

Medical and Prescription Drug Benefits

Administered by Anthem BCBS

Comprehensive and preventive healthcare coverage is important in protecting you and your family from the financial risks of unexpected illness and injury. A little prevention usually goes a long way—especially in healthcare. Routine exams and regular preventive care provide an inexpensive review of your health. Small problems can potentially develop into large expenses. By identifying the problems early, often they can be treated at little cost.

Comprehensive healthcare also provides peace of mind. In case of an illness or injury, you and your family are covered with an excellent medical plan through Anthem BCBS.

Employees hired before July 1, 2014 have a choice of four plans: KeyCare 10 (PPO), KeyCare 15 (PPO), HealthKeepers 10 (POS / HMO Open Access), and HealthKeepers 20 (POS / HMO Open Access). If you make plan changes, you can only choose the plans that are offered to employees hired after July 1, 2014.

Employees hired after July 1, 2014 have a choice of three plans: KeyCare 15 (PPO), HealthKeepers 20 (POS / HMO Open Access), and the High Deductible Lumenos Plan.

	In-Network Benefits				
	KeyCare 10 PPO	KeyCare 15 PPO	HealthKeepers 10 POS / HMO Open Access	HealthKeepers 20 POS / HMO Open Access	Lumenos High Deductible—CDHP
Available to:	Employees Hired before 7/1/2014	All Government Employees	Employees Hired before 7/1/2014	All Government Employees	All Government Employees
Calendar Deductible Individual / Family	\$0 / \$0	\$0 / \$0	\$0 / \$0	\$0 / \$0	\$2,000 / \$4,000
Calendar Out-of-Pocket Maximum Individual / Family (includes deductible)	\$1,000 / \$2,000	\$2,000 / \$4,000	\$1,500 / \$3,000	\$2,000 / \$4,000	\$4,000 / \$8,000
Network	Anthem KeyCare	Anthem KeyCare	Anthem HealthKeepers	Anthem HealthKeepers	Anthem HealthKeepers
Facility Services					
Inpatient	\$200 copay then 10%	\$300 copay then 20%	\$200 per admission	\$200 copay/day not to exceed \$1,000/admission	20% after ded
Outpatient Surgery	\$100 copay then 10%	\$100 copay then 20%	\$150 copay	\$200 copay	20% after ded
Emergency Room (Copay Waived if Admitted)	\$200 copay then 20%	\$200 copay then 20%	\$200 copay	\$200 copay	20% after ded
Physician Services					
Primary Care Office Visits	\$10 copay	\$15 copay	\$10 copay	\$20 copay	20% after ded
Specialist Office Visits	\$20 copay	\$30 copay	\$20 copay	\$40 copay	20% after ded
Urgent Care	PCP \$10 copay / Spec. \$20 copay	PCP \$15 copay / Spec. \$30 copay	PCP \$10 copay / Spec. \$20 copay	PCP \$20 copay / Spec. \$40 copay	20% after ded
Chiropractic Care	PCP \$10 copay / Spec. \$20 copay, 30 visit limit	PCP \$15 copay / Spec. \$30 copay, 30 visit limit	\$20 copay, 30 visit limit	\$25 copay, 30 visit limit	20% after ded, 30 visit limit
Physical & Occupational Therapy	Office Visit: PCP \$10 copay / Spec. \$20 copay Facility: \$20 copay then 10% (30 visits per year PT & OT combined)	Office Visit: PCP \$15 copay / Spec. \$30 copay Facility: \$30 copay then 20% (30 visits per year PT & OT combined)	Office Visit: \$20 copay Facility: \$20 copay (30 visits per year PT & OT combined)	Office Visit: \$25 copay Facility: \$25 copay (30 visits per year PT & OT combined)	20% after ded (30 visits per year PT & OT combined)
Speech Therapy	Office Visit: PCP \$10 copay / Spec. \$20 copay Facility: \$20 copay then 10% (30 visits per year)	Office Visit: PCP \$15 copay / Spec. \$30 copay Facility: \$30 copay then 20% (30 visits per year)	Office Visit: \$20 copay Facility: \$20 copay (30 visits per year)	Office Visit: \$25 copay Facility: \$25 copay (30 visits per year)	20% after ded (30 visits per year)
Preventive Care					
Well Baby Care	Covered @ 100%	Covered @ 100%	Covered @ 100%	Covered @ 100%	Covered @ 100%
Well Adult Care	Covered @ 100%	Covered @ 100%	Covered @ 100%	Covered @ 100%	Covered @ 100%
Mammography	Covered @ 100%	Covered @ 100%	Covered @ 100%	Covered @ 100%	Covered @ 100%
PSA Tests, Screenings	Covered @ 100%	Covered @ 100%	Covered @ 100%	Covered @ 100%	Covered @ 100%

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	In-Network Benefits				
	KeyCare 10 PPO	KeyCare 15 PPO	HealthKeepers 10 POS / HMO Open Access	HealthKeepers 20 POS / HMO Open Access	Lumenos High Deductible—CDHP
Mental Health Services					
Inpatient	\$200 copay then 10%	\$300 copay then 20%	\$200 copay	\$200 copay/day not to exceed \$1,000/admission	20% after ded
Outpatient	Office Visit: \$10 copay Other Outpatient: \$10 copay	Office Visit: \$15 copay Other Outpatient: \$15 copay	Office Visit: \$10 copay Other Outpatient: \$10 copay	Office Visit: \$20 copay Other Outpatient: \$20 copay	20% after ded
Other Services					
Diagnostic X-ray	10% after ded	20% after ded	\$20 copay	\$40 copay	20% after ded
Advanced Diagnostic Imaging (MRI, MRA, CT, PET Scans)	10% after ded	20% after ded	\$100 copay then 10%	\$100 copay then 20%	20% after ded
Home Health Care	Covered @ 100% 90 visits / year	Covered @ 100% 90 visits / year	Covered @ 100% 100 visits / year	Covered @ 100% 100 visits / year	20% after ded 100 visits / year
Hospice Care	Covered @ 100%	Covered @ 100%	Covered @ 100%	Covered @ 100%	20% after ded
Durable Medical Equipment	20% after ded	20% after ded	Covered @ 100%	Covered @ 100%	20% after ded
Skilled Nursing Facility	10% after ded 100 visits / year	20% after ded 100 visits / year	Covered @ 100% 100 visits / year	Covered @ 100% 100 visits / year	20% after ded 100 visits / year
Vision	\$15 copay In-Network with Blue Vision Providers; \$30 OON Allowance				
Prescription Drugs					
Calendar Deductible	\$150 Individual / \$300 Family With 4th quarter carryover				Subject to Combined Medical / Rx Ded
Calendar Out-of-Pocket Maximum	\$3,500 Individual / \$7,000 Family				Subject to Combined Medical / Rx OOPM
Retail					
Tier 1	\$10 copay				20% after ded
Tier 2	\$20 copay				20% after ded
Tier 3	Greater of \$35 copay or 20% up to \$200 / script				20% after ded
Mail Order					
Tier 1	\$20 copay				20% after ded
Tier 2	\$40 copay				20% after ded
Tier 3	Greater of \$70 copay or 20% up to \$400 / script				20% after ded

Potential Financial Responsibility When Using Out-of-Network Providers

The amount the plan pays for covered services provided by non-network providers is based on a maximum allowable amount for the specific service rendered. Although your plan stipulates an out-of-pocket maximum for out-of-network services, please note the maximum allowed amount for an eligible procedure may not be equal to the amount charged by your out-of-network provider. Your out-of-network provider may bill you for the difference between the amount charged and the maximum allowed amount. This is called balance billing and the amount billed to you can be substantial. The out-of-pocket maximum outlined in your policy will not include amounts in excess of the allowable charge and other non-covered expenses as defined by your plan. The maximum reimbursable amount for non-network providers can be based on a number of schedules such as a percentage of reasonable and customary or a percentage of Medicare. The plan document or carrier's master policy is the controlling document, and this Benefit Highlight does not include all of the terms, coverage, exclusions, limitations, and conditions of the actual plan language. Contact your claims payer or insurer for more information.

