Health Insurance Plans

This is a brief comparison. For more information and limits, consult the Summary of Benefits booklet for each plan.

AC = Allowable Charge	Optima (HMO)	HealthKeepers (HMO)	KeyCare (POS)	
Pre-Existing Condition Waiting Period	None	None	None if meets continued coverage criteria	
Dependent Coverage to the end of Calendar Year	**Until 23**	**Until 23**	**Until 23**	
Out of Area Coverage	Out of area dependent rider (enrollment required) Emergency & urgent care only	Emergency & urgent care; may choose PCP in other location; special program if living out of state	Emergency and urgent care; may choose PCP in other location; otherwise out of network benefits apply	
			In Network	**Out of Network**
Open Access	No referral needed to see specialist	Referral needed	Referral needed	No Referral Needed
Deductible per Year	None	None	None	$400/person $800/family
Out of Pocket Maximum per Year	$2000/person $4000/family	$1500/person $3000/family	$2000/person $4000/family	$4000/person $8000/family
Physician Services				
PCP Office Visit	$10 copay then covered at 100%	$10 copay then covered at 100% 20% Injections copay	$15 copay then covered at 100% 20% Injections copay	Covered at 70% AC after deductible
Specialist Office Visit	$25 copay no referral necessary; covered at 100%	$20 copay then covered at 100% 20% Injections copay	$30 copay then covered at 100% 20% Injections copay	Covered at 70% AC after deductible
Lab, X-ray and Diagnostic	$25 copay then covered at 100% for participating labs	$20 copay then covered at 100%	Covered at 80% AC	Covered at 70% AC after deductible
MRI, MRA,CT,CTA, and PET	$100 copay then covered at 100% Pre authorization required	$100 copay then covered at 100%. Pre authorization required	Covered at 80% AC Pre authorization required	Covered at 70% AC after deductible. Pre authorization required
Physical & Other Therapy	$25 copay then covered at 100%	$20 copay then covered at 100%	$30 copay then covered at 100%	Covered at 70% AC after deductible
Maternity	$100 copay for routine pre & post natal care then covered at 100%	$50 copay for routine pre & post natal care then covered at 100%	$30 copay for routine pre & post natal care then covered at 100%	Covered at 70% AC after deductible

	Optima (HMO)	HealthKeepers (HMO)	KeyCare (POS)	
			In Network	**Out of Network**
Hospital Services				
Inpatient Care	$100 copay per day; $500 max per admission; then covered at 100%	$150 copay per admission then covered at 100%	$300 copay per admission then covered at 80% AC	Covered at 70% AC after deductible
Outpatient Surgery	$100 copay per then covered at 100%	$100 copay then covered at 100%	$100 copay, then covered at 80% AC	Covered at 70% AC after deductible
Emergency Room	$100 copay per visit, then covered at 100%	$100 copay then covered at 100%	$100 copay then covered at 80% AC	Covered at 70% AC after deductible
Urgent Care Center	$25 copay per visit, then covered at 100%	$10 or $20 copay then covered at 100%	$15 or $30 copay then covered at 80% AC	Covered at 70% AC after deductible
Mental Health Care and Substance Abuse Services				
Inpatient	$100 copay per day; $500 max per admission, then covered at 100%	$150 copay per admission then covered at 100%	$300 copay per admission then covered at 80% AC	Covered at 70% AC after deductible
Outpatient	$25 copay per visit then covered at 100%	$20 copay per visit	$30 copay per visit	Covered at 70%AC after deductible
Preventive				
Vision	$15 copay every 12 months	$15 copay every 12 months	$15 copay every 12 months	$30 reimbursement every 12 months
Well Baby	$10 copay then routine immunizations & screenings at 100%	$10 copay then routine immunizations & screenings at 100% to age 7	$15 copay then routine immunizations at 100% & screenings at 80% to age 7	Covered at 70%AC after deductible to age 7
Annual Physical	$10 copay then covered at 100% including mammogram	$10 copay then routine screenings at 100%; $20 copay for mammogram	$15 copay then routine screenings at 80%	Covered at 70%AC after deductible
Prescription Drug Benefits				
Retail	31 day supply Preferred: $10 copay Standard: $20 copay Premium: $40 copay Coordinated with other plans	31 day supply Tier 1: $10 copay Tier 2: $20 copay Tier 3: $35 copay or 20% ($200 max) whichever is greater $3,500 yearly max out of pocket. 20% coinsurance for injectable drugs given in provider's office	31 day supply Tier 1: $10 copay Tier 2: $20 copay Tier 3: $35 copay or 20% ($200 max) whichever is greater; $3,500 yearly max out of pocket.. 20% coinsurance for injectable drugs given in provider's office	
Mail Order	90 day supply Preferred: $20 copay Standard: $40 copay Premium $80 copay Coordinated with other plans	90 day supply Tier 1: $20 copay Tier 2: $40 copay Tier 3: $70 copay or 20% ($400 max) whichever is greater	90 day supply Tier 1: $20 copay Tier 2: $40 copay Tier 3: $70 copay; or 20% ($400 max) whichever is greater	

Dental Options This is a brief comparison. For more information and limits, consult the fee schedule, plan summary and/or evidence of coverage.			
UCR = Usual, Customary and Reasonable Charge	**DeltaCare**	**DeltaPreferred Option 1**	**DeltaPreferred Option 2 is available for an additional premium.**
Type	Managed Care	Fee for Service	Fee for Service
Dentist Choice	From Panel	Any; Maximum benefit if participating dentist	
Deductible per Contract Year	None	None	$50/person per patient $150/family per contract year Diagnostic & Preventive services exempt
Maximum Benefit Amount per Contract Year	No limit	$1,000/person	$1,000/person
Diagnostic & Preventive Services			
Oral Exam & Cleaning (2x/yr)	100%	100% UCR	100% UCR
X-rays (bitewings 1x/yr; full mouth 1x/3yrs)	100%	100% UCR	100% UCR
Sealants (age 14 and under)	See fee copay schedule	100% UCR	100% UCR
Basic Services			
Fillings	See fee copay schedule	90% Preferred dentists 80% UCR all others	90% Preferred dentists 80% UCR all others after deductible
Oral Surgery & Extractions	See fee copay schedule	90% Preferred dentists 80% UCR all others	90% Preferred dentists 80% UCR all others after deductible
Endodontics/ Periodontics	See fee copay schedule	90% Preferred dentists 80% UCR all others	90% Preferred dentists 80% UCR all others after deductible
Denture Repair/ Recementation	See fee copay schedule	90% Preferred dentists 80% UCR all others	90% Preferred dentists 80% UCR all others after deductible
Major Services			
Crowns (see limits)	See fee copay schedule	Not Covered	60% Preferred dentists 50% UCR all others after deductible
Prosthetic Coverage	See fee copay schedule	Not Covered	60% Preferred dentists 50% UCR all others after deductible
Orthodontics (age 19 and under)	See fee copay schedule	Not Covered	50% UCR after deductible; $1,000/lifetime maximum

For more information, check out HR Online; call Human Resources at 253-6680; or E-mail HR@james-city.va.us.

Health and Dental Benefit Comparison

Plan Year

July 1, 2007 – June 30, 2008

Monthly Insurance Premiums: All health insurance premiums include a choice of DeltaCare OR DeltaPreferred Option 1 dental coverage. An optional upgrade, DeltaPreferred Option 2, is available for an additional employee contribution. Employees who waive health insurance may enroll in dental coverage only and receive a payment of $15.00/month that is added to their paycheck.

Plans	Coverage Type	Total Premium	Employer Pays	Employee Pays Per Month w/DeltaCare or DeltaPreferred Option 1	*Upgrade* Employee Pays Per Month w/ DeltaPreferred Option 2 (Fee-For-Service)
Healthkeepers Health Maintenance Organization(HMO)	Employee Dual Family	$ 396.00 $ 788.00 $1,104.00	$349.00 $675.00 $921.00	$ 47.00 $113.00 $183.00	$ 56.00 $129.00 $200.00
Optima Health Maintenance Organization(HMO)	Employee Dual Family	$412.00 $822.00 $1,158.00	$349.00 $675.00 $921.00	$ 63.00 $147.00 $237.00	$ 72.00 $163.00 $254.00
KeyCare Point of Service(POS)	Employee Dual Family	$ 456.00 $ 911.00 $1,282.00	$349.00 $675.00 $921.00	$107.00 $236.00 $361.00	$116.00 $252.00 $378.00
Dental Only Dental Health Maintenance Organization	Employee Dual Family			$21.00 $39.00 $62.00	$ 30.00 $ 55.00 $ 79.00