

HIGH DEDUCTIBLE HEALTH PLAN (HDHP)

BENEFITS SUMMARY

Effective July 1, 2014 or October 1, 2014



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HIGH DEDUCTIBLE HEALTH PLAN (HDHP)

WHO IS ELIGIBLE

- **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.**

NOTE: Medicare eligible retirees and the Medicare eligible dependents of any retiree (Medicare eligible or otherwise), may not enroll in TLC HDHP.

If your Local Employer offers a TLC Medicare supplemental plan, be aware that participation in both Parts A and B of Medicare is required to receive maximum benefits under the Medicare supplemental plan. Part D expenses are not covered.

PLAN YEAR

Your benefits are administered on a plan year basis which is July 1 through June 30, or October 1 through September 30, depending upon your renewal date.

SERVICE AREA

This plan is available wherever employees and eligible retirees live or work.

THIS IS A SUMMARY of your medical, behavioral health, employee assistance (EAP), prescription drug, and dental benefits. Your benefits are administered by Anthem Blue Cross and Blue Shield.

The HDHP features a single and family (two or more people) plan year deductible that applies to your medical, behavioral health and prescription drug benefits. **Note that the entire family deductible must be met before the plan pays for covered services for any enrolled family member.** After the deductible is met, you pay 20% coinsurance for covered services, and the plan pays 80%.

Your dental benefits are administered by Delta Dental and they are separate from your HDHP benefits. See page 8 for a description of your dental coverage.

YOUR HIGH DEDUCTIBLE HEALTH PLAN IS HSA COMPATIBLE

Enrollment in a HDHP allows you to set up a personal Health Savings Account (HSA) through a bank or other financial institution to help you manage health care expenses or save for retirement. HSAs were created as part of Medicare reform legislation in 2003. An HSA is a tax-favored account that allows those covered by a HDHP to pay for certain qualified medical expenses tax-free. It can help you save on the cost of your health insurance and health care expenses, and also help pay for covered services before you satisfy the health plan deductible.

If you decide to set up an HSA to work with your HDHP, confer with your tax advisor, bank or other financial institution.

The following Web sites are a good place to start learning more about HSAs.

- www.treasury.gov – Provides an overview of HSAs, answers to frequently asked questions and important IRS forms and applications.
- www.irs.gov – Provides information about how HSAs impact your Federal taxes and qualified medical expenses (Publications 969 and 502). Search using keyword HSA.
- www.hhs.gov – Provides general information about HSAs and other tax-favored health plans. Search using keyword HSA.

Note: If you have an HSA, you cannot also have a Flexible Spending Account unless it is limited in scope. More information is available from tax consultants or financial institutions

HOW THE PLAN WORKS

YOUR MEDICAL AND BEHAVIORAL HEALTH NETWORKS

Medical Benefits

Medical care is provided by primary care physicians (general or family practitioner, internist or pediatrician), specialty care providers and facilities. Referrals are not needed.

Behavioral Health and Employee Assistance Program (EAP) Benefits



Anthem behavioral health associates are available to assist you in locating a behavioral health provider in your network. You also may locate a behavioral health network provider on the Web at

www.anthem.com/tlc, and click on Find a Doctor.

You are encouraged to have all behavioral health services pre-authorized by calling **1-855-223-9277** before receiving care, or within 48 hours of an emergency admission. Anthem Behavioral Healthcare case managers certify the appropriate levels of mental health and substance abuse care based on your diagnosis and medical necessity criteria.

The **EAP** provides up to four counseling sessions per issue free of charge to you and your household members. Contact Anthem EAP toll-free at **1-855-223-9277** for more information.

In-Network Care



Your networks are the Anthem PPO network in Virginia and the BlueCard® PPO and BlueCard Worldwide® networks outside Virginia. Referrals for care are not required.

For the most current list of Anthem PPO network providers go to www.anthem.com/tlc and click on Find a Doctor.

Care When Traveling

If you live or travel outside of Virginia, you will receive the highest level of medical benefits when you receive care from a BlueCard® PPO provider in that area. Providers who participate with other Blue Cross Blue Shield companies will accept your coinsurance at the time of service instead of requiring full payment. These providers or facilities will file claims directly to their local Blue Cross Blue Shield company for you, and have agreed to accept the allowable charge established with their local Blue Cross Blue Shield company as payment in full for their services.

BlueCard Worldwide® gives you access to doctors and hospitals for medical care in more than 200 countries and territories around the world.

Call **1-800-810-BLUE (2583)** to locate a BlueCard PPO or BlueCard Worldwide provider. Be sure to present your TLC/Anthem identification card when you receive care outside Virginia. The suitcase emblem at the top of your card indicates that your plan includes the BlueCard program.

Medical and Behavioral Health Out-of-Pocket Expense Limit

There are separate medical and behavioral health out-of-pocket expense limits for in-network and out-of-network services.

In-Network Services

- If you are the only one covered by the plan, the most you will pay out of your pocket is \$5,000 per plan year for covered services. Once you have reached this amount, your payment for almost all covered in-network services is \$0.
- If two or more people are covered by the plan, the most all of you will pay out of your pocket is \$10,000.

PRESCRIPTION DRUGS

Retail Pharmacy

This is a **mandatory generic** program for up to a 34-day supply of covered drugs at a retail pharmacy.



You'll get the most from your drug program by using network pharmacies. Simply show your ID card and pay the appropriate deductible or coinsurance. Your network has more than 64,000 pharmacies across the country – including most chains and some local, independent pharmacies. Check with your pharmacy to be sure they participate, or call us at **1-800-552-2682**.

If you choose a pharmacy out of the network, you'll need to pay the total cost of the drug when you pick it up, and then file a Prescription Drug Claim Form to get reimbursed. You may be responsible for the difference between the pharmacy's charge and the plan's allowable charge for the drug.

Q. Can I get a 90-day supply of my drug at a network retail pharmacy?

Yes. You'll pay the applicable deductible or coinsurance.

Q. Can I get a brand name drug instead of a generic?

You have a mandatory generic drug program. However, if there is no generic equivalent for the drug, you may get the brand and pay the applicable deductible or coinsurance. If there is a generic equivalent available, you may opt to use the brand, but you'll pay the brand deductible or coinsurance plus the difference between the brand and generic allowable charge.

Q. What if I need more than a 34-day supply because I'm travelling out of the country and won't have access to a participating pharmacy?

You can submit the Prescription Drug Refill Exception Request form to the Department of Human Resource Management (DHRM). It's available at [anthem.com/tlc](https://www.anthem.com/tlc) under Forms.

Home Delivery Pharmacy

Switching to home delivery is simple. You can place your first order by phone or online at [anthem.com](https://www.anthem.com).

By phone: Call **800-355-8279**. A representative will help you with your order. Have your prescription, doctor's name, phone number, drug name and strength, and credit card handy when you call.

Online: Login to [anthem.com](https://www.anthem.com) and select Pharmacy under the Benefits tab. Follow the steps under Pharmacy Self Service to request a new prescription or refill a current prescription.

You pay the applicable deductible or coinsurance for a three-month supply of drugs when you use the Home Delivery service, and the medication is delivered right to your home.

Specialty Pharmacy

Specialty Home Delivery

Your pharmacy program includes access to Accredo, a pharmacy dedicated to providing members with specialty drugs. Specialty medications include biopharmaceutical and injectable drugs. Accredo is also a complete support program with clinicians and personal care coordinators to help members taking specialty drugs achieve the best possible outcomes from their treatments.

Contact Accredo at **1-800-870-6419** to begin using the Specialty Home Delivery service. Provide them with your doctor's name and phone number, and they'll do all the rest.

Specialty Retail

You can also obtain your specialty drugs from a participating retail pharmacy for up to a 34-day supply or a 90-day supply and pay the applicable deductible or coinsurance.

DENTAL

(administered by Delta Dental)

Your dental coverage is provided separately from your HDHP benefits and has a separate deductible



for coverage. To reduce your out-of-pocket expense, choose a Delta Dental network dentist. View the Delta PPO and Premier networks

of dentists at www.deltadentalva.com. Claims will be handled by the dentist's office and you will be responsible only for the dental deductible and coinsurance that applies to the covered care you receive. If you go to a non-network dentist, you pay the dental deductible and coinsurance plus any amount above the allowable charge that the dentist may bill you.

When you anticipate dental charges over \$250, have your Delta Dental dentist file a pre-determination (pre-treatment) estimate.

Get the details at www.deltadentalva.com. Click on **The Local Choice** from the home page.

- View your benefits booklet
- Find a dentist
- Check claims
- Learn about good oral health

BENEFITS AT-A-GLANCE

	BENEFIT	IN-NETWORK
PLAN YEAR DEDUCTIBLE <i>(applies as indicated)</i>	One Person	\$1,500
	Family (two or more people)	\$3,000
PLAN YEAR OUT-OF-POCKET EXPENSE LIMIT	One Person	\$5,000
	Family (two or more people)	\$10,000
OUT-OF-NETWORK BENEFITS	None, except in an emergency.	
MEDICAL AND BEHAVIORAL HEALTH CARE WHEN TRAVELING	The BlueCard® PPO and BlueCard® Worldwide programs are included for medical and behavioral health care outside Virginia.	
LIFETIME MAXIMUM	Unlimited	

COVERED SERVICES	YOU PAY IN-NETWORK
AMBULANCE TRAVEL <i>No Plan Year limit</i>	20% coinsurance, after deductible
AUTISM SPECTRUM DISORDER 2 years to 6 years \$35,000 Annual Limit <i>(Applies to Applied Behavioral Analysis only)</i>	20% coinsurance, after deductible
BEHAVIORAL HEALTH	
INPATIENT TREATMENT	20% coinsurance, after deductible
PARTIAL HOSPITALIZATION (DAY) PROGRAM	20% coinsurance, after deductible
INTENSIVE OUTPATIENT TREATMENT PROGRAM (IOP)	20% coinsurance, after deductible
OUTPATIENT TREATMENT PROGRAM	
Facility Services	20% coinsurance, after deductible
Medical and non-medical professional	20% coinsurance, after deductible
CHIROPRACTIC, SPINAL MANIPULATIONS AND OTHER MANUAL MEDICAL INTERVENTIONS 30-Visit Plan Year limit per member	20% coinsurance, after deductible
DENTAL SERVICES (NON-ROUTINE MEDICAL)	20% coinsurance, after deductible
DIABETIC EDUCATION	20% coinsurance, after deductible
DIABETIC EQUIPMENT	20% coinsurance, after deductible
DIAGNOSTIC TESTS, LABS AND X-RAYS	
Outpatient Surgery	20% coinsurance, after deductible
Outpatient Diagnostic Services Only	20% coinsurance, after deductible
Outpatient Emergency Room	20% coinsurance, after deductible
DIALYSIS TREATMENTS	
Facility Services	20% coinsurance, after deductible
Doctor's Office	20% coinsurance, after deductible
DOCTOR'S VISITS <i>(On an Outpatient basis)</i>	20% coinsurance, after deductible
EMPLOYEE ASSISTANCE PROGRAM (EAP) Up to four Visits per issue <i>(per rolling 12 months)</i>	\$0
EARLY INTERVENTION SERVICES <i>(Birth to 3 years)</i>	20% coinsurance, after deductible

COVERED SERVICES	YOU PAY IN-NETWORK
EMERGENCY ROOM VISITS	
Facility Services	20% coinsurance, after deductible
Professional Provider Services	
Primary Care Physicians	20% coinsurance, after deductible
Specialty Care Providers	20% coinsurance, after deductible
Diagnostic Tests, Labs and X-rays	20% coinsurance, after deductible
HOME HEALTH SERVICES <i>90-Visit Plan Year limit per member</i>	20% coinsurance, after deductible
HOME PRIVATE DUTY NURSE'S SERVICES	20% coinsurance, after deductible
HOSPICE CARE SERVICES	20% coinsurance, after deductible
HOSPITAL SERVICES	
INPATIENT CARE	
Facility Services	20% coinsurance, after deductible
Professional Provider Services	20% coinsurance, after deductible
Diagnostic Services	20% coinsurance, after deductible
OUTPATIENT CARE	
Facility Services	20% coinsurance, after deductible
Professional Provider Services	20% coinsurance, after deductible
Diagnostic Tests, Labs and X-rays	20% coinsurance, after deductible
MATERNITY Professional Provider Services (<i>Prenatal and Postnatal Care</i>)	20% coinsurance, after deductible
HOSPITAL SERVICES FOR DELIVERY Delivery room, anesthesia, routine nursing care for newborn	20% coinsurance, after deductible
DIAGNOSTIC TESTS, LABS AND X-RAYS	20% coinsurance, after deductible
MEDICAL EQUIPMENT (DURABLE), APPLIANCES, FORMULAS, PROSTHETICS AND SUPPLIES	20% coinsurance, after deductible
OUTPATIENT PRESCRIPTION DRUGS (mandatory generic)	
RETAIL PHARMACY Covered drugs per 34-day supply	20% coinsurance, after deductible
HOME DELIVERY SERVICES (MAIL ORDER) Covered drugs for up to a 90-day supply	20% coinsurance, after deductible
DIABETIC SUPPLIES	20% coinsurance, after deductible
SHOTS - ALLERGY & THERAPEUTIC INJECTIONS At a doctor's office, Emergency room or Outpatient hospital department	20% coinsurance, after deductible
SKILLED NURSING FACILITY STAYS 180-day per Stay limit per member ¹	
Facility Services	20% coinsurance, after deductible
Professional Provider Services	20% coinsurance, after deductible

¹ A stay is the period from the admission to the date of discharge from a Facility. If there is less than a 90 day break between two admissions, the days allowable for the subsequent admission are reduced by the days used in the first. If there are more than 90 days between the two admissions, the days available for the subsequent admission start over for a full 180 days.

COVERED SERVICES	YOU PAY IN-NETWORK
SURGERY	
INPATIENT	
Facility Services	20% coinsurance, after deductible
Professional Provider Services	20% coinsurance, after deductible
Diagnostic Services	20% coinsurance, after deductible
OUTPATIENT	
Facility Services	20% coinsurance, after deductible
Professional Provider Services	20% coinsurance, after deductible
THERAPY - OUTPATIENT SERVICES	
CARDIAC REHABILITATION THERAPY	20% coinsurance, after deductible
CHEMOTHERAPY	20% coinsurance, after deductible
INFUSION (includes IV therapy and injected chemotherapy)	20% coinsurance, after deductible
OCCUPATIONAL THERAPY	20% coinsurance, after deductible
PHYSICAL THERAPY	20% coinsurance, after deductible
RADIATION THERAPY	20% coinsurance, after deductible
RESPIRATORY THERAPY	20% coinsurance, after deductible
SPEECH THERAPY	20% coinsurance, after deductible
VISION CORRECTION After surgery or accident	20% coinsurance, after deductible
WELLNESS AND PREVENTIVE CARE SERVICES	
WELL CHILD ² (Birth to 18 years)	
Office Visits at specified intervals	
Primary Care Physicians	\$0, no deductible
Specialty Care Providers	\$0, no deductible
Immunizations	
Primary Care Physicians	\$0, no deductible
Specialty Care Providers	\$0, no deductible
Screening Tests	\$0, no deductible
ROUTINE WELLNESS (18 years and older)	
Check-up Visit (one per Plan Year)	
Primary Care Physicians	\$0, no deductible
Specialty Care Providers	\$0, no deductible
Immunizations	
Primary Care Physicians	\$0, no deductible
Specialty Care Providers	\$0, no deductible
Routine Lab and X-ray Services	\$0, no deductible

² See member handbook for immunization schedule.

COVERED SERVICES	YOU PAY IN-NETWORK
WELLNESS AND PREVENTIVE CARE SERVICES (one of each per Plan Year)	
Gynecological Exam	
Primary Care Physicians	\$0, no deductible
Specialty Care Providers	\$0, no deductible
Pap Test	\$0, no deductible
Mammography Screening	\$0, no deductible
Prostate Exam (digital rectal exam)	
Primary Care Physicians	\$0, no deductible
Specialty Care Providers	\$0, no deductible
Prostate Specific Antigen Test	\$0, no deductible
Colorectal Cancer Screenings	\$0, no deductible

COVERED SERVICES	YOU PAY IN-NETWORK		
DENTAL SERVICES	SINGLE (You Only)	TWO PEOPLE	FAMILY (Three or more people)
Plan Year Deductible	\$25	\$50	\$75
The most Your Health Plan pays per person per Plan Year	\$1,500	\$1,500	\$1,500
Diagnostic and Preventive Services	\$0, no deductible		
Primary Dental Care	20% coinsurance, after dental deductible		
Major Dental Care	50% coinsurance, after dental deductible		
Orthodontic Services (\$1,500 lifetime maximum)	50% coinsurance, no deductible		

IF YOU NEED ASSISTANCE

ANTHEM BLUE CROSS AND BLUE SHIELD

Anthem Member Services

(medical and outpatient pharmacy)

1-800-552-2682

Monday through Friday 8:00 a.m. – 6:00 p.m.

Saturday 9:00 a.m. – 1:00 p.m.

www.anthem.com/tlc

Anthem Behavioral Healthcare and Employee Assistance Program

1-855-223-9277

www.anthemeap.com

(Company Name: Commonwealth of Virginia)

24/7 Nurseline

1-800-337-4770

DELTA DENTAL OF VIRGINIA

Routine Dental Care

1-888-335-8296

www.deltadentalva.com

THE LOCAL CHOICE

The Local Choice Health Benefits Program

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

(804) 786-6460

www.thelocalchoice.virginia.gov



NOTE: This is not a policy. This is a brief summary of the TLC High Deductible Health Plan (HDHP). The TLC HDHP Member Handbook, along with this Benefits Summary, constitute a complete description of the benefits, exclusions, limitations and reductions under the plan. Be sure to keep this summary with your TLC HDHP Member Handbook for a full description of your coverage.