

Spotsylvania County Public Schools
Medical Benefit Plan Options -- October 1, 2017 – September 30, 2018

BENEFITS	KEYCARE EXPANDED (patient liability)	KEYCARE 200 (patient liability)	KEYCARE 500 (patient liability)
PLAN YEAR DEDUCTIBLE	\$100 individual / \$200 family	\$200 individual / \$400 family	\$500 individual / \$1,000 family
OUTPATIENT OFFICE VISITS Primary Care Physician (PCP) Specialist	NOT SUBJECT TO PLAN YEAR DEDUCTIBLE \$15 copayment \$25 copayment	NOT SUBJECT TO PLAN YEAR DEDUCTIBLE \$20 copayment \$40 copayment	NOT SUBJECT TO PLAN YEAR DEDUCTIBLE \$25 copayment \$40 copayment
PREVENTIVE CARE and WELL BABY CARE	NOT SUBJECT TO PLAN YEAR DEDUCTIBLE \$0 copayment	NOT SUBJECT TO PLAN YEAR DEDUCTIBLE \$0 copayment	NOT SUBJECT TO PLAN YEAR DEDUCTIBLE \$0 copayment
AUTISM SPECTRUM DISORDER Diagnosis and Treatment Applied Behavioral Analysis	Member cost shares will be dependent on services rendered 20% coinsurance	Member cost shares will be dependent on services rendered 20% coinsurance	Member cost shares will be dependent on services rendered 20% coinsurance
AMBULANCE SERVICES	AFTER PLAN YEAR DEDUCTIBLE 20% coinsurance	AFTER PLAN YEAR DEDUCTIBLE 20% coinsurance	AFTER PLAN YEAR DEDUCTIBLE 20% coinsurance
DIAGNOSTIC TESTS	NOT SUBJECT TO PLAN YEAR DEDUCTIBLE 10% coinsurance	AFTER PLAN YEAR DEDUCTIBLE 20% coinsurance	AFTER PLAN YEAR DEDUCTIBLE 20% coinsurance
EMERGENCY ROOM	FACILITY: NOT SUBJECT TO PLAN YEAR DEDUCTIBLE \$100 copayment PROFESSIONAL: NOT SUBJECT TO PLAN YEAR DEDUCTIBLE \$15 / \$25 copayment	FACILITY and PROFESSIONAL: AFTER PLAN YEAR DEDUCTIBLE 20% coinsurance	FACILITY: AFTER PLAN YEAR DEDUCTIBLE 20% coinsurance PROFESSIONAL: NOT SUBJECT TO PLAN YEAR DEDUCTIBLE \$25 / \$40 copayment
INPATIENT HOSPITAL SERVICES	FACILITY: NOT SUBJECT TO PLAN YEAR DEDUCTIBLE \$200 copayment PROFESSIONAL: NOT SUBJECT TO PLAN YEAR DEDUCTIBLE 0% coinsurance	FACILITY and PROFESSIONAL: AFTER PLAN YEAR DEDUCTIBLE 20% coinsurance	FACILITY: AFTER PLAN YEAR DEDUCTIBLE 20% coinsurance PROFESSIONAL: NOT SUBJECT TO PLAN YEAR DEDUCTIBLE 0% coinsurance
MATERNITY CARE	FACILITY: NOT SUBJECT TO PLAN YEAR DEDUCTIBLE \$200 copayment PROFESSIONAL (global bill): NOT SUBJECT TO PLAN YEAR DEDUCTIBLE 0% coinsurance	FACILITY and PROFESSIONAL (global bill): AFTER PLAN YEAR DEDUCTIBLE 20% coinsurance	FACILITY: AFTER PLAN YEAR DEDUCTIBLE 20% coinsurance PROFESSIONAL (global bill): NOT SUBJECT TO PLAN YEAR DEDUCTIBLE 0% coinsurance
MEDICAL EQUIPMENT - DURABLE	AFTER PLAN YEAR DEDUCTIBLE 20% coinsurance	AFTER PLAN YEAR DEDUCTIBLE 20% coinsurance	AFTER PLAN YEAR DEDUCTIBLE 20% coinsurance
MENTAL HEALTH and SUBSTANCE ABUSE OFFICE VISITS	NOT SUBJECT TO PLAN YEAR DEDUCTIBLE \$0 copayment	NOT SUBJECT TO PLAN YEAR DEDUCTIBLE \$0 copayment	NOT SUBJECT TO PLAN YEAR DEDUCTIBLE \$0 copayment

SURGERY - OUTPATIENT	FACILITY: NOT SUBJECT TO PLAN YEAR DEDUCTIBLE \$100 copayment PROFESSIONAL: NOT SUBJECT TO PLAN YEAR DEDUCTIBLE \$15 / \$25 copayment	FACILITY and PROFESSIONAL: AFTER PLAN YEAR DEDUCTIBLE 20% coinsurance	FACILITY: AFTER PLAN YEAR DEDUCTIBLE 20% coinsurance PROFESSIONAL: NOT SUBJECT TO PLAN YEAR DEDUCTIBLE \$25 / \$40 copayment
SKILLED NURSING FACILITY 180 day per stay limit	FACILITY and PROFESSIONAL NOT SUBJECT TO PLAN YEAR DEDUCTIBLE 0% coinsurance	FACILITY and PROFESSIONAL: AFTER PLAN YEAR DEDUCTIBLE 20% coinsurance	FACILITY and PROFESSIONAL: NOT SUBJECT TO PLAN YEAR DEDUCTIBLE 0% coinsurance
THERAPIES (physical, occupational, and speech)	AFTER PLAN YEAR DEDUCTIBLE 10% coinsurance	AFTER PLAN YEAR DEDUCTIBLE 20% coinsurance	AFTER PLAN YEAR DEDUCTIBLE 20% coinsurance
PRESCRIPTION DRUGS Retail (30 day supply) Mail Order (90 day supply)	Tier 1 \$10 / Tier 2 \$20 / Tier 3 \$35 Tier 1 \$20 / Tier 2 \$40 / Tier 3 \$70	Tier 1 \$10 / Tier 2 \$20 / Tier 3 \$35 Tier 1 \$20 / Tier 2 \$40 / Tier 3 \$70	Tier 1 \$10 / Tier 2 \$20 / Tier 3 \$35 Tier 1 \$20 / Tier 2 \$40 / Tier 3 \$70
OUT-OF-POCKET (in-network) COMBINED MEDICAL and PRESCRIPTION DRUG	\$1,000 individual / \$2,000 family	\$2,000 individual / \$4,000 family	\$3,000 individual / \$6,000 family
OUT OF NETWORK BENEFITS: PLAN YEAR DEDUCTIBLE COINSURANCE OUT-OF-POCKET	\$200 individual / \$400 family Varies (25% - 45%) \$2,000 individual / \$4,000 family	\$300 individual / \$600 family 40% \$2,750 individual / \$5,500 family	\$1,000 individual / \$2,000 family 30% \$6,000 individual / \$12,000 family
VISION EXAM - ANNUAL	\$25 co-pay (\$50 out of network allowance)	\$40 co-payment (\$50 out of network allowance)	\$40 co-payment (\$50 out of network allowance)
DENTAL Not covered unless enrolled in a separate dental plan	Enrollment in separated Dental Plan required Maximum plan pays \$1,500	Enrollment in separate Dental Plan required Maximum plan pays \$1,500	Enrollment in separate Dental Plan required Maximum plan pays \$1,500



HealthSmart Benefit Solutions

Spotsylvania County Public Schools

Retiree Medicare Supplement Plan

Covered persons may choose any physician or hospital without the reimbursement levels from the plan being affected.

The medical benefits plan is a supplement to Medicare, Parts A and B only. Medicare Part A and Medicare Part B must pay first before any benefits are payable under this plan except for dental and vision benefits. All payments under this plan are subject to the Medicare-approved charges.

Medicare Part A—supplemental benefits

	Service	Plan Pays
Hospital in-patient	Part A deductible per benefit period—days 1-60	100%, after a \$100 deductible
	Part A—daily hospital co-payment—days 61-90	100% of Medicare allowable, after Medicare payment
	Hospital reasonable and customary charges — days 91-120	100% of Medicare allowable, after Medicare payment
	Co-payment for lifetime reserve days (60 days maximum per lifetime)	100%
Skilled nursing facility	Medicare skilled nursing home co-payment—days 21-100 (Medicare covers day 1-20 in full)	100%
	Days 101—180	100% of amount equal to Medicare home co-payment

Medicare Part B—supplemental benefits

Medicare pays 80% and this Plan pays 20% of Medicare approved charges for Part B services. Members must pay the Part B deductible and their 20% co-insurance up to a \$1,000 out-of-pocket, including the Part B deductible before any Part B benefits are payable under this plan

	Service	Plan Pays
Medicare Part B	Physicians care	After \$1,000 of out-of-pocket expenses are met, including the Part B deductible
	Diagnostic, x-ray, and lab (DXL)	100%, after Medicare payment
	Ambulance services	100%, after Medicare payment
	Durable medical equipment	100%, after Medicare payment
	Chiropractic services	100%, after Medicare payment
	Routine mammograms	100%, after Medicare payment

There are no benefits payable under this plan for Medicare Part D

Additional benefits—not part of Medicare

	Service	Plan Pays
	Calendar year deductible (per person)	None
	Maximum annual benefit	\$1,200
Dental benefits	Class I—preventive and diagnostic care	100%
	Class II—primary dental care	80%
Vision benefits	Routine vision exam (once in a 24-month period)	100% up to \$40
	Frames (once in a 24-month period)	100% up to \$75
	Lenses (once in a 24-month period)	100% up to:
	Single	\$50
	Bifocal	\$75
	Trifocal	\$100
	Contacts	\$100

(continued on reverse)

Comparison of Medicare and this plan

Part A services	Medicare	This plan
Hospital in-patient	Pays up to 60 days of medically necessary services, except Part A hospital deductible	Pays Medicare Part A deductible except for the first \$100
	Pays up to an additional 30 days, except daily co-insurance	Pays Medicare Part A co-insurance
	If more than a 90-day hospital stay, possible use of up to 60 Medicare lifetime reserve days, subject to daily co-insurance	Pays 100% of the allowable charge for an additional 30 days
	No payment for more than a 90-day hospital stay if no lifetime reserve days remain or if you choose not to use them	
Skilled nursing facility	Pays up to 100% for 20 days at a medically necessary skilled nursing facility	Pays Medicare Part A co-insurance (days 21–100)
	Pays up to an additional 80 days at a skilled nursing facility, except daily co-insurance	Pays above co-insurance amount for an additional 80 days per Medicare benefit period
	Medicare does not pay for more than 100 days at a skilled nursing facility in a benefit period	
Part B services	Medicare	This plan
Physician and other services	Generally pays 80% of Medicare-approved charges for services such as: doctor's care, out-patient physical and occupational therapy, and designated screenings An annual Medicare Part B deductible may apply	Pays Medicare Part B co-insurance after you pay the \$1,000 calendar year deductible, which includes the Part B deductible
Part D services	Medicare	This plan
Prescription drug coverage	Pays a benefit based on the specific Part D plan in which the beneficiary is enrolled	Not covered under this plan
Other services	Medicare	This plan
Routine vision benefits	Not covered	Pays up to \$40 per exam, \$75 for frames, and up to various maximum amounts for lenses; once in a 24 month period
Routine dental benefits	Not covered	Pays up to an annual maximum benefit of \$1,200 Pays 100% for preventive services and 80% for primary services



Make your next chapter
your best chapter

A complete benefits guide for your retirement

Anthem Blue Cross and Blue Shield
Blue MedicareRx (PDP) with Senior Rx Plus

2018 Group Plan
Spotsylvania County Public Schools

Your 2018 Prescription Drug Benefit Chart
8/30/60/30% (Generic Gap) (with Senior Rx Plus)
Spotsylvania County Public Schools
Effective January 1, 2018

Your retiree drug coverage includes Medicare Part D drug benefits and non-Medicare supplemental drug benefits. The cost shown below is what you pay after all benefits under your retiree drug coverage have been provided.

Formulary	Closed
Deductible	\$0
Supplemental Gap Coverage	Tier 1 Generics
Covered Services	What you pay

Part D Initial Coverage

Below is your payment responsibility from the time you meet your deductible, if you have one, until the amount paid by you and your retiree drug plan for covered Part D prescriptions reaches your Initial Coverage Limit of \$3,750.

Retail Pharmacy	per 30-day supply (Specialty limited to a 30-day supply)
<ul style="list-style-type: none"> • Select Generics • Generics 	\$0 copay \$8 copay
<ul style="list-style-type: none"> • Preferred Brands • Non-Preferred Brands 	\$30 copay \$60 copay
<ul style="list-style-type: none"> • Specialty Drugs (Generic and Brand) 	30% coinsurance

Typically retail pharmacies dispense a 30-day supply of medication. Many of our retail pharmacies can dispense more than a 30-day supply of medication. If you purchase more than a 30-day supply at these retail pharmacies, you will need to pay one copay for each full or partial 30-day supply filled. For example, if you order a 90-day supply, you will need to pay three 30-day supply copays. If you get a 45-day or 50-day supply, you will need to pay two 30-day copays.

Mail-Order Pharmacy	per 90-day supply (Specialty limited to a 30-day supply)
<ul style="list-style-type: none"> • Select Generics • Generics 	\$0 copay \$12 copay
<ul style="list-style-type: none"> • Preferred Brands • Non-Preferred Brands 	\$75 copay \$150 copay
<ul style="list-style-type: none"> • Specialty Drugs (Generic and Brand) 	30% coinsurance

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2018 Custom 8/30/60/30% Spotsylvania County Public Schools Generic Gap

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Covered Services	What you pay
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Part D Gap Coverage

Your payment responsibility changes once you reach your Initial Coverage Limit of \$3,750. Below is your payment responsibility during the period after you meet your Initial Coverage Limit and before Catastrophic coverage begins.

Retail Pharmacy	per 30-day supply (Specialty limited to a 30-day supply)
<ul style="list-style-type: none"> • Select Generics • Generics 	\$0 copay \$8 copay
<ul style="list-style-type: none"> • Preferred Brands 	35% coinsurance (See Coverage Gap Discount Explanation below chart)
<ul style="list-style-type: none"> • Non-Preferred Brands 	35% coinsurance (See Coverage Gap Discount Explanation below chart)
<ul style="list-style-type: none"> • Specialty Drugs (Generic) • Specialty Drugs (Brand) 	44% coinsurance 35% coinsurance (See Coverage Gap Discount Explanation below chart)
Mail-Order Pharmacy	per 90-day supply (Specialty limited to a 30-day supply)
<ul style="list-style-type: none"> • Select Generics • Generics 	\$0 copay \$12 copay
<ul style="list-style-type: none"> • Preferred Brands 	35% coinsurance (See Coverage Gap Discount Explanation below chart)
<ul style="list-style-type: none"> • Non-Preferred Brands 	35% coinsurance (See Coverage Gap Discount Explanation below chart)
<ul style="list-style-type: none"> • Specialty Drugs (Generic) • Specialty Drugs (Brand) 	44% coinsurance 35% coinsurance (See Coverage Gap Discount Explanation below chart)
Part D Catastrophic Coverage	
Your payment responsibility changes after the cost you and the Coverage Gap Discount Program have paid for covered drugs reaches your True Out of Pocket limit of \$5,000.	
<ul style="list-style-type: none"> • Select Generics • Generic Drugs 	\$0 copay 5% coinsurance with a minimum copay of \$3.35 and a maximum copay of \$8.00 (Specialty limited to a 30-day supply)
<ul style="list-style-type: none"> • Brand-Name Drugs 	5% coinsurance with a minimum copay of \$8.35 and a maximum copay of \$30.00 (Specialty limited to a 30-day supply)