

ESSEX COUNTY PUBLIC SCHOOLS

Medical Care – The Local Choice

In Network Benefits	The Local Choice Key Advantage 250	The Local Choice Key Advantage 1000	The Local Choice High Deductible Health Plan
Referrals Required	No	No	No
Plan Accumulator	Plan Year	Plan Year	Plan Year
Deductible	Non-Embedded	Non-Embedded	Embedded
Annual Deductible	\$250 individual \$500 family	\$1,000 individual \$2,000 family	\$2,800 individual \$5,600 family
Maximum Out-of-Pocket	\$3,000 individual \$6,000 family	\$5,000 individual \$10,000 family	\$5,000 individual \$10,000 family
Physician's Office Visits	PCP: \$20 copay Specialist: \$35 copay	PCP: \$25 copay Specialist: \$40 copay	20%, after deductible
Urgent Care	\$35 copay	\$40 copay	20%, after deductible
Emergency Room	\$150 copay (waived if admitted)	20%, after deductible	20%, after deductible
Inpatient Services	\$300 copay per stay	20%, after deductible	20%, after deductible
Outpatient Services	\$150 copay	20%, after deductible	20%, after deductible
Diagnostic Lab Services	10%, after deductible	20%, after deductible	20%, after deductible
Advanced Diagnostic Services	10%, after deductible	20%, after deductible	20%, after deductible
Pharmacy Prescription Drugs (Tier 1/Tier 2/Tier 3/Tier 4)	\$10/\$30/\$45/\$55	\$10/\$30/\$45/\$55	After Deductible 20% coinsurance
Mail Order Prescription Drugs (Tier 1/Tier 2/Tier 3/Tier 4)	\$20/\$60/\$90/\$110	\$20/\$60/\$90/\$110	After Deductible 20% coinsurance
Out of Network Benefits	Key Advantage 250	Key Advantage 1000	High Deductible Health Plan
Annual Deductible	\$500 individual \$1,000 family	\$2,000 individual \$4,000 family	\$2,800 individual \$5,600 family
Maximum Out-of-Pocket	\$5,000 individual \$10,000 family	\$9,000 individual \$18,000 family	\$10,000 individual \$20,000 family
Coinsurance	30% after deductible	30% after deductible	40% after deductible
	Key Advantage 250	Key Advantage 1000	High Deductible Health Plan
Employee Only	\$0.00	\$0.00	\$0.00 *
Employee Plus One	\$536.00	\$388.00	\$214.00
Employee + Family	\$1,071.00	\$855.00	\$601.00

*Employee only HSA Contribution of \$174.00

Dental & Vision Care – The Local Choice

PLEASE NOTE: DENTAL AND VISION BENEFITS ARE INCLUDED IN YOUR MEDICAL PLAN ELECTION

Dental Benefits	The Local Choice Key Advantage 250	The Local Choice Key Advantage 1000	The Local Choice High Deductible Health Plan
Plan Year Deductible (One Person/Two People/Family)	\$25/\$50/\$75	\$25/\$50/\$75	\$25/\$50/\$75
Plan Year Maximum	\$1,500	\$1,500	\$1,500
Preventive Dental Care	\$0	\$0	\$0
Primary Dental Care	20% after deductible	20% after deductible	20% after deductible
Major Dental Care	50% after deductible	50% after deductible	50% after deductible
Orthodontic Care – Child/Adult \$1,500 Lifetime Maximum	50% No deductible	50% No deductible	50% No deductible
Vision Benefits BlueView Vision Network	The Local Choice Key Advantage 250	The Local Choice Key Advantage 1000	The Local Choice High Deductible Health Plan
Routine Eye Exam	\$35 copay	\$40 copay	\$15 copay
Eyeglass Lenses	\$20 copay	\$20 copay	\$20 copay
Eyeglass Frames	Up to \$100 retail allowance*	Up to \$100 retail allowance*	Up to \$100 retail allowance*
Contact Lenses - Elective (in lieu of eyeglass lenses)	Up to \$100 retail allowance	Up to \$100 retail allowance	Up to \$100 retail allowance
Contact Lenses – Non-Elective (in lieu of eyeglass lenses)	Up to \$250 retail allowance	Up to \$250 retail allowance	Up to \$250 retail allowance
UV Coating, Tints, Standard Scratch-Resistant	\$15 copay	\$15 copay	\$15 copay
Standard Polycarbonate	\$40 copay	\$40 copay	\$40 copay
Standard Progressive	\$65 copay	\$65 copay	\$65 copay
Standard Anti-Reflective	\$45 copay	\$45 copay	\$45 copay
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