KHEO
A Keenan Solution

Employee Benefits 2019 Health Plan Comparison Chart

Medical

Plan Benefits	Anthem Blue Cross HMO			Anthem Blue Cross PPO			
	Premier HMO 10	Classic HMO 20	Classic HMO 35	Premier PPO 250		Classic PPO 500	
	In-Network			In-Network	Out-of-Network	In-Network	Out-of-Network
	Member Responsibility			Member Responsibility			
Plan Year Deductible (Individual/Family)	None	None	None	$250/ $750	$250/$750	$500/$1,500	$1,500/$4,500
Annual Out-of-Pocket Maximum (Individual/Family)	$1,500/$3,000	$2,000/$4,000	$2,500/$5,000	$2,500/$5,000	$7,500/$15,000	$4,000/$8,000	$12,000/$24,000
• Office Visit (Primary Care/Specialist)	$10	$20/$40	$35/$45	$15 †	30%	$30 †	40%
• Preventive Care	No charge	No charge	No charge	No charge †	30%	No charge †	40%
• Inpatient Hospitalization	No charge	$250/admit	$750/admit	10%	30% (max $1,000/day)	20%	40% (max $1,000/day)
• Outpatient Surgery & Other Services	No charge	$125/procedure	$375/procedure	10%	30% (max $350/admit)	20%	40% (max $350/admit)
• Urgent Care	$10	$20	$35	$15 †	30%	$30 †	40%
• Emergency Room Services*	$100	$100	$100	$100, then 10%	$100, then 10%	$150, then 20%	$150, then 20%
• Ambulance	$100/trip	$100/trip	$100/trip	10%	10%	20%	20%
• Physical, Speech, Occupational Therapy	$10	$20 office/$40 hospital	$35 office/$45 hospital	10%	30%	20%	40%
• Chiropractic Therapy, Acupuncture	$10	$20	$35	$15 †	30%	$30 †	40%
• Pre-Natal Care	$10	$20	$35	$15 †	30%	$30 †	40%
• X-Ray and Lab	No charge	No charge	No charge	10%	30%	20%	40%
• Advanced Imaging (MRI, PET, CAT)	$100/test	$100/test	$100/test	10%	30% (max $800/test)	20%	40% (max $800/test)
• Skilled Nursing Facility (100 days)	No charge	No charge	No charge	10%	30%	20%	40%
• Home Health Care (100 visits)	$10	$20	$35	10%	30%	20%	40%
• Hospice Care	No charge	No charge	No charge	No charge †	30%	No charge †	40%
Prescription Drugs		ESSENTIAL FORMULARY ‡				ESSENTIAL FORMULARY ‡	
• Rx Deductible (Individual/Familiy)	None	None	$150/$450	None	None	None	None
• Retail (30-day supply)							
– Generic/Tier 1	$5	$10	$15 †	$5	50% up to $250	$10	50% up to $250
– Formulary Brand/Tier 2	$15	$25	$40	$15	50% up to $250	$25	50% up to $250
– Non-Formulary Brand/Tier 3	$30	$40	$55	$30	50% up to $250	$40	50% up to $250
– Specialty/Tier 4	20% up to $250	20% up to $250	30% up to $250	20% up to $250	50% up to $250	20% up to $250	50% up to $250
• Mail Order (90-day supply)							
– Generic/Tier 1	$5	$10	$37.50 †	$5	N/A	$10	N/A
– Formulary Brand/Tier 2	$30	$50	$120	$30	N/A	$50	N/A
– Non-Formulary Brand/Tier 3	$60	$80	$165	$60	N/A	$80	N/A
– Specialty/Tier 4	20% up to $250	20% up to $250	30% up to $250	20% up to $250	N/A	20% up to $250	N/A

* Emergency Room copay waived if admitted

† Deductible waived

‡ The Essential Formulary offers a variety of brand & generic medication choices. It provides savings by excluding drugs that have lower-cost formulary or over-the-counter (OTC) alternatives, and brands with a generic equivalent. Your doctor can request an exception review if a drug is prescribed that is not covered by the Essential Formulary.

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Medical

Plan Benefits	Anthem Blue Cross HSA					
	PPO HSA 2700		PPO HSA 1350/2700*		PPO HSA 3000**	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
	Member Responsibility					
Plan Year Deductible - Single Coverage	$2,700	$8,100	$1,350	$4,050	$3,000	$3,000
Plan Year Deductible - Family Coverage (Individual/Family)	$2,700/$5,400	$8,100/$16,200	$2,700/$3,000	$4,050/$8,100	$3,000/$6,000	$3,000/$6,000
Annual Out-of-Pocket Maximum (Individual/Family)	$5,000/$10,000	$15,000/$30,000	$3,000/$6,000	$9,000/$18,000	$5,000/$10,000	$10,000/$20,000
• Office Visit (Primary Care/Specialist)	No charge	30%	10%	30%	20%	40%
• Preventive Care	No charge †	30%	No charge †	30%	No charge †	40%
• Inpatient Hospitalization	No charge	30% (max $1,000/day)	10%	30% (max $1,000/day)	20%	40% (max $1,000/day)
• Outpatient Surgery & Other Services	No charge	30% (max $350/day)	10%	30% (max $350/day)	20%	40% (max $350/day)
• Urgent Care	No charge	30%	10%	30%	20%	40%
• Emergency Room Services***	No charge	No charge	10%	10%	20%	20%
• Ambulance	No charge	No charge	10%	10%	20%	20%
• Physical, Speech, Occupational Therapy	No charge	30%	10%	30%	20%	40%
• Chiropractic Therapy, Acupuncture	No charge	30%	10%	30%	20%	40%
• Pre-Natal Care	No charge	30%	10%	30%	20%	40%
• X-Ray and Lab	No charge	30%	10%	30%	20%	40%
• Advanced Imaging (MRI, PET, CAT)	No charge	30% (max $800/test)	10%	30% (max $800/test)	20%	40% (max $800/test)
• Skilled Nursing Facility (100 days)	No charge	30%	10%	30%	20%	40%
• Home Health Care (100 visits)	No charge	30%	10%	30%	20%	40%
• Hospice Care	No charge	30%	10%	30%	20%	40%
Prescription Drugs			RX COPAYS APPLY AFTER DEDUCTIBLE			
• Retail (30-day supply)	ESSENTIAL FORMULARY ‡					
– Generic/Tier 1	$5-$15	30% up to $250	$5-$15	30% up to $250	$10	40% up to $250
– Formulary Brand/Tier 2	$40	30% up to $250	$40	30% up to $250	$30	40% up to $250
– Non-Formulary Brand/Tier 3	$60	30% up to $250	$60	30% up to $250	$50	40% up to $250
– Specialty/Tier 4	30% up to $250	30% up to $250	30% up to $250	30% up to $250	30% up to $250	40% up to $250
• Mail Order (90-day supply)						
– Generic/Tier 1	$12.50 - $37.50	N/A	$12.50-$37.50	N/A	$10	N/A
– Formulary Brand/Tier 2	$120	N/A	$120	N/A	$60	N/A
– Non-Formulary Brand/Tier 3	$180	N/A	$180	N/A	$100	N/A
– Specialty/Tier 4	30% up to $250	N/A	30% up to $250	N/A	30% up to $250	N/A

HSA contribution limit for 2019: $3,500 individual/$7,000 family

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* HSA 1350/2700: Single Participant Deductible applies to members enrolled in single only coverage (defined as individual coverage without dependents.) No one member enrolled in family coverage will pay more than the per family member deductible; the family collectively will pay no more than the family maximum deductible.

** HSA 3000 does not provide Medicare Part D Creditable Coverage

*** Emergency Room copay waived if admitted

† Deductible waived

‡ The Essential Formulary offers a variety of brand & generic medication choices. It provides savings by excluding drugs that have lower-cost formulary or over-the-counter (OTC) alternatives, and brands with a generic equivalent. Your doctor can request an exception review if a drug is prescribed that is not covered by the Essential Formulary.

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Dental

Plan Benefits	Anthem Dental Net HMO	Anthem Blue Cross Dental Complete PPO	
		In-Network	Out-of-Network*
		Member Responsibility	
Calendar Year Deductible	None	$50 per Individual	$50 per Individual
		$150 per Family	$150 per Family
Annual Maximum Benefit	N/A	Plan Pays up to $1,500	Plan Pays up to $1,500
Diagnostic & Preventive Services			
• Oral Exams, Cleanings, X-Rays, Fluoride	$0 copay	No charge (deductible waived)	No charge* (deductible waived)
Basic Services			
• Fillings (amalgam)	$0 copay	20%	20%
• Fillings (resin based composite)	$0 – $85 copay	20%	20%
• Endodontics (root canals)	$0 – $240 copay	20%	20%
• Oral Surgery	$0 – $85 copay	20%	20%
• Periodontics (gum treatment)	$22 – $180 copay	20%	20%
Major Services			
• Crowns, Inlays, Onlays	$0 – $225 copay	50%	50%
• Prosthodontics (Dentures, Bridges)	$0 – $275 copay	50%**	50%**
Orthodontics			
• Child (to age 19)	$1,600	50% (deductible waived)	50% (deductible waived)
• Adult	$1,600	50% (deductible waived)	50% (deductible waived)
• Lifetime Maximum Benefit	None	Plan pays up to $1,500	Plan pays up to $1,500

* When utilizing Non-Participating Dentists, the Plan payment will be based on the Maximum Allowable Charges for the services. You will be responsible to pay the dentist any difference between the Plan's payment and the dentist's full charge for the services.

** There is a 24-month waiting period for replacement of congenitally missing teeth or teeth extracted prior to coverage under this plan.

Vision

Plan Benefits	Anthem Blue Cross Blue View Vision	
	In-Network	Out-of-Network
Frequency		
• Eye Exam	Once every 12 months	
• Lenses/Contacts	Once every 12 months	
• Frames	Once every 24 months	
Copay	MEMBER RESPONSIBILITY	PLAN PAYS
• Exam	$25 copay	Up to $49
• Fitting for Contacts	Up to $55	Not covered
• Materials	$0 copay	Up to allowance schedule
Prescription Lenses	PLAN PAYS	PLAN PAYS
• Single	100%	Up to $35
• Lined Bifocal	100%	Up to $49
• Lined Trifocal	100%	Up to $74
Frames	Up to $130 + 20% off balance	Up to $50
Contacts (in lieu of lenses and frames)	Up to $130 + 15% off balance	Up to $92

Carrier Contact Information

	Phone Number	Website
MMCHR (Payroll, HR, Benefits Administration)	800.899.6624	Benefits@mmchr.com
MMCHR Online Employee Access	www.MMChr.com/client-login	
Anthem Medical HMO and PPO	800.888.8288	www.anthem.com/ca
Anthem Medical PPO HSA	866.207.9878	www.anthem.com/ca
Anthem Dental Complete	877.567.1804	www.anthem.com/ca
Anthem Dental Net DHMO	888.209.7852	www.anthem.com/ca
Anthem Blue View Vision	866.723.0515	www.anthem.com/ca
Anthem Life/AD&D Claims	800.552.2137	www.anthem.com/ca
Anthem Life Conversion/Portability	800.801.6142	www.anthem.com/ca
TASC (FSA/HSA)	877.933.3539	www.tasconline.com