



# 2020 Comparison Of Statewide Plans

Effective July 1, 2020 or October 1, 2020

# The Local Choice 2020 Comparison of Statewide Plans

	Key Advantage Expanded			Key Advantage 250		
<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)	<b>In-Network:</b> One Person    Two People    Family \$100            See Family       \$200			<b>In-Network:</b> One Person    Two People    Family \$250            See Family       \$500		
	<b>Out-of-Network:</b> \$200            See Family       \$400			<b>Out-of-Network:</b> \$500            See Family       \$1,000		
<b>Plan Year Out-of-pocket Expense Limit</b>	<b>In-Network:</b> One Person    Two People    Family \$2,000          See Family       \$4,000			<b>In-Network:</b> One Person    Two People    Family \$3,000          See Family       \$6,000		
	<b>Out-of-Network:</b> \$3,000          See Family       \$6,000			<b>Out-of-Network:</b> \$5,000          See Family       \$10,000		
<b>Out-of-Network Benefits</b>	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.		
<b>Medical Care When Traveling (BlueCard)</b>	Included			Included		
<b>Lifetime Maximum</b>	Unlimited			Unlimited		
<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>Autism Spectrum Disorder</b>	Copayment/coinsurance determined by service received			Copayment/coinsurance determined by service received		
<b>Behavioral Health and EAP</b> <i>Inpatient treatment</i> • Facility Services • Professional Provider Services  <i>Outpatient Professional Provider Visits</i>	\$300 copayment per stay \$0			\$400 copayment per stay \$0		
	\$15 copayment			\$20 copayment		
<b>Employee Assistance Program (EAP)</b> 4 visits per issue (per plan year)	\$0			\$0		
<b>Dental Care</b> <b>Preventive Dental Option</b> ( <i>diagnostic and preventive services only for lower premium</i> )	\$0			\$0		
<b>Comprehensive Dental Option</b> ( <i>for higher premium</i> )	<i>One Person    Two People    Family</i>			<i>One Person    Two People    Family</i>		
Dental Plan Year Deductible	\$25	\$50	\$75	\$25	\$50	\$75
Plan Year Maximum (Except Orthodontics)	\$1,500			\$1,500		
• Preventive Dental Care	\$0			\$0		
• Primary Dental Care	20% coinsurance after dental deductible			20% coinsurance after dental deductible		
• Major Dental Care	50% coinsurance after dental deductible			50% coinsurance after dental deductible		
• Orthodontic Services (Includes Adult Ortho)	50% coinsurance, no dental deductible, with \$1,500 lifetime maximum			50% coinsurance, no dental deductible, with \$1,500 lifetime maximum		

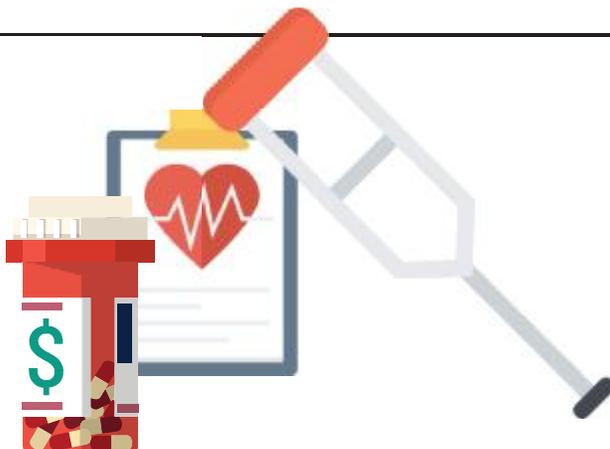
Key Advantage 500			Key Advantage 1000			High Deductible Health Plan		
<b>In-Network:</b>			<b>In-Network:</b>			<b>In-Network:</b>		
One Person	Two People	Family	One Person	Two People	Family	One Person	Two People	Family
\$500	See Family	\$1,000	\$1,000	See Family	\$2,000	\$2,800	See Family	\$5,600
<b>Out-of-Network:</b>			<b>Out-of-Network:</b>			Deductible is combined for In-Network and Out-of-Network services.		
\$1,000	See Family	\$2,000	\$2,000	See Family	\$4,000			
<b>In-Network:</b>			<b>In-Network:</b>			<b>In-Network:</b>		
One Person	Two People	Family	One Person	Two People	Family	One Person	Two People	Family
\$4,000	See Family	\$8,000	\$5,000	See Family	\$10,000	\$5,000	See Family	\$10,000
<b>Out-of-Network:</b>			<b>Out-of-Network:</b>			<b>Out-of-Network:</b>		
\$7,000	See Family	\$14,000	\$9,000	See Family	\$18,000	\$10,000	See Family	\$20,000
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.			Yes. Once you meet the combined deductible you pay 40% coinsurance for medical, behavioral health and prescription drug services from Out-of-Network providers.		
Included			Included			Included		
Unlimited			Unlimited			Unlimited		
<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		
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		
\$0			\$0			\$0		
<i>One Person</i>	<i>Two People</i>	<i>Family</i>	<i>One Person</i>	<i>Two People</i>	<i>Family</i>	<i>One Person</i>	<i>Two People</i>	<i>Family</i>
\$25	\$50	\$75	\$25	\$50	\$75	\$25	\$50	\$75
\$1,500			\$1,500			\$1,500		
\$0			\$0			\$0		
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 \$1,500 lifetime maximum			50% coinsurance, no dental deductible, with \$1,500 lifetime maximum			50% coinsurance, no dental deductible, with \$1,500 lifetime maximum		

# The Local Choice 2020 Comparison of Statewide Plans (continued)

Covered Services	Key Advantage Expanded In-Network You Pay	Key Advantage 250 In-Network You Pay
<b>Diabetic Education</b>	\$0	\$0
<b>Diabetic Equipment</b>	20% coinsurance after deductible	20% coinsurance after deductible
<b>Diabetic Supplies - See Outpatient Prescription Drugs</b>		
<b>Diagnostic Tests and X-rays</b> (for specific conditions or diseases at a doctor's office, emergency room or outpatient hospital department)	20% coinsurance, no deductible	20% 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>Early Intervention Services</b>	Copayment/coinsurance determined by service received	Copayment/coinsurance determined by service received
<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>	\$250 copayment per visit (waived if admitted to hospital)  \$15 copayment \$25 copayment 20% coinsurance, no deductible	\$350 copayment per visit (waived if admitted to hospital)  \$20 copayment \$35 copayment 20% coinsurance after deductible
<b>Home Health Services</b> (90 visit plan year limit per member)	\$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
<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 <i>Diagnostic Tests and X-Rays</i>	\$300 copayment per stay  \$0 \$0  \$100 copayment \$15 copayment \$25 copayment 20% coinsurance, no deductible	\$400 copayment per stay  \$0 \$0  \$150 copayment \$20 copayment \$35 copayment 20% coinsurance after deductible
<b>LiveHealth Online</b> (Online doctor's visits)	\$0	\$0



Key Advantage 500 In-Network You Pay	Key Advantage 1000 In-Network You Pay	High Deductible Health Plan In-Network You Pay
\$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 \$40 copayment	\$25 copayment \$40 copayment	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
\$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
\$0	\$0	Determined by services received



# The Local Choice 2020 Comparison of Statewide Plans (continued)

Covered Services	Key Advantage Expanded In-Network You Pay	Key Advantage 250 In-Network You Pay
<b>Maternity</b> <i>Professional Provider Services (Prenatal &amp; Postnatal Care)</i> - Primary Care Physicians - Specialty Care Providers  <i>Delivery</i> - 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 \$300 copayment per stay*  20% coinsurance, no deductible	\$20 copayment \$35 copayment  \$0 \$0 \$400 copayment per stay*  20% coinsurance after deductible
<b>Medical Equipment, Appliances, Formulas, Prosthetics 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> *You may purchase up to a 90-day supply at a retail pharmacy by paying multiple copayments, or the coinsurance after the deductible  <i>Home Delivery Services (Mail Order)</i> 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
<b>Diabetic Supplies</b>	20% coinsurance, no deductible	20% coinsurance, no deductible
<b>Routine vision - Blue View Vision Network</b> (Once Every Plan Year) <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"> <li>• Elective</li> <li>• Non-Elective</li> </ul> <i>Upgrade Eyeglass Lenses (Available for Additional Cost)</i> <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>	\$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
<b>Shots – Allergy &amp; Therapeutic Injections</b> (At Doctor's Office, Emergency Room or Outpatient Hospital Department)	20% coinsurance, no deductible	20% coinsurance after deductible

\*This plan will waive the hospital copayment if the member enrolls in the maternity management pre-natal program within the first 16 weeks 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**

\$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  
20% coinsurance after deductible

\$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

Tier 1 - \$10 copayment  
Tier 2 - \$30 copayment  
Tier 3 - \$45 copayment  
Tier 4 - \$55 copayment

Tier 1 - \$10 copayment  
Tier 2 - \$30 copayment  
Tier 3 - \$45 copayment  
Tier 4 - \$55 copayment

20% coinsurance after deductible

Tier 1 - \$20 copayment  
Tier 2 - \$60 copayment  
Tier 3 - \$90 copayment  
Tier 4 - \$110 copayment

Tier 1 - \$20 copayment  
Tier 2 - \$60 copayment  
Tier 3 - \$90 copayment  
Tier 4 - \$110 copayment

20% coinsurance after deductible

20% coinsurance, no deductible

20% coinsurance, no deductible

20% coinsurance after deductible

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

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

\$15 copayment  
\$20 copayment  
Up to \$100 retail allowance\*\*

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

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

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

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

20% coinsurance after deductible

20% coinsurance after deductible

20% coinsurance after deductible



# The Local Choice 2020 Comparison of Statewide Plans (continued)

Covered Services	Key Advantage Expanded In-Network You Pay	Key Advantage 250 In-Network You Pay
<b>Skilled Nursing Facility Stays</b> (180-Day Per Stay Limit Per Member) <i>Facility Services</i> <i>Professional Provider Services</i>	\$0 \$0	\$0 \$0
<b>Spinal Manipulations and Other Manual Medical Interventions</b> (30 Visits Per Plan Year Limit Per Member) <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>Infusion Services, Cardiac Rehabilitation Therapy, Chemotherapy, Radiation Therapy, Respiratory Therapy, Occupational Therapy, Physical Therapy, and Speech Therapy</i> <i>Facility Services</i> <i>Professional Provider Services</i> – Primary Care Physicians – 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
<b>Wellness services</b> <i>Well Child (Office Visits at Specified Intervals Through Age 6)</i> – Primary Care Physicians; – Specialty Care Providers; – Immunizations and Screening Tests  <i>Routine Wellness – Age 7 &amp; Older</i> • Annual Check-Up Visit (One Per Plan Year) – 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> • 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 500**  
In-Network You Pay

**Key Advantage 1000**  
In-Network You Pay

**High Deductible Health Plan**  
In-Network You Pay

\$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

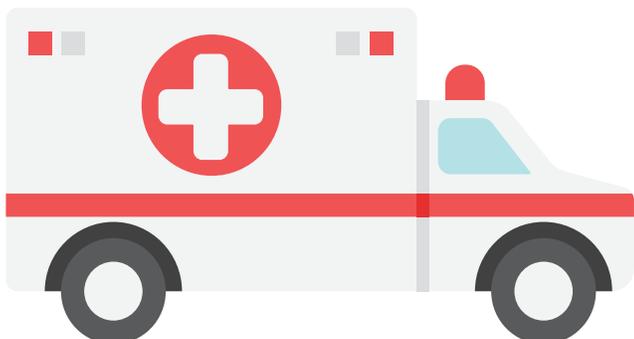
20% coinsurance after deductible

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





## Health & Wellness Programs

Be your healthy best! The TLC plans include access to a host of health and wellness programs to help you manage your health issues.

- o **Sydney:** The **Sydney mobile app** acts like a personal health guide, answering your questions and connecting you to the right resources at the right time. And you can use the chatbot to get answers quickly. Download from the App Store (iOS) or Google Play (Android).
  - Find care and check costs
  - View and use digital ID cards
  - Check all benefits and view claims
- o **ConditionCare:** Take advantage of free and confidential support to manage these conditions:
  - Asthma
  - Heart failure
  - Diabetes
  - Hypertension
  - Chronic obstructive pulmonary disease (COPD)
  - High cholesterol
  - Coronary artery disease (CAD)
  - Metabolic syndrome
  - Obesity

You may receive a call from ConditionCare if your claims indicate you or an enrolled family member may be dealing with one or more of these conditions. While you're encouraged to enroll and take advantage of help from registered nurses and other health care professionals, you may also opt out of the program when they call.
- o **Future Moms:** Enroll and receive pre- and post-natal support. Access a nurse coach and other maternity support specially designed to help women have healthy pregnancies and healthy babies.
- o **MyHealth Advantage:** Receive personalized health-related suggestions, tips, and reminders via mail or email to alert you of potential health risks, care gaps or cost-saving opportunities.
- o **Staying Healthy Reminders:** Receive yearly reminders of important checkups, tests, screenings, immunizations, and other preventive care needs for you and your family.
- o **24/7 NurseLine & Audio Health Tape Library:**  
Sometimes you need health questions answered right away - even in the middle of the night. Call 24/7 NurseLine (800-337-4770) to speak with a nurse. Or use the Audio Health Library if you want to learn about a health topic on your own. Your call is always free and completely confidential.



See more information on Health & Wellness programs at [www.anthem.com/tlc](http://www.anthem.com/tlc).