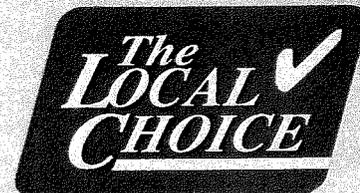


# Comparison of Statewide Plans 2015

---

*Effective July 1, 2015 or October 1, 2015*



# The Local Choice 2015 Comparison of Statewide Plans

**Plan Year Deductible**  
(Key Advantage: Applies to Certain Medical Services as Indicated on Chart)

(HDHP: Applies to Medical, Behavioral Health, and Prescription Drug Services)

**Plan Year Out-of-pocket Expense Limit**

**Out-of-Network Benefits**

**Medical Care When Traveling (BlueCard)**

**Lifetime Maximum**

## Covered Services

**Ambulance Travel**

**Autism Spectrum Disorder**  
2 years through 6 years

**Behavioral Health and EAP**

*Inpatient treatment*

- Facility Services
- Professional Provider Services

*Outpatient Professional Provider Visits*

**Employee Assistance Program (EAP)**  
4 visits per issue (per plan year)

**Dental Care**

**Preventive Dental Option** (*diagnostic and preventive services only for lower premium*)

**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)

## Key Advantage 250

**In-Network:**

One Person	Two People	Family
\$250	See Family	\$500

<b>Out-of-Network:</b>		
One Person	Two People	Family
\$500	See Family	\$1,000

**In-Network:**

One Person	Two People	Family
\$3,000	See Family	\$6,000

**Out-of-Network:**

One Person	Two People	Family
\$5,000	See Family	\$10,000

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.

Included

Unlimited

## In-Network You Pay

20% coinsurance after deductible

Copayment/coinsurance determined by service received

\$300 copayment per stay

\$0

\$20 copayment

\$0

\$0

One Person	Two People	Family
\$25	\$50	\$75
\$1,500		
\$0		
20% coinsurance after dental deductible		
50% coinsurance after dental deductible		
50% coinsurance, no dental deductible, with \$1,500 lifetime maximum		

**Note:** Highlighted areas indicate a benefit change for 2015.

## Key Advantage 500

In-Network:		
One Person	Two People	Family
\$500	See Family	\$1,000
Out-of-Network:		
\$1,000	See Family	\$2,000

In-Network:		
One Person	Two People	Family
\$4,000	See Family	\$8,000
Out-of-Network:		
\$7,000	See Family	\$14,000

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.

Included

Unlimited

### In-Network You Pay

20% coinsurance after deductible

Copayment/coinsurance determined by service received

20% coinsurance after deductible

\$0

\$25 copayment

\$0

\$0

One Person	Two People	Family
\$25	\$50	\$75
\$1,500		
\$0		
20% coinsurance after dental deductible		
50% coinsurance after dental deductible		
50% coinsurance, no dental deductible, with \$1,500 lifetime maximum		

## High Deductible Health Plan

One Person	Two People	Family
\$2,800	See Family	\$5,600
Deductible is combined for In-Network and Out-of-Network services.		

One Person	Two People	Family
\$5,000	See Family	\$10,000
\$10,000	See Family	\$20,000

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

Unlimited

### In-Network You Pay

20% coinsurance after deductible

\$0

\$0

One Person	Two People	Family
\$25	\$50	\$75
\$1,500		
\$0		
20% coinsurance after dental deductible		
50% coinsurance after dental deductible		
50% coinsurance, no dental deductible, with \$1,500 lifetime maximum		

# The Local Choice 2015 Comparison of Statewide Plans (continued)

Covered Services	Key Advantage 250 In-Network You Pay
Diabetic Education	\$0
Diabetic Equipment	20% coinsurance after deductible
Diabetic Supplies - See Outpatient Prescription Drugs	10% coinsurance after deductible
Diagnostic Tests and X-rays (for specific conditions or diseases at a doctor's office, emergency room or outpatient hospital department)	10% coinsurance after deductible
Doctor Visits - on an Outpatient Basis <i>Primary Care Physicians</i> <i>Specialty Care Providers</i>	\$20 copayment \$35 copayment
Early Intervention Services	Copayment/coinsurance determined by service received
Emergency Room Visits <i>Facility Services</i>	\$150 copayment per visit (waived if admitted to hospital)
<i>Professional Provider Services</i> - Primary Care Physicians - Specialty Care Providers <i>Diagnostic Tests and X-rays</i>	\$20 copayment \$35 copayment 10% coinsurance after 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
<b>Hospital Services</b> <i>Inpatient Treatment</i> • Facility Services • Professional Provider Services - Primary Care Physicians - Specialty Care Providers	\$300 copayment per stay \$0 \$0
<i>Outpatient Treatment</i> • Facility Services • Professional Provider Services - Primary Care Physicians - Specialty Care Providers <i>Diagnostic Tests and X-Rays</i>	\$150 copayment \$20 copayment \$35 copayment 10% coinsurance after deductible
<b>Infusion Services</b> <i>Facility Services</i> <i>Professional Provider Services</i> <i>Home Services</i> <i>Infusion Medications</i> - Outpatient Settings - Home Settings	10% coinsurance after deductible 10% coinsurance after deductible 10% coinsurance after deductible 10% coinsurance after deductible 10% coinsurance after deductible

**Key Advantage 500  
In-Network You Pay**

\$0

20% coinsurance after deductible

20% coinsurance after deductible

\$25 copayment  
\$40 copayment

Copayment/coinsurance determined by  
service received

20% coinsurance after deductible

\$25 copayment  
\$40 copayment  
20% coinsurance after deductible

\$0

20% coinsurance after deductible

\$0

20% coinsurance after deductible

\$0  
\$0

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

**High Deductible Health Plan  
In-Network You Pay**

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  
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

**Maternity**  
*Professional Provider Services (Prenatal & Postnatal Care)*

- Primary Care Physicians
- Specialty Care Providers

**Delivery**

- Primary Care Physicians
- Specialty Care Providers

*Hospital Services for Delivery (Delivery Room, Anesthesia, Routine Nursing Care for Newborn)*

*Outpatient Diagnostic Tests*

**Medical Equipment, Appliances, Formulas, Prosthetics and Supplies**

**Outpatient Prescription Drugs - Mandatory Generic**

*Retail up to 34-day supply\**

\*You may purchase up to a 90-day supply at a retail pharmacy by paying multiple copayments, or the coinsurance after the deductible

*Home Delivery Services (Mail Order)*

Covered Drugs for up to a 90-Day Supply

## Diabetic Supplies

**Routine vision - Blue View Vision Network**  
 (Once Every Plan Year)

*Routine Eye Exam*

*Eyeglass Lenses*

*Eyeglass Frames*

*Contact Lenses (In Lieu of Eyeglass Lenses)*

- Elective
- Non-Elective

*Upgrade Eyeglass Lenses (Available for Additional Cost)*

- UV Coating, Tints, Standard Scratch-Resistant
- Standard Polycarbonate
- Standard Progressive
- Standard Anti-Reflective
- Other Add-Ons

**Shots - Allergy & Therapeutic Injections**  
 (At Doctor's Office, Emergency Room or Outpatient Hospital Department)

**Skilled Nursing Facility Stays**  
 (180-Day Per Stay Limit Per Member)

*Facility Services*

*Professional Provider Services*

## Key Advantage 250 In-Network You Pay

\$20 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.

\$0

\$0

\$300 copayment per stay\*

10% 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 - \$20 copayment  
 Tier 2 - \$60 copayment  
 Tier 3 - \$90 copayment  
 Tier 4 - \$110 copayment

20% coinsurance, no deductible

\$35 copayment

\$20 copayment

Up to \$100 retail allowance\*\*

Up to \$100 retail allowance

Up to \$250 retail allowance

\$15

\$40

\$65

\$45

20% off retail

10% coinsurance after deductible

\$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.

**Note: Highlighted areas indicate a benefit change for 2015.**

**Key Advantage 500  
In-Network You Pay**

**High Deductible Health Plan  
In-Network You Pay**

\$25 copayment  
\$40 copayment  
If your doctor submits one bill for delivery, prenatal copayment required for physician care. If your doctor payment responsibility will be determined by the doctor.

\$0  
\$0  
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 - \$20 copayment  
Tier 2 - \$60 copayment  
Tier 3 - \$90 copayment  
Tier 4 - \$110 copayment

20% coinsurance, no deductible

\$40 copayment  
\$20 copayment  
Up to \$100 retail allowance\*\*

Up to \$100 retail allowance  
Up to \$250 retail allowance

\$15  
\$40  
\$65  
\$45  
20% off retail

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

\$15 copayment  
\$20 copayment  
Up to \$100 retail allowance\*\*

Up to \$100 retail allowance  
Up to \$250 retail allowance

\$15  
\$40  
\$65  
\$45  
20% off retail

20% coinsurance after deductible

20% coinsurance after deductible

20% coinsurance after deductible

# The Local Choice 2015 Comparison of Statewide Plans (continued)

## Covered Services

**Spinal Manipulations and Other Manual Medical Interventions**  
 (30 Visits Per Plan Year Limit Per Member)  
*Primary Care Physicians*  
*Specialty Care Providers*

### Surgery – See Hospital Services

**Therapy Services**  
*Cardiac Rehabilitation Therapy, Chemotherapy, Radiation Therapy, Respiratory Therapy, Occupational Therapy, Physical Therapy, and Speech Therapy*

**Facility Services**  
**Professional Provider Services**  
 - Primary Care Physicians  
 - Specialty Care Providers

**Wellness services**  
*Well Child (Office Visits at Specified Intervals Through Age 6)*  
 - Primary Care Physicians;  
 - Specialty Care Providers;  
 - Immunizations and Screening Tests

**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  
 • Routine Screenings, Immunizations, Lab and X-Ray Services (Outside of Annual Check-Up Visit)

**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

## Key Advantage 250 In-Network You Pay

\$20 copayment  
 \$35 copayment

10% coinsurance after deductible

10% coinsurance after deductible  
 10% coinsurance after deductible

No copayment, coinsurance, or deductible

---

**Key Advantage 500**  
In-Network You Pay

---

\$25 copayment  
\$40 copayment

---

20% coinsurance after deductible

20% coinsurance after deductible  
20% coinsurance after deductible

---

No copayment, coinsurance, or deductible

---

---

**High Deductible Health Plan**  
In-Network You Pay

---

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

---

# 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](http://anthem.com/tlc). Choose the EAP link, enter Commonwealth of Virginia as your company, and select The Local Choice.

---

### 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.

---

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

**Note:** Highlighted areas indicate a benefit change for 2015.

---

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](http://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](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.

---

**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](http://thelocalchoice.virginia.gov)**

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

---

