

Comparison of Statewide Plans 2009

Effective July 1, 2009 or October 1, 2009



The Local Choice 2009 Comparison of Statewide Plans

	Key Advantage Expanded	Key Advantage 200
Plan year deductible (Key Advantage: applies to certain medical services as indicated on chart) (HDHP: applies to medical, behavioral health, and prescription drug services)	In-Network: One Person Two People Family \$100 \$200 \$300 Out-of-Network: \$200 \$400 \$600	In-Network: One Person Two People Family \$200 \$400 \$600 Out-of-Network: \$400 \$800 \$1,200
Out-of-pocket expense limit	In-Network: One Person Two People Family \$1,000 \$2,000 \$3,000 Out-of-Network: \$2,000 \$4,000 \$6,000	In-Network: One Person Two People Family \$1,500 \$3,000 \$4,500 Out-of-Network: \$3,000 \$6,000 \$9,000
Out-of-network benefits	Yes. Once you meet the out-of-network deductible, the Plan's payment is reduced by 25% for covered 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.
Medical care when traveling	Included	Included
Lifetime maximum	None	None
Covered Services	In-Network You Pay	In-Network You Pay
Ambulance travel	20% coinsurance after deductible	20% coinsurance after deductible
Behavioral health and EAP <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
Employee Assistance Program (EAP) (up to 4 visits per incident)	\$0	\$0
Dental <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>	One Person Two People Family \$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	One Person Two People Family \$25 \$50 \$75 \$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
Diagnostic tests, and x-rays (for specific conditions or diseases at a doctor's office, emergency room or outpatient hospital department)	10% coinsurance, no deductible	10% coinsurance after deductible
Doctor visits – on an outpatient basis <i>Primary care physicians</i> <i>Specialty care providers</i>	\$15 copayment \$25 copayment	\$20 copayment \$35 copayment
Emergency room visits <i>Facility services</i> <i>Professional provider services -</i> • Primary care physicians • Specialty care providers <i>Diagnostic tests, and x-rays</i>	\$100 copayment per visit (waived if admitted) \$15 copayment \$25 copayment 10% coinsurance, no deductible	\$150 copayment per visit (waived if admitted) \$20 copayment \$35 copayment 10% coinsurance after deductible
Home health services (90 visit plan year limit)	\$0	\$0
Home private duty nurse's services	20% coinsurance after deductible	20% coinsurance after deductible
Hospice care services	\$0	\$0

Key Advantage 300			Key Advantage 500			High Deductible Health Plan		
In-Network:			In-Network:					
One Person	Two People	Family	One Person	Two People	Family	One Person	Two People	Family
\$300	\$600	\$900	\$500	\$1,000	\$1,500	\$1,200	See Family	\$2,400
Out-of-Network:			Out-of-Network:					
\$600	\$1,200	\$1,800	\$1,000	\$2,000	\$3,000			
In-Network:			In-Network:					
One Person	Two People	Family	One Person	Two People	Family	One Person	Two People	Family
\$2,500	\$5,000	\$7,500	\$3,000	\$6,000	\$9,000	\$5,000	See Family	\$10,000
Out-of-Network:			Out-of-Network:					
\$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		
In-Network You Pay			In-Network You Pay			In-Network You Pay		
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		
One Person	Two People	Family	One Person	Two People	Family	One Person	Two People	Family
\$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 2009 Comparison of Statewide Plans (continued)

Covered Services	Key Advantage Expanded In-Network You Pay	Key Advantage 200 In-Network You Pay
Hospital services <i>Inpatient treatment:</i> <ul style="list-style-type: none"> • Facility services • Professional provider services - <ul style="list-style-type: none"> - Primary care physicians - Specialty care providers <i>Outpatient treatment</i> <ul style="list-style-type: none"> • Facility services • Professional provider services - <ul style="list-style-type: none"> - Primary care physicians - Specialty care providers • Diagnostic tests, and x-rays 	\$200 copayment per stay \$0 \$0 \$100 copayment \$15 copayment \$25 copayment 10% coinsurance, no deductible	\$300 copayment per stay \$0 \$0 \$150 copayment \$20 copayment \$35 copayment 10% coinsurance after deductible
Infusion services <i>Facility services</i> <i>Professional provider services</i> <i>Home services</i> <i>Infusion medications -</i> <ul style="list-style-type: none"> • Outpatient settings • Home settings 	10% coinsurance after deductible 10% coinsurance after deductible 10% coinsurance after deductible 10% coinsurance after deductible 10% coinsurance after deductible	10% coinsurance after deductible 10% coinsurance after deductible 10% coinsurance after deductible 10% coinsurance after deductible 10% coinsurance after deductible
Maternity <i>Professional provider services (prenatal & postnatal care)</i> <ul style="list-style-type: none"> • Primary care physicians • Specialty care providers <i>Delivery -</i> <ul style="list-style-type: none"> • Primary care physicians • Specialty care providers <i>Hospital services for delivery (delivery room, anesthesia, routine nursing care for newborn)</i> <i>Outpatient diagnostic tests</i>	\$15 copayment \$25 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. \$0 \$0 \$200 copayment per stay* 10% coinsurance, no deductible	\$20 copayment \$35 copayment \$0 \$0 \$300 copayment per stay* 10% coinsurance after deductible
Medical equipment, appliances, formulas and supplies	20% coinsurance after deductible	20% coinsurance after deductible
Outpatient prescription drugs - mandatory generic <i>Retail up to 34-day supply*</i> *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 - \$10 copayment Tier 2 - \$20 copayment Tier 3 - \$35 copayment Tier 1 - \$20 copayment Tier 2 - \$40 copayment Tier 3 - \$70 copayment	Tier 1 - \$10 copayment Tier 2 - \$20 copayment Tier 3 - \$35 copayment Tier 1 - \$20 copayment Tier 2 - \$40 copayment Tier 3 - \$70 copayment
Routine vision - Blue View Vision Network (once every 12 months) <i>Routine eye exam</i> <i>Eyeglass lenses</i> <i>Eyeglass frames</i> <i>Contact lenses (in lieu of eyeglass lenses)</i> <ul style="list-style-type: none"> • Elective • Non-Elective <i>Lens Options</i> <ul style="list-style-type: none"> • UV coating, tints, standard scratch-resistant • Standard polycarbonate • Standard progressive • Standard anti-reflective • Other add-ons 	\$25 copayment \$20 copayment Up to \$100 retail allowance** Up to \$100 retail allowance Up to \$250 retail allowance \$15 \$40 \$65 \$45 20% off retail	\$35 copayment \$20 copayment Up to \$100 retail allowance** Up to \$100 retail allowance Up to \$250 retail allowance \$15 \$40 \$65 \$45 20% off retail

*This plan will waive \$200 of the hospital copayment if the member enrolls in the maternity management pre-natal program within the first trimester of pregnancy, and satisfactorily completes the entire program.

**You may select a frame greater than the covered allowance and receive a 20% discount for any additional cost over the allowance.

**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 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

\$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.

\$0
\$0

20% coinsurance per stay after deductible

20% coinsurance after deductible

20% coinsurance after deductible

Tier 1 - \$10 copayment
Tier 2 - \$20 copayment
Tier 3 - \$35 copayment

Tier 1 - \$20 copayment
Tier 2 - \$40 copayment
Tier 3 - \$70 copayment

\$40 copayment
\$20 copayment
Up to \$100 retail allowance**

Up to \$100 retail allowance
Up to \$250 retail allowance

\$15
\$40
\$65
\$45
20% off retail

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

\$25 copayment
\$40 copayment

\$0
\$0

20% coinsurance per stay after deductible

20% coinsurance after deductible

20% coinsurance after deductible

Tier 1 - \$10 copayment
Tier 2 - \$20 copayment
Tier 3 - \$35 copayment

Tier 1 - \$20 copayment
Tier 2 - \$40 copayment
Tier 3 - \$70 copayment

\$40 copayment
\$20 copayment
Up to \$100 retail allowance**

Up to \$100 retail allowance
Up to \$250 retail allowance

\$15
\$40
\$65
\$45
20% off retail

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

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20% coinsurance after deductible

20% coinsurance after deductible

20% coinsurance after deductible

20% coinsurance after deductible

Not covered
Not covered
Not covered

Not covered
Not covered

Not covered
Not covered
Not covered
Not covered
Not covered

The Local Choice 2009 Comparison of Statewide Plans (continued)

Covered Services	Key Advantage Expanded In-Network You Pay	Key Advantage 200 In-Network You Pay
Shots – allergy & therapeutic injections (at doctor’s office, emergency room or outpatient hospital department)	10% coinsurance, no deductible	10% coinsurance after deductible
Skilled nursing facility stays (180-day per stay limit) <i>Facility services</i> <i>Professional provider services</i>	\$0 \$0	\$0 \$0
Spinal manipulations and other manual medical interventions (\$500 plan year limit) <i>Primary care physicians</i> <i>Specialty care providers</i>	\$15 copayment \$25 copayment	\$20 copayment \$35 copayment
Surgery – see Hospital services		
Therapy services <i>Cardiac Rehabilitation therapy, Chemotherapy, Radiation therapy, Respiratory therapy, Occupational therapy, Physical therapy, and Speech therapy</i> <ul style="list-style-type: none"> • Facility services • Professional provider services <ul style="list-style-type: none"> – Primary care physicians – Specialty care providers 	10% coinsurance after deductible 10% coinsurance after deductible 10% coinsurance after deductible	10% coinsurance after deductible 10% coinsurance after deductible 10% coinsurance after deductible
Wellness services <i>Well child (office visits at specified intervals through age 6)</i> <ul style="list-style-type: none"> • Primary care physicians; • Specialty care providers; • Immunizations and screening tests <i>Routine wellness – age 7 & older</i> <ul style="list-style-type: none"> • Annual check-up visit (one per plan year) – <ul style="list-style-type: none"> – Primary care physicians; – Specialty care providers; – Immunizations, lab and x-ray services • Routine screenings, immunizations, lab and x-ray services (outside of Annual check-up visit) <i>Preventive care (one of each per plan year)</i> <ul style="list-style-type: none"> • Gynecological exam • Pap test • Mammography screening • Prostate exam (digital rectal exam) • Prostate specific antigen test • Colorectal cancer screenings 	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

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
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
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

