Basic PPO Medical/Vision/Rx Plan
Boise Municipal Health Care Trust
January 1, 2020

Medical	Basic PPO		Medical
	In Network	Out of Network	
Deductible:	$5,000 Individual		Deductible
	$10,000 Family		
Out of Pocket:	$5,500 Individual	$12,000 Indiv.	Out of Pocket
	$11,000 Individual	$24,000 Indiv.	
Ambulance Services:	70% billed after deductible		Ambulance Services
Chiropractic and/or Acupuncture/Naturopath (Limited to 23 visits per benefit period):	70% after deductible	50% after ded.	Chiropractic and/or Acupuncture/Naturopath (Limited to 23 visits per benefit period)
Diagnostic Services:	70% after deductible	50% after ded.	Diagnostic Services
Durable Medical Equipment:	70% after deductible	50% after ded.	Durable Medical Equipment
Emergency Services:	70% billed after deductible		Emergency Services
Improved Hearing Aids (Hardware & Exams):	100% to $3,000 per year; Bal @10% ***In-Network Only*** *Does not apply to deductible or OOP*		Hearing Aids (Hardware & Exams)
Hospice Services:	100%	50%	Hospice Services
Hospital Services (Inpatient or Outpatient):	70% after deductible	50% after ded.	Hospital Services (Inpatient or Outpatient)
Inpatient or Outpatient Physical, Speech & Occupational Rehab/Therapy:	70% after deductible	50% after ded.	Inpatient or Outpatient Physical, Speech & Occupational Rehab/Therapy
Physician Office Visit: *(Additional labs, x-rays, other diagnostic services, not included in the copay)*	$20 Co-pay	50% after ded.	Physician Office Visit *(Additional labs, x-rays, other diagnostic services, not included in the copay)*
NEW MDLive (Telehealth):	$10 Co-pay		Physician consultation by phone, video, or the MDLive app, 24/7.
Preventive Care & Immunizations:	100%		Preventive Care & Immunizations
Maternity Services:	70% after deductible	50% after ded.	Maternity Services
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)	50% of Max Allowance (Does not apply to Deductible)	Breastfeeding Support & Supplies *(Includes rental and/or purchase of (1) manual or electric breast pump per benefit period)*
Mental Health Inpatient:	70% after deductible	50% after ded.	Mental Health Inpatient
Mental Health Outpatient:	$20 Co-pay	50% after ded.	Mental Health Outpatient
Supplemental Accident:	100% *$500 per incident*		Supplemental Accident
Surgical/Medical (Professional Services):	70% after deductible	50% after ded.	Surgical/Medical (Professional Services)
Surgery (Med Necessary Obesity):	70% after deductible	50% after ded.	Surgery (Med Necessary Obesity)

Prescription Drug	Basic PPO	Prescription Drug
Out of Pocket:	$3,600 Individual/$7,200 Family	Out of Pocket
Generic:	$10	Generic
Preferred Brand Name:	$20	Preferred Brand Name
Non-Pref Brand/Preferred Specialty:	$40	Non-Preferred Brand/Preferred Specialty
Non-Preferred Specialty:	$55	Non-Preferred Specialty
Retail Supply:	90 days for 3 co-pays	Retail Supply
Mail Order :	90 days for 2 co-pays	Mail Order

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Vision	VSP Choice Plan		
	In Network		Out of Network
Exams, including Retinal Imaging:	$25 Copay		Up to $45 less any applicable copay
Lenses (Single, Lined Bifocals/Trifocals):	Covered in full after copay		Up to $30 single, $50 bifocal, $65 trifocal
Lense 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:	Avg 20-25% off	Avg 20-25% off	N/A
Frames:	$250 Allowance + 20% Remaining		Up to $70
Contact Lenses:			
Fitting & Evaluation	Covered in Full no Copay		Covered in Full no Copay
Elective Contacts	$250 Allowance + 15% Remaining		$105 Allowance
Necessary Contacts	Covered in Full		$210 Allowance