

NON-MEDICARE RETIREE PLAN COMPARISON OCTOBER 1, 2017 – SEPTEMBER 30, 2018

Chesapeake Public Schools	KeyCare 20	KeyCare 25	KeyCare 30	KeyCare 30/2000/30	Lumenos with Health Savings Account (HSA)
IN NETWORK BENEFITS	<u>Member Pays</u>	<u>Member Pays</u>	<u>Member Pays</u>	<u>Member Pays</u>	<u>Member Pays</u>
PREVENTIVE CARE	No Charge	No Charge	No Charge	No Charge	No Charge
DIAGNOSTIC OFFICE VISITS - PCP/SPECIALIST	\$20/\$40	\$25/\$50	\$30/\$50	\$30/\$50	20% after CY Ded
ANNUAL VISION EXAM (Blue View Vision Participating Provider)	\$15 \$30 OON allowance	\$15 \$30 OON allowance	\$15 \$30 OON allowance	\$15 \$30 OON allowance	\$15 \$30 OON allowance
CALENDAR YEAR DEDUCTIBLE – Individual/Family	N/A	\$500/\$1000	\$1000/\$2000	\$2000/\$4000	\$3000/\$6000[6]
DIAGNOSTIC LAB/X-RAY	20%	20% after CY Ded	20% after CY Ded	30% after CY Ded	20% after CY Ded
ADVANCED DIAGNOSTIC IMAGING (MRI, MRA, CT SCAN, ETC.)					
Office & O/P Facility Setting	20%	20% after CY Ded	20% after CY Ded	30% after CY Ded	20% after CY Ded
PHYSICAL, OCCUPATIONAL, SPEECH THERAPY [1]					
Office Setting	\$10	20% after CY Ded	20% after CY Ded	30% after CY Ded	20% after CY Ded
Outpatient Facility Setting	\$10 + 20%	20% after CY Ded	20% after CY Ded	30% after CY Ded	20% after CY Ded
SPINAL MANIPULATION & MANUAL MEDICAL THERPAY SERVICES [2]					
Office & Outpatient Facility Setting	\$20/\$40	\$25	\$25	\$25	20% after CY Ded
OUTPATIENT SURGERY [3]	\$200 + 20%	20% after CY Ded	20% after CY Ded	30% after CY Ded	20% after CY Ded
MATERNITY PRE/POST NATAL CARE [4]	\$200	20% after CY Ded	20% after CY Ded	30% after CY Ded	20% after CY Ded
MENTAL HEALTH/SUBSTANCE ABUSE VISITS					
Office Visits	\$20	\$25	\$30	\$30	20% after CY Ded
O/P Facility (Partial Day/Intensive O/P) O/P Facility	20%	20% after CY Ded	20% after CY Ded	30% after CY Ded	20% after CY Ded
INPATIENT HOSPITAL SERVICES [5]	\$400 + 20%	20% after CY Ded	20% after CY Ded	30% after CY Ded	20% after CY Ded
EMERGENCY ROOM	\$200 + 20%	20% after CY Ded	20% after CY Ded	30% after CY Ded	20% after CY Ded
OUT OF NETWORK BENEFIT					
CY Deductible – Individual/Family	\$500/\$1000	\$750/\$1500	\$1500/\$3000	\$3500/\$7000	\$3000/\$6000 [6]
Coinsurance	30% after CY Ded	40% after CY Ded	40% after CY Ded	50% after CY Ded	40% after CY Ded
OUT-OF-POCKET					
In-Network	\$3500/\$7000 (7)	\$4000/\$8000 (7)	\$4500/\$9000 (7)	\$6000/12000 (7)	\$5000/10000
Out of Network	\$5000/\$10000 (7)	\$5500/\$11000 (7)	\$6250/\$12500 (7)	\$8500/\$17000 (7)	\$10000/\$20000
PHARMACY	Retail/Home Delivery: \$100 individual/\$200 family CY Deductible (does not apply to Tier 1) 30 Day Supply: Tier 1-\$15, Tier 2-\$45 after CY Ded, Tier 3-\$85 after CY Ded, Tier 4-10% after CY Ded (\$200 max) 90 Day Supply: Tier 1-\$30, Tier 2-\$90 after CY Ded, Tier 3-\$170 after CY Ded, Tier 4-10% after CY Ded (\$400 max) CPS Wellness Center: 30 Day Supply: Tier 1-\$2, Tier 2-\$20, Tier 3-\$40, Tier 4-10% (\$200 max) 90 Day Supply: Tier 1-\$4, Tier 2-\$40, Tier 3-\$80, Tier 4-10% (\$400 max)				[8]

[1] 30 combined PT/OT visits per CY, 30 ST visits per CY

[2] 30 visits per CY

[3] Free standing ambulatory surgery center or hospital based facility

[4] All routine outpatient pre and postnatal care of the mother rendered by the OB/GYN

[5] Includes Inpatient stays for Mental Health/Substance Abuse & Maternity

[6] Combined in & out of network

[7] Under the Affordable Care Act, prescription, medical and behavioral costs all count toward one combined out of pocket maximum.

[8] Pharmacy Benefit for Lumenos with HSA plan is the same as all other plans except that it does not include the \$100/\$200 CY Deductible.