



# KEY ADVANTAGE WITH EXPANDED BENEFITS

## BENEFITS SUMMARY

*Effective July 1, 2016 or October 1, 2016*

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](http://www.thelocalchoice.virginia.gov) and at [www.anthem.com/tlc](http://www.anthem.com/tlc).

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# 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.*

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## 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.

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## SERVICE AREA

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

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**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](http://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](http://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 Out-of-Pocket Expense Limit

There are separate out-of-pocket expense limits for in-network and out-of-network services. There is no out-of-pocket expense limit for 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 \$2,000 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 \$4,000. However, no family member will pay more than \$2,000 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 \$3,000 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 \$6,000. However, no family member will pay more than \$3,000 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:**

- 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](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** 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<sup>SM</sup> once every plan year. 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<sup>SM</sup>, 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](http://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)*



You have two choices for your dental benefits. The Comprehensive dental option is included in your plan and includes Preventive, Primary, Major and Orthodontic dental services. The Preventive option includes only the twice per plan year routine oral exam, cleaning, x-rays, sealants and fluoride for children. This option is available for a lower premium, and you must choose it by completing an enrollment form.

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](http://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](http://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
<b>PLAN YEAR DEDUCTIBLE</b> <i>(applies as indicated)</i>	One Person	\$100	\$200
	Family (two or more people)	\$200	\$400
<b>PLAN YEAR OUT-OF-POCKET EXPENSE LIMIT</b>	One Person	\$2,000	\$3,000
	Family (two or more people)	\$4,000	\$6,000
<b>OUT-OF-NETWORK BENEFITS</b>	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.		
<b>MEDICAL AND BEHAVIORAL HEALTH CARE WHEN TRAVELING</b>	The BlueCard® PPO and BlueCard® Worldwide programs are included for medical and behavioral health care outside Virginia.		
<b>LIFETIME MAXIMUM</b>	Unlimited		

COVERED SERVICES	YOU PAY IN-NETWORK		
<b>AMBULANCE TRAVEL</b> <i>No Plan Year limit</i>	20% coinsurance, after deductible		
<b>AUTISM SPECTRUM DISORDER</b> 2 years through 10 years	Copayment/coinsurance determined by service received		
<b>BEHAVIORAL HEALTH</b>			
<b>INPATIENT TREATMENT</b>	\$200 copayment per stay <sup>1</sup>		
<b>RESIDENTIAL TREATMENT</b>	\$200 copayment per stay <sup>1</sup>		
<b>PARTIAL HOSPITALIZATION (DAY) PROGRAM</b>	\$100 copayment per stay <sup>1</sup>		
<b>INTENSIVE OUTPATIENT TREATMENT PROGRAM (IOP)</b>	\$100 copayment per episode of care		
<b>OUTPATIENT TREATMENT PROGRAM</b>			
Facility Services	\$100 copayment		
Professional Provider Services	\$15 copayment		
<b>CHIROPRACTIC, SPINAL MANIPULATIONS AND OTHER MANUAL MEDICAL INTERVENTIONS</b> 30-Visit Plan Year limit per member			
Primary Care Physicians	\$15 copayment		
Specialty Care Providers	\$25 copayment		
<b>DENTAL CARE</b>			
<b>PREVENTIVE DENTAL OPTION</b> (diagnostic and preventive services only for lower premium)	\$0		
<b>COMPREHENSIVE DENTAL OPTION</b> (for higher premium)			
Dental Plan Year Deductible	One Person \$25	Two People \$50	Family \$75
Plan Year Maximum (Except Orthodontics)	\$1,500		
Preventive Dental Care	\$0		
Primary Dental Care	20% coinsurance after dental deductible		
Major Dental Care	50% coinsurance after dental deductible		
Orthodontic Services (Includes Adult Ortho)	50% coinsurance, no dental deductible, with \$1,500 lifetime maximum		
<b>DENTAL SERVICES (NON-ROUTINE MEDICAL)</b>	20% coinsurance, after deductible		

<sup>1</sup>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
<b>DIABETIC EDUCATION</b>	\$0
<b>DIABETIC EQUIPMENT</b>	20% coinsurance, after deductible
<b>DIAGNOSTIC TESTS, LABS AND X-RAYS</b>	
Outpatient Surgery	10% coinsurance, no deductible
Outpatient Diagnostic Services Only	10% coinsurance, no deductible
Outpatient Emergency Room	10% coinsurance, no deductible
<b>DIALYSIS TREATMENTS</b>	
Facility Services	\$0
Doctor's Office	\$0
<b>DOCTOR'S VISITS</b> <i>(On an Outpatient basis)</i>	
Primary Care Physicians	\$15 copayment
Specialty Care Providers	\$25 copayment
<b>EMPLOYEE ASSISTANCE PROGRAM (EAP)</b> Up to four Visits per issue <i>(per plan year)</i>	\$0
<b>EARLY INTERVENTION SERVICES</b> <i>(Birth to 3 years)</i>	Copayment/coinsurance determined by service received
<b>EMERGENCY ROOM VISITS</b>	
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
<b>HOME HEALTH SERVICES</b> <i>90-Visit Plan Year limit per member</i>	\$0
<b>HOME PRIVATE DUTY NURSE'S SERVICES</b>	20% coinsurance, after deductible
<b>HOSPICE CARE SERVICES</b>	\$0
<b>HOSPITAL SERVICES</b>	
<b>INPATIENT CARE</b>	
Facility Services	\$200 copayment per stay <sup>1</sup>
Professional Provider Services	
Primary Care Physicians	\$0
Specialty Care Providers	\$0
Diagnostic Services	\$0
<b>OUTPATIENT CARE</b>	
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
<b>MATERNITY</b> <sup>2</sup>	
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

COVERED SERVICES	YOU PAY IN-NETWORK
<b>HOSPITAL SERVICES FOR DELIVERY</b> Delivery room, anesthesia, routine nursing care for newborn	\$200 copayment per stay
<b>DIAGNOSTIC TESTS, LABS AND X-RAYS</b>	10% coinsurance, no deductible
<b>MEDICAL EQUIPMENT (DURABLE), APPLIANCES, FORMULAS, PROSTHETICS AND SUPPLIES</b>	20% coinsurance, after deductible
<b>OUTPATIENT PRESCRIPTION DRUGS</b> (mandatory generic)	
<b>RETAIL PHARMACY</b> Covered drugs per 34-day supply	
Tier 1	\$10 copayment
Tier 2	\$30 copayment
Tier 3	\$45 copayment
Tier 4	\$55 copayment
<b>HOME DELIVERY SERVICES (MAIL ORDER)</b> 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
<b>DIABETIC SUPPLIES</b>	20% coinsurance, no deductible
<b>SHOTS - ALLERGY &amp; THERAPEUTIC INJECTIONS</b> At a doctor's office, Emergency room or Outpatient hospital department	10% coinsurance, no deductible
<b>SKILLED NURSING FACILITY STAYS</b> 180-day per Stay limit per member <sup>3</sup>	
Facility Services	\$0
Professional Provider Services	\$0
<b>SURGERY</b>	
<b>INPATIENT</b>	
Facility Services	\$200 copayment per stay
Professional Provider Services	
Primary Care Physicians	\$0
Specialty Care Providers	\$0
Diagnostic Services	\$0
<b>OUTPATIENT</b>	
Facility Services	\$100 copayment per visit
Professional Provider Services	
Primary Care Physicians	\$15 copayment
Specialty Care Providers	\$25 copayment

<sup>2</sup>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.

<sup>3</sup>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
<b>THERAPY - OUTPATIENT SERVICES</b>	
<b>CARDIAC REHABILITATION THERAPY</b>	10% coinsurance, after deductible
<b>CHEMOTHERAPY</b>	10% coinsurance, after deductible
<b>INFUSION</b> (includes IV therapy and injected chemotherapy)	10% coinsurance, after deductible
<b>OCCUPATIONAL THERAPY</b>	10% coinsurance, after deductible
<b>PHYSICAL THERAPY</b>	10% coinsurance, after deductible
<b>RADIATION THERAPY</b>	10% coinsurance, after deductible
<b>RESPIRATORY THERAPY</b>	10% coinsurance, after deductible
<b>SPEECH THERAPY</b>	10% coinsurance, after deductible
<b>VISION CORRECTION</b> After surgery or accident	20% coinsurance, after deductible
<b>WELLNESS AND PREVENTIVE CARE SERVICES</b>	
<b>WELL CHILD</b> <sup>4</sup> (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
<b>ROUTINE WELLNESS</b> (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
<b>WELLNESS AND PREVENTIVE CARE SERVICES</b> (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

<sup>4</sup>See member handbook for immunization schedule.

## ROUTINE VISION – BLUE VIEW VISION NETWORK

You have an allowance for eyeglass lenses or contact lenses every plan year. 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
<i>Routine Vision Blue View Vision Network (once per plan year)</i>	<ul style="list-style-type: none"> <li>■ Routine eye exam</li> <li>■ Eyeglass lenses</li> </ul>	<p>You pay \$25 copayment</p> <p>You pay \$20 copayment</p>	<p>Plan pays up to to \$50</p> <p>Plan pays up to: \$50 single lenses; \$75 bifocal; \$100 trifocal</p>
	<ul style="list-style-type: none"> <li>■ Eyeglass frames</li> </ul>	<p>Plan pays up to \$100* retail allowance</p>	<p>Plan pays up to \$80</p>
	<ul style="list-style-type: none"> <li>■ Contact lenses (<i>in lieu of eyeglass lenses</i>)                             <ul style="list-style-type: none"> <li>• Elective<sup>1</sup></li> </ul> </li> </ul>	<p>Plan pays up to \$100 allowance then 15% discount off remaining balance</p>	<p>Plan pays up to \$80</p>
	<ul style="list-style-type: none"> <li>• Non-Elective<sup>1</sup></li> </ul>	<p>Plan pays up to \$250 allowance</p>	<p>Plan pays up to \$210</p>
	<ul style="list-style-type: none"> <li>■ Lens options                             <ul style="list-style-type: none"> <li>• UV coating, tints, standard scratch-resistant</li> </ul> </li> </ul>	<p>You pay \$15</p>	<p>Not available</p>
	<ul style="list-style-type: none"> <li>• Standard polycarbonate</li> </ul>	<p>You pay \$40</p>	<p>Not available</p>
	<ul style="list-style-type: none"> <li>• Standard progressive (<i>in addition to bifocal copayment</i>)</li> </ul>	<p>You pay \$65</p>	<p>Not available</p>
	<ul style="list-style-type: none"> <li>• Standard anti-reflective</li> </ul>	<p>You pay \$45</p>	<p>Not available</p>
	<ul style="list-style-type: none"> <li>• Other add-ons</li> </ul>	<p>You pay 20% off retail</p>	<p>Not available</p>

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

<sup>1</sup> 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.

# YOUR TLC TAKE CARE PACKAGE

## Wellness programs and Web tools included in your plan

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### 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 issues, and more. Tap into all your EAP has to offer at [anthem.com/tlc](http://anthem.com/tlc). Choose the EAP link, enter Commonwealth of Virginia as your company, and select The Local Choice.

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### 24/7 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.

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### 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.

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### 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.

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**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.**

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### ConditionCare 800-445-7922

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

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

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### 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](http://www.quitnow.net/commonwealth) to get all the help you need.

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### 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.

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### 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.

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### Anthem.com

Be sure to register at [anthem.com](http://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.

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**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.**

# 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](http://www.anthem.com/tlc)**

### **Anthem Behavioral Healthcare and Employee Assistance Program**

**1-855-223-9277**

**[www.anthemeap.com](http://www.anthemeap.com)**

*(Company Name: Commonwealth of Virginia)*

### **24/7 Nurseline**

**1-800-337-4770**

### **LiveHealth Online**

**[LiveHealthOnline.com](http://LiveHealthOnline.com)**

## DELTA DENTAL OF VIRGINIA

### **Routine Dental Care**

**1-888-335-8296**

**[www.deltadentalva.com](http://www.deltadentalva.com)**

## THE LOCAL CHOICE

*The Local Choice Health Benefits Program*

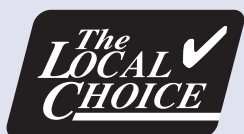
Commonwealth of Virginia

Department of Human Resource Management

101 North 14th Street – 13th Floor

Richmond, VA 23219

**[www.thelocalchoice.virginia.gov](http://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.*