



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

## Medical and Prescription Drug Benefits

	In-Network Benefits		
	KeyCare 15 PPO	HealthKeepers 20 POS / HMO Open Access	Lumenos High Deductible—CDHP
<b>Mental Health Services</b>			
<b>Inpatient</b>	\$300 copay then 20%	\$200 copay/day not to exceed \$1,000/admission	20% after ded
<b>Outpatient</b>	Office Visit: \$15 copay Other Outpatient: \$15 copay	Office Visit: \$20 copay Other Outpatient: \$20 copay	20% after ded
<b>Other Services</b>			
<b>Diagnostic X-ray</b>	20%	\$40 copay	20% after ded
<b>Advanced Diagnostic Imaging (MRI, MRA, CT, PET Scans)</b>	20%	\$100 copay then 20%	20% after ded
<b>Home Health Care</b>	Covered @ 100% 90 visits / year	Covered @ 100% 100 visits / year	20% after ded 100 visits / year
<b>Hospice Care</b>	Covered @ 100%	Covered @ 100%	20% after ded
<b>Durable Medical Equipment</b>	20%	Covered @ 100%	20% after ded
<b>Skilled Nursing Facility</b>	20% 100 visits / year	Covered @ 100% 100 visits / year	20% after ded 100 visits / year
<b>Vision</b>	\$15 copay In-Network with Blue Vision Providers; \$30 OON Allowance		
<b>Prescription Drugs</b>			
<b>Calendar Deductible</b>	\$150 Individual / \$300 Family With 4th quarter carryover		Subject to Combined Medical / Rx Ded
<b>Calendar Out-of-Pocket Maximum</b>	\$3,500 Individual / \$7,000 Family		Subject to Combined Medical / Rx OOPM
<b>Retail</b>			
<b>Tier 1</b>	\$10 copay		20% after ded
<b>Tier 2</b>	\$20 copay		20% after ded
<b>Tier 3</b>	Greater of \$35 copay or 20% up to \$50 / script		20% after ded
<b>Mail Order</b>			
<b>Tier 1</b>	\$20 copay		20% after ded
<b>Tier 2</b>	\$40 copay		20% after ded
<b>Tier 3</b>	Greater of \$70 copay or 20% up to \$100 / 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.

