Medicare Complementary

Medical, Dental and Vision administered by
Anthem Blue Cross and Blue Shield

January 1, 2016 - December 31, 2016

The Local Choice is a unique health benefits program managed by the Commonwealth of Virginia Department of Human Resource Management (DHRM). The Medicare Complementary plan may be offered to you if you are eligible for Medicare and to your Medicare-eligible family members by your group. Benefits are administered on a calendar year basis to coincide with your Medicare coverage. Changes in your monthly premium are effective July 1 (or October 1 for certain school groups) to coincide with your former employer's The Local Choice (TLC) health plan renewal.

The Medicare Complementary plan provides medical benefits that work with Medicare Part A and Part B. In addition, the plan offers benefits for services not covered by the government program, including vision and dental. It does not provide prescription drug coverage. **This guide is only an overview. For a complete description of the benefits, exclusions, limitations, and reductions, please see the Medicare Coordinating Plans Member Handbook.**

Service Area

Wherever retirees live.

How The Plan Works

To receive full benefits you must be enrolled under both Part A and Part B of Medicare. Always show both your Medicare card and your Anthem Blue Cross and Blue Shield identification card when you receive care.

Choose Health Care Providers Carefully

Physicians

Ask your doctor if he or she is a Medicare participating physician. Your benefits cover the patient's share of Part B expenses after you pay the first $1,000 of expenses each calendar year. This $1,000 out-of-pocket expense is made up of your Part B Medicare deductible and copayments. A doctor who participates in Medicare agrees to:

- File claims on your behalf
- Accept Medicare's payment for covered services

This means your copayment is limited to a percentage of the Medicare-approved charge. Go to **Medicare.gov** for additional information about Medicare-participating physicians.

This brochure describes benefits based on Medicare-approved charges. Doctors who do not accept assignments may not charge you any more than 15% above what Medicare considers a reasonable fee. This applies to all doctors and all services.

Hospitals

Hospitals that participate in the Medicare program are covered. Admissions not approved by Medicare are not covered.

Medicare Complementary Plan

What The Plan Covers

		Plan Pays
PART A SERVICES		
Hospital Inpatient	■ Medicare Part A hospital deductible less $100 per benefit period, days 1-60	In full
	■ Medicare Part A daily hospital copayment amount, days 61-90	In full
	■ 100% of hospital's reasonable charges, for eligible expenses for an additional 365 days	In full
	■ Copayment amount for Medicare Lifetime Reserve Days (60 days available)	In full
Skilled Nursing Facility	■ Medicare Part A skilled nursing home copayment, days 21-100 (Medicare covers days 1-20 in full.)	In full
	■ A daily amount equal to Medicare skilled nursing home copayment, days 101-180 (Medicare provides no coverage beyond 100 days.)	In full
PART B SERVICES		
Doctors' Care And Medical Services (after $1,000 out-of-pocket expense limit)	Medicare pays 80% and the plan pays 20% of Medicare-approved charges for Part B services. Enrollees are responsible for the first $1,000 in covered expenses for Part B doctors' care and other medical services. Expenses that apply to the $1,000 out-of-pocket expense limit include the Medicare Part B $166 calendar year deductible and 20% of Medicare-approved charges for Part B services.	
	After the $1,000 out-of-pocket expense limit is met during a calendar year	
		Plan Pays
	■ Physicians' care	20%*
	■ Diagnostic x-rays and lab tests	20%*
	■ Ambulance service	20%*
	■ Durable medical equipment and supplies	20%*
	■ Chiropractic services—Benefits coordinated with Medicare	20%*
	■ Routine mammography screenings	20%*

**Percent of Medicare charges*

Plan Deductibles And Copayments

You are responsible for these amounts:

- $100 deductible per benefit period for the first 60 days of hospital inpatient care
- $166 Medicare Part B calendar year deductible (included in the $1,000 out-of-pocket expense limit)
- 20% of Medicare-approved charges for Part B services (not to exceed the $1,000 out-of-pocket expense limit each calendar year)

Dental Benefits

The plan pays up to $1,500 per member per calendar year. It also pays 100% of the allowable charge for diagnostic and preventive services, such as oral examinations and dental x-rays. It pays 80% of the allowable charge for basic services, such as fillings, re-cementing of crowns, inlays and bridges, or repair of removable dentures. The remaining 20% is your responsibility. The plan also pays 5% for major services such as crowns, dentures, and implants.

When you need services, simply present your plan identification card to your dentist. If you go to an Anthem Dental Complete network dentist, you will be responsible only for your coinsurance. If services are provided by a non-network dentist, you pay your coinsurance, plus the difference, if any, between the plan's allowable charge for a covered service and the dentist's charge. Network dentists are listed on the Web at **www.anthem.com/tlc**, or call Anthem Dental Complete at **1-855-648-1411** to determine if a dentist is in the network.

Plan Pays $1,500 Maximum Per Person Per Calendar Year		**In-Network You Pay**
Diagnostic And Preventive Services	Twice-a-year visits to the dentist for oral examinations, x-rays, and cleanings	$0
Basic Dental Care	Fillings, oral surgery, periodontal services, scaling, repair of dentures, root canals and other endodontic services, and recementing of existing crowns and bridges	20% AC**
Major Dental Care	Crowns (single crowns, inlays and onlays, prosthodontics (partial or complete dentures and fixed bridges) and dental implants	95% AC**
Out-Of-Network Care	For services by a non-network dentist, you pay the applicable coinsurance plus any amounts above the allowable charge.	

***Allowable Charge (AC)** — The allowable charge is the lesser amount of the Anthem Dental Complete plan allowance for that covered service, or the provider's submitted charge for that covered service. Participating Anthem Dental Complete dentists have agreed to accept Anthem's payment, plus any required coinsurance (if applicable) as payment in full for covered benefits.*

Using Your Dental Benefits

To reduce your out-of-pocket expense, choose an Anthem Dental Complete dentist. View the Provider Directory on the Web at **www.anthem.com/tlc**.

In-network claims will be handled by the dentist's office and you will be responsible only for any coinsurance, which applies to the covered care you receive. If you go to a non-network dentist, you may pay more of the bill.

Vision Benefits

Your routine vision benefits are through the Anthem Blue View Vision network. Available once per your calendar year, your vision benefits include a routine eye exam, eyewear and special eye accessory discounts. You may receive services from any ophthalmologist, optometrist, optician and/or retail location in the Anthem Blue View Vision network.

To locate an Anthem Blue View Vision provider, select Find A Doctor at **www.anthem.com/tlc**, or contact Member Services at **800-552-2682** for assistance. To receive vision services, simply present your Anthem identification card to your Blue View Vision provider when you receive your eye exam or purchase covered eyewear. Your Blue View Vision provider will verify eligibility and file your claims.

While some vision benefits are also covered out-of-network, you will receive the most value when you choose a Blue View Vision provider. If you use an out-of-network provider, your benefits will be covered at a lower payment level. You will need to pay for covered services and purchases at the time of your visit and send an out-of-network claim form to Blue View Vision. The claim form is available at **anthem.com/tlc** under Forms.

Certain non-routine vision care such as eye surgery may be covered under your primary medical coverage under your Medicare plan. Refer to your Medicare and You Handbook or contact Medicare for more information.

Routine vision care services		In-Network You Pay
Routine eye exam (once per calendar year)		$20 copayment
Eyeglass frames Once per calendar year you may select any eyeglass frame[1] and receive the following allowance toward the purchase price:		$100 allowance then 20% off remaining balance
Eyeglass lenses (standard) *Polycarbonate lenses included for children under 19 years old.* *Once per calendar year you may receive any one of the following lenses:* ■ Standard plastic single vision lenses (1 pair) ■ Standard plastic bifocal lenses (1 pair) ■ Standard plastic trifocal lenses (1 pair) ■ Standard progressive lenses (1 pair)		 $20 copay; then covered in full $20 copay; then covered in full $20 copay; then covered in full $85 copay; then covered in full
Eyeglass lens upgrades When receiving services from a Blue View Vision provider, you may choose to upgrade your new eyeglass lenses at a discounted cost. Eyeglass lenses copayment applies, plus the cost for the upgrade.	*Lens options* ■ UV coating ■ Tint (solid and gradient) ■ Standard scratch resistance ■ Standard polycarbonate ■ Standard anti-reflective coating ■ Other add-ons and services	*Member cost for upgrades* $15 $15 $15 $40 $45 20% off retail price
Contact lenses Prefer contact lenses over glasses? You may choose to receive contact lenses instead of eyeglasses (frames and lenses) and receive an allowance toward the cost of a supply of contact lenses once per calendar year.	*Lens options* ■ Elective conventional lenses[2] ■ Elective disposable lenses[2] ■ Non-elective contact lenses[2]	 $100 allowance then 15% off the remaining balance $100 allowance (no additional discount) $250 allowance (no additional discount)

[1] Discount is not available on certain frame brands in which the manufacturer imposes a no-discount policy.
[2] Elective contact lenses are in lieu of eyeglass lenses. Non-elective lenses are covered when glasses are not an option for vision correction.

Options For Prescription Drug Coverage

If you want prescription drug coverage, you must enroll in a separate Medicare Part D prescription drug plan.

Several Medicare Part D plan options are being offered. To determine what drug coverage option best meets your needs, consult the Medicare and You Handbook, call **1-800-MEDICARE (1-800-633-4227)** or visit the Medicare Web site at **www.medicare.gov**.

This is not a policy. This is a brief summary of the Medicare Complementary health benefits plan. For a complete description of the benefits, exclusions, terms, and conditions, please see the Medicare Coordinating Plans Member Handbook.

If You Need Assistance

Anthem Blue Cross and Blue Shield

Medical and Routine Vision Care
1-800-552-2682
Monday through Friday 8:00 a.m. – 6:00 p.m.
Saturday 9:00 a.m. – 1:00 p.m.
On the Web at **www.anthem.com/tlc**

Dental Care:
1-855-648-1411
Monday - Friday 8:00 a.m. - 9:00 p.m.
On the Web at **www.anthem.com/tlc**

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
On the Web at **www.thelocalchoice.virginia.gov**