City of Fredericksburg			
Medical Benefit Comparison - Effective July 1, 2020			
Anthem Blue Cross and Blue Shield			
Benefit Options	**Lumenos HSA**	**HealthKeepers 20**	**KeyCare 300**
Network Information	**PPO Network**	**POS Open Access (HMO)**	**PPO Network**
Deductibles, Plan Limits and Out-of-Pocket Maximums are based on a calendar year			
In-Network Benefits			
Calendar Year Deductible (Applies to Inpatient and Most Outpatient Facility Services)			
Individual / Family	$2,000/$4,000	$0	$300/$600
Calendar Year Out-of-Pocket Limit - Medical			
Individual / Family	$4,000/$8,000	$3,000/$6,000	$3000/$6000
Referrals	Not Required	Not Required	Not Required
Preventive Care			
Preventive Care	$0	$0	$0
Preventive Screening (mammograms, pap tests, PSA's, etc.)	$0	$0	$0
Well Baby Care	$0	$0	$0
Professional Provider/Other Outpatient Services			
Primary Care Physician	20% After CY Deductible	$20	20% After CY Deductible
Specialist	20% After CY Deductible	$40	20% After CY Deductible
Urgent Care Facility	20% After CY Deductible	$40	20% After CY Deductible
Diagnostic Outpatient X-Ray and Lab Tests	20% After CY Deductible	20%	20% After CY Deductible
Outpatient Mental Health and Substance Abuse	20% After CY Deductible	$20 office-based; 20% facility-based	20% After CY Deductible
Ambulatory and Hospital Facility Services			
Hospital Emergency Room	20% After CY Deductible	$200 co-pay	20% After CY Deductible
Ambulance Travel (Ground or Air)	20% After CY Deductible	20%	20% After CY Deductible
OP Facility MRI, CAT, PET, Nuclear	20% After CY Deductible	20%	20% After CY Deductible
Outpatient Surgery Facility	20% After CY Deductible	$200 co-pay/visit + 20% co-insurance	20% After CY Deductible
Inpatient (no days limit)	20% After CY Deductible	$400 co-pay/admission + 20% co-insurance	20% After CY Deductible
Home Health Care Services	20% After CY Deductible (100 visits/year)	20% (100 visits/year)	20% After CY Deductible (100 visits/year)
Maternity (diagnositic tests not included in pre & post natal copay)	20% After CY Deductible	$20/$40 co-pay + Inpatient Copay and Coinsurance for delivery	20% After CY Deductible
Other Medical Services			
Rehab./Physical, Speech &	20% After CY Deductible	$40 per visit	20% After CY Deductible
	60 visit maximum Outpatient Short Term Rehab. (Physical and OT combined; Speech separate) per calendar year	60 visit maximum Outpatient Short Term Rehab. (Physical and OT combined; Speech separate) per calendar year	60 visit maximum Outpatient Short Term Rehab. (Physical and OT combined; Speech separate) per calendar year
Skilled Nursing Home Facility (100 days per admission)	20% After CY Deductible	20%	20% After CY Deductible
See Anthem Summary of Benefits for a complete coverage details			
Outpatient Prescription Drugs			
Retail Pharmacies: up to 30-day supply	Level 1 Pharmacy: Tier 1: $10, Tier 2: $40, Tier 3: $60, Tier 4: 20% up to $250 per prescription Level 2 Pharmacy: Tier 1: $20, Tier 2: $50, Tier 3: $70, Tier 4: 20% up to $250 per prescription HSA Plan - Include Preventive Maintenance Rx (see Summary of Benefits)		
Mail Order Maintenance: up to 90-day supply	Tier 1: $20, Tier 2: $80, Tier 3: $120, Tier 4: Not Available HSA Plan - Includes Preventive Maintenance Rx (see Summary of Benefits)		
Retail (select) Pharmacies up to 90-day supply	Tier 1: $30, Tier 2: $90, Tier 3: $150, Tier 4: Not Available HSA Plan - Includes Preventive Maintenance Rx (see Summary of Benefits)		
Calendar Year Out-of-Pocket Limit - Prescription Drugs			
Individual / Family	Included in medical out of pocket (see above)	$3,350/$6,700	$3,350/$6,700
Out-of-Network Coverage	Anthem Blue Cross Blue Shield will pay non-participating provider on the in-network contracted costs and these physicians		
Calendar Year Deductible (Individual/Family)	$4,000/$8,000	$500/$1,000	$400/$800
Benefits after Deductible	40% co-insurance on all services	30% co-insurance on all services	40% co-insurance on all services
Maximum Out of Pocket	$8,000/$16,000	$4,500/$9,000	$4,000/$8,000
Vision			
Exam Copay - In Network	$15	$15	$15
Exam Allowance (once per 12 month period)	Covered 100% after Copay (does not include contact lense exam)	Covered 100% after Copay (does not include contact lense exam)	Covered 100% after Copay (does not include contact lense exam)
***See Anthem Summary of Benefits for a complete coverage details**			