



Greene County Public Schools

The Local Choice 2021-2022 Comparison of Statewide Plans

Key Advantage 500

Key Advantage 1000

High Deductible Plan

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 \$500	Two People \$1,000	Family \$1,000	One Person \$1,000	Two People \$2,000	Family \$2,000	One Person \$2,800	Two People \$5,600	Family \$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			In-Network		
	One Person \$4,000	Two People \$8,000	Family \$8,000	One Person \$5,000	Two People \$10,000	Family \$10,000	One Person \$5,000	Two People \$10,000	Family \$10,000
Out of Network Benefits	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
	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			20% coinsurance after deductible		

The Local Choice 2021-2022 Comparison of Statewide Plans continued

Covered Services	Key Advantage 500	Key Advantage 1000	High Deductible Plan
Behavioral Health and EAP *** Inpatient Treatment Facility Services Outpatient Treatment Outpatient Professional Provider Visits	20% Coinsurance after Deductible 20% Coinsurance after Deductible 20% Coinsurance after Deductible \$25	20% Coinsurance after Deductible 20% Coinsurance after Deductible 20% Coinsurance after Deductible \$25	20% Coinsurance after Deductible 20% Coinsurance after Deductible 20% Coinsurance after Deductible 20% Coinsurance after Deductible
Chiropractic Care/Spinal Manipulations and other Medical Interventions	Primary \$25 Specialty \$40	\$25 \$40	20% Coinsurance after Deductible
Employee Assistance Program (EAP) 4 visits per issue (per plan year)	\$0	\$0	\$0
Diabetic Supplies (Mail Order)	20% coinsurance after deductible	20% Coinsurance no Deductible	20% coinsurance after deductible
Diabetic Education	\$0	\$0	20% coinsurance after deductible
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	Copay/coinsurance determined by service rendered	20% coinsurance after deductible
Emergency Room Visits <i>Facility Services</i> Professional Provider Services Primary Care Physician Specialty Care Providers	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
Diagnostic Tests, Labs and X-Rays Home Health Services (90 visit plan year limit per member)	20% coinsurance after deductible \$0	20% coinsurance after deductible \$0	20% coinsurance after deductible 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

The Local Choice 2021-2022 Comparison of Statewide Plans continued

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

The Local Choice 2021-2022 Comparison of Statewide Plans continued

Covered Services	Key Advantage 500	Key Advantage 1000	High Deductible Plan
<p>Outpatient Prescription Drugs</p> <p>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</p> <p>Home Delivery Services (Mail Order) Covered Drugs for up to a 90 day Supply</p>	<p>Tier 1 - \$10 Copayment Tier 2 - \$30 Copayment Tier 3 - \$45 Copayment Tier 4 - \$55 Copayment</p> <p>Tier 1 - \$20 Copayment Tier 2 - \$60 Copayment Tier 3 - \$90 Copayment Tier 4 - \$110 Copayment</p>	<p>Tier 1 - \$10 Copayment Tier 2 - \$30 Copayment Tier 3 - \$45 Copayment Tier 4 - \$55 Copayment</p> <p>Tier 1 - \$20 Copayment Tier 2 - \$60 Copayment Tier 3 - \$90 Copayment Tier 4 - \$110 Copayment</p>	<p>20% coinsurance after deductible</p> <p>20% coinsurance after deductible</p>
<p>Diabetic Equipment</p>	<p>20% coinsurance no deductible</p>	<p>20% coinsurance no deductible</p>	<p>20% coinsurance after deductible</p>
<p>Shots - Allergy & Therapeutic Injections (At Doctor's Office, Emergency Room or Outpatient Hospital Department)</p>	<p>20% coinsurance after deductible</p>	<p>20% coinsurance after deductible</p>	<p>20% coinsurance after deductible</p>
<p>Skilled Nursing Facility Stays (180 Day Per Stay Limit Per Member) <i>Facility Services</i></p>	<p>\$0</p>	<p>\$0</p>	<p>20% coinsurance after deductible</p>
<p><i>Professional Provider Services</i></p>	<p>\$0</p>	<p>\$0</p>	<p>20% coinsurance after deductible</p>
<p>Spinal Manipulation and Other Manual Medical Interventions <i>Primary Care Providers</i> <i>Specialty Care Providers</i></p>	<p>\$25 Copayment \$40 Copayment</p>	<p>\$25 Copayment \$40 Copayment</p>	<p>20% coinsurance after deductible 20% coinsurance after deductible</p>
<p>Surgery - See Hospital Services</p>			
<p>Therapy Services <i>Cardiac Rehabilitation Therapy, Chemotherapy, Radiation Therapy, Respiratory Therapy, Physical Therapy and Speech Therapy</i> Facility Services Professional Provider Services - Specialty Care Providers</p>	<p>20% coinsurance after deductible 20% coinsurance after deductible 20% coinsurance after deductible</p>	<p>20% coinsurance after deductible 20% coinsurance after deductible 20% coinsurance after deductible</p>	<p>20% coinsurance after deductible 20% coinsurance after deductible 20% coinsurance after deductible</p>

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

The Local Choice 2021-2022 Comparison of Statewide Plans continued

Covered Services	Key Advantage 500	Key Advantage 1000	High Deductible Plan
<p>Wellness Services <i>Well Child (Office Visits at Specified intervals through Age 6)</i> - Primary Care Physicians - Specialty Care Providers -Immunizations and Screening Tests</p>	No copayment, coinsurance, or deductible	No copayment, coinsurance, or deductible	No copayment, coinsurance, or deductible
<p><i>Routine Wellness - Age 7 & Older Annual Check-Up Visit (One per Plan Year)</i> - Primary Care Physicians -Specialty Care Providers -Immunizations and Screening Tests Routine Screenings, Immunizations, Lab and X-Ray Services (Outside of Annual Check Up Visit)</p>	No copayment, coinsurance, or deductible	No copayment, coinsurance, or deductible	No copayment, coinsurance, or deductible
<p>Preventive Care (One of Each Per Plan Year) <i>Gynecological Exam</i> <i>Pap Test</i> <i>Mammography Screening</i> <i>Prostate Exam (Digital Rectal Exam)</i> <i>Prostate Specific Antigen Test</i> <i>Colorectal Cancer Screenings</i></p>	No copayment, coinsurance, or deductible	No copayment, coinsurance, or deductible	No copayment, coinsurance, or deductible

Covered Services

Key Advantage 500

Key Advantage 1000

High Deductible Plan

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
<i>Eyeglass Lenses</i>	\$20 Copayment	\$20 Copayment	\$20 Copayment
<i>Eyeglass Frames</i>	Up to \$100 retail allowance*	Up to \$100 retail allowance*	Up to \$100 retail allowance*
<i>Contact Lenses (In Lieu of Eyeglass Lenses)</i>			
-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
<i>Upgrade Eyeglass Lenses (Available for Additional Cost)</i>			
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 2021-2022 Comparison of Statewide Plans continued

Key Advantage 500

Key Advantage 1000

High Deductible Plan*

Comprehensive Dental Care Option	Key Advantage 500			Key Advantage 1000			High Deductible Plan*			
	One Person \$25	Two People \$50	Family \$75	One Person \$25	Two People \$50	Family \$75	One Person \$25	Two People \$50	Family \$75	
Dental Plan Year Deductible										
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		
	Premium		Your Cost	Premium		Your Cost	Premium		Your Cost	
Employee Only Cost		\$670.00	\$37.50		\$636.00	\$8.34		\$524.00	\$8.34	
Employee Plus Child		\$1,240.00	\$375.00		\$1,177.00	\$320.84		\$969.00	\$229.17	
Employee Plus Spouse		\$1,240.00	\$375.00		\$1,177.00	\$320.84		\$969.00	\$229.17	
Employee Plus Children		\$1,809.00	\$615.00		\$1,717.00	\$584.00		\$1,415.00	\$481.10	
Employee Plus Family		\$1,809.00	\$615.00		\$1,717.00	\$584.00		\$1,415.00	\$481.10	
*Hospital Indemnity Policy is included with the High Deductible Plan, Greene County Public Schools Pays 100% for the Employee only coverage on this benefit				HDHP Plan		Medical and Hospital Indemnity Cost				
				Your Cost		Hospital Ind.		Your Total Cost		
High Deductible Health Plan with Hospital Indemnity				Employee Only Cost	\$8.34	\$0.00	\$8.34			
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				Employee Plus Child	\$229.17	\$5.94	\$235.11			
				Employee Plus Spouse	\$229.17	\$10.77	\$239.94			
				Employee Plus Children	\$481.10	\$7.13	\$488.23			
				Employee Plus Family	\$481.10	\$16.71	\$497.81			
Health Screens -\$50 per/of screening to a maximum of 1/insured										
Preventive Only Dental Option (diagnostic and preventive services only for lower premiums)	\$500 Deductible Plan			\$1,000 Deductible Plan			HDHP Plan			
			Your Cost			Your Cost			Your Cost	
Employee Only Cost			\$35.84			\$8.34			\$8.34	
Employee Plus Child			\$365.84			\$312.50			\$222.50	
Employee Plus Spouse			\$365.84			\$312.50			\$222.50	
Employee Plus Children			\$599.42			\$568.14			\$465.46	
Employee Plus Family			\$599.42			\$568.14			\$465.46	

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	\$450.00	\$100.08	\$100.08
EE+ Child	\$4,500.00	\$3,850.08	\$2,750.04
EE+ Spouse	\$4,500.00	\$3,850.08	\$2,750.04
EE+ Children	\$7,380.00	\$7,008.00	\$5,773.20
EE + Family	\$7,380.00	\$7,008.00	\$5,773.20

Maximum Out of Pocket + Premiums

Employee Only (less employer contributions to HSA)	\$4,450	\$5,100	\$5,100.08
Employee Cost - H.S.A Contribution \$1,192.80 (Only applicable to Employee Only HDHP Plan)			
EE+ Child	\$12,500	\$13,850	\$12,750.00
EE+ Spouse	\$12,500	\$13,850	\$12,750.00
EE+ Children	\$15,380	\$17,008	\$15,773.00
EE + Family	\$15,380	\$17,008	\$15,773.00

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 2021-2022 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	
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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 MUST BE SENT TO RHONDA HOUCHENS IN THE CENTRAL OFFICE

No Later Than SEPTEMBER 3rd , The Local Choice WILL NOT ACCEPT Any Open Enrollment Forms After the Cut Off

Our Contact Information

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