The Local Choice Health Benefits Program

Carroll County

Proposed Rates Effective from
for July 01, 2020 through June 30, 2021
With Comprehensive Dental

	Single	Dual	Family
ACTIVE EMPLOYEES			
Key Advantage Expanded	$847	$1,567	$2,287
* Key Advantage 250	$770	$1,425	$2,079
* Key Advantage 500	$707	$1,308	$1,909
Key Advantage 1000	$670	$1,240	$1,809
* High Deductible Health Plan	$558	$1,032	$1,506
RETIREES NOT ELIGIBLE FOR MEDICARE			
Key Advantage Expanded	$1,694	$3,134	$4,574
* Key Advantage 250	$1,540	$2,850	$4,158
* Key Advantage 500	$1,414	$2,616	$3,818
Key Advantage 1000	$1,340	$2,480	$3,618
* High Deductible Health Plan	$1,116	$2,064	$3,012

With Preventive Dental Only

ACTIVE EMPLOYEES			
Key Advantage Expanded	$830	$1,536	$2,241
* Key Advantage 250	$753	$1,393	$2,033
* Key Advantage 500	$690	$1,277	$1,863
Key Advantage 1000	$653	$1,208	$1,763
* High Deductible Health Plan	$541	$1,001	$1,461
RETIREES NOT ELIGIBLE FOR MEDICARE			
Key Advantage Expanded	$1,660	$3,072	$4,482
* Key Advantage 250	$1,506	$2,786	$4,066
* Key Advantage 500	$1,380	$2,554	$3,726
Key Advantage 1000	$1,306	$2,416	$3,526
* High Deductible Health Plan	$1,082	$2,002	$2,922

*** Benefit Plans Currently Offered**

Coverage under The Local Choice Key Advantage and HDHP contracts is for:

- Active Employees and their Dependents
- Retirees not eligible for Medicare and their Dependents not eligible for Medicare, and/or
- Dependents of Medicare eligible Retirees who are not Medicare eligible.

If coverage is offered to Medicare eligible retirees and their Medicare eligible Dependents, it must be obtained through one of our Medicare Supplemental contracts which require participation in both Parts A and B of Medicare to receive maximum benefits.

The PCORI fee is the responsibility of the group and payment should be submitted directly to HHS, therefore, this fee has not been included in your rates.

THE LOCAL CHOICE HEALTH CARE PROGRAM

Anthem Blue Cross and Blue Shield

Renewal Analysis For:

(Excludes Advantage 65 premiums and claims)

Carroll County
Group #T68030
for July 01, 2020 through June 30, 2021

I. Income at Current Rates (1)	$2,188,524
II. Projected Medical Claims Related Charges (2)	
A. Paid Claims for 12/1/2018 through 11/30/2019	$1,075,725
B. Claims in excess of the $100,000 pooling limit	($27,550)
C. Subtotal	$1,048,175
D. Change in Incurred But Not Reported Claims	$10,482
E. Benefit Adjustment	$0
F. Enrollment Adjustment	$0
G. Trend	$111,159
H. Impact of blending	$19,639
I. Total Medical Projected Incurred claims	$1,189,455
III. Projected Reinsurance Charges	$220,525
IV. Projected Medical Administrative Charges, Network Access Fees, and Affordable Care Act(3)	$93,375
V. Projected Dental Capitation	$94,461
VI. Projected Drug Capitation	$491,202
VII. TLC Contingency Reserve or Risk Fee(4)	$99,506
VIII. Total Income Requirements (II. + III. + IV. + V. + VI. + VII.)	$2,188,524
Percentage Adjustment	0.0%

[1] Illustrative income is based on current enrollment as follows:

	KA 250	KA 500	HDHP	TOTAL
Single	41	30	30	101
Dual	15	18	9	42
Family	4	24	3	31
TOTAL:	60	72	42	174

[2] There are 1 claims in excess of the $100,000 pooling limit.
Medical trends used in the renewal development were 6.5% annual.
For a 19 month projection, this equates to 10.5%

[3] Administrative charge as a percent of income requirements is 4.3%

[4] Includes DHRM Program Administration and CommonHealth

Assumes all have Comprehensive Dental.

The LOCAL CHOICE

2020

Comparison Of Statewide Plans

Effective July 1, 2020 or October 1, 2020

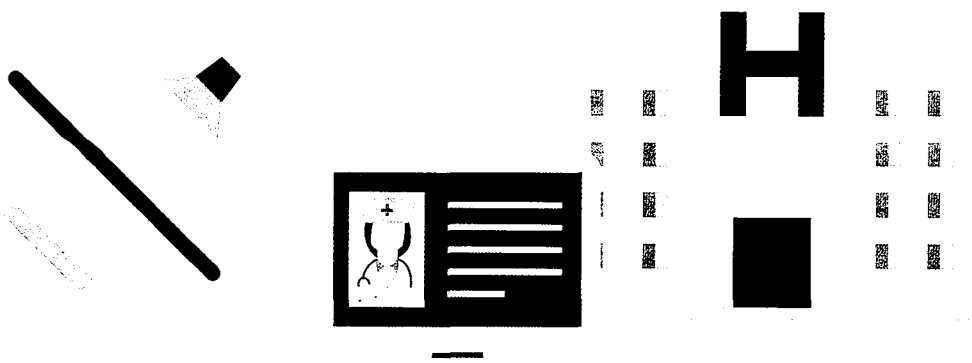
The Local Choice 2020 Comparison of Statewide Plans

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

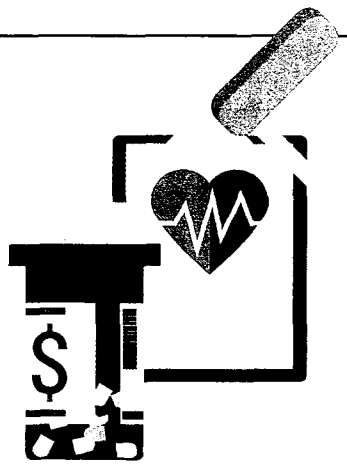
Key Advantage 500			Key Advantage 1000			High Deductible Health Plan		
In-Network:			**In-Network:**					
One Person	Two People	Family	One Person	Two People	Family	One Person	Two People	Family
$500	*See Family*	$1,000	$1,000	*See Family*	$2,000	$2,800	See Family	$5,600
Out-of-Network:			**Out-of-Network:**			Deductible is combined for In-Network and Out-of-Network services.		
$1,000	*See Family*	$2,000	$2,000	*See Family*	$4,000			
In-Network:			**In-Network:**			**In-Network:**		
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
Out-of-Network:			**Out-of-Network:**			**Out-of-Network:**		
$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		
In-Network You Pay			In-Network You Pay			In-Network You Pay		
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		
One Person	*Two People*	*Family*	*One Person*	*Two People*	*Family*	*One Person*	*Two People*	*Family*
$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
Diabetic Education	$0	$0
Diabetic Equipment	20% coinsurance after deductible	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, no deductible	20% coinsurance after deductible
Doctor Visits – on an Outpatient Basis *Primary Care Physicians* *Specialty Care Providers*	 $15 copayment $25 copayment	 $20 copayment $35 copayment
Early Intervention Services	Copayment/coinsurance determined by service received	Copayment/coinsurance determined by service received
Emergency Room Visits *Facility Services* *Professional Provider Services* - Primary Care Physicians - Specialty Care Providers *Diagnostic Tests and X-rays*	 $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
Home Health Services (90 visit plan year limit per member)	$0	$0
Home Private Duty Nurse's Services	20% coinsurance after deductible	20% coinsurance after deductible
Hospice Care Services	$0	$0
Hospital Services *Inpatient Treatment* • Facility Services • Professional Provider Services - Primary Care Physicians - Specialty Care Providers *Outpatient Treatment* • Facility Services • Professional Provider Services - Primary Care Physicians - Specialty Care Providers *Diagnostic Tests and X-Rays*	 $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
LiveHealth Online *(Online doctor's visits)*	$0	$0



Key Advantage 500 In-Network You Pay	Key Advantage 1,000 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

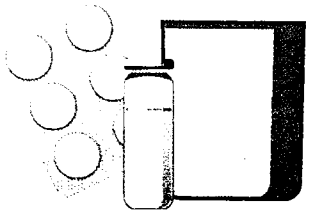


The Local Choice 2020 Comparison of Statewide Plans (continued)

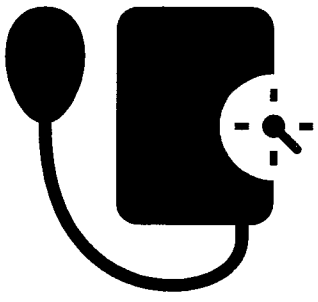
Covered Services	Key Advantage Expanded In-Network You Pay	Key Advantage 250 In-Network You Pay
Maternity		
Professional Provider Services (Prenatal & Postnatal Care)		
- Primary Care Physicians	$15 copayment	$20 copayment
- Specialty Care Providers	$25 copayment	$35 copayment
	If your doctor submits 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.	
Delivery		
- Primary Care Physicians	$0	$0
- Specialty Care Providers	$0	$0
Hospital Services for Delivery (Delivery Room, Anesthesia, Routine Nursing Care for Newborn)	$300 copayment per stay*	$400 copayment per stay*
Outpatient Diagnostic Tests	20% coinsurance, no deductible	20% coinsurance after deductible
Medical Equipment, Appliances, Formulas, Prosthetics and Supplies	20% coinsurance after deductible	20% coinsurance after deductible
Outpatient Prescription Drugs - Mandatory Generic		
*Retail up to 34-day supply**	Tier 1 - $10 copayment	Tier 1 - $10 copayment
*You may purchase up to a 90-day supply at a retail pharmacy by paying multiple copayments, or the coinsurance after the deductible	Tier 2 - $30 copayment Tier 3 - $45 copayment Tier 4 - $55 copayment	Tier 2 - $30 copayment Tier 3 - $45 copayment Tier 4 - $55 copayment
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	Tier 1 - $20 copayment Tier 2 - $60 copayment Tier 3 - $90 copayment Tier 4 - $110 copayment
Diabetic Supplies	20% coinsurance, no deductible	20% coinsurance, no deductible
Routine vision - Blue View Vision Network (Once Every Plan Year)		
Routine Eye Exam	$25 copayment	$35 copayment
Eyeglass Lenses	$20 copayment	$20 copayment
Eyeglass Frames	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
• Non-Elective	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
• Standard Polycarbonate	$40	$40
• Standard Progressive	$65	$65
• Standard Anti-Reflective	$45	$45
• Other Add-Ons	20% off retail	20% off retail
Shots - Allergy & Therapeutic Injections (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.*

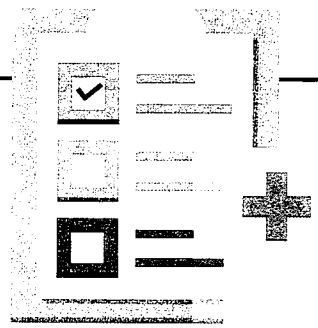


Key Advantage 500 In-Network You Pay	Key Advantage 1000 In-Network You Pay	High Deductible Health Plan In-Network You Pay
$25 copayment $40 copayment If your doctor submits one bill for delivery, prenatal and postnatal care services, there is no copayment required for physician care. If your doctor bills 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	$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	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

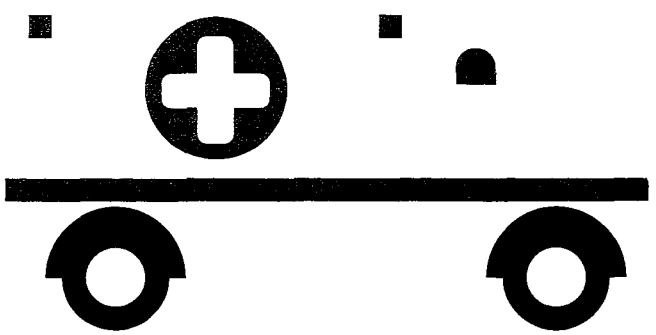


The Local Choice 2020 Comparison of Statewide Plans (continued)

Covered Services	Key Advantage Expanded In-Network You Pay	Key Advantage 250 In-Network You Pay
Skilled Nursing Facility Stays (180-Day Per Stay Limit Per Member)		
Facility Services	$0	$0
Professional Provider Services	$0	$0
Spinal Manipulations and Other Manual Medical Interventions (30 Visits Per Plan Year Limit Per Member)		
Primary Care Physicians	$15 copayment	$20 copayment
Specialty Care Providers	$25 copayment	$35 copayment
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	20% coinsurance after deductible
Professional Provider Services		
- Primary Care Physicians	20% coinsurance after deductible	20% coinsurance after deductible
- Specialty Care Providers	20% coinsurance after deductible	20% coinsurance after deductible
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
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	No copayment, coinsurance, or deductible	No copayment, coinsurance, or deductible
• Routine Screenings, Immunizations, Lab and X-Ray Services (Outside of Annual Check-Up Visit)	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



Key Advantage 500 In-Network You Pay	Key Advantage 1,000 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	$25 copayment	20% coinsurance after deductible
$40 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
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	No copayment, coinsurance, or deductible
No copayment, coinsurance, or deductible	No copayment, coinsurance, or deductible	No copayment, coinsurance, or deductible

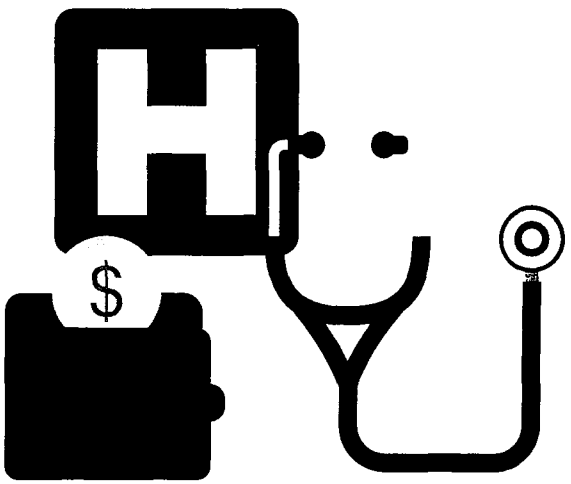


Health & Wellness Programs

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

- **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
- **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.
- **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.
- **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.
- **Staying Healthy Reminders:** Receive yearly reminders of important checkups, tests, screenings, immunizations, and other preventive care needs for you and your family.
- **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.**