CITY of BOISE
MEDICAL/VISION + PRESCRIPTION COVERAGE

GENERAL EMPLOYEE
JANUARY 1, 2021

MEDICAL/VISION

	PREFERRED PPO		ECONOMY PPO	
	IN NETWORK	OUT OF NETWORK	IN NETWORK	OUT OF NETWORK
DEDUCTIBLE	$300 Individual		$500 Individual	
	$600 Family		$1,000 Family	
OUT OF POCKET	$2,000 Individual	$4,000 Individual	$3,000 Individual	$6,000 Individual
	$4,000 Family		$6,000 Family	
AMBULANCE SERVICES	80% Billed after deductible		70% Billed after deductible	
CHIROPRACTIC AND/OR ACUPUNCTURE/ NATUROPATH *(Limited to 23 visits per benefit period)*	80% after deductible	60% after deductible	70% after deductible	50% 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	70% after deductible	50% after deductible
DURABLE MEDICAL EQUIPMENT	80% after deductible	60% after deductible	70% after deductible	50% after deductible
EMERGENCY SERVICES	80% billed after deductible		70% 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%	50% after deductible
HOSPITAL SERVICES *(Inpatient or Outpatient)*	80% after deductible	60% after deductible	70% after deductible	50% after deductible
INPATIENT OR OUTPATIENT PHYSICAL, SPEECH + OCCUPATIONAL REHAB/THERAPY	80% after deductible	60% after deductible	70% after deductible	50% after deductible
PHYSICIAN OFFICE VISIT *(Additional labs, x-rays, other diagnostic services not included in the copay)*	$20 co-pay	60% after deductible	$20 co-pay	50% after deductible
SPECIALIST PHYSICIAN OFFICE VISIT *(Dermatologist, Endocrinologist, Podiatrist, Otolaryngologist (ear, nose, throat), etc.)*	$30 co-pay	60% after deductible	$30 co-pay	50% after deductible
MDLIVE (TELEHEALTH) *(Physician consult by phone, video or MDLive App 24/7)*	$10 co-pay		$10 co-pay	
PREVENTATIVE CARE + IMMUNIZATIONS	100%		100%	
MATERNITY SERVICES	80% after deductible	60% after deductible	70% after deductible	50% 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)*	50% of Max Allowance *(Does not apply to deductible)*
MENTAL HEALTH INPATIENT	80% after deductible	60% after ded.	70% after deductible	50% after ded.
MENTAL HEALTH OUTPATIENT	$20 Co-pay	60% after ded.	$20 Co-pay	50% after ded.
SUPPLEMENTAL ACCIDENT	100%		100%	
	$500 per incident		$500 per incident	
SURGICAL/MEDICAL *(Professional Services)*	80% after deductible	60% after deductible	70% after deductible	50% after deductible
SURGERY *(Medical Necessary Obesity)*	80% after deductible	60% after deductible	70% after deductible	50% after deductible

PRESCRIPTION DRUG

	PREFERRED + ECONOMY PPO		
OUT OF POCKET	$3,600 Individual/ $7,200 Family		
GENERIC	$10 co-pay	PREFERRED SPECIALTY	$75 co-pay
NON-PREFERRED GENERIC	$10 co-pay	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		