

## MEDICAL: Anthem BCBS

Whichever plan you choose, you will be enrolled in that plan for the full plan year. You will not be able to change plans mid-year. Please review all options to determine which plan will be best for you and/or your family.

Dependent age limit is to age 26 end of the calendar year.

	Option 1	Option 2	Option 3
	HDHP 4000	Exclusive Network	Traditional PPO 2500
	High Deductible Health Plan (HDHP/HSA) – Blue Preferred Select	HMO – Blue Preferred Select	PPO – Blue Preferred Select
<b>Network</b> ( <a href="http://www.anthem.com">www.anthem.com</a> ): <b>All plans utilize Anthem's Blue Preferred Select provider network</b> When in or around Columbia/St. Louis area: search <b>Blue Preferred Select</b> to receive in network benefits If traveling outside the Columbia/St. Louis area: search <b>National PPO (Blue Card PPO)</b> to receive in network benefits. <b>IMPORTANT:</b> This Anthem network DOES NOT include BJC Hospital or affiliates in St. Louis, MO.			
<b>In Network (Individual/Family)</b>			
Calendar Year Deductible	\$4,000/\$8,000	\$0	\$2,500/\$7,500
Coinsurance	20%	10%	20%
Out of Pocket Max	\$6,000/\$12,000	\$3,000/\$6,000	\$6,000/\$12,000
Part D Creditable	No	Yes	Yes
Office Visit	Deductible	\$35 (Primary) & \$50 (Specialist)	\$30 (Primary) & \$50 (Specialist)
Live Health Online ( <a href="http://www.livehealthonline.com">www.livehealthonline.com</a> )	Deductible (\$59 fee)	\$10	\$10
Preventive Care <a href="http://www.anthem.com/preventive-care/">www.anthem.com/preventive-care/</a>	<b>*Covered in full, no cost to Employee with in-network providers and billed as preventive</b>		
Urgent Care	Deductible	\$75	\$50
Hospital	Deductible	\$300 (Emergency Room) \$500 (Inpatient Hospital)	\$250 (Emergency Room)
Vision Exams ( <b>Refractory exam only</b> )	No cost to you (Limited to 1 exam per year from a Blue View Vision Provider) <i>*eye exams with a medical diagnosis are subject to deductible</i>		
<b>Pharmacy Benefits</b>	<b>All HSA plans include <u>PreventiveRx + (Essential)</u> –</b> includes a list of medications that are covered in full (deductible waived, no cost to member)		
	<b>All other covered prescriptions apply to deductible/co-pay referenced below –</b> <i>Essential Drug List-4 tier w/Retail90</i>		
Retail Prescription 30 day supply <i>Essentials Drug List 4-tier</i> ( <a href="http://www.anthem.com">www.anthem.com</a> )	Tier 1: Deductible, then \$15 Tier 2: Deductible, then \$112 Tier 3: Deductible, then \$225 Tier 4: Deductible, then 25% to \$400 max	Tier 1: \$10 Tier 2: \$35 Tier 3: \$75 Tier 4: 25% to \$250 max	
Mail Order Prescription Co-pays: 90 day supply Carelton Rx ( <a href="http://www.careltonrx.com">www.careltonrx.com</a> )	Tier 1: Deductible, then \$15 Tier 2: Deductible, then \$112 Tier 3: Deductible, then \$225 Tier 4: Deductible, then 25% to \$400 max	Tier 1: \$10 Tier 2: \$90 Tier 3: \$75 Tier 4: 25% to \$250 max	
<b>Out of Network (Individual/Family)</b>			
Deductible	\$8,000/\$16,000	No Benefits	\$2,500/\$7,500
Coinsurance	0%	No Benefits	50%
Out of Pocket Max	\$16,000/\$32,000	No Benefits	\$10,000/\$30,000

**\*Preventive Services:** Preventive care is defined as "care you receive to prevent illnesses or diseases". If you truly want these services applied as your free preventive visit, make sure you keep this visit and other medical care separate. If your provider bills the claim with a diagnosis code because you discussed other current conditions, received medication refills, or other ailments, this may no longer be considered preventive care and charges would apply to deductible/coinsurance.

**Medical Prior Authorization/Pre-Certification of services:** Before obtaining outpatient or inpatient services including testing, please confirm that your provider has reviewed Anthem's medical policy or submitted a prior authorization of care to confirm the service meets medical necessity to be covered by the plan. Failure to confirm this information could result in denied claims.

Option 1: H.S.A. 4000			
Monthly Premium	Full Rate	School District Contribution	Employee Cost
Employee Only	\$639.68	\$606.84	\$32.84
Employee & Spouse	\$1,343.34	\$606.84	\$736.50
Employee & Child	\$959.52	\$606.84	\$352.68
Employee & Children	\$1,183.42	\$606.84	\$576.58
Family (1 Child)	\$1,663.18	\$606.84	\$1,056.34
Family (Children)	\$1,887.06	\$606.84	\$1,280.22

Option 2: HMO			
Monthly Premium	Full Rate	School District Contribution	Employee Cost
Employee Only	\$937.28	\$606.84	\$330.44
Employee & Spouse	\$1,968.30	\$606.84	\$1,361.46
Employee & Child	\$1,405.92	\$606.84	\$799.08
Employee & Children	\$1,733.98	\$606.84	\$1,127.14
Family (1 Child)	\$2,436.94	\$606.84	\$1,830.10
Family (Children)	\$2,764.98	\$606.84	\$2,158.14

Option 3: Traditional Plan – PPO 2500			
Monthly Premium	Full Rate	School District Contribution	Employee Cost
Employee Only	\$999.36	\$606.84	\$392.52
Employee & Spouse	\$2,098.66	\$606.84	\$1,491.82
Employee & Child	\$1,499.04	\$606.84	\$892.20
Employee & Children	\$1,848.82	\$606.84	\$1,241.98
Family (1 Child)	\$2,598.34	\$606.84	\$1,991.50
Family (Children)	\$2,948.12	\$606.84	\$2,341.28