2020 Summary of Health Benefits

$1,200 Deductible Traditional EPO Plan – Grandfathered

To receive maximum benefits from your medical insurance coverage, you must use a doctor, EPO hospital or facility that is part of the Network.

To locate a Signature Care Provider: 1-800-666-4449 or www.parkviewtotalhealth.com

Pre Certification: Managed Care Concepts 1-866-750-2723

Benefits Effective: January 1, 2020

Benefits	EPO Hospital & PPO Providers	PPO Hospital & No EPO Hospital or PPO Provider Available	NON-PPO Providers
Calendar Year Deductible (Embedded)	$1,200 Individual / $3,600 Family	PPO Hospital - $2,200 Individual / $6,600 Family No EPO Hospital or PPO Available - $1,200 Individual/ $3,600 Family	$4,200 Individual / $12,600 Family
Co-Insurance Benefit	80%	70%	50%
Out of pocket maximum *	$2,500 Individual / $5,000 Family	PPO Hospital - $5,500 Individual / $11,000 Family No EPO Hospital or PPO Available - $2,500 Individual/$5,000 Family	$14,000 Individual / $28,000 Family
Lifetime Maximum	Unlimited lifetime maximum Unlimited Plan year maximum		
Preventive Care Physical exam, well-baby, Immunizations, PSA's, etc.	$30 Copay up to $1,000 benefit, then deductible, then 20%	$30 Copay up to $1,000 benefit, then deductible, then 30%	Deductible, then 50%
Physician Office Visit (Visit only) All other services subject to deductible and coinsurance	$30 Copay	$30 Copay	Deductible, then 50%
Hospital Services	Deductible, then 20%	Deductible, then 30%	Deductible, then 50%
Maternity Services	Deductible, then 20%	Deductible, then 30%	Deductible, then 50%
Urgent Care Visit (Visit only) All other services subject to deductible and coinsurance	$35 Copay	$35 Copay	$35 Copay
Emergency Room	Deductible then 20%	Deductible, then 30%	Deductible, then 50%
Ambulance Services	Deductible, then 20%	Deductible, then 20%	Deductible, then 20%
Chiropractic Services - Spinal Limited to 25 visits per calendar year	Deductible, then 20%	Deductible, then 20%	Deductible, then 20%
Physical, Occupational & Speech Therapy	Deductible, then 20%	Deductible, then 30%	Deductible, then 50%
Mental Health, Alcohol & Substance Abuse	Deductible, then 20%	Deductible, then 30%	Deductible, then 50%
Laboratory Services If Lab Card used: 100%, not subject to deductible	Deductible, then 20%	Deductible, then 30%	Deductible, then 50%
Retail and Mail Order Prescription Drugs			
Prescription Drugs **Retail 34 Day Supply****	Generic - $15 Copay Formulary Brand no generic available- $40 Copay Non-Formulary Brand no generic available- $60 Copay Brand generic is available - $15 plus difference	N/A	Not Covered
Prescription Drugs **Mail Order 90 Day Supply**	Generic - $30 Copay Formulary Brand- $80 Copay Non-Formulary Brand- $120 Copay	N/A	Not Covered

- * The out-of-pocket limit does NOT include premiums, deductibles, copays, balance-billed charges, pre-cert penalties and excluded charges.
- ** Benefits apply to network retail pharmacies, no coverage at Walgreens
- Balance billing protection when you use a an in-network provider
- In-Patient hospital admission and many out-patient procedures require mandatory notification to Managed Care Concepts: 1-866-750-2723

This is an outline of benefits and not to be determined as a contract, for further definitions of covered benefits, see the Summary Plan Description

Third Party Administrator: Automated Group Administration ◆ 7605 Westfield Drive ◆ Fort Wayne, IN 46825 ◆ (260)489-6447 (800)888-6472 ◆ (260) 489-0365 Fax

Dental Coverage

Benefits Effective: January 1, 2020

	Signature Care Dental Network	Non-Network Providers
DENTAL BENEFITS FOR ALL PLANS		
Maximum calendar year benefit	$1,200 per covered person	$1,000 per covered person
Deductible	$50 per person; $150 per family	$50 per person; $150 per family
Preventative	100%, deductible does not apply	80/20, after deductible
Basic Service	90/10, after deductible	80/20, after deductible
Major service	60/40, after deductible	50/50, after deductible
Orthodontia	Not covered	Not covered

To locate a Signature Care Dental Provider:

www.Parkview.com/DentalProvider

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