2018 SUMMARY OF HEALTH BENEFITS

Listed below is a summary of some of the health benefits covered by Automated Group Administration, Inc. Plan. This listing is intended only to highlight some of the benefits provided and should not be relied upon to determine coverage. If this summary of benefits conflicts in any way with the contract issued to the enrolling group, the contract will prevail.

Medical Coverage

	$3,400 Deductible PPO		$1,200 Deductible PPO	
DEDUCTIBLE				
	Individual	**Family**	**Individual**	**Family**
In Network	$3,400	$6,800	$1,200	$3,600
Out of Network	$6,000	$12,000	$3,500	$10,500
CO-INSURANCE				
In Network	100%, after deductible		80/20, after deductible	
Network not available	100%, after deductible		70/30, after deductible	
Network available, not used	50/50, after deductible		50/50, after deductible	
OUT OF POCKET MAXIMUM (Does not include deductible or co-pays.)				
	Individual	**Family**	**Individual**	**Family**
In Network	$0	$0	$2,500	$5,000
Out of Network	$10,000	$20,000	$12,500	$25,000
OTHER MAXIMUMS				
Lifetime Maximum	Unlimited		Unlimited	
Annual Maximum	Unlimited		Unlimited	
DOCTOR OFFICE VISITS				
In Network	All charges are subject to the deductible, then paid at 100%		• $30 Co-pay • Covers office charges only • All other services provided by physician are subject to deductible / co-insurance	
Out of Network	50/50, after deductible		50/50, after deductible	
PHYSICIAN SERVICES FOR WELLNESS (physical exams, well-baby, immunizations, PSAs, etc.)				
In Network	100% up to $1,000 per person. Amount over $1,000 subject to deductible, then paid at 100%		100% after $30 co-pay up to $1,000. Amount over $1,000 is paid 80/20 after deductible	
Out of Network	50/50 after deductible, up to $1,000		50/50 after deductible, up to $1,000	
URGENT CARE FACILITY				
In & Out-of-Network	All charges are subject to deductible/co-insurance		100% after $35 co-pay. Covers office charges only. All other services are subject to deductible/co-insurance	

Prescription Coverage

	$3,400 Deductible PPO	$1,200 Deductible PPO
RETAIL PRESCRIPTION DRUGS (34-day supply)		
In Network	All charges are subject to the deductible first, then: • 100% - Generics • $40 - Formulary name brand • $60 - Non-formulary name brand	• $15 - Generics • $40 - Formulary name brand • $60 - Non-formulary name brand
Out of Network	Not covered except through Drug Card	Not covered except through Drug Card
MAIL ORDER PRESCRIPTION DRUGS (90-day supply)		
In Network	All charges are subject to the deductible first. Once deductible has been met: • 100% - Generics • $80 - Formulary name brand • $120 - Non-formulary name brand	• $30 - Generics • $80 - Formulary name brand • $120 - Non-formulary name brand
Out of Network	Not covered.	Not covered.

Major Medical Coverage

Major medical coverage will require a deductible and sharing of costs up to the out of pocket maximum. All hospitals within our networks offer payment plans to employees for their portion of cost: AGA determines the amount providers can charge for the Employee's portion, provides a document to the provider from which the employee is billed. This is the only paperwork the employee will see.

	$3,400 Deductible PPO	$1,200 Deductible PPO
PRE-CERTIFICATION RESPONSIBILITY		
In Network	Provider	Provider
Out of Network	Employee	Employee
INPATIENT HOSPITALIZATION		
In Network	100%, after deductible	80/20, after deductible
Network not available	100%, after deductible	70/30, after deductible
Network available, not used	50/50, after deductible	50/50, after deductible
EMERGENCY ROOM (all charges)		
In Network	All charges are subject to the deductible first. Once deductible has been met, ER visits will have a $150 co-pay	80/20, after deductible
Network not available	Same as in-network	70/30, after deductible
Network available, not used	50/50, after deductible	50/50, after deductible

Major Medical Coverage *(cont.)*

	$3,400 Deductible PPO	$1,200 Deductible PPO
HEART SURGERY AND RELATED PROCEDURES (in/out patient)		
In Network	Subject to deductible	80/20, after deductible
Out of Network	50/50, after deductible	50/50, after deductible
SURGERY - DOCTOR'S CHARGES		
In Network	100%, after deductible	80/20, after deductible
Network not available	100%, after deductible	70/30, after deductible
Network available, not used	50/50, after deductible	50/50, after deductible
OUTPATIENT CARE (includes surgery, chemotherapy, lab, x-ray & diagnostic services)		
In Network	100%, after deductible	80/20, after deductible
Network not available	100%, after deductible	70/30, after deductible
Network available , not used	50/50	50/50, after deductible
Lab Work	Subject to deductible • LabCorp = larger discounts and less out of pocket expenses	100% if Labcorp is used If Labcorp is not used, charges are subject to deductible
SKILLED NURSING FACILITY (l30 days maximum)		
Home Health Care Durable Medical Equipment	100%, after deductible	80/20, after deductible
In Network	100%, after deductible	80/20, after deductible
Network not available	100%, after deductible	70/30, after deductible
Network available, not used	50/50, after deductible	50/50, after deductible
CHIROPRACTIC CARE—SPINAL (25 visits per year maximum)		
In or Out of Network	100%, after deductible	80/20, after deductible
INFERTILITY SERVICES		
In or Out of Network	Not covered.	Not covered.
AMBULANCE SERVICES		
In or Out of Network	100%, after deductible	80/20, after deductible
MENTAL HEALTH—INPATIENT		

(continued next page)

Major Medical Coverage *(cont.)*

	$3,400 Deductible PPO	$1,200 Deductible PPO
AMBULANCE SERVICES		
In or Out of Network	100%, after deductible	80/20, after deductible
MENTAL HEALTH—INPATIENT		
In Network	100%, after deductible	80/20, after deductible
Network not available	100%, after deductible	70/30, after deductible
Network available, not used	50/50, after deductible	50/50, after deductible
MENTAL HEALTH—OUTPATIENT		
In Network	100%, after deductible	80/20, after deductible
Network not available	100%, after deductible	70/30, after deductible
Network available, not used	50/50, after deductible	50/50, after deductible
ALCOHOL / SUBSTANCE ABUSE		
In Network	100%, after deductible	80/20, after deductible
Network not available	100%, after deductible	70/30, after deductible
Network available, not used	50/50, after deductible	50/50, after deductible

Dental Coverage

DENTAL BENEFITS FOR ALL PLANS	
Maximum calendar year benefit	$1,000 per covered person
Deductible	$50 per person; $150 per family
Preventative& basic care	80/20, after deductible
Major service	50/50, after deductible
Orthodontia	Not covered

Preventative Care: Up to 2 dental exams per calendar year; 4 bitewing x-rays per calendar year; 1 full mouth x-ray in 3 continuous calendar years.

Basic Care: Amalgam, synthetic or plastic fillings; extractions, cysts & neoplasms; root canals; non-surgical treatment for diseases of gums and mouth tissues.

Major Services: Inlays, gold fillings and crowns: dentures and precision attachments; fixed bridgework and surgical treatments for diseases of gums and mouth tissues.

www.cityoffortwayne.org/citybenefits