Comparison of Statewide Plans 2013

Effective July 1, 2013 or October 1, 2013

The LOCAL CHOICE

The Local Choice 2013 Comparison of Statewide Plans

	Key Advantage Expanded	Key Advantage 250
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: $100 Two People: *See Family* Family: $200 **Out-of-Network:** $200 / *See Family* / $400	**In-Network:** One Person: $250 Two People: *See Family* Family: $500 **Out-of-Network:** $500 / *See Family* / $1,000
Plan Year Out-of-pocket expense limit	**In-Network:** One Person: $1,000 Two People: *See Family* Family: $2,000 **Out-of-Network:** $2,000 / *See Family* / $4,000	**In-Network:** One Person: $2,000 Two People: *See Family* Family: $4,000 **Out-of-Network:** $4,000 / *See Family* / $8,000
Out-of-network benefits	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. Copayments and coinsurance for routine vision, outpatient prescription drugs and dental services will still apply.	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. Copayments and coinsurance for routine vision, outpatient prescription drugs and dental services will still apply.
Medical care when traveling	Included	Included
Lifetime maximum	Unlimited	Unlimited
Covered Services	**In-Network You Pay**	**In-Network You Pay**
Ambulance travel	20% coinsurance after deductible	20% coinsurance after deductible
Autism Spectrum Disorder 2 years to 6 years $35,000 Annual Limit (Applies to Applied Behavioral Analysis only)	Copayment/coinsurance determined by service received	Copayment/coinsurance determined by service received
Behavioral health and EAP *Inpatient treatment* • Facility services • Professional provider services *Outpatient professional provider visits*	 $200 copayment per stay $0 $15 copayment	 $300 copayment per stay $0 $20 copayment
Employee Assistance Program (EAP) 4 visits per incident (per rolling 12 months)	$0	$0
Dental *Dental plan year deductible* *Plan year maximum (except Orthodontics)* *Diagnostic and preventive services* *Basic dental care* *Major dental care* *Orthodontic services (includes adult ortho)*	One Person: $25 Two People: $50 Family: $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: $25 Two People: $50 Family: $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
Diabetic Education	$0	$0
Diabetic Equipment	20% coinsurance after deductible	20% coinsurance after deductible
Diabetic Supplies - see Outpatient prescription drugs		
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 *Primary care physicians* *Specialty care providers*	 $15 copayment $25 copayment	 $20 copayment $35 copayment
Early Intervention Services	Copayment/coinsurance determined by service received	Copayment/coinsurance determined by service received

Key Advantage 500			Key Advantage 1000			High Deductible Health Plan		
In-Network:			**In-Network:**					
One Person	Two People	Family	One Person	Two People	Family	One Person	Two People	Family
$500	*See Family*	$1,000	$1,000	*See Family*	$2,000	$1,500	See Family	$3,000
Out-of-Network:			**Out-of-Network:**					
$1,000	*See Family*	$2,000	$2,000	*See Family*	$4,000			
In-Network:			**In-Network:**					
One Person	Two People	Family	One Person	Two People	Family	One Person	Two People	Family
$3,000	*See Family*	$6,000	$4,000	*See Family*	$8,000	$5,000	See Family	$10,000
Out-of-Network:			**Out-of-Network:**					
$6,000	*See Family*	$12,000	$8,000	*See Family*	$16,000			
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. Copayments and coinsurance for routine vision, outpatient prescription drugs and dental services will still apply.			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. Copayments and coinsurance for routine vision, outpatient prescription drugs and dental services will still apply.			No coverage, except in emergency.		
Included			Included			Included		
Unlimited			Unlimited			Unlimited		
In-Network You Pay			**In-Network You Pay**			**In-Network You Pay**		
20% coinsurance after deductible			20% coinsurance after deductible			20% coinsurance after deductible		
Copayment/coinsurance determined by service received			Copayment/coinsurance determined by service received			20% coinsurance after deductible		
20% coinsurance after deductible			20% coinsurance 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		
$0			$0			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		
$25 copayment			$25 copayment			20% coinsurance after deductible		
$40 copayment			$40 copayment			20% coinsurance after deductible		
Copayment/coinsurance determined by service received			Copayment/coinsurance determined by service received			20% coinsurance after deductible		

The Local Choice 2013 Comparison of Statewide Plans (continued)

Covered Services	Key Advantage Expanded In-Network You Pay	Key Advantage 250 In-Network You Pay
Emergency room visits		
Facility services	$100 copayment per visit (waived if admitted to hospital)	$150 copayment per visit (waived if admitted to hospital)
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
Home health services (90 visit plan year limit per member)	$0	$0
Home private duty nurse's services	20% coinsurance after deductible	20% coinsurance after deductible
Hospice care services	$0	$0
Hospital services		
Inpatient treatment:		
• Facility services	$200 copayment per stay	$300 copayment per stay
• Professional provider services		
– Primary care physicians	$0	$0
– Specialty care providers	$0	$0
Outpatient treatment		
• Facility services	$100 copayment	$150 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
Infusion services		
Facility services	10% coinsurance after deductible	10% coinsurance after deductible
Professional provider services	10% coinsurance after deductible	10% coinsurance after deductible
Home services	10% coinsurance after deductible	10% coinsurance after deductible
Infusion medications -		
• Outpatient settings	10% coinsurance after deductible	10% coinsurance after deductible
• Home settings	10% coinsurance after deductible	10% coinsurance after deductible
Maternity		
Professional provider services (prenatal & postnatal care)		
• 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.	
Delivery		
• Primary care physicians	$0	$0
• Specialty care providers	$0	$0
Hospital services for delivery (delivery room, anesthesia, routine nursing care for newborn)	$200 copayment per stay*	$300 copayment per stay*
Outpatient diagnostic tests	10% coinsurance, no deductible	10% coinsurance after deductible
Medical equipment, appliances, formulas, prosthetics and supplies	20% coinsurance after deductible	20% coinsurance after deductible
Outpatient prescription drugs - mandatory generic		
*Retail up to 34-day supply**	Tier 1 – $10 copayment Tier 2 – $20 copayment Tier 3 – $35 copayment	Tier 1 – $10 copayment Tier 2 – $20 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		
Home Delivery Services (Mail Order) Covered drugs for up to a 90-day supply	Tier 1 – $20 copayment Tier 2 – $40 copayment Tier 3 – $70 copayment	Tier 1 – $20 copayment Tier 2 – $40 copayment Tier 3 – $70 copayment
Diabetic Supplies	20% coinsurance, no deductible	20% coinsurance, no deductible

**This plan will waive the hospital copayment if the member enrolls in the maternity management pre-natal program within the first trimester of pregnancy, has a dental cleaning during pregnancy and satisfactorily completes the 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 500 In-Network You Pay	Key Advantage 1000 In-Network You Pay	High Deductible Health Plan In-Network You Pay
20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible
$25 copayment $40 copayment 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	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	$0 $0	20% coinsurance after deductible 20% coinsurance after deductible
20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible
$25 copayment $40 copayment 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	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
$25 copayment $40 copayment	$25 copayment $40 copayment	20% coinsurance after deductible 20% coinsurance after deductible
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	$0 $0	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
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 20% coinsurance, no deductible	Tier 1 – $20 copayment Tier 2 – $40 copayment Tier 3 – $70 copayment 20% coinsurance, no deductible	20% coinsurance after deductible 20% coinsurance after deductible

The Local Choice 2013 Comparison of Statewide Plans (continued)

Covered Services	Key Advantage Expanded In-Network You Pay	Key Advantage 250 In-Network You Pay
Routine vision - Blue View Vision Network (once every 12 months)		
Routine eye exam	$25 copayment	$35 copayment
Eyeglass lenses	$20 copayment	$20 copayment
Eyeglass frames	Up to $100 retail allowance**	Up to $100 retail allowance**
Contact lenses (in lieu of eyeglass lenses)		
• Elective	Up to $100 retail allowance	Up to $100 retail allowance
• Non-Elective	Up to $250 retail allowance	Up to $250 retail allowance
Upgrade eyeglass lenses (available for additional cost)		
• UV coating, tints, standard scratch-resistant	$15	$15
• Standard polycarbonate	$40	$40
• Standard progressive	$65	$65
• Standard anti-reflective	$45	$45
• Other add-ons	20% off retail	20% off retail
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 per member)		
Facility services	$0	$0
Professional provider services	$0	$0
Spinal manipulations and other manual medical interventions (30 visits per plan year limit per member)		
Primary care physicians	$15 copayment	$20 copayment
Specialty care providers	$25 copayment	$35 copayment
Surgery – see Hospital services		
Therapy services *Cardiac Rehabilitation therapy, Chemotherapy, Radiation therapy, Respiratory therapy Occupational therapy, Physical therapy, and Speech therapy*		
Facility services	10% coinsurance after deductible	10% coinsurance after deductible
Professional provider services		
• Primary care physicians	10% coinsurance after deductible	10% coinsurance after deductible
• Specialty care providers	10% coinsurance after deductible	10% coinsurance after deductible
Wellness services *Well child (office visits at specified intervals through age 6)*		
• Primary care physicians; • Specialty care providers; • Immunizations and screening tests	No copayment, coinsurance, or deductible	No copayment, coinsurance, or deductible
Routine wellness - age 7 & older		
• Annual check-up visit (one per plan year) – Primary care physicians – Specialty care providers – Immunizations, lab and x-ray services	No copayment, coinsurance, or deductible	No copayment, coinsurance, or deductible
• Routine screenings, immunizations, lab and x-ray services (outside of Annual check-up visit)	No copayment, coinsurance, or deductible	No copayment, coinsurance, or deductible
Preventive care (one of each per plan year) • 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

Key Advantage 500 In-Network You Pay	Key Advantage 1000 In-Network You Pay	High Deductible Health Plan In-Network You Pay
$40 copayment	$40 copayment	Not covered
$20 copayment	$20 copayment	Not covered
Up to $100 retail allowance**	Up to $100 retail allowance**	Not covered
Up to $100 retail allowance	Up to $100 retail allowance	Not covered
Up to $250 retail allowance	Up to $250 retail allowance	Not covered
$15	$15	Not covered
$40	$40	Not covered
$65	$65	Not covered
$45	$45	Not covered
20% off retail	20% off retail	Not covered
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	$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
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