

# Greene County Public Schools

## Local Choice Plan Options - October 1, 2024

	Key Advantage 500	Key Advantage 1000	High Deductible Health Plan
<b>Plan year Deductible</b> <small>(Key Advantage: applies to certain medical services as indicated on chart)</small>  <small>(HDHP: applies to medical, behavioral health, and prescription drug services)</small>	<b>In-Network:</b> <u>One Person</u> <u>Family</u> \$500                                      \$1,000 <b>Out-of-Network</b> \$1,000                                      \$2,000	<b>In-Network:</b> <u>One Person</u> <u>Family</u> \$1,000                                      \$2,000 <b>Out-of-Network</b> \$2,000                                      \$4,000	<b>One Person</b> <b>Family</b> \$3,200                                      \$6,400 Deductible is now combined for in-network and out-of-network services
<b>Out-of-pocket expense limit</b>	<b>In-Network:</b> <u>One Person</u> <u>Family</u> \$4,000                                      \$8,000 <b>Out-of-Network</b> \$7,000                                      \$14,000	<b>In-Network:</b> <u>One Person</u> <u>Family</u> \$5,000                                      \$10,000 <b>Out-of-Network</b> \$9,000                                      \$18,000	<b>In-Network:</b> <u>One Person</u> <u>Family</u> \$5,000                                      \$10,000 <b>Out-of-network</b> \$10,000/\$20,000
<b>Out-of-network benefits</b>  <small>BlueCard® PPO and BlueCard Worldwide® networks when traveling outside Virginia</small>	<b>Yes.</b> Once you meet the out-of-network deductible, you pay 30% coinsurance for medical and behavioral health services. Copayments do not apply to medical and behavioral health services.  Included	<b>Yes.</b> Once you meet the out-of-network deductible, you pay 30% coinsurance for medical and behavioral health services. Copayments do not apply to medical and behavioral health services.  Included	<b>Yes,</b> once you met the combined deductible you pay 40% coinsurance for medical, behavioral health and prescription drug services to Out-of-Network providers  Included
<b>Lifetime maximum</b>	None	None	None
<b>Covered Services</b>	<b>In-Network You Pay</b>	<b>In-Network You Pay</b>	<b>In-Network You Pay</b>
<b>Ambulance travel</b>	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible
<b>Autism Spectrum Disorder- Behavioral health and EAP</b> <i>Inpatient treatment</i> • Facility services • Professional provider services <i>Outpatient professional provider visits</i>	Copayment/coinsurance determined by service  20% coinsurance per stay after deductible \$0 \$25 copay	Copayment/coinsurance determined by service  20% coinsurance per stay after deductible \$0 \$25 copayment	20% coinsurance after deductible  20% coinsurance after deductible 20% coinsurance after deductible 20% coinsurance after deductible
<b>Employee Assistance Program (EAP)</b> <small>(up to 4 visits per incident)</small>	\$0	\$0	\$0
<b>Dental</b> Dental plan year deductible Plan year maximum (except Orthodontics) Diagnostic and preventive services Primary services Complex restorative Orthodontic services	<u>One Person</u> <u>Two People</u> <u>Family</u> \$25                      \$50                      \$75 \$1,500 \$0, no deductible 20% coinsurance after dental deductible 50% coinsurance after dental deductible 50% coinsurance, no dental deductible, with \$1,500 lifetime maximum	<u>One Person</u> <u>Two People</u> <u>Family</u> \$25                      \$50                      \$75 \$1,500 \$0, no deductible 20% coinsurance after dental deductible 50% coinsurance after dental deductible 50% coinsurance after dental deductible, with \$1,500 lifetime maximum	<u>One Person</u> <u>Two People</u> <u>Family</u> \$25                      \$50                      \$75 \$1,500 \$0, no deductible 20% coinsurance after dental deductible 50% coinsurance after dental deductible 50% coinsurance, no dental deductible, with \$1,500 lifetime maximum
<b>Diabetic Education</b>	<b>\$0</b>	<b>\$0</b>	20% coinsurance after deductible
<b>Diabetic Equipment</b>	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible
<b>Diagnostic tests and x-rays</b> <small>(for specific conditions or diseases at a doctor's office, emergency room or outpatient hospital department)</small>	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance, after deductible
<b>Doctor visits - on an outpatient basis</b> Primary care physicians Specialty care providers	\$25 copayment \$40 copayment	\$25 copayment \$40 copayment	20% coinsurance after deductible 20% coinsurance after deductible
<b>Emergency room visits</b> <i>Facility services</i> <i>Professional provider services</i> • Primary care physicians • Specialty care providers <i>Diagnostic tests, and x-rays</i>	20% coinsurance after deductible  \$25 copayment \$40 copayment 20% coinsurance, no deductible	20% coinsurance after deductible  \$25 copayment \$40 copayment 20% coinsurance after deductible	20% coinsurance after deductible  20% coinsurance after deductible 20% coinsurance after deductible 20% coinsurance after deductible
<b>Home health services</b> (90 visit plan year limit)	\$0	\$0	20% coinsurance after deductible
<b>Home private duty nurse's services</b>	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible
<b>Hospice care services</b>	\$0	\$0	20% coinsurance after deductible
<b>Hospital services</b> <i>Inpatient treatment</i> • Facility services • Professional provider services - • Primary care physicians • Specialty care providers <i>Outpatient treatment</i> • Facility services • Professional provider services - • Primary care physicians • Specialty care providers • Diagnostic tests and x-rays	20% coinsurance per stay after deductible \$0 \$0  20% coinsurance after deductible  \$25 copayment \$40 copayment 20% coinsurance, no deductible	20% coinsurance per stay after deductible \$0 \$0  20% coinsurance after deductible  \$25 copayment \$40 copayment 20% coinsurance after deductible	20% coinsurance after deductible 20% coinsurance after deductible 20% coinsurance after deductible  20% coinsurance after deductible 20% coinsurance after deductible 20% coinsurance after deductible
<b>Infusion services</b> Facility services Professional provider services - Home services Infusion medications - • Outpatient settings • Home settings	20% coinsurance after deductible 20% coinsurance after deductible 20% coinsurance after deductible  20% coinsurance after deductible 20% coinsurance after deductible	20% coinsurance after deductible 20% coinsurance after deductible 20% coinsurance after deductible  20% coinsurance after deductible 20% coinsurance after deductible	20% coinsurance after deductible 20% coinsurance after deductible 20% coinsurance after deductible  20% coinsurance after deductible 20% coinsurance after deductible

	Key Advantage 500	Key Advantage 1000	High Deductible Health Plan
<b>Maternity</b> <i>Professional provider services (prenatal &amp; postnatal care)</i>			
<ul style="list-style-type: none"> <li>Primary care physicians</li> <li>Specialty care providers</li> </ul>	\$25 copayment \$40 copayment If your doctor submits one bill for delivery, prenatal and postnatal care services, there is no copayment required for physician care. If your doctor bills for these services separately, your payment responsibility will be determined by the services rece	\$25 copayment \$40 copayment	20% coinsurance after deductible 20% coinsurance after deductible
<i>Delivery</i>			
<ul style="list-style-type: none"> <li>Primary care physicians</li> <li>Specialty care providers</li> </ul>	\$0 \$0	\$0 \$0	20% coinsurance after deductible 20% coinsurance after deductible
<i>Hospital services for delivery (delivery room, anesthesia, routine nursing care for newborn)</i>	20% coinsurance per stay after deductible	20% coinsurance per stay after deductible	20% coinsurance after deductible 20% coinsurance after deductible
<i>Outpatient diagnostic tests</i>	20% coinsurance after deductible	20% coinsurance per stay after deductible	20% coinsurance after deductible 20% coinsurance after deductible
*This plan will waive \$200 of the hospital copayment if the member enrolls in the Future Moms pre-natal program within the first trimester of pregnancy, has a dental cleaning and satisfactorily completes the entire program. Call Future Moms at <b>800-828-5891</b>			
<b>Medical equipment, appliances, formulas and supplies</b>	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible
<b>Outpatient prescription drugs - mandatory generic</b> Retail up to 34-day supply  (You may purchase up to a 90-day supply at a retail pharmacy by paying multiple copayments, or the coinsurance after the deductible)  Mail Service up to 90-day supply	Tier 1 - \$10 copayment Tier 2 - \$30 copayment Tier 3 - \$45 copayment Tier 4-\$55  Tier 1 - \$20 copayment Tier 2 - \$60 copayment Tier 3 - \$90 copayment Tier 4-\$110	Tier 1 - \$10 copayment Tier 2 - \$30 copayment Tier 3 - \$45 copayment Tier 4-\$55  Tier 1 - \$20 copayment Tier 2 - \$60 copayment Tier 3 - \$90 copayment Tier 4-\$110	20% coinsurance after deductible     20% coinsurance after deductible
<b>Routine vision - Blue View Vision Network</b> (once every 12 months)			
Routine eye exam	\$40 copayment	\$40 copayment	\$15 copayment
Eyeglass frames	Up to \$100 retail allowance**	Up to \$100 retail allowance**	Up to \$100 retail allowance**
Eyeglass lenses	\$20 copayment	\$20 copayment	\$20 copayment
Contact lenses (in lieu of eyeglass lenses)			
<ul style="list-style-type: none"> <li>Elective</li> <li>Non-Elective</li> </ul>	Up to \$100 retail allowance Up to \$250 retail allowance	Up to \$100 retail allowance Up to \$250 retail allowance	Up to \$100 retail allowance Up to \$250 retail allowance
Lens Options			
<ul style="list-style-type: none"> <li>UV coating, tints, standard scratch-resistant</li> <li>Standard polycarbonate</li> <li>Standard progressive</li> <li>Standard anti-reflective</li> <li>Other add-ons</li> </ul>	\$15 \$40 \$65 \$45 20% off retail	\$15 \$40 \$65 \$45 20% off retail	\$15 \$40 \$65 \$45 20% off retail
** You may select a frame greater than the covered allowance and receive a 20% discount for any additional cost over the allowance.			
<b>Shots</b> (allergy & therapeutic injections at doctor's office, emergency room or outpatient hospital department)	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible
<b>Skilled nursing facility stays</b> (180-day per stay limit)			
Facility services	\$0	\$0	20% coinsurance after deductible
Professional provider services	\$0	\$0	20% coinsurance after deductible
<b>Spinal manipulations and other manual medical interventions</b> (30 visits per plan year)			
Primary care physicians	\$25 copayment	\$25 copayment	20% coinsurance after deductible
Specialty care physicians	\$40 copayment	\$40 copayment	20% coinsurance after deductible
<b>Surgery - see Hospital services</b>			
<b>Therapy services</b> <i>Cardiac Rehabilitation therapy, Chemotherapy, Radiation therapy, and Respiratory therapy, Occupational therapy, Physical therapy, and Speech therapy</i>			
<ul style="list-style-type: none"> <li>Facility services</li> <li>Professional provider services <ul style="list-style-type: none"> <li>Primary care physicians</li> <li>Specialty care providers</li> </ul> </li> </ul>	20% coinsurance after deductible  20% coinsurance after deductible 20% coinsurance after deductible	20% coinsurance after deductible  20% coinsurance after deductible 20% coinsurance after deductible	20% coinsurance after deductible  20% coinsurance after deductible 20% coinsurance after deductible

	Key Advantage 500	Key Advantage 1000	High Deductible Health Plan
<b>Wellness services</b>			
<i>Well child (office visits at specified intervals through age 6)</i>			
<ul style="list-style-type: none"> <li>• Primary care physicians;</li> <li>• Specialty care providers;</li> <li>• Immunizations and screening tests</li> </ul>	No copayment, coinsurance, or deductible	No copayment, coinsurance, or deductible	No copayment, coinsurance, or deductible
<i>Routine wellness - (age 7 &amp; older)</i>			
<ul style="list-style-type: none"> <li>• Annual check-up visit (one per plan year) - <ul style="list-style-type: none"> <li>- Primary care physicians;</li> <li>- Specialty care providers;</li> <li>- Immunizations, lab and x-ray services</li> </ul> </li> <li>• Routine screenings, Immunizations, lab and x-ray services (outside of Annual check-up visit)</li> </ul>	No copayment, coinsurance, or deductible	No copayment, coinsurance, or deductible	No copayment, coinsurance, or deductible
<i>Preventive care (one each per plan year)</i>			
<ul style="list-style-type: none"> <li>• Gynecological exam</li> <li>• Pap test</li> <li>• Mammography screening</li> <li>• Prostate exam (digital rectal exam)</li> <li>• Prostate specific antigen test</li> <li>• Colorectal cancer screenings</li> </ul>	No copayment, coinsurance, or deductible	No copayment, coinsurance, or deductible	No copayment, coinsurance, or deductible
<i>Women's Preventative Care</i>			
<ul style="list-style-type: none"> <li>• Well-woman visits</li> <li>• Screening for gestational diabetes</li> <li>• Testing for human papillomavirus (HPV)</li> <li>• Counseling for sexually transmitted infections</li> <li>• Screening and counseling for human immunodeficiency virus (HIV)</li> <li>• FDA-approved contraception methods and contraceptive counseling</li> <li>• Breastfeeding support, supplies and counseling</li> <li>• Screening and counseling for interpersonal and domestic violence</li> </ul>	No copayment, coinsurance, or deductible	No copayment, coinsurance, or deductible	No copayment, coinsurance, or deductible

This is a brief benefits comparison for illustrative purposes only. Please refer to your plans Member Handbook for a complete description of the benefits, exclusions, limitations, and reductions for your specific plan. Yellow highlight indicates change from previous year