Caroline County Public Schools Comparison of Health Plans

	Key Advantage 250	Key Advantage 500	High Deductible Health Plan
Plan Year Deductible (Key Advantage: Applies to Certain Medical Services as indicated on Chart) (HDHP: Applies to Medical, Behavioral Health, In-Network and Prescription Drug Services)	**In-Network:** One Person - $250 Two People - $500 Family - $500 **Out-of-Network:** One Person - $500 Two People - $1,000 Family - $1,000	**In-Network:** One Person - $500 Two People - $1,000 Family - $1,000 **Out-of-Network:** One Person - $1,000 Two People - $2,000 Family - $2,000	**In-Network:** One Person - $2,800 Two People - $5,6000 Family - $5,600 **Out-of-Network:** Deductible is combined for In-Network and Out-of-Network
Plan Year Out-of-pocket Expense Limit	**In-Network:** One Person - $3,000 Two People - $6,000 Family - $6,000 **Out-of-Network:** One Person - $5,000 Two People - $10,000 Family - $10,000	**In-Network:** One Person - $4,000 Two People - $8,000 Family - $8,000 **Out-of-Network:** One Person - $7,000 Two People - $14,000 Family - $14,000	**In-Network:** One Person - $5,000 Two People - $10,000 Family - $10,000 **Out-of-Network:** One Person - $10,000 Two People - $20,000 Family - $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 still apply.		Yes. Once you meet the combined deductible you pay 40% coinsurance for medical and behavioral health and prescription drug services from Out-of-Network providers.
Medical Care When Traveling (BlueCard)	Included		
Lifetime Maximum	Unlimited		

Caroline County Public Schools Comparison of Health Plans

Covered Services	Key Advantage 250 In-Network You Pay	Key Advantage 500 In-Network You Pay	High Ded. Health Plan In-Network You Pay
Ambulance Travel	20% coinsurance after deductible		
Autism Spectrum Disorder	Copayment / coinsurance determined by service received		20% coinsurance after deductible
Behavioral Health and EAP Inpatient treatment Facility Services Professional Provider Services Outpatient Professional Provider Visits	 $400 copayment per stay $0 $20 copayment	 20% coinsurance after deductible $0 $25 copayment	 20% coinsurance after deductible 20% coinsurance after deductible 20% coinsurance after deductible
Employee Assistance Program (EAP) 4 visits per issue (per plan year)	$0		
Comprehensive Dental Care Dental Plan Year Deductible Plan Year Maximum (Except Orthodontics) . Preventive Dental Care . Primary Dental Care . Major Dental Care . Orthodontic Services (Includes Adult Ortho)	 One Person - $25, Two People - $50, Family - $75 $1,500 $0 20% coinsurance after dental deductible 50% coinsurance after dental deductible 50% coinsurance, no dental deductible, with $1,500 lifetime maximum		
Diabetic Education	$0		20% coinsurance after deductible
Diabetic Equipment	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)	20% coinsurance after deductible		
Doctor Visits - on an Outpatient Basis Primary Care Physicians Specialty Care Providers	 $20 copayment $35 copayment	 $25 copayment $40 copayment	 20% coinsurance after deductible 20% coinsurance after deductible
Early Intervention Services	Copayment / coinsurance determined by services received		20% coinsurance after deductible

Caroline County Public Schools Comparison of Health Plans

Covered Services	Key Advantage 250 In-Network You Pay	Key Advantage 500 In-Network You Pay	High Ded. Health Plan In-Network You Pay
Emergency Room Visits			
Facility Services	$350 copayment per visit (waived if admitted to hospital)	20% coinsurance after deductible	20% coinsurance after deductible
Professional Provider Services			
.Primary Care Physicians	$20 copayment	$25 copayment	20% coinsurance after deductible
.Specialty Care Providers	$35 copayment	$40 copayment	20% coinsurance after deductible
Diagnostic Tests and X-rays	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible
Home Health Services (90 visit plan year limit per member)	$0		20% coinsurance after deductible
Home Private Duty Nurse's Services	20% coinsurance after deductible		
Hospice Care Services	$0		20% coinsurance after deductible
Hospital Services			
Inpatient Treatment			
.Facility Services	$400 copayment per stay	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
Outpatient Treatment			
.Facility Services	$150 copayment	20% coinsurance after deductible	20% coinsurance after deductible
.Professional Provider Services			
-Primary Care Physicians	$20 copayment	$25 copayment	20% coinsurance after deductible
-Specialty Care Providers	$35 copayment	$40 copayment	20% coinsurance after deductible
Diagnostic Tests and X-rays	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible
LiveHealth Online (Online doctor's visits)	$0		Determined by services received
Maternity			
Professional Provider Services (Prenatal & Postnatal Care)			
-Primary Care Physicians	$20 copayment	$25 copayment	20% coinsurance after deductible
-Specialty Care Providers	$35 copayment	$40 copayment	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.		

Caroline County Public Schools Comparison of Health Plans

Covered Services	Key Advantage 250 In-Network You Pay	Key Advantage 500 In-Network You Pay	High Ded. Health Plan In-Network You Pay
Maternity continued			
Delivery			
-Primary Care Physicians	$0	$0	20% coinsurance after deductible
-Specialty Care Providers	$0	$0	20% coinsurance after deductible
Hospital Services for Delivery (Delivery Room, Anesthesia, Routine Nursing Care for Newborn)	$400 copayment per stay*	20% coinsurance after deductible	20% coinsurance after deductible
Outpatient Diagnostic Tests	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible
Medical Equipment, Appliances, Formulas, Prosthetics and Supplies	20% coinsurance after deductible		
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)	Tier 1 - $10 copayment Tier 2 - $30 copayment Tier 3 - $45 copayment Tier 4 - $55 copayment		20% coinsurance after deductible
Home Delivery Services (Mail Order) Covered Drugs for up to a 90-Day Supply	Tier 1 - $20 copayment Tier 2 - $60 copayment Tier 3 - $90 copayment Tier 4 - $110 copayment		20% coinsurance after deductible
Diabetic Supplies	20% coinsurance, no deductible		20% coinsurance after deductible
Routine vision - Blue View Vision Network			
(Once Every Plan Year)			
Routine Eye Exam	$35 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 Polycarbonate	$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
Shots - Allergy & Therapeutic Injections (At Doctor's Office, Emergency Room or Outpatient Hospital Department)	20% coinsurance after deductible		

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Covered Services	Key Advantage 250 In-Network You Pay	Key Advantage 500 In-Network You Pay	High Ded. Health Plan In-Network You Pay
Skilled Nursing Facility Stays (180-Day Per Stay Limit Per Member)			
Facility Services	$0		20% coinsurance after deductible
Professional Provider Services	$0		20% coinsurance after deductible
Spinal Manipulations and Other Manual Medical Interventions (30 Visits Per Plan Year Limit Per Member)			
Primary Care Physicians	$20 copayment	$25 copayment	20% coinsurance after deductible
Specialty Care Providers	$35 copayment	$40 copayment	20% coinsurance after deductible
Surgery	See Hospital Services		
Therapy Services Infusion Services, Cardiac Rehabilitation Therapy, Chemotherapy, Radiation Therapy, Respiratory Therapy, Occupational Therapy, Physical Therapy, and Speech Therapy			
Facility Services	20% coinsurance after deductible		
Professional Provider Services			
-Primary Care Physicians	20% coinsurance after deductible		
-Specialty Care Providers	20% coinsurance after deductible		

Wellness Services - All plans cover the below services with no copayment, coinsurance or deductible

Well Child (Office Visits at Specified Intervals Through Age 6)
-Primary Care Physicians
-Specialty Care Providers
-Immunizations and Screening Tests

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
.Routine Screenings, Immunizations, Lab and X-ray Services (Outside of Annual Check-Up Visit)

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

*This plan will waive the hospital copayment if the member enrolls in the maternity management prenatal 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