

2018 COMPARISON OF STATEWIDE PLANS

Effective July 1, 2018 or October 1, 2018



The Local Choice 2018 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:			In-Network:		
	One Person	Two People	Family	One Person	Two People	Family
	\$100	See Family	\$200	\$250	See Family	\$500
	Out-of-Network:			Out-of-Network:		
	\$200	See Family	\$400	\$500	See Family	\$1,000
Plan Year Out-of-pocket Expense Limit	In-Network:			In-Network:		
	One Person	Two People	Family	One Person	Two People	Family
	\$2,000	See Family	\$4,000	\$3,000	See Family	\$6,000
	Out-of-Network:			Out-of-Network:		
	\$3,000	See Family	\$6,000	\$5,000	See Family	\$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 10 years	Copayment/coinsurance determined by service received			Copayment/coinsurance determined by service received		
Behavioral Health and EAP <i>Inpatient treatment</i> • Facility Services • Professional Provider Services <i>Outpatient Professional Provider Visits</i>	\$300 copayment per stay			\$400 copayment per stay		
	\$0			\$0		
	\$15 copayment			\$20 copayment		
Employee Assistance Program (EAP) 4 visits per issue (per plan year)	\$0			\$0		
Dental Care Preventive Dental Option (<i>diagnostic and preventive services only for lower premium</i>)	\$0			\$0		
Comprehensive Dental Option (<i>for higher premium</i>) Dental Plan Year Deductible Plan Year Maximum (Except Orthodontics) • Preventive Dental Care • Primary Dental Care • Major Dental Care • Orthodontic Services (Includes Adult Ortho)	<i>One Person</i>	<i>Two People</i>	<i>Family</i>	<i>One Person</i>	<i>Two People</i>	<i>Family</i>
	\$25	\$50	\$75	\$25	\$50	\$75
	\$1,500			\$1,500		
	\$0			\$0		
	20% coinsurance after dental deductible			20% 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		

Note: Yellow highlights denote benefit change for 2018.

Key Advantage 500			Key Advantage 1000			High Deductible Health Plan		
In-Network:			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:			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:			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		
<i>One Person</i>	<i>Two People</i>	<i>Family</i>	<i>One Person</i>	<i>Two People</i>	<i>Family</i>	<i>One Person</i>	<i>Two People</i>	<i>Family</i>
\$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 2018 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)	20% coinsurance, no deductible	20% coinsurance after deductible
Doctor Visits – on an Outpatient Basis <i>Primary Care Physicians</i> <i>Specialty Care Providers</i>	\$15 copayment \$25 copayment	\$20 copayment \$35 copayment
Early Intervention Services	Copayment/coinsurance determined by service received	Copayment/coinsurance determined by service received
Emergency Room Visits <i>Facility Services</i> <i>Professional Provider Services</i> – Primary Care Physicians – Specialty Care Providers <i>Diagnostic Tests and X-rays</i>	\$250 copayment per visit (waived if admitted to hospital) \$15 copayment \$25 copayment 20% coinsurance, no deductible	\$350 copayment per visit (waived if admitted to hospital) \$20 copayment \$35 copayment 20% 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 <i>Inpatient Treatment</i> • Facility Services • Professional Provider Services – Primary Care Physicians – Specialty Care Providers <i>Outpatient Treatment</i> • Facility Services • Professional Provider Services – Primary Care Physicians – Specialty Care Providers <i>Diagnostic Tests and X-Rays</i>	\$300 copayment per stay \$0 \$0 \$100 copayment \$15 copayment \$25 copayment 20% coinsurance, no deductible	\$400 copayment per stay \$0 \$0 \$150 copayment \$20 copayment \$35 copayment 20% coinsurance after deductible
Infusion Services <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	10% coinsurance after deductible 10% coinsurance after deductible 10% coinsurance after deductible 10% coinsurance after deductible 10% coinsurance after deductible

Note: Yellow highlights denote benefit change for 2018.

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 2018 Comparison of Statewide Plans (continued)

Covered Services	Key Advantage Expanded In-Network You Pay	Key Advantage 250 In-Network You Pay
Maternity <i>Professional Provider Services (Prenatal & Postnatal Care)</i> – Primary Care Physicians – Specialty Care Providers <i>Delivery</i> – Primary Care Physicians – Specialty Care Providers <i>Hospital Services for Delivery (Delivery Room, Anesthesia, Routine Nursing Care for Newborn)</i> <i>Outpatient Diagnostic Tests</i>	\$15 copayment \$25 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* 20% coinsurance, no deductible	\$20 copayment \$35 copayment \$0 \$0 \$400 copayment per stay* 20% coinsurance after deductible
Medical Equipment, Appliances, Formulas, Prosthetics and Supplies	20% coinsurance after deductible	20% coinsurance after deductible
Outpatient Prescription Drugs - Mandatory Generic <i>Retail up to 34-day supply*</i> *You may purchase up to a 90-day supply at a retail pharmacy by paying multiple copayments, or the coinsurance after the deductible <i>Home Delivery Services (Mail Order)</i> Covered Drugs for up to a 90-Day Supply	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	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
Diabetic Supplies	20% coinsurance, no deductible	20% coinsurance, no deductible
Routine vision - Blue View Vision Network (Once Every Plan Year) <i>Routine Eye Exam</i> <i>Eyeglass Lenses</i> <i>Eyeglass Frames</i> <i>Contact Lenses (In Lieu of Eyeglass Lenses)</i> <ul style="list-style-type: none"> • Elective • Non-Elective <i>Upgrade Eyeglass Lenses (Available for Additional Cost)</i> <ul style="list-style-type: none"> • UV Coating, Tints, Standard Scratch-Resistant • Standard Polycarbonate • Standard Progressive • Standard Anti-Reflective • Other Add-Ons 	\$25 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	\$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
Shots - Allergy & Therapeutic Injections (At Doctor's Office, Emergency Room or Outpatient Hospital Department)	20% coinsurance, no deductible	20% coinsurance after deductible
Skilled Nursing Facility Stays (180-Day Per Stay Limit Per Member) <i>Facility Services</i> <i>Professional Provider Services</i>	\$0 \$0	\$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: Yellow highlights denote benefit change for 2018.

**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

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

20% coinsurance after deductible

20% coinsurance after deductible

\$25 copayment
\$40 copayment

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

20% coinsurance, no 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

20% coinsurance after deductible

20% coinsurance after deductible

20% coinsurance after 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

\$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

\$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

\$0

\$0

\$0

\$0

20% coinsurance after deductible

20% coinsurance after deductible

The Local Choice 2018 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) <i>Primary Care Physicians</i> <i>Specialty Care Providers</i>	\$15 copayment \$25 copayment	\$20 copayment \$35 copayment
Surgery – See Hospital Services		
Therapy Services <i>Cardiac Rehabilitation Therapy, Chemotherapy, Radiation Therapy, Respiratory Therapy, Occupational Therapy, Physical Therapy, and Speech Therapy</i> Facility Services Professional Provider Services – Primary Care Physicians – Specialty Care Providers	20% coinsurance after deductible 20% coinsurance after deductible 20% coinsurance after deductible	20% coinsurance after deductible 20% coinsurance after deductible 20% coinsurance after deductible
Wellness services <i>Well Child (Office Visits at Specified Intervals Through Age 6)</i> – Primary Care Physicians; – Specialty Care Providers; – Immunizations and Screening Tests <i>Routine Wellness – Age 7 & Older</i> • 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) <i>Preventive Care (One of Each Per Plan Year)</i> • 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 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

 Note: Yellow highlights denote benefit change for 2018.

**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

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No copayment, coinsurance, or deductible

No copayment, coinsurance, or deductible

Your TLC Take Care Package – Wellness Programs and Web Resources Included in Your Plan

[LiveHealthOnline.com](https://livehealthonline.com)

Go to livehealthonline.com or download the app so you'll be ready whenever you need these LiveHealth Online services. Your cost share will mirror your cost share for similar in-person services:

- **LiveHealth Online Medical** – Use your smartphone, tablet or computer to see a board-certified doctor in minutes, any time, day or night. It's a fast, easy way to get care for common medical conditions like the flu, colds, allergies, pink eye, sinus infections, and more.
 - **LiveHealth Online Psychology** – Use your device to make an appointment to see a therapist or psychologist online.
 - **LiveHealth Online Psychiatry** – **NEW this plan year!** Unlike therapists who provide counseling support, psychiatrists can also provide medication management. Use your device to set up a visit online.
 - **LiveHealth Online EAP** – You can access your free EAP counseling sessions from your device. Contact the EAP at 855-223-9277 to learn more.
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New GenericSelect Program

Save money with the new GenericSelect program. If you are taking a brand name drug that has an equally effective generic alternative, you may receive a mailing about an opportunity to switch to the lower cost generic drug. If you make the switch, you will pay **zero copayment for the first GenericSelect prescription**. Subsequent refills will cost you only the lower tier generic copayment.

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.

Future Moms 800-828-5891

Expecting? Enroll in **Future Moms** within the first trimester (14 weeks) 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, count on **Future Moms** for your first and any subsequent pregnancies. Once your baby is born, take advantage of online visits with a certified lactation consultant, counselor or registered dietitian at no extra cost to you through **LiveHealth Online!** Sign up at livehealthonline.com or download the app, then sign up for **Future Moms with Breastfeeding Support**. Take advantage of personalized support to help you with breastfeeding techniques, learn about baby hunger cues, foods to avoid, and more.

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.

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.

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 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.

Web Resources

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 prescription 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.

