



The Local Choice Health Benefits Program

July 1, 2005

Comparison of Benefits

The Local Choice Advantage

THE PLANS

STATEWIDE SELF FUNDED PLANS

- Key Advantage With Expanded Benefits
- Key Advantage 200
- Key Advantage 300
- Key Advantage 500

For Medicare Eligible Retirees/Dependents

- Advantage 65
- Advantage 65 With Dental/Vision
- Medicare Complementary

REGIONAL PLAN

Northern Virginia

(includes Washington, D.C. and parts of Maryland)

- Kaiser Foundation Health Plan of the Mid-Atlantic States Inc. – HMO

PROGRAM HIGHLIGHTS

- Premium stability through well managed benefit plans, strong cash reserves, provider discounts, and low administrative costs for statewide plans
- Dedicated customer service for The Local Choice members
- Well-established provider networks offering members a wide choice of providers, including BlueCard PPO® and BlueCard Worldwide® for medical services under the statewide plans
- Compliance with the Virginia Procurement Act, eliminating the need for costly and complex procurement process
- CommonHealth Wellness, at no cost to the group, promoting employee health through a variety of wellness programs, including Baby Benefits
- Professional program management and Benefits Administrator training from the Department of Human Resource Management

For information about The Local Choice Program, contact:

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Commonwealth of Virginia
Department of Human Resource Management
101 North 14th Street – 13th Floor
Richmond, Virginia 23219

(804) 786-6460

Email: tlc@dhrm.virginia.gov

Web: www.thelocalchoice.virginia.gov

The Local Choice 2005 – Comparison of Key Advantage Plan Benefits

	Key Advantage Expanded			Key Advantage 200		
Deductible – per plan year <i>(applies to certain medical services as indicated on chart)</i>	<u>One Person</u> \$100	<u>Two People</u> \$200	<u>Family</u> \$300	In-Network: <u>One Person</u> \$200	<u>Two People</u> \$400	<u>Family</u> \$600
				Out-of-Network: \$400	\$800	\$1,200
Out-of-pocket expense limit – per plan year	\$1,000	\$2,000	\$3,000	In-Network: \$1,500	\$3,000	\$4,500
				Out-of-Network: \$3,000	\$6,000	\$9,000
Out-of-network benefits	Yes. Plan's payment reduced by 25% for covered medical and behavioral health services			Yes. Once you meet the out-of-network deductible, you pay 20% coinsurance for medical and behavioral health services. Copayments do not apply to medical and behavioral health services.		
BlueCard® PPO and BlueCard Worldwide®	Included			Included		
Lifetime maximum	None			None		

Covered Services	Key Advantage Expanded In-Network You Pay			Key Advantage 200 In-Network You Pay		
Ambulance travel	20% coinsurance after deductible			20% coinsurance after deductible		
Behavioral health and EAP <i>Inpatient treatment</i>	\$200 copayment per stay			\$300 copayment per stay		
• Facility services	\$0			\$0		
• Professional provider services	\$0			\$0		
• Primary care physicians						
• Specialty care providers						
<i>Outpatient visits</i>	\$15 copayment			\$20 copayment		
<i>Employee Assistance Program (EAP)</i> <i>(up to 4 visits per incident)</i>	\$0			\$0		
Dental	<u>One Person</u>	<u>Two People</u>	<u>Family</u>	<u>One Person</u>	<u>Two People</u>	<u>Family</u>
<i>Dental plan year deductible</i>	\$25	\$50	\$75	\$25	\$50	\$75
<i>Plan year maximum (except Orthodontics)</i>	\$1,500			\$1,200		
<i>Diagnostic and preventive services</i>	\$0, no deductible			\$0, no deductible		
<i>Primary services</i>	20% coinsurance after dental deductible			20% coinsurance after dental deductible		
<i>Complex restorative</i>	50% coinsurance after dental deductible			50% coinsurance after dental deductible		
<i>Orthodontic services</i>	50% coinsurance after dental deductible; \$1,500 lifetime maximum			50% coinsurance after dental deductible; \$1,200 lifetime maximum		

The Local Choice 2005 – Comparison of Key Advantage Plan Benefits

	Key Advantage 300			Key Advantage 500		
Deductible – per plan year <i>(applies to certain medical services as indicated on chart)</i>	In-Network: <u>One Person</u> <u>Two People</u> <u>Family</u> \$300 \$600 \$900 Out-of-Network: \$600 \$1,200 \$1,800			In-Network: <u>One Person</u> <u>Two People</u> <u>Family</u> \$500 \$1,000 \$1,500 Out-of-Network: \$1,000 \$2,000 \$3,000		
Out-of-pocket expense limit – per plan year	In-Network: \$2,500 \$5,000 \$7,500 Out-of-Network: \$5,000 \$10,000 \$15,000			In-Network: \$3,000 \$6,000 \$9,000 Out-of-Network: \$6,000 \$12,000 \$18,000		
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.			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.		
BlueCard® PPO and BlueCard Worldwide®	Included			Included		
Lifetime maximum	None			None		

Covered Services	Key Advantage 300 In-Network You Pay	Key Advantage 500 In-Network You Pay
Ambulance travel	20% coinsurance after deductible	20% coinsurance after deductible
Behavioral health and EAP <i>Inpatient treatment</i>		
• Facility services	20% coinsurance per stay after deductible	20% coinsurance per stay after deductible
• Professional provider services		
• Primary care physicians	\$0	\$0
• Specialty care providers	\$0	\$0
Outpatient visits	\$25 copayment	\$25 copayment
Employee Assistance Program (EAP) <i>(up to 4 visits per incident)</i>	\$0	\$0
Dental		
Dental plan year deductible	<u>One Person</u> <u>Two People</u> <u>Family</u> \$25 \$50 \$75	<u>One Person</u> <u>Two People</u> <u>Family</u> \$25 \$50 \$75
Plan year maximum (except Orthodontics)	\$1,200	\$1,200
Diagnostic and preventive services	\$0, no deductible	\$0, no deductible
Primary services	20% coinsurance after dental deductible	20% coinsurance after dental deductible
Complex restorative	50% coinsurance after dental deductible	50% coinsurance after dental deductible
Orthodontic services	50% coinsurance after dental deductible; \$1,200 lifetime maximum	50% coinsurance after dental deductible; \$1,200 lifetime maximum

Covered Services	Key Advantage Expanded In-Network You Pay	Key Advantage 200 In-Network You Pay
Diagnostic tests, and x-rays <i>(for specific conditions or diseases at a doctor's office, emergency room or outpatient hospital department)</i>	10% coinsurance, no deductible	10% coinsurance after deductible
Doctor visits – on an outpatient basis <i>Primary care physicians</i>	\$15 copayment	\$20 copayment
<i>Specialty care providers</i>	\$25 copayment	\$35 copayment
Emergency room visits <i>Facility services</i>	\$75 copayment per visit (waived if admitted)	\$100 copayment per visit (waived if admitted)
<i>Professional provider services</i> • <i>Primary care physicians</i> • <i>Specialty care providers</i>	\$15 copayment \$25 copayment	\$20 copayment \$35 copayment
<i>Diagnostic tests, and x-rays</i>	10% coinsurance, no deductible	10% coinsurance after deductible
Home health services <i>(90 visit plan year limit)</i>	\$0	\$0
Home private duty nurse's services	20% coinsurance after deductible	20% coinsurance after deductible
Hospice care services	\$0	\$0
Hospital services <i>Inpatient treatment</i> • <i>Facility services</i> • <i>Professional provider services</i> • <i>Primary care physicians</i> • <i>Specialty care providers</i>	\$200 copayment per stay \$0 \$0	\$300 copayment per stay \$0 \$0
<i>Outpatient treatment</i> • <i>Facility services</i> • <i>Professional provider services</i> • <i>Primary care physicians</i> • <i>Specialty care providers</i> • <i>Diagnostic tests, and x-rays</i>	\$75 copayment \$15 copayment \$25 copayment 10% coinsurance, no deductible	\$100 copayment \$20 copayment \$35 copayment 10% coinsurance after deductible
Infusion services <i>Facility services</i>	\$0	\$0
<i>Professional provider services</i>	\$0	\$0
<i>Home services</i>	\$0	\$0
<i>Infusion medications</i> • <i>Outpatient settings</i> • <i>Home settings</i>	\$0 \$0	\$0 \$0

Covered Services	Key Advantage 300 In-Network You Pay	Key Advantage 500 In-Network You Pay
Diagnostic tests, and x-rays <i>(for specific conditions or diseases at a doctor's office, emergency room or outpatient hospital department)</i>	20% coinsurance after deductible	20% coinsurance after deductible
Doctor visits – on an outpatient basis <i>Primary care physicians</i>	\$25 copayment	\$25 copayment
<i>Specialty care providers</i>	\$40 copayment	\$40 copayment
Emergency room visits <i>Facility services</i>	20% coinsurance after deductible	20% coinsurance after deductible
<i>Professional provider services</i> • <i>Primary care physicians</i> • <i>Specialty care providers</i>	\$25 copayment \$40 copayment	\$25 copayment \$40 copayment
<i>Diagnostic tests, and x-rays</i>	20% coinsurance after deductible	20% coinsurance after deductible
Home health services <i>(90 visit plan year limit)</i>	\$0	\$0
Home private duty nurse's services	20% coinsurance after deductible	20% coinsurance after deductible
Hospice care services	\$0	\$0
Hospital services <i>Inpatient treatment</i> • <i>Facility services</i> • <i>Professional provider services</i> • <i>Primary care physicians</i> • <i>Specialty care providers</i>	20% coinsurance per stay after deductible \$0 \$0	20% coinsurance per stay after deductible \$0 \$0
<i>Outpatient treatment</i> • <i>Facility services</i> • <i>Professional provider services</i> • <i>Primary care physicians</i> • <i>Specialty care providers</i> • <i>Diagnostic tests, and x-rays</i>	20% coinsurance after deductible \$25 copayment \$40 copayment 20% coinsurance after deductible	20% coinsurance after deductible \$25 copayment \$40 copayment 20% coinsurance after deductible
Infusion services <i>Facility services</i>	\$0	\$0
<i>Professional provider services</i>	\$0	\$0
<i>Home services</i>	\$0	\$0
<i>Infusion medications</i> • <i>Outpatient settings</i> • <i>Home settings</i>	\$0 \$0	\$0 \$0

Covered Services	Key Advantage Expanded In-Network You Pay	Key Advantage 200 In-Network You Pay
Maternity Professional provider services (prenatal & postnatal care) <ul style="list-style-type: none"> • Primary care physicians • Specialty care providers 	\$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.	\$20 copayment \$35 copayment
Delivery <ul style="list-style-type: none"> • Primary care physicians • Specialty care providers 	\$0 \$0	\$0 \$0
Hospital services for delivery (delivery room, anesthesia, routine nursing care for newborn)	\$200 copayment per stay	\$300 copayment per stay
Diagnostic tests	10% coinsurance, no deductible	10% coinsurance after deductible
Medical equipment, appliances, formulas and supplies	20% coinsurance after deductible	20% coinsurance after deductible
Outpatient prescription drugs <ul style="list-style-type: none"> • Retail up to 34-day supply* (mandatory generic) *You may purchase up to a 90-day supply at a retail pharmacy by paying multiple copayments • Home delivery up to 90-day supply (mandatory generic) 	Tier 1 – \$15 copayment Tier 2 – \$20 copayment Tier 3 – \$35 copayment Tier 1 – \$30 copayment Tier 2 – \$40 copayment Tier 3 – \$70 copayment	Tier 1 – \$15 copayment Tier 2 – \$20 copayment Tier 3 – \$35 copayment Tier 1 – \$30 copayment Tier 2 – \$40 copayment Tier 3 – \$70 copayment
Routine vision (once every 24 months) Routine eye exam	\$25 copayment	Not covered
Eyeglass frames (one pair)	Remaining cost after Plan pays \$75	Not covered
Eyeglass lenses (one pair) <ul style="list-style-type: none"> • Single vision lenses • Bifocal lenses • Trifocal lenses OR Contact lenses (any type)	Remaining cost after Plan pays \$50 Remaining cost after Plan pays \$75 Remaining cost after Plan pays \$100 Remaining cost after Plan pays \$100	Not covered Not covered Not covered Not covered
Shots – allergy & therapeutic injections (at doctor's office, emergency room or outpatient hospital department)	10% coinsurance, no deductible	10% coinsurance after deductible
Skilled nursing facility stays (180-day per stay limit) Facility services	\$0	\$0
Professional provider services	\$0	\$0

Covered Services	Key Advantage 300 In-Network You Pay	Key Advantage 500 In-Network You Pay
Maternity Professional provider services (prenatal & postnatal care) <ul style="list-style-type: none"> • Primary care physicians • Specialty care providers 	\$25 copayment \$40 copayment <i>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.</i>	\$25 copayment \$40 copayment
Delivery <ul style="list-style-type: none"> • Primary care physicians • Specialty care providers 	\$0 \$0	\$0 \$0
Hospital services for delivery (delivery room, anesthesia, routine nursing care for newborn)	20% coinsurance per stay after deductible	20% coinsurance per stay after deductible
Diagnostic tests	20% coinsurance after deductible	20% coinsurance after deductible
Medical equipment, appliances, formulas and supplies	20% coinsurance after deductible	20% coinsurance after deductible
Outpatient prescription drugs <ul style="list-style-type: none"> • Retail up to 34-day supply* (mandatory generic) *You may purchase up to a 90-day supply at a retail pharmacy by paying multiple copayments • Home delivery up to 90-day supply (mandatory generic) 	Tier 1 – \$15 copayment Tier 2 – \$20 copayment Tier 3 – \$35 copayment Tier 1 – \$30 copayment Tier 2 – \$40 copayment Tier 3 – \$70 copayment	Tier 1 – \$15 copayment Tier 2 – \$20 copayment Tier 3 – \$35 copayment Tier 1 – \$30 copayment Tier 2 – \$40 copayment Tier 3 – \$70 copayment
Routine vision (once every 24 months) Routine eye exam	Not covered	Not covered
Eyeglass frames (one pair)	Not covered	Not covered
Eyeglass lenses (one pair) <ul style="list-style-type: none"> • Single vision lenses • Bifocal lenses • Trifocal lenses OR Contact lenses (any type)	Not covered Not covered Not covered Not covered	Not covered Not covered Not covered Not covered
Shots – allergy & therapeutic injections (at doctor's office, emergency room or outpatient hospital department)	20% coinsurance after deductible	20% coinsurance after deductible
Skilled nursing facility stays (180-day per stay limit) Facility services	\$0	\$0
Professional provider services	\$0	\$0

Covered Services	Key Advantage 300 In-Network You Pay	Key Advantage 500 In-Network You Pay
Spinal manipulations and other manual medical interventions (<i>\$500 plan year limit</i>)		
Primary care physicians	\$25 copayment	\$25 copayment
Specialty care providers	\$40 copayment	\$40 copayment
Surgery – see Hospital services		
Therapy services <i>Cardiac rehabilitation therapy, chemotherapy, radiation therapy, and respiratory therapy</i>		
• Facility services	\$0	\$0
• Hospital services	\$0	\$0
• Professional provider services	\$0	\$0
<i>Occupational therapy visits, physical therapy visits, and speech therapy visits</i>		
• Hospital services	\$40 copayment	\$40 copayment
• Professional provider services		
• Primary care physicians	\$25 copayment	\$25 copayment
• Specialty care providers	\$40 copayment	\$40 copayment
Wellness services <i>Well child (office visits at specified intervals through age 6)</i>		
• Primary care physicians	\$25 copayment	\$25 copayment
• Specialty care providers	\$40 copayment	\$40 copayment
• Immunizations and screening tests	20% coinsurance, no deductible	20% coinsurance, no deductible
<i>Routine wellness – age 7 & older</i>		
• Annual check-up visit		
• Primary care physicians	\$25 copayment	\$25 copayment
• Specialty care providers	\$40 copayment	\$40 copayment
• Immunizations, lab and x-ray services*	20% coinsurance, no deductible	20% coinsurance, no deductible
	* Your health plan pays 80% coinsurance up to \$200 per plan year for routine immunizations, lab and x-ray services	* Your health plan pays 80% coinsurance up to \$200 per plan year for routine immunizations, lab and x-ray services
<i>Preventive care (one of each per plan year)</i>		
• Gynecological exam		
• Primary care physicians	\$25 copayment	\$25 copayment
• Specialty care providers	\$40 copayment	\$40 copayment
• Pap test	20% coinsurance, no deductible	20% coinsurance, no deductible
• Mammography screening – age 35 or older	20% coinsurance, no deductible	20% coinsurance, no deductible
• Prostate exam (digital rectal exam) – age 40 and older		
• Primary care physicians	\$25 copayment	\$25 copayment
• Specialty care providers	\$40 copayment	\$40 copayment
• Prostate specific antigen test – age 40 and older	20% coinsurance, no deductible	20% coinsurance, no deductible
• Colorectal cancer screenings – age 40 and older	20% coinsurance, no deductible	20% coinsurance, no deductible

If You Need Assistance

Anthem Blue Cross and Blue Shield

Medical and Vision Care
(804) 355-8506 in Richmond
1-800-552-2682 outside Richmond
Monday through Friday 8:00 a.m. – 6:00 p.m.
Saturday 9:00 a.m. – 1:00 p.m.

On the Web at www.anthem.com

ValueOptions, Inc.

Behavioral Health Care and EAP
1-866-725-0602

On the Web at www.achievesolutions.net/tlc

Medco Health Solutions, Inc.

Prescription Drugs
1-800-355-8279

On the Web at www.medco.com

Delta Dental Plan of Virginia

Dental Care
1-888-335-8296

On the Web at www.deltadentalva.com

The Local Choice

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Commonwealth of Virginia
Department of Human Resource Management
101 North 14th Street – 13th Floor
Richmond, VA 23219
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NOTE: This is not a policy. This is a brief summary of the plans offered through The Local Choice Health Benefits Program. For a complete description of the benefits, exclusions, limitations, and reductions under each plan, please see the appropriate plan member handbook.