City of Miami Springs

Medical, Dental, and Vision Insurance Plans

2023-24 SUMMARY OF BENEFITS

HUMANA MEDICAL			
MEDICAL PLANS	**HMO SILVER PLAN**	**HMO GOLD PLAN/ POLICE HMO**	**POS PLAN**
POLICY #	865234	865234	865234
ANNUAL DEDUCTIBLE			
In-network	$750/$1,500	$0	$750/$1,500
Out-of-network	N/A	N/A	$1,500/$3,000
OUT OF POCKET LIMIT			
In-network	$2,250/$5,500	$1,500/$3,000	$2,750/$5,500
Out-of-network	N/A	N/A	$5,500/$11,000
LIFETIME MAXIMUM			
In-network	Unlimited	Unlimited	Unlimited
Out-of-network	N/A	N/A	Unlimited
OFFICE VISIT			
In-network Primary	$25 Copay	$15 Copay	$20 Copay
In-network Specialist	$50 Copay	$15 Copay	$20 Copay
Open Access	Yes	Yes	Yes
Out-of-network	N/A	N/A	40% after deductible
PRESCRIPTION DRUGS			
Formulary	Yes	Yes	Yes
Level 1	$10	$10	$10
Level 2	$35	$35	$35
Level 3	$60	$50	$60
Specialty	$200	$200	$200
Mail Order	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	$100 Copay	$50 Copay	$100 Copay
URGENT CARE	$50 Copay	$25 Copay	$50 Copay
HOSPITAL INPATIENT			
In-network	0% after deductible	$500 Copay/admit	20% after deductible
Out-of-network	N/A	N/A	40% after deductible
OUTPATIENT SURGERY			
In-network	0% after deductible	0% after deductible	20% after deductible
Out-of-network	N/A	N/A	40% after deductible
MAJOR DIAGNOSTIC (CT/PET scans, MRIs)			
In-network	0% after deductible	0% after deductible	20% after deductible
Out-of-network	N/A	N/A	40% after deductible

continued

Rev 09/13/23

HUMANA MEDICAL			
MEDICAL PLANS	**HMO SILVER PLAN**	**HMO GOLD PLAN/ POLICE HMO**	**POS PLAN**
MENTAL HEALTH			
Inpatient			
In-network	0% after deductible	$500 Copay/admit	20% after deductible
Out-of-network	N/A	N/A	40% after deductible
Outpatient			
In-network	$25 Copay	$15 Copay	$20 Copay
Out-of-network	N/A	N/A	40% after deductible
DRUG & ALCOHOL ABUSE			
Inpatient			
In-network	0% after deductible	$500 Copay/admit	20% after deductible
Out-of-network	N/A	N/A	40% after deductible
Outpatient			
In-network	$25 Copay	$15 Copay	$20 Copay
Out-of-network	N/A	N/A	40% after deductible
DEPENDENT CHILD/ STUDENT AGE	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 130	
COPAYMENTS	Exam: $10 (Standard) to $39; Standard Lenses: $15; In-Network
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