

**CITY OF OWENSBORO
HEALTH INSURANCE BENEFIT SUMMARY**

	STANDARD		BASIC	
BENEFIT SCHEDULE	In-Network	Out-of-Network	In-Network	Out-of-Network
ANNUAL DEDUCTIBLE	Single \$450 / Family \$900 Excludes Office Visit and RX Co-pays		Single \$750 / Family \$1,500 Excludes Office Visit and RX Co-pays	
ANNUAL OUT OF POCKET MAXIMUM	Single \$1,250 / Family \$2,500 *Co-Pays, Deductibles apply to Out of Pocket Max.In-network and out-of-network out of pocket amounts accumulate toward one another. * Non Network Human Organ and Tissue Transplant Services not included	Unlimited	Single \$1,750 / Family \$3,500 *Co-Pays, Deductibles apply to Out of Pocket Max.In-network and out-of-network out of pocket amounts accumulate toward one another. * Non Network Human Organ and Tissue Transplant Services not included	Unlimited
CO-INSURANCE	Plan Pays: 70% Member Pays: 30%	Plan Pays: 50% Member Pays: 50%	Plan Pays: 60% Member Pays: 40%	Plan Pays: 40% Member Pays: 60%
LIFETIME MAXIMUM	Unlimited		Unlimited	
	Member Responsibility Shown		Member Responsibility Shown	
PHYSICIAN OFFICE VISITS (PRIMARY/SPECIALIST)	\$15 Co-Pay per Office Visit	50%	\$30 Co-pay per Office Visit	60%
PREVENTIVE CARE SERVICES** **As determined by Anthem Preventive Care Guidelines	No Cost Share	50%	No Cost Share	60%
EMERGENCY ROOM	***\$50 co-pay,deductible then 30%	***\$50 co-pay,deductible then 30%	***\$50 co-pay,deductible then 40%	***\$50 co-pay,deductible then 40%
URGENT CARE CENTER SERVICES	Deductible then 30%	50%	Deductible then 40%	60%
INPATIENT & OUTPATIENT SERVICES	Deductible then 30%	50%	Deductible then 40%	60%
OUTPATIENT DIAGNOSTIC SERVICES:	Deductible then 30%	50%	Deductible then 40%	60%
OUTPATIENT THERAPY SERVICES: Office Visit	\$15 co-pay	50%	\$30 co-pay	60%
OUTPATIENT THERAPY SERVICES @Hospital/Alt	Deductible then 30%	50%	Deductible then 40%	60%
INPATIENT MENTAL ILLNESS/SUBSTANCE ABUSE: Office Visit	\$15 co-pay	50%	\$30 co-pay	60%
INPATIENT MENTAL ILLNESS/SUBSTANCE ABUSE @Hospital/Alt	Deductible then 30%	Not Covered	Deductible then 40%	Not Covered
1 ROUTINE VISION EXAM PER YEAR (does not include contact lens exam)	No Cost Share - Exam Only	50%	No Cost Share - Exam Only	60%
PRESCRIPTION DRUGS (PHARMACY):	\$10 Generic / \$20 Formulary / \$30 Non Formulary	50% coinsurance; minimum \$30 retail	\$10 Generic / \$20 Formulary / \$30 Non Formulary	50% coinsurance; minimum \$30 retail
PRESCRIPTION DRUGS (MAIL):	\$20 Generic / \$40 Formulary / \$60 Non Formulary	Not Covered	\$20 Generic / \$40 Formulary / \$60 Non Formulary	Not Covered
	STANDARD		BASIC	
TIER OPTIONS	Monthly Rates effective January 1, 2016		Monthly Rates effective January 1, 2016	
1) EMPLOYEE	\$187.00		\$112.00	
2) EMPLOYEE/SPOUSE	\$478.00		\$287.00	
3) EMPLOYEE/CHILD(REN)	\$393.00		\$236.00	
4) FAMILY (EMP/SPOUSE/CHILD(REN))	\$543.00		\$325.00	
Rates and all other information provided in this summary are subject to change.				
NOTE: This summary is not intended to replace the Health Plan Document. The Health Plan Document supercedes any information provided in this summary, including but not limited to clerical errors.				