### CITY OF OWENSBORO

**HEALTH INSURANCE BENEFIT SUMMARY**

<table>
<thead>
<tr>
<th>BENEFIT HIGHLIGHTS</th>
<th>HDHP</th>
<th>PPO</th>
</tr>
</thead>
<tbody>
<tr>
<td>ANNUAL DEDUCTIBLE:</td>
<td>In-Network</td>
<td>Out-of-Network</td>
</tr>
<tr>
<td>Single</td>
<td>$3,500</td>
<td>$7,000</td>
</tr>
<tr>
<td>Family</td>
<td>$7,500</td>
<td>$15,000</td>
</tr>
<tr>
<td>ANNUAL OUT OF POCKET MAXIMUM:</td>
<td>In-Network</td>
<td>Out-of-Network</td>
</tr>
<tr>
<td>Single</td>
<td>$3,5000</td>
<td>$7,000</td>
</tr>
<tr>
<td>Family</td>
<td>$7,500</td>
<td>$15,000</td>
</tr>
<tr>
<td>DOCTOR'S VISIT</td>
<td>Deductible then Co-insurance</td>
<td>Deductible then Co-insurance</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CO-INSURANCE (after deductible is met)</td>
<td>Plan Pays: 100%</td>
<td>Plan Pays: 40%</td>
</tr>
<tr>
<td></td>
<td>Member Pays: 0%</td>
<td>Member Pays: 60%</td>
</tr>
<tr>
<td>PRESCRIPTIONS (PHARMACY) GENERIC/FORMULARY/NON FORMULARY</td>
<td>Deductible then Co-insurance</td>
<td>Deductible then Co-insurance</td>
</tr>
<tr>
<td></td>
<td>No Cost Share</td>
<td>60%</td>
</tr>
<tr>
<td><strong>PREVENTIVE CARE SERVICES</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>**As determined by Anthem Preventive Care Guidelines</td>
<td></td>
<td></td>
</tr>
<tr>
<td>URGENT CARE CENTER Co-Pay</td>
<td>Deductible then Co-insurance; then $100 Co-Pay per visit</td>
<td>Deductible then Co-insurance; then $100 Co-Pay per visit</td>
</tr>
<tr>
<td>INPATIENT &amp; OUTPATIENT SERVICES</td>
<td>Deductible then Co-insurance</td>
<td>Deductible then Co-insurance</td>
</tr>
<tr>
<td>ONE ROUTINE VISION EXAM PER YEAR (does not include contact lens exam)</td>
<td>No Cost Share - Exam Only</td>
<td>60%</td>
</tr>
<tr>
<td>PRESCRIPTION DRUGS (MAIL): GENERIC/FORMULARY/NON FORMULARY</td>
<td>Deductible then Co-insurance</td>
<td>Not Covered</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>TIER OPTIONS</th>
<th>HDHP Plan</th>
<th>PPO Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) EMPLOYEE</td>
<td>$22.50</td>
<td>$81.50</td>
</tr>
<tr>
<td>2) EMPLOYEE/SPouse</td>
<td>$45.00</td>
<td>$190.50</td>
</tr>
<tr>
<td>3) EMPLOYEE/CHILD(REN)</td>
<td>$30.00</td>
<td>$175.00</td>
</tr>
<tr>
<td>4) FAMILY (EMPLOYEE/SPouse/CHILD(REN))</td>
<td>$60.00</td>
<td>$253.00</td>
</tr>
</tbody>
</table>

Effective 1/1/2021

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 supersedes any information provided in this summary, including but not limited to clerical errors.***

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**2021 CITY OF OWENSBORO HEALTH INSURANCE SUMMARY****

**CO-INSURANCE (after deductible is met)**

- **Plan Pays:**
  - 100%
- **Member Pays:**
  - 0%

**CO-PAY (after deductible is met)**

- **Primary Co-Pay:** $30
- **Specialist Co-Pay:** $50

**Deductible then Co-insurance**

- **Plan Pays:**
  - 40%
- **Member Pays:**
  - 60%

**Out of Pocket Maximum (OOPM)**

- **Medical/Prescription:**
  - **In-Network:**
    - $3,500
  - **Out-of-Network:**
    - $7,000
  - **In-Network:**
    - $750
  - **Out-of-Network:**
    - $750

**Primary Care**

- **In-Network:**
  - $3,500
- **Out-of-Network:**
  - $7,000

**Visit Charges**

- **In-Network:**
  - $175.00
- **Out-of-Network:**
  - $253.00

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**HDHP Plan**

Effective 1/1/2021

**PPO Plan**

Effective 1/1/2021

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**URGENT CARE CENTER SERVICES**

- **In-Network:**
  - $30
- **Out-of-Network:**
  - $60

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**INPATIENT & OUTPATIENT SERVICES**

- **In-Network:**
  - $175.00
- **Out-of-Network:**
  - $253.00

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**ONE ROUTINE VISION EXAM PER YEAR (does not include contact lens exam)**

- **In-Network:**
  - No Cost Share
- **Out-of-Network:**
  - 60%

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**PRESCRIPTION DRUGS (MAIL): GENERIC/FORMULARY/NON FORMULARY**

- **In-Network:**
  - Not Covered
- **Out-of-Network:**
  - $20/$40/$60

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**PREVENTIVE CARE SERVICES**

- **In-Network:**
  - No Cost Share
- **Out-of-Network:**
  - 60%