



# Comparison of Statewide Plans 2008

*Effective July 1, 2008 or October 1, 2008*

# The Local Choice 2008 Comparison of Statewide Plans

	Key Advantage Expanded			Key Advantage 200		
<b>Plan year deductible</b> (Key Advantage: applies to certain medical services as indicated on chart)  (HDHP: applies to medical, behavioral health, and prescription drug services)	<u>One Person</u> \$100	<u>Two People</u> \$200	<u>Family</u> \$300	<b>In-Network:</b> <u>One Person</u> \$200	<u>Two People</u> \$400	<u>Family</u> \$600
				<b>Out-of-Network:</b> \$400	\$800	\$1,200
<b>Out-of-pocket expense limit</b>	<u>One Person</u> \$1,000	<u>Two People</u> \$2,000	<u>Family</u> \$3,000	<b>In-Network:</b> <u>One Person</u> \$1,500	<u>Two People</u> \$3,000	<u>Family</u> \$4,500
				<b>Out-of-Network:</b> \$3,000	\$6,000	\$9,000
<b>Out-of-network benefits</b>	Yes. Plan's payment reduced by 25% for covered medical and behavioral health services.			Yes. Once you meet the out-of-network deductible, you pay 20% coinsurance for medical and behavioral health services. Copayments do not apply to medical and behavioral health services.		
<b>BlueCard® PPO and BlueCard Worldwide®</b>	Included			Included		
<b>Lifetime maximum</b>	None			None		
<b>Covered Services</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		
<b>Behavioral health and EAP</b> <i>Inpatient treatment</i> • Facility services • Professional provider services  <i>Outpatient professional provider visits</i>	\$200 copayment per stay \$0 \$15 copayment			\$300 copayment per stay \$0 \$20 copayment		
<b>Employee Assistance Program (EAP)</b> (up to 4 visits per incident)	\$0			\$0		
<b>Dental</b> <i>Dental plan year deductible</i> <i>Plan year maximum (except Orthodontics)</i> <i>Diagnostic and preventive services</i> <i>Primary services</i> <i>Complex restorative</i> <i>Orthodontic services</i>	<u>One Person</u> \$25 \$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>Two People</u> \$50 \$1,200 \$0, no deductible 20% coinsurance after dental deductible 50% coinsurance after dental deductible 50% coinsurance, no dental deductible, with \$1,200 lifetime maximum	<u>Family</u> \$75 \$75 \$0, no deductible 20% coinsurance after dental deductible 50% coinsurance after dental deductible 50% coinsurance, no dental deductible, with \$1,200 lifetime maximum	<u>One Person</u> \$25 \$1,200 \$0, no deductible 20% coinsurance after dental deductible 50% coinsurance after dental deductible 50% coinsurance, no dental deductible, with \$1,200 lifetime maximum	<u>Two People</u> \$50 \$50 \$0, no deductible 20% coinsurance after dental deductible 50% coinsurance after dental deductible 50% coinsurance, no dental deductible, with \$1,200 lifetime maximum	<u>Family</u> \$75 \$75 \$0, no deductible 20% coinsurance after dental deductible 50% coinsurance after dental deductible 50% coinsurance, no dental deductible, with \$1,200 lifetime maximum
<b>Diagnostic tests, and x-rays</b> (for specific conditions or diseases at a doctor's office, emergency room or outpatient hospital department)	10% coinsurance, no deductible			10% coinsurance after deductible		
<b>Doctor visits – on an outpatient basis</b> <i>Primary care physicians</i> <i>Specialty care providers</i>	\$15 copayment \$25 copayment			\$20 copayment \$35 copayment		
<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>	\$75 copayment per visit (waived if admitted) \$15 copayment \$25 copayment 10% coinsurance, no deductible			\$100 copayment per visit (waived if admitted) \$20 copayment \$35 copayment 10% coinsurance after deductible		
<b>Home health services</b> (90 visit plan year limit)	\$0			\$0		
<b>Home private duty nurse's services</b>	20% coinsurance after deductible			20% coinsurance after deductible		
<b>Hospice care services</b>	\$0			\$0		

Key Advantage 300			Key Advantage 500			High Deductible Health Plan		
<b>In-Network:</b>			<b>In-Network:</b>			<b>In-Network:</b>		
<u>One Person</u>	<u>Two People</u>	<u>Family</u>	<u>One Person</u>	<u>Two People</u>	<u>Family</u>	<u>One Person</u>	<u>Two People</u>	<u>Family</u>
\$300	\$600	\$900	\$500	\$1,000	\$1,500	\$1,200	See Family	\$2,400
<b>Out-of-Network:</b>			<b>Out-of-Network:</b>			<b>Out-of-Network:</b>		
\$600	\$1,200	\$1,800	\$1,000	\$2,000	\$3,000			
<b>In-Network:</b>			<b>In-Network:</b>			<b>In-Network:</b>		
<u>One Person</u>	<u>Two People</u>	<u>Family</u>	<u>One Person</u>	<u>Two People</u>	<u>Family</u>	<u>One Person</u>	<u>Two People</u>	<u>Family</u>
\$2,500	\$5,000	\$7,500	\$3,000	\$6,000	\$9,000	\$5,000	See Family	\$10,000
<b>Out-of-Network:</b>			<b>Out-of-Network:</b>			<b>Out-of-Network:</b>		
\$5,000	\$10,000	\$15,000	\$6,000	\$12,000	\$18,000			
Yes. 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.			Yes. 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.			No coverage, except in emergency.		
Included			Included			Included		
None			None			None		
<b>In-Network You Pay</b>			<b>In-Network You Pay</b>			<b>In-Network You Pay</b>		
20% coinsurance after deductible			20% coinsurance after deductible			20% coinsurance after deductible		
20% coinsurance per stay after deductible			20% coinsurance per stay after deductible			20% coinsurance after deductible		
\$0			\$0			20% coinsurance after deductible		
\$25 copayment			\$25 copayment			20% coinsurance after deductible		
\$0			\$0			\$0		
<u>One Person</u>	<u>Two People</u>	<u>Family</u>	<u>One Person</u>	<u>Two People</u>	<u>Family</u>	<u>One Person</u>	<u>Two People</u>	<u>Family</u>
\$25	\$50	\$75	\$25	\$50	\$75	\$25	\$50	\$75
\$1,200			\$1,200			\$1,500		
\$0, no deductible			\$0, no deductible			\$0, no deductible		
20% coinsurance after dental deductible			20% coinsurance after dental deductible			20% coinsurance after dental deductible		
50% coinsurance after dental deductible			50% coinsurance after dental deductible			50% coinsurance after dental deductible		
50% coinsurance, no dental deductible, with \$1,200 lifetime maximum			50% coinsurance, no dental deductible, with \$1,200 lifetime maximum			50% coinsurance, no dental deductible, with \$1,500 lifetime maximum		
20% coinsurance after deductible			20% coinsurance after deductible			20% coinsurance after deductible		
\$25 copayment			\$25 copayment			20% coinsurance after deductible		
\$40 copayment			\$40 copayment			20% coinsurance after deductible		
20% coinsurance after deductible			20% coinsurance after deductible			20% coinsurance after deductible		
\$25 copayment			\$25 copayment			20% coinsurance after deductible		
\$40 copayment			\$40 copayment			20% coinsurance after deductible		
20% coinsurance after deductible			20% coinsurance after deductible			20% coinsurance after deductible		
\$0			\$0			20% coinsurance after deductible		
20% coinsurance after deductible			20% coinsurance after deductible			20% coinsurance after deductible		
\$0			\$0			20% coinsurance after deductible		

# The Local Choice 2008 Comparison of Statewide Plans (continued)

Covered Services	Key Advantage Expanded In-Network You Pay	Key Advantage 200 In-Network You Pay
<b>Hospital services</b>		
<i>Inpatient treatment:</i>		
• Facility services	\$200 copayment per stay	\$300 copayment per stay
• Professional provider services -		
• Primary care physicians	\$0	\$0
• Specialty care providers	\$0	\$0
<i>Outpatient treatment</i>		
• Facility services	\$75 copayment	\$100 copayment
• Professional provider services -		
• Primary care physicians	\$15 copayment	\$20 copayment
• Specialty care providers	\$25 copayment	\$35 copayment
• Diagnostic tests, and x-rays	10% coinsurance, no deductible	10% coinsurance after deductible
<b>Infusion services</b>		
<i>Facility services</i>	\$0	\$0
<i>Professional provider services</i>	\$0	\$0
<i>Home services</i>	\$0	\$0
<i>Infusion medications -</i>		
• Outpatient settings	\$0	\$0
• Home settings	\$0	\$0
<b>Maternity</b>		
<i>Professional provider services (prenatal &amp; postnatal care)</i>		
• Primary care physicians	\$15 copayment	\$20 copayment
• Specialty care providers	\$25 copayment	\$35 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 received.	
<i>Delivery -</i>		
• Primary care physicians	\$0	\$0
• Specialty care providers	\$0	\$0
<i>Hospital services for delivery (delivery room, anesthesia, routine nursing care for newborn)</i>	\$200 copayment per stay*	\$300 copayment per stay*
<i>Outpatient diagnostic tests</i>	10% coinsurance, no deductible	10% coinsurance after deductible
<b>Medical equipment, appliances, formulas and supplies</b>	20% coinsurance after deductible	20% coinsurance after deductible
<b>Outpatient prescription drugs - mandatory generic</b>		
<i>Retail up to 34-day supply*</i>	Tier 1 – \$10 copayment	Tier 1 – \$10 copayment
	Tier 2 – \$20 copayment	Tier 2 – \$20 copayment
	Tier 3 – \$35 copayment	Tier 3 – \$35 copayment
*You may purchase up to a 90-day supply at a retail pharmacy by paying multiple copayments, or the coinsurance after the deductible		
<i>Mail Service up to 90-day supply</i>	Tier 1 – \$20 copayment	Tier 1 – \$20 copayment
	Tier 2 – \$40 copayment	Tier 2 – \$40 copayment
	Tier 3 – \$70 copayment	Tier 3 – \$70 copayment
<b>Routine vision</b> (once every 24 months)		
<i>Routine eye exam</i>	\$25 copayment	\$35 copayment
<i>Eyeglass frames (one pair)</i>	Remaining cost after Plan pays \$75	Remaining cost after Plan pays \$75
<i>Eyeglass lenses (one pair)</i>		
• Single vision lenses	Remaining cost after Plan pays \$50	Remaining cost after Plan pays \$50
• Bifocal lenses	Remaining cost after Plan pays \$75	Remaining cost after Plan pays \$75
• Trifocal lenses	Remaining cost after Plan pays \$100	Remaining cost after Plan pays \$100
OR		
<i>Contact lenses (any type)</i>	Remaining cost after Plan pays \$100	Remaining cost after Plan pays \$100

\*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, and satisfactorily completes the entire program. Call Future Moms at **800-828-5891** to enroll.

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Key Advantage 300 In-Network You Pay	Key Advantage 500 In-Network You Pay	High Deductible Health Plan In-Network You Pay
20% coinsurance per stay after deductible \$0 \$0	20% coinsurance per stay after deductible \$0 \$0	20% coinsurance after deductible 20% coinsurance after deductible 20% coinsurance after deductible
20% coinsurance after deductible \$25 copayment \$40 copayment 20% coinsurance after 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
\$0 \$0 \$0	\$0 \$0 \$0	20% coinsurance after deductible 20% coinsurance after deductible 20% coinsurance after deductible
\$0 \$0	\$0 \$0	20% coinsurance after deductible 20% coinsurance after deductible
\$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 received.	\$25 copayment \$40 copayment	20% coinsurance after deductible 20% coinsurance after deductible
\$0 \$0	\$0 \$0	20% coinsurance after deductible 20% coinsurance after deductible
20% coinsurance per stay after deductible	20% coinsurance per stay 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
Tier 1 – \$10 copayment Tier 2 – \$20 copayment Tier 3 – \$35 copayment	Tier 1 – \$10 copayment Tier 2 – \$20 copayment Tier 3 – \$35 copayment	20% coinsurance after deductible
Tier 1 – \$20 copayment Tier 2 – \$40 copayment Tier 3 – \$70 copayment	Tier 1 – \$20 copayment Tier 2 – \$40 copayment Tier 3 – \$70 copayment	20% coinsurance after deductible
Not covered Not covered	Not covered Not covered	Not covered Not covered
Not covered Not covered Not covered	Not covered Not covered Not covered	Not covered Not covered Not covered
Not covered	Not covered	Not covered

# The Local Choice 2008 Comparison of Statewide Plans (continued)

Covered Services	Key Advantage Expanded In-Network You Pay	Key Advantage 200 In-Network You Pay
<b>Shots – allergy &amp; therapeutic injections</b> (at doctor's office, emergency room or outpatient hospital department)	10% coinsurance, no deductible	10% coinsurance after deductible
<b>Skilled nursing facility stays</b> (180-day per stay limit) <i>Facility services</i>	\$0	\$0
<i>Professional provider services</i>	\$0	\$0
<b>Spinal manipulations and other manual medical interventions</b> (\$500 plan year limit) <i>Primary care physicians</i> <i>Specialty care providers</i>	\$15 copayment \$25 copayment	\$20 copayment \$35 copayment
<b>Surgery – see Hospital services</b>		
<b>Therapy services</b> <i>Cardiac rehabilitation therapy, chemotherapy, radiation therapy, and respiratory therapy</i> <ul style="list-style-type: none"> <li>• Facility services</li> <li>• Hospital services</li> <li>• Professional provider services</li> </ul>	\$0 \$0 \$0	\$0 \$0 \$0
<i>Occupational therapy visits, physical therapy visits, and speech therapy visits</i> <ul style="list-style-type: none"> <li>• Hospital 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>	\$25 copayment \$15 copayment \$25 copayment	\$35 copayment \$20 copayment \$35 copayment
<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; Specialty care providers; Immunizations and screening tests</li> </ul>	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) – Primary care physicians; Specialty care providers; Immunizations, lab and x-ray services</li> </ul>	No copayment, coinsurance, or deductible	No copayment, coinsurance, or deductible
<ul style="list-style-type: none"> <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
<i>Preventive care (one of 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

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Key Advantage 300 In-Network You Pay	Key Advantage 500 In-Network You Pay	High Deductible Health Plan In-Network You Pay
20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible
\$0	\$0	20% coinsurance after deductible
\$0	\$0	20% coinsurance after deductible
\$25 copayment \$40 copayment	\$25 copayment \$40 copayment	20% coinsurance after deductible 20% coinsurance after deductible
\$0	\$0	20% coinsurance after deductible
\$0	\$0	20% coinsurance after deductible
\$0	\$0	20% coinsurance after deductible
\$40 copayment	\$40 copayment	20% coinsurance after deductible
\$25 copayment \$40 copayment	\$25 copayment \$40 copayment	20% coinsurance after deductible 20% coinsurance after deductible
No copayment, coinsurance, or deductible	No copayment, coinsurance, or deductible	No copayment, coinsurance, or deductible
No copayment, coinsurance, or deductible	No copayment, coinsurance, or deductible	No copayment, coinsurance, or deductible
No copayment, coinsurance, or deductible	No copayment, coinsurance, or deductible	No copayment, coinsurance, or deductible
No copayment, coinsurance, or deductible	No copayment, coinsurance, or deductible	No copayment, coinsurance, or deductible

