FY 2018 Recommended Budget

Budget Question

Board Question #: 43

BUDGET QUESTION: Please compare and contrast the County and Schools health plans, their cost per employee, and their total cost.

RESPONSE: Please see Attachment A for a comparison of plan information. Please see Attachment B for a comparison of monthly employer, employee, and total premium costs for each plan.

Attachment A

Benefit Comparison Spotsylvania Schools & Government
2016 - 2017

	Spotsylvania Public Schools			Spotsylvania County Government	
	KeyCare Expanded (patient liability)	**KeyCare 200 (patient liability)**	**KeyCare 500 (patient liability)**	**OPTIONAL PLAN KEYCARE 20 (patient liability)**	**BASIC PLAN KEYCARE 30 (patient liability)**
DEDUCTIBLE CY(January 1 through December 31) or PY(Plan Year)	$100 individual / $200 family	$200 individual / $400 family	$500 individual / $1,000 family	$0 individual / $0 family CY	$500 individual / $1,000 family CY
OUTPATIENT OFFICE VISITS Primary Care Physician (PCP) Specialist	NOT SUBJECT TO PLAN YEAR DEDUCTIBLE $15 copay $25 copay	NOT SUBJECT TO PLAN YEAR DEDUCTIBLE $20 copay $40 copay	NOT SUBJECT TO PLAN YEAR DEDUCTIBLE $25 copay $40 copay	$20 copayment $40 copayment	DEDUCTIBLE DOES NOT APPLY $30 copayment $50 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	$0 copayment	DEDUCTIBLE DOES NOT APPLY $0 copayment
ANNUAL VISION EXAM	$25 co-pay ($50 out of network allowance)	$40 co-payment ($50 out of network allowance)	$25 co-pay ($50 out of network allowance)	$15 co-payment ($30 out of network allowance)	DEDUCTIBLE DOES NOT APPLY $15 co-payment ($30 out of network allowance)
DIAGNOSTIC TESTS	NOT SUBJECT TO PLAN YEAR DEDUCTIBLE 10% coinsurance	AFTER PLAN YEAR DEDUCTIBLE 20% coinsurance	AFTER PLAN YEAR DEDUCTIBLE 20% coinsurance	20% coinsurance	SUBJECT TO DEDUCTIBLE 20% coinsurance

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2016 - 2017

Attachment A

	Spotsylvania Public Schools			Spotsylvania County Government	
	KeyCare Expanded (patient liability)	**KeyCare 200 (patient liability)**	**KeyCare 500 (patient liability)**	**OPTIONAL PLAN KEYCARE 20 (patient liability)**	**BASIC PLAN KEYCARE 30 (patient liability)**
THERAPIES: Physical, speech, occupational	AFTER PLAN YEAR DEDUCTIBLE 10% coinsurance	AFTER PLAN YEAR DEDUCTIBLE 20% coinsurance	AFTER PLAN YEAR DEDUCTIBLE 20% coinsurance	FACILITY: $40 copayment + 20% coinsurance PROFESSIONAL: $20/$40 copayment Physical and occupational therapy have a combined 30 visit limit per calendar year. Speech therapy has a 30 visit limit per calendar year.	FACILITY and PROFESSIONAL: SUBJECT TO DEDUCTIBLE 20% coinsurance Physical and occupational therapy have a combined 30 visit limit per calendar year. Speech therapy has a 30 visit limit per calendar year.
OUTPATIENT SURGERY	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	FACILITY: $100 copayment + 20% coinsurance PROFESSIONAL: $20/$40 copayment	FACILITY and PROFESSIONAL: SUBJECT TO DEDUCTIBLE 20% 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	FACILITY: $400 copayment + 20% coinsurance PROFESSIONAL (global bill): 20% coinsurance	FACILITY and PROFESSIONAL: SUBJECT TO DEDUCTIBLE 20% coinsurance

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2016 - 2017

Attachment A

	Spotsylvania Public Schools			Spotsylvania County Government	
	KeyCare Expanded (patient liability)	KeyCare 200 (patient liability)	KeyCare 500 (patient liability)	OPTIONAL PLAN KEYCARE 20 (patient liability)	BASIC PLAN KEYCARE 30 (patient liability)
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	$20 copayment	DEDUCTIBLE DOES NOT APPLY $30 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	FACILITY: $400 copayment + 20% coinsurance PROFESSIONAL: 20% coinsurance	FACILITY and PROFESSIONAL: SUBJECT TO DEDUCTIBLE 20% coinsurance NO CO-PAY APPLIES
SKILLED NURSING FACILITY 100 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	FACILITY and PROFESSIONAL: 20% coinsurance	FACILITY and PROFESSIONAL: SUBJECT TO DEDUCTIBLE 20% coinsurance
DURABLE MEDICAL EQUIPMENT	AFTER PLAN YEAR DEDUCTIBLE 20% coinsurance	AFTER PLAN YEAR DEDUCTIBLE 20% coinsurance	AFTER PLAN YEAR DEDUCTIBLE 20% coinsurance	20% coinsurance	SUBJECT TO DEDUCTIBLE 20% coinsurance
AMBULANCE SERVICES	AFTER PLAN YEAR DEDUCTIBLE 20% coinsurance	AFTER PLAN YEAR DEDUCTIBLE 20% coinsurance	AFTER PLAN YEAR DEDUCTIBLE 20% coinsurance	20% coinsurance	SUBJECT TO DEDUCTIBLE 20% coinsurance

Attachment A

Benefit Comparison Spotsylvania Schools & Government
2016 - 2017

	Spotsylvania Public Schools			Spotsylvania County Government	
	KeyCare Expanded (patient liability)	**KeyCare 200 (patient liability)**	**KeyCare 500 (patient liability)**	**OPTIONAL PLAN KEYCARE 20 (patient liability)**	**BASIC PLAN KEYCARE 30 (patient liability)**
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	FACILITY: $100 copayment + 20% coinsurance PROFESSIONAL: $20/$40 copayment	FACILITY and PROFESSIONAL: SUBJECT TO DEDUCTIBLE 20% coinsurance NO CO-PAY APPLIES
OUT-OF-POCKET (in-network)	$1,000 individual / $2,000 family	$2,000 individual / $4,000 family	$3,000 individual / $6,000 family	$3,000 individual / $6,000 family COPAYMENTS, and COINSURANCE ACCUMULATE TO ANNUAL OUT-OF-POCKET	$3,500 individual / $7,000 family DEDUCTIBLE, COPAYMENTS, and COINSURANCE ACCUMULATE TO ANNUAL OUT-OF-POCKET
(out-of-network) CALENDAR 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	$500 individual / $1,000 family 30% coinsurance $4,500 individual / $9,000 family COMBINED MEDICAL and PRESCRIPTION DRUG CALENDAR YEAR	$1,500 individual / $3,000 family 40% coinsurance $5,250 individual / $10,500 family COMBINED MEDICAL and PRESCRIPTION DRUG CALENDAR YEAR

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2016 - 2017

	Spotsylvania Public Schools			Spotsylvania County Government	
	KeyCare Expanded (patient liability)	KeyCare 200 (patient liability)	KeyCare 500 (patient liability)	OPTIONAL PLAN KEYCARE 20 (patient liability)	BASIC PLAN KEYCARE 30 (patient liability)
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	Tier 1$10 /Tier 2$20 /Tier 3$35 Tier 1$10 /Tier 2$40 /Tier 3$105	Tier 1$10 /Tier 2$30 /Tier 3$50 Tier 1$10 /Tier 2$60 /Tier 3$150

Rate Comparison Spotsylvania Schools & Government 2016-2017

Active Full Time Employees Rates 2016-2017

	Spotsylvania Schools								
	KeyCare Expanded			KeyCare 200			KeyCare 500 (Basic Plan)		
Coverage Level	Total Monthly Cost	Employer Montly Cost	Employee Monthly Cost	Total Monthly Cost	Employer Monthly Cost	Employee Monthly Cost	Total Monthly Cost	Employer Montly Cost	Employee Monthly Cost
Employee Only	806.61	674.98	131.63	785.67	690.90	94.77	696.40	674.98	21.42
Premium split		84%	16%		88%	12%		97%	3%
Employee + 1 Child	1469.28	1101.42	367.86	1431.31	1131.73	299.58	1265.76	1101.42	164.34
Premium split		75%	25%		79%	21%		87%	13%
Employee + Spouse	1469.28	1101.42	367.86	1431.31	1131.73	299.58	1265.76	1101.42	164.34
Premium split		75%	25%		79%	21%		87%	13%
Employee + Family	2146.80	1518.51	628.29	2091.38	1564.29	527.09	1828.82	1518.51	310.31
Premium split		71%	29%		75%	25%		83%	17%
Employee + Children	2146.80	1518.51	628.29	2091.38	1564.29	527.09	1828.82	1518.51	310.31
Premium split		71%	29%		75%	25%		83%	17%

Dental

	Spotsylvania County Government					
	KeyCare 20			KeyCare 30 (Basic Plan)		
Coverage Level	Total Monthly Cost	Employer Monthly Cost	Employee Monthly Cost	Total Monthly Cost	Employer Monthly Cost	Employee Monthly Cost
Employee Only	649.00	551.00	98.00	605.00	551.00	54.00
Premium split		85%	15%		91%	9%
Employee + 1 Child	935.00	743.00	192.00	875.00	743.00	132.00
Premium split		79%	21%		85%	15%
Employee + Spouse	1409.00	1121.00	288.00	1319.00	1121.00	198.00
Premium split		80%	20%		85%	15%
Employee + Family	1714.00	1364.00	350.00	1604.00	1364.00	240.00
Premium split		80%	20%		85%	15%
Employee + Children	1714.00	1364.00	350.00	1604.00	1364.00	240.00
Premium split		80%	20%		85%	15%