sharing

This information is for comparison purposes only and not a complete description of benefits. All descriptions of coverage are subject to the provisions of the corresponding plan, which contains all the terms and conditions of coverage and exclusions and limitations. Certain services not specifically noted may be excluded. Please refer to the plan issued for a complete description of benefits, exclusions limitations and conditions of coverage. If there is a difference between this comparison and its corresponding plan, the plan will control.

Blue Cross of Idaho
An Independent Licensee of the Blue Cross and Blue Shield Association

COVERED SERVICES *Some services may require Prior Authorization.*	**In-Network**	**Out-of-Network**
	The Participant is responsible to pay these amounts:	
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.	
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 (Deductible does not apply)	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 Services • **Inpatient Facility and Professional Services**	Deductible and Cost Sharing	Deductible and Cost Sharing
Mental Health and Substance Use Disorder Outpatient Services • **Outpatient Psychotherapy Services** • **Pediatric Outpatient Psychotherapy Services** *(For Participants under the age of eighteen (18).)* • **Facility and other Professional Services**	 Primary Care Provider Copayment per visit No Charge (Deductible does not apply Deductible and Cost Sharing	Deductible and Cost Sharing
Outpatient Applied Behavioral Analysis (ABA) **Pediatric Outpatient Applied Behavioral Analysis (ABA)** *(For Participants under the age of eighteen (18).)*	Primary Care Provider Copayment per visit No Charge (Deductible does not apply)	Deductible and Cost Sharing
Morbid Obesity *(Up to a combined In-Network and Out of-Network Lifetime Benefit Limit of $5,000, per Participant)*	Deductible and Cost Sharing	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

This information is for comparison purposes only and not a complete description of benefits. All descriptions of coverage are subject to the provisions of the corresponding plan, which contains all the terms and conditions of coverage and exclusions and limitations. Certain services not specifically noted may be excluded. Please refer to the plan issued for a complete description of benefits, exclusions limitations and conditions of coverage. If there is a difference between this comparison and its corresponding plan, the plan will control.

Blue Cross of Idaho
An Independent Licensee of the Blue Cross and Blue Shield Association

COVERED SERVICES *Some services may require Prior Authorization.*	**In-Network**	**Out-of-Network**
	The Participant is responsible to pay these amounts:	
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 (Deductible does not apply)	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
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.		

This information is for comparison purposes only and not a complete description of benefits. All descriptions of coverage are subject to the provisions of the corresponding plan, which contains all the terms and conditions of coverage and exclusions and limitations. Certain services not specifically noted may be excluded. Please refer to the plan issued for a complete description of benefits, exclusions limitations and conditions of coverage. If there is a difference between this comparison and its corresponding plan, the plan will control.