



**Henrico County General Government and Public Schools**

Anthem HealthKeepers

Benefit Comparison: January 1, 2020 - December 31, 2020

	Standard POS	Premier POS	HDHP with HSA
<b>IN NETWORK BENEFITS</b>			
<b>Deductible (Individual/Family)</b>	\$300 / \$300	\$300 / \$300	\$3,000/\$6,000 (combined with out of network)
<b>Out-of-Pocket Maximum</b>	Medical: \$2,500/\$5,000 Pharmacy: \$500/\$1,000	Medical: \$2,500/\$5,000 Pharmacy: \$500/\$1,000	Medical and Pharmacy Combined: \$4,000 / \$8,000
<b>Inpatient Benefits</b>	<b>You Pay</b>	<b>You Pay</b>	<b>You Pay</b>
<b>Hospital</b>	30% after deductible	5% after deductible	0% after deductible
<b>Physician Charges</b>	30% after deductible	5% after deductible	0% after deductible
<b>Maternity</b> (Facility charges for delivery)	30% after deductible	5% after deductible	0% after deductible
<b>Mental Health and Substance Abuse</b> (Facility charges)	30% after deductible	5% after deductible	0% after deductible
<b>Outpatient Benefits</b>	<b>You Pay</b>	<b>You Pay</b>	<b>You Pay</b>
<b>Referrals to Specialist Required</b>	No	No	No
<b>Preventive Care</b>	No charge	No charge	No charge
<b>Primary Care Physician (PCP) or OB/ GYN Office Visit</b>	\$25	\$20	0% after deductible
<b>Specialist Office Visit</b>	\$45	\$40	0% after deductible
<b>Urgent Care Center</b>	\$25 PCP / \$45 Specialist	\$20 PCP / \$40 Specialist	0% after deductible
<b>Allergy Testing</b>	\$25 PCP / \$45 Specialist	\$20 PCP / \$40 Specialist	0% after deductible
<b>Allergy Serum and Injections</b>	\$25 PCP / \$45 Specialist	\$10	0% after deductible
<b>Mammogram</b>	No charge	No charge	No charge
<b>Labs, Diagnostic X-rays</b>	No charge	No charge	0% after deductible
<b>Advanced Diagnostic Imaging-in Office setting</b>	10% after deductible	5% after deductible	0% after deductible
<b>Advanced Diagnostic Imaging-All other settings</b>	30% after deductible	5% after deductible	0% after deductible
<b>Maternity Outpatient Services</b>			
Initial office visit to confirm diagnosis	\$25	\$20	0% after deductible
Pre- and post-natal care and delivery	\$50 per pregnancy	\$50 per pregnancy	0% after deductible
Maternity ultrasounds	No charge	No charge	0% after deductible
<b>Emergency Room</b> (waived if admitted to the hospital)	\$150	\$150	0% after deductible

	<b>Standard POS</b>	<b>Premier POS</b>	<b>HDHP with HSA</b>
	<b>You Pay</b>	<b>You Pay</b>	<b>You Pay</b>
<b>Outpatient Surgery Facility Professional Provider</b>	30% after deductible 30% after deductible	5% after deductible	0% after deductible
<b>Outpatient Therapy: occupational, speech and physical</b>	\$45	\$25	0% after deductible
<b>Spinal Manipulation</b> (30 visit limit per CY)	\$25	\$25	0% after deductible
<b>Outpatient Mental Health and Substance Abuse</b>	\$25	\$20	0% after deductible
<b>Durable Medical Equipment</b>	No charge after deductible	No charge after deductible	0% after deductible
<b>Home Health Care</b> (90 visit limit per CY)	\$45 per visit after deductible	No charge after deductible	0% after deductible
<b>Skilled Nursing Facility</b> (100 days per admission)	30% after deductible	5% after deductible	0% after deductible
<b>Hospice Care</b>	30% after deductible	5% after deductible	0% after deductible
<b>Prescription Drugs*</b>	<b>Mandatory Generic</b>	<b>Mandatory Generic</b>	<b>Mandatory Generic</b>
Rx Deductible ( <i>individual/family</i> )	\$150/\$150	\$150/\$150	Plan deductible applies
Retail Pharmacy ( <i>30 day supply</i> )	After deductible: \$10/\$30/\$55	After deductible: \$10/\$30/\$55	After deductible: \$10/\$30/\$55
Mail Order ( <i>90 day supply</i> )	After deductible: \$10/\$60/\$165	After deductible: \$10/\$60/\$165	After deductible: \$10/\$60/\$165
Retail 90 ( <i>90 day supply purchased at a participating retail pharmacy</i> )	After deductible: \$30/\$90/\$165	After deductible: \$30/\$90/\$165	After deductible: \$30/\$90/\$165
<b>Routine Vision - Blue View Vision</b>			
<b>Annual Routine Eye Exam</b>	\$15	\$15	\$15 (deductible does not apply)
<b>OUT-OF-NETWORK BENEFITS</b>			
Deductible (Individual/Family)	\$400/\$800	\$400/\$800	\$3,000/\$6,000 (combined with in-network)
Coinsurance	30%	30%	30%
Out-of-Pocket Maximum	\$2,500/\$5,000	\$2,500/\$5,000	\$6,000/\$12,000
<b>Lifetime Maximum</b>	<b>Unlimited</b>	<b>Unlimited</b>	<b>Unlimited</b>

\* As of 1/1/18, prescription drug coverage for the Premier POS and Standard POS plans is being provided by Express Scripts Direct. If you're enrolled in the HDHP with HSA plan, your prescription drug coverage will continue to be provided by Anthem IngenioRx.