Henrico County General Government and Public Schools

Benefit Comparison: January 1, 2017 - December 31, 2017

	Standard POS	Premier POS	Lumenos with HSA
IN NETWORK BENEFITS			
Deductible (Individual/Family)	$150 / $150	$150 / $150	$3,000/$6,000 (combined with out of network)
Out-of-Pocket Maximum	$3,000 / $6,000	$3,000 / $6,000	$4,000 / $8,000
Inpatient Benefits	**You Pay**	**You Pay**	**You Pay**
Hospital	30% after deductible	$200 per day (not to exceed $1,000 per admission) after deductible	0% after deductible
Physician Charges	30% after deductible	No charge	0% after deductible
Maternity (Facility charges for delivery)	30% after deductible	$200 per day (not to exceed $1,000 per admission) after deductible	0% after deductible
Mental Health and Substance Abuse (Facility charges)	30% after deductible	$200 per day (not to exceed $1,000 per admission) after deductible	0% after deductible
Outpatient Benefits	**You Pay**	**You Pay**	**You Pay**
Referrals to Specialist Required	No	No	No
Preventive Care	No charge	No charge	No charge
Primary Care Physician (PCP) or OB/GYN Office Visit	$25	$20	0% after deductible
Specialist Office Visit	$45	$40	0% after deductible
Urgent Care Center	$25 PCP / $45 Specialist	$20 PCP / $40 Specialist	0% after deductible
Allergy Testing	$25 PCP / $45 Specialist	$20 PCP / $40 Specialist	0% after deductible
Allergy Serum and Injections	$25 PCP / $45 Specialist	$10	0% after deductible
Mammogram	No charge	No charge	No charge
Labs, Diagnostic X-rays	No charge	No charge	0% after deductible
Advanced Diagnostic Imaging-in Office setting	10% after deductible	$50 copay after deductible	0% after deductible
Advanced Diagnostic Imaging-All other settings	30% after deductible	$200 after deductible	0% after deductible
Maternity Outpatient Services			
Initial office visit to confirm diagnosis	$25	$20	0% after deductible
Pre- and post-natal care and delivery	$50 per pregnancy	$50 per pregnancy	0% after deductible
Maternity ultrasounds	No charge	No charge	0% after deductible
Emergency Room (waived if admitted to the hospital)	$150	$150	0% after deductible

	Standard POS	Premier POS	Lumenos with HSA
	You Pay	**You Pay**	**You Pay**
Outpatient Surgery Facility **Professional Provider**	30% after deductible 30% after deductible	$200 after deductible No charge	0% after deductible
Outpatient Therapy: occupational, speech and physical	$45	$25	0% after deductible
Spinal Manipulation (30 visit limit per CY)	$25	$25	0% after deductible
Outpatient Mental Health and Substance Abuse	$25	$20	0% after deductible
Durable Medical Equipment	No charge after deductible	No charge after deductible	0% after deductible
Home Health Care (90 visit limit per CY)	$45 per visit after deductible	No charge after deductible	0% after deductible
Skilled Nursing Facility (100 days per admission)	30% after deductible	No charge after deductible	0% after deductible
Hospice Care	30% after deductible	No charge after deductible	0% after deductible
Prescription Drugs	**Mandatory Generic**	**Mandatory Generic**	**Mandatory Generic**
Rx Deductible ***(individual/family)***	$150/$150	$150/$150	Plan deductible applies
Retail Pharmacy ***(30 day supply)***	After deductible: $10/$30/$55	After deductible: $10/$30/$55	After deductible: $10/$30/$55
Mail Order ***(90 day supply)***	After deductible: $10/$60/$165	After deductible: $10/$60/$165	After deductible: $10/$60/$165
Retail 90 ***(90 day supply purchased at a participating retail pharmacy)***	After deductible: $30/$90/$165	After deductible: $30/$90/$165	After deductible: $30/$90/$165
Routine Vision - Blue View Vision			
Annual Routine Eye Exam	$15	$15	$15 (deductible does not apply)
OUT-OF-NETWORK BENEFITS			
Deductible (Individual/Family)	$400/$800	$400/$800	$3,000/$6,000 (combined with in- network)
Coinsurance	30%	30%	30%
Out-of-Pocket Maximum	$3,000/$6,000	$3,000/$6,000	$6,000/$12,000
Lifetime Maximum	**Unlimited**	**Unlimited**	**Unlimited**