MEDICAL/VISION + PRESCRIPTION COVERAGE

JANUARY 1, 2023

MEDICAL/VISION

	ST. LUKE'S HEALTH PARTNERS (SLHP)		BLUE CROSS OF IDAHO PPO (BCI)	
	IN NETWORK	OUT OF NETWORK	IN NETWORK	OUT OF NETWORK
DEDUCTIBLE	$300 Individual		$350 Individual	
	$600 Family		$700 Family	
OUT OF POCKET	$2,000 Individual	$3,000 Individual	$2,500 Individual	$5,000 Individual
	$4,000 Family		$5,000 Family	
AMBULANCE SERVICES	80% Billed after deductible	60% Billed after deductible	80% Billed after deductible	60% Billed after deductible
CHIROPRACTIC AND/OR ACUPUNCTURE/ NATUROPATH *(Limited to 23 visits per benefit period)*	80% after deductible	60% after deductible	80% after deductible	60% after deductible
DIABETES PREVENTION PROGRAM	Free 16-week program for prediabetics to reduce risk of developing diabetes. Log in to members.bcidaho.com to see if you qualify.			
DIAGNOSTIC SERVICES	80% after deductible	60% after deductible	80% after deductible	60% after deductible
DURABLE MEDICAL EQUIPMENT	80% after deductible	60% after deductible	80% after deductible	60% after deductible
EMERGENCY SERVICES	80% billed after deductible		80% billed after deductible	
HEARING AIDS *(Hardware and exams)*	100% to $3,000 per year; Bal @10%, ***In-Network Only,*** Does not apply to deductible or OOP"			
HOSPICE SERVICES	100%	60%	100%	60% after deductible
HOSPITAL SERVICES *(Inpatient or Outpatient)*	80% after deductible	60% after deductible	80% after deductible	60% after deductible
INPATIENT OR OUTPATIENT PHYSICAL, SPEECH + OCCUPATIONAL REHAB/THERAPY	80% after deductible	60% after deductible	80% after deductible	60% after deductible
PHYSICIAN OFFICE VISIT *(Additional labs, x-rays, other diagnostic services not included in the copay)*	$0 co-pay	60% after deductible	$20 co-pay	60% after deductible
SPECIALIST PHYSICIAN OFFICE VISIT *(Dermatologist, Endocrinologist, Podiatrist, Otolaryngologist (ear, nose, throat), etc.)*	$30 co-pay	60% after deductible	$40 co-pay	60% after deductible
PREVENTATIVE CARE + IMMUNIZATIONS	100%	60%	100%	60%
MATERNITY SERVICES	80% after deductible	60% after deductible	80% after deductible	60% after deductible
BREASTFEEDING SUPPORT + SUPPLIES *(Includes rental and/or purchase of (1) manual or electric breast pump per benefit period)*	100% of Max Allowance *(Does not apply to Deductible)*	60% of Max Allowance *(Does not apply to deductible)*	100% of Max Allowance *(Does not apply to deductible)*	60% of Max Allowance *(Does not apply to deductible)*
MENTAL HEALTH INPATIENT	80% after deductible	60% after deductible	80% after deductible	60% after deductible
MENTAL HEALTH OUTPATIENT	$0 co-pay	60% after ded.	$20 co-pay	60% after deductible
SUPPLEMENTAL ACCIDENT	100%		100%	
	$500 per incident		$500 per incident	
SURGICAL/MEDICAL *(Professional Services)*	80% after deductible	60% after deductible	80% after deductible	60% after deductible
SURGERY *(Medical Necessary Obesity)*	80% after deductible	60% after deductible	80% after deductible	60% after deductible

PRESCRIPTION DRUG

	ST. LUKE'S HEALTH PARTNERS (SLHP) + BLUE CROSS OF IDAHO PPO (BCI)		
OUT OF POCKET	$3,600 Individual/ $7,200 Family		
GENERIC	$0 co-pay SLHP; $10 co-pay for BCI	PREFERRED SPECIALTY	$75 co-pay
NON-PREFERRED GENERIC		NON-PREFERRED SPECIALTY	$150 co-pay
PREFERRED BRAND NAME	$30 co-pay	RETAIL SUPPLY	90 days for 3 co-pays
NON-PREFERRED BRAND NAME	$60 co-pay	MAIL ORDER	90 days for 2 co-pays

VISION

Ensure you make the most of your **IN-NETWORK** savings by creating your member account at VSP.com.
Refer to your Blue Cross ID Card to enter your member ID (without the preceeding CIJ) to begin.

VSP CHOICE PLAN			
	IN NETWORK		OUT OF NETWORK
EXAMS INCLUDES RETINAL IMAGING	$25 co-pay		Up to $45 less any applicable co-pay
LENSES *(single, lined bifocals/trifocals)*	Covered in full after co-pay		Up to $30 single, $50 bifocal, $65 trifocal
LENS EXTRAS	SINGLE VISION	MULTIFOCAL	
Anti-reflective coating	Covered in Full	Covered in Full	N/A
Polycarbonate Lenses (for children)	Covered in Full	Covered in Full	N/A
Polycarbonate Lenses (for all)	Covered in Full	Covered in Ful	N/A
Standard Progressive Lenses	N/A	Covered in Full	$50
Premium Progressive Lenses	N/A	$95-$105	$50
Custom Progressive Lenses	N/A	$150-$175	$50
Other Lens Options	Average 20-25% off	Average 20-25% off	N/A
FRAMES	$250 Allowance + 20% Remaining		Up to $70
CONTACT LENSES	*Contacts are in lieu of Rx Glasses*		
Fitting + Evaluation	Covered in Full no Copay		Covered in Full no Copay Up to $105 Allowance
Elective Contacts	$250 Allowance (In-Network ONLY)		
Necessary Contacts	Covered in Full		