University of Idaho
Benefit Services

2024 Preventive Care & Wellness Benefits At-a-Glance

This University of Idaho Active Health plan provides coverage for certain Preventive Services as required by the Patient Protection and Affordable Care Act of 2010. Coverage is provided on an in-network basis only, with no cost- sharing (for example, no deductibles or copayments), for the following services:

- Services described in the United States Preventive Services Task Force (USPSTF) A and B recommendations,
- Services described in guidelines issued by the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control (CDC), and
- Health Resources and Services Administration (HRSA) guidelines including the American Academy of Pediatrics *Bright Futures* guidelines and HRSA guidelines relating to services for women.
- In-network preventive services that are identified by the Plan as part of the ACA guidelines will be covered with no cost-sharing by the participant or dependent. This means that the service will be covered at 100% of the Plan's allowable charge, with no copayment or deductible.

Covered services are only available from in-network providers and include, but are not limited to, the following:

- **Adult examinations** – Annual physical examinations including Pap tests, fecal occult blood test, PSA tests, cholesterol panel, chemistry panel, diabetes screening, urinalysis, complete blood count, bone density, tuberculosis skin or tine test, thyroid stimulating test, uric acid, GGT (liver function test), screening EKG, preventive screening mammogram, colorectal cancer screening, one routine wellness hearing exam per year, thyroid stimulating hormone, transmittable disease screening (Chlamydia, Gonorrhea, HIV, Syphilis, Tuberculosis), aortic aneurysm ultrasound, alcohol misuse assessment, genetic counseling for high-risk family history of breast or ovarian cancer, health risk assessment for depression, lipid disorder screening, smoking and tobacco use tobacco cessation counseling visit, dietary counseling (up to three visits per year), urinary incontinence screening.
- **Women's Preventive Care Services** – Coverage for additional preventive services including breast-feeding support, supplies and counseling, contraception methods and counseling, domestic violence screening, gestational diabetes screening, HIV screening and counseling, Human Papillomavirus testing (beginning at age 30, and every 3 years thereafter), sexually transmitted infections counseling, and well-women visits.
- **Well-baby care and well-child care** – Routine or scheduled well-baby and well-child examinations, including PKU, thyroxine and sickle cell tests, newborn hearing test, and screening examinations for sports physicals.
- **Maternity benefits** – Urine culture, Hepatitis B virus screening, iron deficiency screening, Rh(D) incompatibility screening
- **Immunizations and travel vaccines** – Acellular Pertussis, Cholera, Diphtheria, Hemophilus Influenza B, Hepatitis A, Hepatitis B, Human Papilloma Virus (HPV), Influenza, H1N1, Japanese Encephalitis, Measles, Meningococcal, Mumps, Plague,

Pneumococcal (pneumonia), Poliomyelitis (polio), Rotavirus, Rubella, Tetanus, Typhoid, Typhim VI, Typhus, Varicella (Chicken Pox), Yellow Fever and Zoster.

Coverage of Preventive Services and Vaccines for COVID-19

Effective January 1, 2021, the Plan will cover a preventive service within 15 business days of the date it becomes a **Qualifying Coronavirus Preventive Service** on an in-network basis, without participant cost sharing (such as a copayment, coinsurance, or a deductible), prior authorization, or other medical management requirements.

Effective January 1, 2021, through the end of the **COVID-19 Public Health Emergency**, the Plan will cover a preventive service within 15 business days of the date it becomes a **Qualifying Coronavirus Preventive Service** on an out-of-network basis, without participant cost sharing (such as a copayment, coinsurance, or a deductible), prior authorization, or other medical management requirements. The plan will reimburse an out- of-network provider for the item or service in an amount that the Plan determines is reasonable, as determined in comparison to prevailing market rates for such services. A reasonable amount shall include the amount that the provider would be paid under Medicare for the item or service.