CITY OF OWENSBORO
HEALTH INSURANCE BENEFIT SUMMARY

	2021 CITY OF OWENSBORO HEALTH INSURANCE SUMMARY****			
	HDHP		PPO	
BENEFIT HIGHLIGHTS	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
ANNUAL DEDUCTIBLE:	Single $3,500	Single $7,000	Single $750	Single $750
	Family $7,500	Family $15,000	Family $1,500	Family $1,500
ANNUAL OUT OF POCKET MAXIMUM:	Single $3,5000	Single $7,000	Single $1,750	Unlimited
	Family $7,500	Family $15,000	Family $3,500	Unlimited
DOCTOR'S VISIT	Deductible then Co-insurance	Deductible then Co-insurance	Primary Co-Pay $30	60%
			Specialist Co-Pay $50	60%
CO-INSURANCE (after deductible is met)	Plan Pays: 100%	Plan Pays: 40%	Plan Pays: 60%	Plan Pays: 40%
	Member Pays: 0%	Member Pays: 60%	Member Pays: 40%	Member Pays: 60%
PRESCRIPTIONS (PHARMACY) GENERIC/FORMULARY/NON FORMULARY	Deductible then Co-insurance	Deductible then Co-insurance	$10/$20/$30/25% up to $350 per prescription	50% (minimums apply)
	Member Responsibility Shown	Member Responsibility Shown	Member Responsibility Shown	Member Responsibility Shown
PREVENTIVE CARE SERVICES** **As determined by Anthem Preventive Care Guidelines	No Cost Share	60%	No Cost Share	60%
EMERGENCY ROOM	Deductible then Co-insurance; then $100 Co-Pay per visit	Deductible then Co-insurance; then $100 Co-Pay per visit	***$100 co-pay,deductible then 40%	***$100 co-pay,deductible then 40%
			***co-pay waived if admitted	
URGENT CARE CENTER Co-Pay	Deductible then Co-insurance	Deductible then Co-insurance	$30	60%
URGENT CARE CENTER SERVICES	Deductible then Co-insurance	Deductible then Co-insurance	Deductible then 40%	60%
INPATIENT & OUTPATIENT SERVICES	Deductible then Co-insurance	Deductible then Co-insurance	Deductible then 40%	60%
ONE ROUTINE VISION EXAM PER YEAR (does not include contact lens exam)	No Cost Share - Exam Only	60%	No Cost Share - Exam Only	60%
PRESCRIPTION DRUGS (MAIL): GENERIC/FORMULARY/NON FORMULARY	Deductible then Co-insurance	Not Covered	$20/$40/$60	Not Covered
	HDHP Plan		**PPO Plan**	
	Effective 1/1/2021		**Effective 1/1/2021**	
TIER OPTIONS	**EMPLOYEE COST PER PAY (24)**		**EMPLOYEE COST PER PAY (24)**	
1) EMPLOYEE	$22.50		$81.50	
2) EMPLOYEE/SPOUSE	$45.00		$190.50	
3) EMPLOYEE/CHILD(REN)	$30.00		$175.00	
4) FAMILY (EMPLOYEE/SPOUSE/CHILD(REN))	$60.00		$253.00	

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.**