



City of Miami Springs
 Medical, Dental, and Vision Insurance Plans
2020-21 SUMMARY OF BENEFITS

HUMANA MEDICAL				
MEDICAL PLANS	HMO BRONZE PLAN	HMO SILVER PLAN	HMO GOLD PLAN/ POLICE HMO	POS PLAN
POLICY #	865234	865234	865234	865234
UHC EQUIVALENT PLAN	N/A	Low HMO	High HMO/Police HMO	POS
ANNUAL DEDUCTIBLE				
<i>In-network</i>	\$1,500/\$3,000	\$750/\$1,500	\$0	\$750/\$1,500
<i>Out-of-network</i>	N/A	N/A	N/A	\$1,500/\$3,000
OUT OF POCKET LIMIT				
<i>In-network</i>	\$5,000/\$10,000	\$2,250/\$5,500	\$1,500/\$3,000	\$2,750/\$5,500
<i>Out-of-network</i>	N/A	N/A	N/A	\$5,500/\$11,000
LIFETIME MAXIMUM				
<i>In-network</i>	Unlimited	Unlimited	Unlimited	Unlimited
<i>Out-of-network</i>	N/A	N/A	N/A	Unlimited
OFFICE VISIT				
<i>In-network Primary</i>	\$25 Copay	\$25 Copay	\$15 Copay	\$20 Copay
<i>In-network Specialist</i>	\$50 Copay	\$50 Copay	\$15 Copay	\$20 Copay
<i>Open Access</i>	Yes	Yes	Yes	Yes
<i>Out-of-network</i>	N/A	N/A	N/A	40% after deductible
PRESCRIPTION DRUGS				
<i>Formulary</i>	Yes	Yes	Yes	Yes
<i>Level 1</i>	\$10	\$10	\$10	\$10
<i>Level 2</i>	\$40	\$35	\$35	\$35
<i>Level 3</i>	\$70	\$60	\$50	\$60
<i>Specialty</i>	25%	\$200	\$200	\$200
<i>Mail Order</i>	2.5 x Copay for 90-day supply for Levels 1, 2, & 3	2.5 x Copay for 90-day supply for Levels 1, 2, & 3	2.5 x Copay for 90-day supply for Levels 1, 2, & 3	2.5 x Copay for 90-day supply for Levels 1, 2, & 3
EMERGENCY ROOM	\$350 Copay	\$100 Copay	\$50 Copay	\$100 Copay
URGENT CARE	\$75 Copay	\$50 Copay	\$25 Copay	\$50 Copay
HOSPITAL INPATIENT				
<i>In-network</i>	0% after deductible	0% after deductible	\$500 Copay/admit	20% after deductible
<i>Out-of-network</i>	N/A	N/A	N/A	40% after deductible
OUTPATIENT SURGERY				
<i>In-network</i>	0% after deductible	0% after deductible	0% after deductible	20% after deductible
<i>Out-of-network</i>	N/A	N/A	N/A	40% after deductible
MAJOR DIAGNOSTIC (CT/PET scans, MRIs)				
<i>In-network</i>	\$300 Copay	0% after deductible	0% after deductible	20% after deductible
<i>Out-of-network</i>	N/A	N/A	N/A	40% after deductible

HUMANA MEDICAL				
MEDICAL PLANS	HMO BRONZE PLAN	HMO SILVER PLAN	HMO GOLD PLAN/ POLICE HMO	POS PLAN
MENTAL HEALTH				
Inpatient				
<i>In-network</i>	0% after deductible	0% after deductible	\$500 Copay/admit	20% after deductible
<i>Out-of-network</i>	N/A	N/A	N/A	40% after deductible
Outpatient				
<i>In-network</i>	\$25 Copay	\$25 Copay	\$15 Copay	\$20 Copay
<i>Out-of-network</i>	N/A	N/A	N/A	40% after deductible
DRUG & ALCOHOL ABUSE				
Inpatient				
<i>In-network</i>	0% after deductible	0% after deductible	\$500 Copay/admit	20% after deductible
<i>Out-of-network</i>	N/A	N/A	N/A	40% after deductible
Outpatient				
<i>In-network</i>	\$25 Copay	\$25 Copay	\$15 Copay	\$20 Copay
<i>Out-of-network</i>	N/A	N/A	N/A	40% after deductible
DEPENDENT CHILD/ STUDENT AGE	Up to age 30	Up to age 30	Up to age 30	Up to age 30
CIGNA DENTAL				
DENTAL PLANS	CIGNA DMHO		CIGNA DPPO	
NETWORK	In-network only		In-network and Out-of-network	
DEDUCTIBLE	None		\$50 per individual/ \$150 per family	
CO-INSURANCE	100%		In/Out: 100%/80%/50%	
DENTIST	\$5 Copay		In/Out: Deductible & Co-insurance	
SPECIALIST	Copay applies		In/Out: Deductible & Co-insurance	
CLEANINGS	One every six months		One every six months	
PREVENTATIVE	Most procedures covered 100%; Some procedures have Copays		In/Out: Covered 100%; No deductible	
BASIC COVERAGE	Some procedures covered 100%; Most procedures have Copays		In/Out: Covered 80% after deductible	
MAJOR COVERAGE	Copay applies		In/Out: Covered 50% after deductible	
PERIODONTIC & ENDODONTIC	Copay applies		Major Coverage Oral Surgery Simple: Basic	
ORTHODONTIC COVERAGE	Copay applies/Limits apply		50% \$1000 – Children only	
ANNUAL MAXIMUM	None		\$1,500	
DEPENDENT CHILD/ STUDENT AGE	Up to age 26		Up to age 26	
HUMANA VISION				
COPAYMENTS	Exam: \$10; Materials: \$15; Participating Doctors			
VISION EXAM	Once every 12 months; Copay applies			
LENSES	Once every 12 months; Single, Bifocal, Trifocal, & Lenticular- Copay applies			
FRAMES	Once every 24 months; \$130 in-network, \$65 out-of-network reimbursement			
CONTACT LENSES ELECTIVE	Materials- \$130 in-network, \$104 out-of-network reimbursement			
CONTACT LENSES MEDICALLY NECESSARY	No charge in-network; \$200 out-of-network reimbursement			