

Pittsylvania County and Schools
October 1, 2016 through September 30, 2017
Health Plan Comparison Chart



	Anthem KeyCare 30	Anthem KeyCare 500	HDHP w/HSA \$3000/100%
Annual deductibles			
	Separate in-network and out-of network deductibles	Separate in-network and out-of network deductibles	<u>Combined</u> in-network and out-of-network deductible
In-network	\$1,000 per member; \$2,000 per family	\$500 per member; \$1,000 per family	\$3,000 per member; \$6,000 per family
Out-of-network	\$1,500 per member; \$3,000 per family	\$750 per member; \$1,500 per family	\$3,000 per member; \$6,000 per family
Combined medical and prescription drug out-of-pocket maximum			
In-network	\$6,000 per member; \$12,000 per family	\$5,500 per member; \$11,000 per family	\$4,000 per member; \$8,000 per family
Out-of-network	\$11,000 per member; \$22,000 per family	\$10,000 per member; \$20,000 per family	\$6,000 per member; \$12,000 per family
Office visit copayment/coinsurance			
In-network	\$30/visit In-network deductible does not apply.	Subject to in-network deductible + 20% coinsurance	Subject to deductible + 0% coinsurance
Physical therapy, occupational therapy, and speech therapy*	Subject to in-network deductible + 20% coinsurance	Subject to in-network deductible + 20% coinsurance	Subject to deductible + 0% coinsurance
Out-of-network office visits, physical therapy, occupational therapy, and speech therapy*	Subject to out-of network deductible + 40% coinsurance	Subject to out-of-network deductible + 40% coinsurance	Subject to deductible + 20% coinsurance
*Physical and occupational therapies have a combined 30 visit calendar year limit combined for in- and out-of-network care. Speech therapy has an in- and out-of-network combined limit of 30 visits.			
Outpatient mental health/substance abuse visits			
In-network	\$30/visit In-network deductible does not apply.	Subject to in-network deductible + 20% coinsurance	Subject to deductible + 0% coinsurance
Out-of-network	Subject to out-of-network deductible + 40% coinsurance	Subject to out-of-network deductible + 40% coinsurance	Subject to deductible + 20% coinsurance

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Spinal manipulation (chiropractic care services) – 30 visit combined in- and out-of-network calendar year limit			
In-network	\$25/visit In-network deductible does not apply.	Subject to in-network deductible + 20% coinsurance	Subject to deductible + 0% coinsurance
Out-of-network	Subject to out-of-network deductible + 40% coinsurance	Subject to out-of-network deductible + 40% coinsurance	Subject to deductible + 20% coinsurance
Wellness/Preventive Care Benefits During the course of a routine screening procedure, abnormalities or problems may be identified that require immediate intervention or additional diagnosis. If this occurs, and your provider performs additional necessary procedures, the service will be considered diagnostic and/or surgical, rather than screening, depending on the claim for the services submitted by your provider, which will result in a member cost share.			
In-network	Paid at 100% of Allowable Charge	Paid at 100% of Allowable Charged	Paid at 100% of Allowable Charge
Out-of-network	Subject to out-of-network deductible + 40% coinsurance	Subject to out-of-network deductible + 40% coinsurance	Subject to deductible + 20% coinsurance
Emergency care			
In-network	Subject to in-network deductible + 20% coinsurance	Subject to in-network deductible + 20% coinsurance	Subject to deductible + 0% coinsurance
Out-of-network	Subject to out-of-network deductible + 40% coinsurance	Subject to out-of-network deductible + 40% coinsurance	Subject to deductible + 20% coinsurance
Inpatient hospitalization			
In-network	Subject to in-network deductible + 20% coinsurance	Subject to in-network deductible + 20% coinsurance	Subject to deductible + 0% coinsurance
Out-of-network	Subject to out-of-network deductible + 40% coinsurance	Subject to out-of-network deductible + 40% coinsurance	Subject to deductible + 20% coinsurance
Maternity care			
In-network	\$30 for initial visit / Remaining pre- and post-natal care and delivery is subject to in-network deductible + 20% coinsurance	Subject to in-network deductible, + 20% coinsurance	Subject to deductible + 0% coinsurance

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Out-of-network	Subject to out-of network deductible + 40% coinsurance	Subject to out-of-network deductible + 40% coinsurance	Subject to deductible + 20% coinsurance
Outpatient prescription drug			
All plans have combined medical and prescription drug calendar year out-of-pocket for covered prescriptions.			
Retail pharmacy (Up to a 30-day supply at a participating pharmacy)	\$10/\$40/\$60/20%* (\$200 maximum per script on Tier 4 medications.)	\$10/\$40/\$60/20% (\$200 maximum per script on Tier 4 medications.)	Subject to deductible + copay of \$10/\$30/\$50/20% (\$200 maximum per script for Tier 4 medications)
Home Delivery Program (Up to a 90-day supply delivered to your home)	\$20/\$80/\$120/20%*	\$20/\$80/\$120/20%*	Subject to deductible + copay of \$25/\$75/\$125/20%* (\$400 maximum per script for Tier 4 medications)
Retail Maintenance (Up to a 90-day supply purchased at participating retail pharmacy)	\$30/\$120/\$180/n/a	\$30/\$120/\$180/n/a	Subject to deductible + copay of \$30/\$90/\$150/n/a
Preventive Plus Rx	n/a	n/a	Medications on the Preventive Plus Rx list are covered at 100% of Allowable Charge when purchased at a participating pharmacy.
*Specialty medications must be purchased through Accredo Specialty Pharmacy. Most specialty medications are limited up to a 30-day supply with the exception of medications used to treat HIV/AIDS and transplant medications, which will be filled up to 90-day supply.			
Routine vision care			
Blue View Vision	\$15/visit for annual routine eye exam	\$15/visit for annual routine eye exam	\$15/visit for annual routine eye exam
Out-of-network	\$30 allowance	\$30 allowance	\$30 allowance
Please see the next page for information on the Special Features and Programs included in your health insurance benefits.			

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Special features and programs			
Future Moms	Included	Included	Included
Condition Care (asthma, chronic obstructive pulmonary disease (COPD), diabetes (Type I and II), heart failure, coronary artery disease)	Included	Included	Included
24/7 NurseLine	Included	Included	Included
EAP	Included	Included	Included
LiveHealth Online <ul style="list-style-type: none"> • Medical care • Behavioral health 	\$30 copay/visit \$30 copay/visit	Subject to in-network deductible + 20% coinsurance Subject to in-network deductible + 20% coinsurance	\$49 copay/visit \$80 copay/visit - LCSW \$95 copay/visit - PhD Psychologist