

City of Boise

Benefit Comparison - Police Union - January 1, 2008

	Traditional \$200	POS - HMO Blue	
Medical			
Network	NA	In Network	Out of Network
Deductible			
Individual	\$200	NA	\$500
Family	\$400	NA	NA
Out of Pocket			
Individual	\$1,200	\$1,500	NA
Family	\$1,400	NA	NA
Ambulance Services	80% after deductible	\$50 Air or Ground	60% after ded
Supplemental Accident	100%	\$75 Co-pay	60% after ded
	\$300 per incident	Facility Only	
Hospital Services	80% after deductible	\$200 Co-pay IP \$100 Co-pay OP	60% after ded
Chiropractic	80% after deductible \$1,000 per year	\$10 Co-pay	60% after ded
		\$800 per year	
Diagnostic Services	80% after deductible	No Co-pay	60% after ded
Durable Medical Equipment	80% after deductible	20% Co-pay	60% after ded
InPatient Physical Rehab	80% after deductible (<i>prof serv</i>)	\$200 Co-pay	60% after ded
OutPatient Phys Therapy	80% after deductible	\$10 Co-pay	60% after ded
Physician Office Visit	80% after deductible	\$10 Co-pay	60% after ded
Psychiatric Inpatient	80% - acute 50% - rehab 8 days acute 21 days rehab	20% Co-pay per admit	50% after ded
		8 days per year	
Psychiatric Outpatient	80% after deductible (<i>12 visits/year</i>)	\$25 Co-pay (<i>20 visits/year</i>)	50% after ded
Surgical/Medical Prof	80% after deductible	No Co-pay	60% after ded
Hospice Services	80% after deductible (<i>\$10,000 lifetime</i>)	No Co-pay	60% after ded
Med Necessary Obesity Surg	NA	NA	
Wellness/Preventive	100% to \$500 per year	\$10 Co-pay	No Benefit
<i>Carry Over</i>	<i>last 3 months</i>		
Maximum benefit	\$2,000,000	\$2,000,000	
Applies to Max	All covered services	All covered services	
Prescription Drug			
Generic	\$5	\$5	
Brand	20% to \$50	\$12	
Non Participating	\$25 and 50%	\$5 Generic; \$12 Brand	
Retail Supply	90 days	34 days or 100 unit doses	
Mail Order	\$5/20% to \$50	NA	
Mail Order Supply	90 days	NA	
Dental			
Deductible	\$25	\$25	
Benefit Maximum	\$1,500	\$1,500	
Preventive Service	100%	100%	
Basic Services	80%	80%	
Major Service	50%	50%	
Orthodontia	75% not subject to ded	75% not subject to ded	
Ortho Max	\$2,500	\$2,500	
Vision			
Exams	100% 1 per year	\$10 Copay 1 per year	
Materials	No Benefit	No Benefit	
Contacts	No Benefit	No Benefit	
Employee Cost Share			
Employee Only	\$0.00	\$0.00	
Employee + Spouse (2 party)	\$46.39	\$12.58	
Employee + Child (2 party)	\$46.39	\$12.58	
Employee + Children (family)	\$63.79	\$25.21	
Family	\$63.79	\$25.21	