



MEDICAL/VISION + PRESCRIPTION COVERAGE

JANUARY 1, 2024

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 <i>(Limited to 23 visits per benefit period)</i>	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 <i>(Hardware and exams)</i>	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 <i>(Inpatient or Outpatient)</i>	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 <i>(Additional labs, x-rays, other diagnostic services not included in the copay)</i>	\$0 co-pay	60% after deductible	\$20 co-pay	60% after deductible
SPECIALIST PHYSICIAN OFFICE VISIT <i>(Dermatologist, Endocrinologist, Podiatrist, Otolaryngologist (ear, nose, throat), etc.)</i>	\$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 <i>(Includes rental and/or purchase of (1) manual or electric breast pump per benefit period)</i>	100% of Max Allowance <i>(Does not apply to Deductible)</i>	60% of Max Allowance <i>(Does not apply to deductible)</i>	100% of Max Allowance <i>(Does not apply to deductible)</i>	60% of Max Allowance <i>(Does not apply to deductible)</i>
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 <i>(Professional Services)</i>	80% after deductible	60% after deductible	80% after deductible	60% after deductible
SURGERY <i>(Medical Necessary Obesity)</i>	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 preceding 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 <i>(single, lined bifocals/trifocals)</i>	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 Full	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	<i>Contacts are in lieu of Rx Glasses</i>			
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			