CITY OF OWENSBORO
HEALTH INSURANCE BENEFIT SUMMARY
January 1, 2015 through December 31, 2015

	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	Unlimited	Single $1,750 / Family $3,500	Unlimited
	*Co-Pays, Deductibles apply to Out of Pocket Max.In-network and out-of-network out of pocket amounts accumulate toward one another.		*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		* Non Network Human Organ and Tissue Transplant Services not included	
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**	No Cost Share	50%	No Cost Share	60%
**As determined by Anthem Preventive Care Guidelines				
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%
	***co-pay waived if admitted		***co-pay waived if admitted	
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	**Current Monthly Rates**	**Monthly Rates Eff July 1, 2015**	**Current Monthly Rates**	**Monthly Rates Eff July 1, 2015**
1) EMPLOYEE	$111.00	$122.00	$55.00	$61.00
2) EMPLOYEE/SPOUSE	$278.00	$284.00	$139.00	$142.00
3) EMPLOYEE/CHILD(REN)	$229.00	$252.00	$114.00	$126.00
4) FAMILY (EMP/SPOUSE/CHILD(REN))	$315.00	$366.00	$157.00	$183.00

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.