PREVENTIVE CARE BENEFITS		
	In-Network	**Out-of-Network**
For specifically listed Covered Services: *Annual adult physical examinations; routine or scheduled well-baby and well-child examinations, including vision and developmental screenings; Bone Density; Chemistry Panels; Cholesterol Screening; Colorectal Cancer Screening (Colonoscopy, Sigmoidoscopy, Fecal Occult Blood Test); 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)); Sexually Transmitted Infections assessment; HIV assessment; Screening and assessment for interpersonal and domestic violence; Urinalysis (UA); 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 3 visits per Participant, per Benefit Period); Preventive Lead Screening; Lung Cancer Screening for Participants age 55 and over; Hepatitis C Virus Infection Screening; Urine Culture for Pregnant Women; Hepatitis B Virus Screening for Pregnant Women; Iron Deficiency Screening for Pregnant Women; Rh (D) Incompatibility Screening for Pregnant Women; Diabetes Screening for Pregnant Women.* *The specifically listed Preventive Care Services may be adjusted accordingly to coincide with federal government changes, updates, and revisions.*	Plan pays 100% of Maximum Allowance (Deductible does not apply)	Plan pays 60% of Maximum Allowance after Deductible
For services not specifically listed	Plan pays 80% of Maximum Allowance after Deductible	Plan pays 60% of Maximum Allowance after Deductible
	In-Network	**Out-of-Network**
Immunizations *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.*	Listed immunizations require no Copayment, Deductible, or Coinsurance	Listed immunizations require no Deductible or Coinsurance
Other immunizations not specifically listed may be covered at the discretion of BCI when Medically Necessary.	Plan pays 80% of Maximum Allowance after Deductible	Plan pays 60% of Maximum Allowance after Deductible