CITY OF FORT LAUDERDALE 2018 MEDICAL PLAN COMPARISON SUMMARY

2018 Medical Plan Coverage	2018 OAPIN1 (HMO1)	2018 OAPIN2 (HMO2)	2018 Choice Fund (CDHP)	
Health Reimbursement Account (HRA)*	N/A	N/A	$750 = EE, $1,000 = EE+1, $1,500 = EE+2 or more	
2018 Medical Plan Coverage	**2018 OAPIN1 (HMO1) You Pay**	**2018 OAPIN2 (HMO2) You Pay**	**2018 Choice Fund (CDHP) You Pay**	
			In-Network	**Out-of-Network****
Deductible	No Deductible	$1,000 = EE $2,000 = EE+1 $3,000 = EE+Family	$2,000 = EE $3,000 = EE+1 $4,000 = EE+2 or more	$2,000 = EE $3,000 = EE+1 $4,000 = EE+2 or more
Coinsurance	See Below	See Below	You pay 10%	You pay 30%
Your Out-of-Pocket Maximum	$5,000 = EE $7,000 = EE+1 $10,000 = EE+2 or more	$6,350 = EE $10,000 = EE+1 $12,700 = EE + 2 or more	$5,000 = EE $7,000 = EE+1 $10,000 = EE+2 or more (Includes calendar year deductible & coinsurance)	$5,000 = EE $7,000 = EE+1 $10,000 = EE+2 or more (Includes calendar year deductible & coinsurance)
Lifetime Maximum	Unlimited	Unlimited	Unlimited	Unlimited
Preventative Services	No Charge	No Charge	No Charge	Not Covered
Primary Care Physician	$40	$40	Subject to calendar year deductible & coinsurance (HRA applies)	Subject to calendar year deductible & coinsurance (HRA applies)
Specialist Physician	$60	$60		
Maternity	$60	$60		
Hospital	$500/day, $2,500 Maximum	Deductible then 20% Coinsurance		
Outpatient Surgery	$500	Deductible then 20% Coinsurance		
Outpatient Diagnostics (X-rays, Ultrasound, etc.)	10% Coinsurance	10% Coinsurance		
Outpatient Diagnostics (CAT & PET scans, MRI)	$200 per test	$200 per test		
Routine Lab	10% Coinsurance	10% Coinsurance		
Emergency Room	$200	$200		
Urgent Care	$60	$60		
Mental Health (outpatient)	$40	$40		
Mental Health (inpatient)	$500 per day for first 5 days	Deductible then 20% Coinsurance		
Allergy Treatments/Injections	$10	$10		
Ambulance	No Charge	$100 copay		
Prescription Drugs – Pharmacy, 30-day supply ***	$20 generic $40 preferred $60 non-preferred	$20 generic $40 preferred $60 non-preferred	Subject to calendar year deductible & coinsurance of 30% generic, 40% preferred, 60% non-preferred (HRA applies)	Subject to calendar year deductible & coinsurance of 30% generic, 40% preferred, 60% non-preferred (HRA applies)
Prescription Maintenance Drugs – Retail or Mail Order, *** Mandatory 90-day supply ****	$40 generic $80 preferred $120 non-preferred	$40 generic $80 preferred $120 non-preferred		
Prescription for Chronic Conditions & Preventative ****	Generic prescription provided – waiving copays	Generic prescription provided – waiving copays	Generic prescription provided – waiving copays	Generic prescription provided – waiving copays
Vision	(Only medical conditions)	(Only medical conditions)	(Only medical conditions)	(Only medical conditions)

* Health Reimbursement Account (HRA) City annual contributions: The HRA funding is prorated for enrollment after January.
** Cigna's reimbursement is based on Usual Customary and Reasonable (UCR) charges. *** Members Pay the Difference generic program pharmacy benefit rules apply. **** Cigna 90 Now Program: For specified maintenance medications, you must obtain a 90-day prescription (filled at either a 90-day network retail pharmacy or Cigna Home Delivery) for the medication to be covered by the plan. Otherwise, after three 30-day fill(s), you pay the entire cost of the prescription.