Comparison of Statewide Plans 2015

Effective July 1, 2015 or October 1, 2015

The LOCAL CHOICE

The Local Choice 2015 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 $500	Two People *See Family* **Out-of-Network:** *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 2 years through 6 years	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*	 $200 copayment per stay $0 $15 copayment			 $300 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:**					
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:**					
$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 2015 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)	10% coinsurance, no deductible	10% coinsurance after deductible
Doctor Visits – on an Outpatient Basis		
Primary Care Physicians	$15 copayment	$20 copayment
Specialty Care Providers	$25 copayment	$35 copayment
Early Intervention Services	Copayment/coinsurance determined by service received	Copayment/coinsurance determined by service received
Emergency Room Visits		
Facility Services	$100 copayment per visit (waived if admitted to hospital)	$150 copayment per visit (waived if admitted to hospital)
Professional Provider Services		
– Primary Care Physicians	$15 copayment	$20 copayment
– Specialty Care Providers	$25 copayment	$35 copayment
Diagnostic Tests and X-rays	10% coinsurance, no deductible	10% 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	$200 copayment per stay	$300 copayment per stay
• Professional Provider Services		
– Primary Care Physicians	$0	$0
– Specialty Care Providers	$0	$0
Outpatient Treatment		
• Facility Services	$100 copayment	$150 copayment
• Professional Provider Services		
– Primary Care Physicians	$15 copayment	$20 copayment
– Specialty Care Providers	$25 copayment	$35 copayment
Diagnostic Tests and X-Rays	10% coinsurance, no deductible	10% coinsurance after deductible
Infusion Services		
Facility Services	10% coinsurance after deductible	10% coinsurance after deductible
Professional Provider Services	10% coinsurance after deductible	10% coinsurance after deductible
Home Services	10% coinsurance after deductible	10% coinsurance after deductible
Infusion Medications		
– Outpatient Settings	10% coinsurance after deductible	10% coinsurance after deductible
– Home Settings	10% coinsurance after deductible	10% coinsurance after deductible

Key Advantage 500 In-Network You Pay	Key Advantage 1000 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
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	20% coinsurance after deductible 20% coinsurance after deductible	20% coinsurance after deductible 20% coinsurance after deductible

The Local Choice 2015 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)	$200 copayment per stay*	$300 copayment per stay*
Outpatient Diagnostic Tests	10% coinsurance, no deductible	10% 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)	10% coinsurance, no deductible	10% coinsurance after deductible
Skilled Nursing Facility Stays (180-Day Per Stay Limit Per Member)		
Facility Services	$0	$0
Professional Provider Services	$0	$0

**This plan will waive the hospital copayment if the member enrolls in the maternity management pre-natal program within the first trimester 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	$25 copayment	20% coinsurance after deductible
$40 copayment	$40 copayment	20% coinsurance after deductible
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.		
$0	$0	20% coinsurance after deductible
$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
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
$0	$0	20% coinsurance after deductible
$0	$0	20% coinsurance after deductible

The Local Choice 2015 Comparison of Statewide Plans (continued)

Covered Services	Key Advantage Expanded In-Network You Pay	Key Advantage 250 In-Network You Pay
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 *Cardiac Rehabilitation Therapy, Chemotherapy, Radiation Therapy, Respiratory Therapy, Occupational Therapy, Physical Therapy, and Speech Therapy*		
Facility Services	10% coinsurance after deductible	10% coinsurance after deductible
Professional Provider Services		
– Primary Care Physicians	10% coinsurance after deductible	10% coinsurance after deductible
– Specialty Care Providers	10% coinsurance after deductible	10% 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 1000 In-Network You Pay	High Deductible Health Plan In-Network You Pay
$25 copayment $40 copayment	$25 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 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

Your TLC Take Care Package

Wellness programs and Web tools included in your plan

Employee Assistance Program (EAP) 855-223-9277

Your EAP includes up to 4 free confidential counseling sessions per issue for you, your covered dependents and members of your household. It's also a valuable source for information about emotional well-being, childcare and elder care resources, financial and legal issues, and more. Tap into all your EAP has to offer at anthem.com/tlc. Choose the EAP link, enter Commonwealth of Virginia as your company, and select The Local Choice.

27/7 NurseLine & Audio Health Tape Library 800-337-4770

Sometimes you need health questions answered right away – even in the middle of the night. Call 24/7 NurseLine 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.

LiveHealthOnline.com

No time to wait for an appointment? No problem. See a doctor 24/7 from your computer or mobile device. All you need is the LiveHealth Online app or a computer with a webcam to see a doctor from your home, the office, or anywhere. Enroll now so you'll be ready to use LiveHealth Online next time you need to see a doctor right away. Your PCP copayment or coinsurance will apply for the cost of the visit.

Future Moms 800-828-5891

Expecting? Enroll in Future Moms for free pre- and post-natal support to help ensure a healthy pregnancy. It's there for you, your spouse, or other covered dependents. Since no two pregnancies are alike, be sure to enroll whether it's your first or third baby that's on the way.

Key Advantage Expanded or Key Advantage 250 members: Enroll within the first trimester (14 weeks) and have a dental cleaning during pregnancy, and your plan will waive the hospital copayment for delivery.

ConditionCare 800-445-7922

Take advantage of free and confidential support to manage these conditions:

- Asthma
- Diabetes
- Chronic obstructive pulmonary disease (COPD)
- Coronary artery disease (CAD)
- Obesity
- Heart failure
- Hypertension
- High cholesterol
- Metabolic syndrome

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.

Quit for Life Tobacco Cessation 866-784-8454

This nationally acclaimed program is free, confidential, and it works! When you're ready to be tobacco free, you don't have to quit alone. Call or go to www.quitnow.net/commonwealth to get all the help you need.

MyHealth Advantage

You may receive a MyHealth Note in the mail. It's our way of reminding you about important health screenings and other medical reminders. It also gives you a convenient summary of your recent medical claims, prescriptions and money saving health care tips.

Anthem.com/tlc

This is your "go to" site for detailed information about your plan, including benefit summaries and your member handbook. No login or registration is needed.

Anthem.com

Be sure to register at anthem.com so you can access your personal, confidential plan information including claims. You can Find a Doctor, print a temporary ID card, order home delivery prescriptions refills, and check your claims from here. Use the Estimate Your Cost tool to compare costs at different facilities for more than 400 medical procedures.

Go mobile! Be sure to download the Anthem Blue Cross and Blue Shield app to your smart phone. It's great to be able to find a doctor or the nearest Urgent Care Center on the go. Log in to the app and see all the other things you can do right from your phone.

thelocalchoice.virginia.gov

This is your resource for forms, BES information and member notifications.