

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 (PPO)	
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	Available for all covered services if using Blue Cross/Blue Shield provider	
			In Network	Out of Network
Open Access	No referral needed to see specialist	Referral needed	No 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%	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%	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, MRS, MRA, CT, CTA, and PET Regardless of location	\$100 copay then covered at 100% Pre authorization required	\$150 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 80%	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 (PPO)	
			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%	\$150 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%	\$150 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 17	\$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: \$30 copay Premium: \$50 copay Coordinated with other plans	31 day supply Tier 1: \$10 copay Tier 2: \$30 copay Tier 3: \$50 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: \$30 copay Tier 3: \$50 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: \$60 copay Premium \$100 copay Coordinated with other plans	90 day supply Tier 1: \$20 copay Tier 2: \$60 copay Tier 3: \$100 copay or 20% (\$400 max) whichever is greater	90 day supply Tier 1: \$20 copay Tier 2: \$60 copay Tier 3: \$100 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% ^{AC}	100% ^{AC}
X-rays (bitewings 1x/yr; full mouth 1x/3yrs)	100%	100% ^{AC}	100% ^{AC}
Sealants (age 16 and under)	See fee copy schedule	100% ^{AC}	100% ^{AC}
Basic Services			
Fillings	See fee copy schedule	90% Preferred dentists 80% ^{AC} all others	90% Preferred dentists 80% ^{AC} all others after deductible
Oral Surgery & Extractions	See fee copy schedule	90% Preferred dentists 80% ^{AC} all others	90% Preferred dentists 80% ^{AC} all others after deductible
Endodontics/Periodontics	See fee copy schedule	90% Preferred dentists 80% ^{AC} all others	90% Preferred dentists 80% ^{AC} all others after deductible
Denture Repair/Recementation	See fee copy schedule	90% Preferred dentists 80% ^{AC} all others	90% Preferred dentists 80% ^{AC} all others after deductible
Major Services			
Crowns (see limits)	See fee copy schedule	Not Covered	60% Preferred dentists 50% ^{AC} all others after deductible
Prosthetic Coverage	See fee copy schedule	Not Covered	60% Preferred dentists 50% ^{AC} all others after deductible
Orthodontics (age 19 and under)	See fee copy schedule	Not Covered	50% ^{AC} \$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, 2009 – June 30, 2010

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	\$ 413.00	\$368.00	\$ 45.00	\$ 55.00
	Dual	\$ 823.00	\$711.00	\$112.00	\$129.00
	Family	\$1,153.00	\$971.00	\$182.00	\$200.00
Optima Health Maintenance Organization(HMO)	Employee	\$440.00	\$368.00	\$ 72.00	\$ 82.00
	Dual	\$877.00	\$711.00	\$166.00	\$183.00
	Family	\$1,237.00	\$971.00	\$266.00	\$284.00
KeyCare Preferred Provider (PPO)	Employee	\$ 485.00	\$368.00	\$117.00	\$127.00
	Dual	\$ 970.00	\$711.00	\$259.00	\$276.00
	Family	\$1,365.00	\$971.00	\$394.00	\$412.00
Dental Only Dental Health Maintenance Organization	Employee			\$22.00	\$32.00
	Dual			\$41.00	\$58.00
	Family			\$66.00	\$84.00