The Local Choice 2020-2021 Comparison of Statewide Plans

Covered Services	Key Advantage 500			Key Advantage 1000			High Deductible Plan		
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**			**In network**			**In network**		
	One Person	Two People	Family	One Person	Two People	Family	One Person	Two People	Family
	$500	$1,000	$1,000	$1,000	$2,000	$2,000	$2,800	$5,600	$5,600
	Out of Network			**Out of Network**			**Out of Network**		
	$1,000	$2,000	$2,000	$2,000	$4,000	$4,000	Deductible is combined for In-Network and Out of Network services.		
Plan Year Out of Pocket **Expense Limit**	**In-Network**						**In-Network**		
	One Person	Two People	Family	One Person	Two People	Family	One Person	Two People	Family
	$4,000	$8,000	$8,000	$5,000	See Family	$10,000	$5,000	$10,000	$10,000
	Out of Network			**Out of Network**			**Out of Network**		
	$7,000	$14,000	$14,000	$9,000	$18,000	$18,000	$10,000	$20,000	$20,000
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.			Yes. Once you meet the combined deductible you pay 40% coinsurance for medical, behavioral health and prescription drug services from Out-of-Network providers		
Medical Care When Traveling (Blue Card)	Included			Included			Included		
Lifetime Maximum	Unlimited			Unlimited			Unlimited		
Ambulance Travel	20% coinsurance after the Deductible			20% coinsurance after deductible			20% coinsurance after deductible		
Autism Spectrum Disorder	Copayment/coinsurance determined by service received			Copayment/coinsurance determined by service received			Copayment/coinsurance determined by service received		

The Local Choice 2020-2021 Comparison of Statewide Plans continued

Covered Services	Key Advantage 500	Key Advantage 1000	High Deductible Plan
Behavioral Health and EAP *** Inpatient Treatment Facility Services Professional Provider Services Outpatient Professional Provider Visits	20% Coinsurance after Deductible $0 $25	20% Coinsurance after Deductible $0 $25	20% Coinsurance after Deductible 20% Coinsurance after Deductible 20% Coinsurance after Deductible
Employee Assistance Program (EAP) 4 visits per issue (per plan year)	$0	$0	$0
Diabetic Supplies	$0	$0	20% coinsurance after deductible
Diabetic Education	$0	$0	$0
Diabetic Equipment	20% coinsurance after deductible	20% coinsurance after deductible	20% Coinsurance after Deductible
Diabetic Supplies - See Outpatient Prescription Drugs			
Diagnostic Test and X-Rays (for specific conditions or diseases at a doctor's office, emergency room or outpatient hospital department)	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible
Doctor Visits - on an Outpatient Basis Primary Care Physicians Specialty Care Providers	 $25 Copayment $40 Copayment	 $25 Copayment $40 Copayment	 20% coinsurance after deductible 20% coinsurance after deductible
Early Intervention Services	Copay/coinsurance determined by service rendered	Copay/coinsurance determined by service rendered	20% coinsurance after deductible
Emergency Room Visits *Facility Services* ***Professional Provider Services*** **Primary Care Physician** **Specialty Care Providers**	 20% coinsurance after deductible $25 Copayment $40 Copayment	 20% coinsurance after deductible $20 Copayment $40 Copayment	 20% coinsurance after deductible 20% coinsurance after deductible 20% coinsurance after deductible
Home Health Services (90 visit plan year limit per member)	$0	$0	20% coinsurance after deductible
Home Private Duty Nurse's Services	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible
Hospice Care Services	$0	$0	20% coinsurance after deductible

*** No Limit on Behavioral Health (Medical Necessity Criteria must be met, and Prior Authorization is Recommended, EAP expanded, Child and Elder Care Resources, Legal/Financial Services/Identity Protection, Work/Life

The Local Choice 2020-2021 Comparison of Statewide Plans continued

Covered Services	Key Advantage 500	Key Advantage 1000	High Deductible Plan
Hospital Services			
Inpatient Treatment			
Facility Services	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible
Professional Provider Services			
- Primary Care Physicians	$0	$0	20% coinsurance after deductible
- Specialty Care Providers	$0	$0	20% coinsurance after deductible
Hospital Services Continued			
Outpatient Treatment			
Facility Services	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible
Professional Provider Services			
-Primary Care Physicians	$25	$25	20% coinsurance after deductible
-Specialty Care Providers	$40	$40	20% coinsurance after deductible
Diagnostic Test and X-Rays	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible
Infusion Services			
Facility Services	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible
Professional Provider Services	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible
Home Services	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible
Infusion Medications	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible
- Outpatient Settings	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible
- Home Settings	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible
Maternity			
Professional Provider Services (Prenatal Post Natal Care)	If your doctor submits one bill for delivery, prenatal and postnatal care services, there is no copayment required for		20% coinsurance after deductible
- Primary Care Physicians	$25	$25	20% coinsurance after deductible
- Specialty Care Provider	$40	$40	20% coinsurance after deductible
Delivery			
- Primary Care Physicians	$0	$0	20% coinsurance after deductible
- Specialty Care Provider	$0	$0	20% coinsurance after deductible
Hospital Services for Delivery (Delivery Room, Anesthesia Routine Nursing Care for Newborn)	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible

The Local Choice 2020-2021 Comparison of Statewide Plans continued

Covered Services	Key Advantage 500	Key Advantage 1000	High Deductible Plan
Outpatient Prescription Drugs **Mandatory Generic **** 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 Home Delivery Services (Mail Order) Covered Drugs for up to a 90 day Supply	Tier 1 - $10 Copayment Tier 2 - $30 Copayment Tier 3 - $45 Copayment Tier 4 - $55 Copayment Tier 1 - $20 Copayment Tier 2 - $60 Copayment Tier 3 - $90 Copayment Tier 4 - $110 Copayment	Tier 1 - $10 Copayment Tier 2 - $30 Copayment Tier 3 - $45 Copayment Tier 4 - $55 Copayment Tier 1 - $20 Copayment Tier 2 - $60 Copayment Tier 3 - $90 Copayment Tier 4 - $110 Copayment	20% coinsurance after deductible 20% coinsurance after deductible
Diabetic Supplies	20% coinsurance no deductible	20% coinsurance no deductible	20% coinsurance after deductible
Shots - 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
Skilled Nursing Facility Stays (180 Day Per Stay Limit Per Member) *Facility Services* *Professional Provider Services*	$0 $0	$0 $0	20% coinsurance after deductible 20% coinsurance after deductible
Spinal Manipulation and Other Manual Medical Interventions *Primary Care Providers* *Specialty Care Providers*	$25 Copayment $40 Copayment	$25 Copayment $40 Copayment	20% coinsurance after deductible 20% coinsurance after deductible
Surgery - See Hospital Services			
Therapy Services *Cardiac Rehabilitation Therapy, Chemotherapy, Radiation Therapy, Respiratory Therapy, Physical Therapy and Speech Therapy* Facility Services Professional Provider Services - Specialty Care Providers	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

*** Price of compound drugs will be based on the primary ingredient

The Local Choice 2020-2021 Comparison of Statewide Plans continued

Covered Services	Key Advantage 500	Key Advantage 1000	High Deductible Plan
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	No copayment, coinsurance, or deductible
Routine Wellness - Age 7 & Older Annual Check-Up Visit (One per Plan Year	No copayment, coinsurance, or deductible	No copayment, coinsurance, or deductible	No copayment, coinsurance, or deductible
- Primary Care Physicians -Specialty Care Providers -Immunizations and Screening Tests Routine Screenings, Immunizations, Lab and X-Ray Services (Outside of Annual Check Up Visit)	No copayment, coinsurance, or deductible	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	No copayment, coinsurance, or deductible

The Local Choice 2020-2021 Comparison of Statewide Plans continued

Covered Services	Key Advantage 500	Key Advantage 1000	High Deductible Plan
Routine Vision - Blue View Vision Network (Once Every Plan Year)			
Routine Eye Exam	$40 Copayment	$40 Copayment	$15 Copayment
Eyeglass Lenses	$20 Copayment	$20 Copayment	$20 Copayment
Eyeglass Frames	Up to $100 retail allowance*	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	Up to $100 retail allowance
-Non-Elective	Up to $250 retail allowance	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	$15
Standard Poly	$40	$40	$40
Standard Progressive	$65	$65	$65
Standard Anti-Reflective	$45	$45	$45
Other Add-Ons	20% off Retail	20% off Retail	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

The Local Choice 2020-2021 Comparison of Statewide Plans continued

	Key Advantage 500			Key Advantage 1000			High Deductible Plan*		
Comprehensive Dental Care Option	One Person	Two People	Family	One Person	Two People	Family	One Person	Two People	Family
Dental Plan Year Deductible	$25	$50	$75	$25	$50	$75	$25	$50	$75
Plan Year Maximum (Except Orthodontics)	$1,500			$1,500			$1,500		
Preventive Dental Care	$0			$0			$0		
Primary Dental Care	20% coinsurance after dental deductible			20% coinsurance after dental deductible			20% coinsurance after dental deductible		
Major Dental Care	50% coinsurance after dental deductible			50% coinsurance after dental deductible			50% coinsurance after dental deductible		
Orthodontic Services (Includes Adult Ortho)	50% coinsurance no dental deductible with $1500 lifetime maximum			50% coinsurance no dental deductible with $1500 lifetime maximum			50% coinsurance no dental deductible with $1500 lifetime maximum		
							Medical Premiums Only		
Employee Only Cost			$45.00			$10.00		$565.00	$10.00
Employee Plus Child			$450.00			$385.00		$789.00	$275.00
Employee Plus Spouse			$450.00			$385.00		$789.00	$275.00
Employee Plus Children			$917.00			$833.00		$920.00	$633.00
Employee Plus Family			$917.00			$833.00		$920.00	$633.00

***Hospital Idenmity Policy is included with the High Deductible Plan, Greene County Public Schools Pays 100% for the Employee only coverage on this benefit**

High Deductible Health Plan with Hospital Indemnity

Plan Benefits Summary-Hospital/ICU Admission $1,000 per day to a maximum of 1 day(s) per year per insured, max of 3 day(3) per year per covered family

Health Screens-$50 per/of screening to a maximum of 1/insured

	HDHP Plan Your Cost	Hospital Ind.	Medical and Hospital Indemnity Cost Your Total Cost
Employee Only Cost	$10.00		$10.00
Employee Plus Child	$275.00	$7.13	$282.13
Employee Plus Spouse	$275.00	$12.92	$287.92
Employee Plus Children	$633.00	$7.13	$640.13
Employee Plus Family	$633.00	$20.05	$653.05

Preventive Only Dental Option (diagnostic and preventive services only for lower premiums)	Key Advantage 500: $0	Key Advantage 1000: $0	High Deductible Plan: $0
	Your Cost	You Cost	Your Cost
Employee Only Cost	$43.00	$10.00	$10.00
Employee Plus Child	$439.00	$375.00	$267.00
Employee Plus Spouse	$439.00	$375.00	$267.00
Employee Plus Children	$895.00	$813.00	$614.00
Employee Plus Family	$895.00	$813.00	$614.00

Plan Selection Help

All comparisons are based on the Comprehensive Dental Option

Maximum Out of Pocket	Key Advantage 500	Key Advantage 1000	**High Deductible Plan**
Single	$4,000	$5,000	$5,000
Family	$8,000	$10,000	$10,000

Annual Employee Cost			
Employee Only	$450	$100	$100
EE+ Child	$4,500	$3,850	$2,750
EE+ Spouse	$4,500	$3,850	$2,750
EE+ Children	$9,170	$8,330	$6,330
EE + Family	$9,170	$8,330	$6,330

Maximum Out of Pocket + Premiums			
Employee Only	$4,450	$5,100	$5,100
Employee Cost - H.S.A Contribution $1,138.80 (Only applicapble to Employee Only HDHP Plan)			$3,961
EE+ Child	$12,500	$13,850	$12,750
EE+ Spouse	$12,500	$13,850	$12,750
EE+ Children	$17,170	$18,330	$16,330
EE + Family	$17,170	$18,330	$16,330

EMPLOYEE BENEFIT WORKSHEET for The Local Choice Elections

* NEW EMPLOYEES When you waive Health Insurance complete the Local Choice Enrollment form and waive coverage

If you have previously waived coverage, and will to continue waive coverage for the **2020-2021** School year, you do not have to complete another form

If you waive Health Insurance, you will be enrolled in the Guardian Dental Plan, Employee Only coverage is provided at not cost to you.

Selecting Health Insurance Coverage

Plan Name	Key Advantage 500		Key Advantage 1000		High Deductible Plan	
	Preventive	Comprehensive	Preventive	Comprehensive	Preventive	Comprehensive
Employee Only						
Employee & Child						
Employee & Spouse						
Employee Children						
Employee & Family						

Waiving Health Insurance Coverage

*Waive Health Coverage	

WHO NEEDS TO COMPLETE A NEW ENROLLMENT FORM

If you are
Changing Plans,
Adding or Deleting Dependents
Enrolling or Deleting Coverage for the First time

ALL FORMS MUCH BE SENT TO RHONDA HOUCHENS IN THE CENTRAL OFFICE

No Later Than SEPTEMBER 4th , The Local Choice WILL NOT ACCEPT Any Open Enrollment Forms After the Cut Off

Our Contact Information

Darla Rose - Benefits Consultant - 434-327-1652
drose@bankersinsurance.net

Linda Cotton - Account Manager - 434-977-5313 and ask for her
lcotton@bankersinsurance.net