Applies to **non-grandfathered** individual and group plans

Highlights of your preventive care benefits:

- You pay nothing; no coinsurance, copayment or deductible, for covered preventive care services when you visit in-network providers.
- Preventive care benefits for services from out-of-network providers are subject to your out-of-network benefit.
- Updates for 2019: Colorectal Cancer Screenings was updated to remove the specifically listed procedures. Urinary Incontinence Screening was added. Preeclampsia screening was added.

Covered Preventive Care Services	In-Network	Out-of-Network
Specifically Listed 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 younger; 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); Urinary Incontinence Screening; Aortic aneurysm ultrasound; Alcohol misuse 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; Smoking cessation counseling visit; Dietary counseling (limited to three visits per participant, per benefit period); Behavioral counseling for participants who are overweight or obese; Preventive lead screening; Lung cancer screening for participants age 55 and older; Hepatitis C virus infection screening. For Groups who offer maternity coverage to enrollees and enrolled eligible dependent spouses: Gestational diabetes screening for pregnant women; Iron deficiency screening for pregnant women; Rh (D) incompatibility screening for pregnant women; and Urine culture for pregnant women; preeclampsia screening.	You pay nothing of the allowed amount for specifically listed preventive care services per person, per benefit period. No copayment, deductible or coinsurance required.	You pay costs subject to your out-of-network benefit.
Women's Preventive Health Services (Applies to group and individual plan members unless otherwise noted.)	**In-Network**	**Out-of-Network**
Well Woman visits (for recommended age-appropriate preventive services); breastfeeding support, supplies and counseling.	You pay nothing of the allowed amount for specifically listed preventive care services per person, per benefit period. No copayment, deductible or coinsurance required.	You pay costs subject to your out-of-network benefit.
For Groups that offer Prescribed Contraceptive Coverage: Blue Cross of Idaho pays 100 percent for women's preventive prescription drugs and devices as specifically listed on the Blue Cross of Idaho website, ***bcidaho.com***; deductible does not apply. The day supply allowed shall not exceed a 90-day supply at one time, as applicable to the specific contraceptive drug or supply.		
Prescribed Contraceptive Services Includes diaphragms, intrauterine devices (IUDs), implantables, injections and tubal ligation		

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<table>
<tr><th>Immunizations</th><th>In-Network</th><th>Out-of-Network</th></tr>
<tr><td>Accellular Pertussis, Diphtheria, Hemophilus 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.</td><td colspan="2">You pay nothing for specifically listed immunizations.

No copayment, deductible or coinsurance required.</td></tr>
<tr><td>Other immunizations not specifically listed may be covered when Medically Necessary and approved by the Blue Cross of Idaho Pharmacy and Therapeutics Committee.</td><td>You pay costs subject to your in-network benefit.</td><td>You pay costs subject to your out-of-network benefit.</td></tr>
</table>

Please Note: Your provider must bill these services as preventive/wellness services.

The specifically listed preventive care services may be adjusted accordingly to coincide with federal government changes, updates, and revisions.

The descriptions above are general in nature, to allow for an overall view of Blue Cross of Idaho's preventive care coverage.
For complete descriptions of your policy and policy changes, please read your contract and contract amendment language.