KEY ADVANTAGE WITH EXPANDED BENEFITS

BENEFITS SUMMARY

Effective July 1, 2014 or October 1, 2014
Amended December 2014

BENEFIT HIGHLIGHTS

The TLC Key Advantage Member Handbook and this Key Advantage Expanded Benefits Summary constitute a complete description of the benefits, exclusions, limitations, and reductions under the plan. An electronic version of the handbook is available online at **www.thelocalchoice.virginia.gov** and at **www.anthem.com/tlc**.

KEY ADVANTAGE WITH EXPANDED BENEFITS

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 Key Advantage With Expanded Benefits.*

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, vision, behavioral health and employee assistance (EAP), prescription drug, and dental benefits. Your benefits are administered by Anthem Blue Cross and Blue Shield, with the exception of your dental benefits. Under a separate agreement with Anthem, Delta Dental of Virginia will administer routine dental benefits.

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. Higher copayments apply for specialist and facility visits.

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.

Out-of-Network Care

You may receive care outside these networks. However, you have a separate plan year out-of-network deductible and out-of-pocket expense limit. Once you have met the out-of-network deductible, you pay 30% coinsurance for all covered medical and behavioral health services. Claims payments are made directly to the member, rather than to the provider. See page 2 for more information about how your out-of-pocket expense limit works both in and out of the network.

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 copayment or 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. There is no out-of-pocket expense limit for routine vision, prescription drug or dental services.

In-Network Services

- If you are the only one covered by the plan, the most you will pay out of your pocket is $1,000 per plan year for covered services. Once you have reached this amount, your payment for 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 $2,000. However, no family member will pay more than $1,000 toward the limit. Then your payments for covered in-network services are $0.

Out-of-Network Services

- If you are the only one covered by the plan, the most you will pay out of your pocket is $2,000 per plan year for covered services. Once you have reached this amount, your payment for covered services is $0. However, out-of-network providers may bill you for amounts above the plan's allowable charge, and payment is your responsibility.
- If two or more people are covered by the plan, the most all of you will pay out of your pocket is $4,000. However, no family member will pay more than $2,000 toward the limit. Then your payments for covered services are $0. However, out-of-network providers may bill you for amounts above the plan's allowable charge, and payment is your responsibility.

The following do not count toward the out-of pocket expense limit, and you are responsible for paying these costs when the out-of-pocket expense limit has been reached:

- Routine vision, prescription drug and dental services
- Cost of care in excess of benefit limits
- Cost of services and supplies not covered under the plan
- Additional amount non-network providers may bill you when their charge is more than the plan's allowable charge

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 copayment. 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 three copayments for the drug. Keep in mind that you pay **only two copayments for a 90-day supply** when you use the home delivery pharmacy.

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 only the applicable copayment. If there is a generic equivalent available, you may opt to use the brand, but you'll pay the brand copayment 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** under Forms.

Home Delivery Pharmacy

Switching to home delivery is simple. You can place your first order by phone or online at **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** 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 only two copayments 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 **1-877-886-1705** 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 pay three copayments for a 90-day supply.

ROUTINE VISION BENEFITS

Your routine vision benefits are available from Blue View Vision℠ once every 12 months . The 12-month count begins on the date you receive your eye examination or purchase eyeglass frames or lenses. You may have your eye exam and purchase lenses and frames from any Blue View participating optician, optometrist or retail setting, including 1-800 CONTACTS, LensCrafters®, Target® Optical, Sears Optical℠, and JCPenney® Optical. If you receive your eye exam, eyeglass frames or lenses from a non-Blue View provider, the non-Blue View network benefits will apply. Please see page 8 for more details on your routine vision benefits.

Go to www.anthem.com/tlc and click on Find a Doctor to find a Blue View provider near you.

Note: If you need medical, non-routine treatment for your eyes, consult your physician or an Anthem PPO network eye specialist.

DENTAL

(administered by Delta Dental)

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	OUT-OF-NETWORK
PLAN YEAR DEDUCTIBLE *(applies as indicated)*	One Person	$100	$200
	Family (two or more people)	$200	$400
PLAN YEAR OUT-OF-POCKET EXPENSE LIMIT	One Person	$1,000	$2,000
	Family (two or more people)	$2,000	$4,000
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 out-of-network medical and behavioral health services. Copayments and coinsurance for routine vision, outpatient prescription drugs and dental services will still apply.		
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 *No Plan Year limit*	20% coinsurance, after deductible		
AUTISM SPECTRUM DISORDER (Amended 12/2014 retroactive to 7/1/2012 and 10/1/2012 for certain School Groups) 2 years through 6 years	Copayment/coinsurance determined by service received		
BEHAVIORAL HEALTH			
INPATIENT TREATMENT	$200 copayment per stay[1]		
RESIDENTIAL TREATMENT	$200 copayment per stay[1]		
PARTIAL HOSPITALIZATION (DAY) PROGRAM	$100 copayment per stay[1]		
INTENSIVE OUTPATIENT TREATMENT PROGRAM (IOP)	$100 copayment per episode of care		
OUTPATIENT TREATMENT PROGRAM			
Facility Services	$100 copayment		
Professional Provider Services	$15 copayment		
CHIROPRACTIC, SPINAL MANIPULATIONS AND OTHER MANUAL MEDICAL INTERVENTIONS 30-Visit Plan Year limit per member			
Primary Care Physicians	$15 copayment		
Specialty Care Providers	$25 copayment		
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		

[1]A stay is the period from the admission to the date of discharge from a Facility. All hospital stays less than 90 days apart for the same diagnosis are considered the same stay, and a new hospital inpatient copayment will not apply. If you are readmitted within 90 days for a different diagnosis, a copayment will apply. For Behavioral Health Partial Day Program or Intensive Outpatient Treatment Program (IOP), the copayment is also waived if you are admitted within 15 days if an inpatient stay is for the same diagnosis.

COVERED SERVICES	YOU PAY IN-NETWORK
DENTAL SERVICES (NON-ROUTINE MEDICAL)	20% coinsurance, after deductible
DIABETIC EDUCATION	$0
DIABETIC EQUIPMENT	20% coinsurance, after deductible
DIAGNOSTIC TESTS, LABS AND X-RAYS	
Outpatient Surgery	10% coinsurance, no deductible
Outpatient Diagnostic Services Only	10% coinsurance, no deductible
Outpatient Emergency Room	10% coinsurance, no deductible
DIALYSIS TREATMENTS	
Facility Services	$0
Doctor's Office	$0
DOCTOR'S VISITS *(On an Outpatient basis)*	
Primary Care Physicians	$15 copayment
Specialty Care Providers	$25 copayment
EMPLOYEE ASSISTANCE PROGRAM (EAP) Up to four Visits per issue *(per rolling 12 months)*	$0
EARLY INTERVENTION SERVICES (Birth to 3 years)	Copayment/coinsurance determined by service received
EMERGENCY ROOM VISITS	
Facility Services	$100 copayment per visit (waived if admitted to hospital)
Professional Provider Services	
Primary Care Physicians	$15 copayment
Specialty Care Providers	$25 copayment
Diagnostic Tests, Labs and X-rays	10% coinsurance, no deductible
HOME HEALTH SERVICES *90-Visit Plan Year limit per member*	$0
HOME PRIVATE DUTY NURSE'S SERVICES	20% coinsurance, after deductible
HOSPICE CARE SERVICES	$0
HOSPITAL SERVICES	
INPATIENT CARE	
Facility Services	$200 copayment per stay[1]
Professional Provider Services	
Primary Care Physicians	$0
Specialty Care Providers	$0
Diagnostic Services	$0
OUTPATIENT CARE	
Facility Services	$100 copayment per visit
Professional Provider Services	
Primary Care Physicians	$15 copayment
Specialty Care Providers	$25 copayment
Diagnostic Tests, Labs and X-rays	10% coinsurance, no deductible

COVERED SERVICES	YOU PAY IN-NETWORK
MATERNITY[2]	
Professional Provider Services	
Prenatal and Postnatal Care	
Primary Care Physicians	$15 copayment
Specialty Care Providers	$25 copayment
Delivery	
Primary Care Physicians	$0
Specialty Care Providers	$0
HOSPITAL SERVICES FOR DELIVERY Delivery room, anesthesia, routine nursing care for newborn	$200 copayment per stay
DIAGNOSTIC TESTS, LABS AND X-RAYS	10% coinsurance, no 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	
First Tier	$10 copayment
Second Tier	$20 copayment
Third Tier	$35 copayment
HOME DELIVERY SERVICES (MAIL ORDER) Covered drugs for up to a 90-day supply	
First Tier	$20 copayment
Second Tier	$40 copayment
Third Tier	$70 copayment
DIABETIC SUPPLIES	20% coinsurance, no deductible
SHOTS – ALLERGY & THERAPEUTIC INJECTIONS At a doctor's office, Emergency room or Outpatient hospital department	10% coinsurance, no deductible
SKILLED NURSING FACILITY STAYS 180-day per Stay limit per member[3]	
Facility Services	$0
Professional Provider Services	$0

[2]This plan will waive the hospital copayment if the member enrolls in the Future Moms pre-natal program within the first trimester of pregnancy, has a dental cleaning during pregnancy and satisfactorily completes the entire program. Call Future Moms at **1-800-828-5891** to enroll.

[3]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	$200 copayment per stay
Professional Provider Services	
Primary Care Physicians	$0
Specialty Care Providers	$0
Diagnostic Services	$0
OUTPATIENT	
Facility Services	$100 copayment per visit
Professional Provider Services	
Primary Care Physicians	$15 copayment
Specialty Care Providers	$25 copayment
THERAPY – OUTPATIENT SERVICES	
CARDIAC REHABILITATION THERAPY	10% coinsurance, after deductible
CHEMOTHERAPY	10% coinsurance, after deductible
INFUSION (includes IV therapy and injected chemotherapy)	10% coinsurance, after deductible
OCCUPATIONAL THERAPY	10% coinsurance, after deductible
PHYSICAL THERAPY	10% coinsurance, after deductible
RADIATION THERAPY	10% coinsurance, after deductible
RESPIRATORY THERAPY	10% coinsurance, after deductible
SPEECH THERAPY	10% coinsurance, after deductible
VISION CORRECTION After surgery or accident	20% coinsurance, after deductible
WELLNESS AND PREVENTIVE CARE SERVICES	
WELL CHILD[4] (Birth to 18 years)	
Office Visits at specified intervals	
Primary Care Physicians	No copayment, coinsurance, or deductible
Specialty Care Providers	No copayment, coinsurance, or deductible
Immunizations	
Primary Care Physicians	No copayment, coinsurance, or deductible
Specialty Care Providers	No copayment, coinsurance, or deductible
Screening Tests	No copayment, coinsurance, or deductible
ROUTINE WELLNESS (18 years and older)	
Check-up Visit (one per Plan Year)	
Primary Care Physicians	No copayment, coinsurance, or deductible
Specialty Care Providers	No copayment, coinsurance, or deductible
Immunizations	
Primary Care Physicians	No copayment, coinsurance, or deductible
Specialty Care Providers	No copayment, coinsurance, or deductible
Routine Lab and X-ray Services	No copayment, coinsurance, or deductible

[4]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	No copayment, coinsurance, or deductible
Specialty Care Providers	No copayment, coinsurance, or deductible
Pap Test	No copayment, coinsurance, or deductible
Mammography Screening	No copayment, coinsurance, or deductible
Prostate Exam (digital rectal exam)	
Primary Care Physicians	No copayment, coinsurance, or deductible
Specialty Care Providers	No copayment, coinsurance, or deductible
Prostate Specific Antigen Test	No copayment, coinsurance, or deductible
Colorectal Cancer Screenings	No copayment, coinsurance, or deductible

ROUTINE VISION – BLUE VIEW VISION NETWORK

You have an allowance for eyeglass lenses or contact lenses every 12 months. You pay the remaining cost for frames and lenses after Your Health Plan's Reimbursement.

Network	Covered Services	Blue View Vision Network	Non-Blue View
Routine Vision Blue View Vision Network (once every 12 months)	■ Routine eye exam	You pay $25 copayment	Plan pays up to to $50
	■ Eyeglass lenses	You pay $20 copayment	Plan pays up to: $50 single lenses; $75 bifocal; $100 trifocal
	■ Eyeglass frames	Plan pays up to $100* retail allowance	Plan pays up to $80
	■ Contact lenses *(in lieu of eyeglass lenses)*		
	• Elective[1]	Plan pays up to $100 allowance then 15% discount off remaining balance	Plan pays up to $80
	• Non-Elective[1]	Plan pays up to $250 allowance	Plan pays up to $210
	■ Lens options		
	• UV coating, tints, standard scratch-resistant	You pay $15	Not available
	• Standard polycarbonate	You pay $40	Not available
	• Standard progressive *(in addition to bifocal copayment)*	You pay $65	Not available
	• Standard anti-reflective	You pay $45	Not available
	• Other add-ons	You pay 20% off retail	Not available

*You may select a frame greater than the covered allowance and receive a 20% discount for any additional cost over the allowance.

[1] Elective contact lenses are typically elected in lieu of eyeglass lenses. Non-Elective contact lenses are medically necessary contacts when glasses are not an option for vision correction, such as after cataract surgery.

IF YOU NEED ASSISTANCE

ANTHEM BLUE CROSS AND BLUE SHIELD

Anthem Member Services
(medical, outpatient pharmacy and routine vision)
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

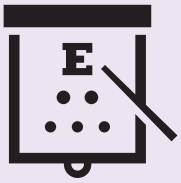
DELTA DENTAL OF VIRGINIA

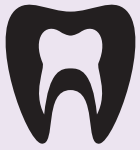
Routine Dental Care
1-888-335-8296
www.deltadentalva.com

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 Key Advantage With Expanded Benefits health benefits plan. The Key Advantage 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 Key Advantage Member Handbook for a full description of your coverage.

T20902 (1/2014)