The Local Choice: High Deductible Health Plan (HDHP)

Coverage Period: 10/01/2015 – 09/30/2016

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for:** Individual/Family | **Plan Type:** High Deductible

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.thelocalchoice.virginia.gov or by calling 1-888-642-4414.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	Combined deductible for in-network providers **$2,800** person **/ $5,600** family Doesn't apply to preventive care	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. For participating providers **$5,000** person **/ $10,000** family For non-participating providers **$10,000** person **/ $20,000** family	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses. There are no out-of-network benefits except in an emergency.
What is not included in the out–of–pocket limit?	Deductible and coinsurance for routine dental service and adult routine vision services	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. See **www.anthem.com** or call **1-800-552-2682** for a list of in-network providers.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.

Questions: Call 1-888-642-4414 or visit us at www.thelocalchoice.virginia.gov.
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.thelocalchoice.virginia.gov or call 1-888-642-4414 to request a copy.

Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $25) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use in-network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% coinsurance after deductible	40% coinsurance after deductible	——————none——————
	Specialist visit	20% coinsurance after deductible	40% coinsurance after deductible	——————none——————
	Other practitioner office visit	20% coinsurance after deductible	40% coinsurance after deductible	Coverage is limited to 30 visits annual max for chiropractic.
	Preventive care/ screening/immunization	No charge	40% coinsurance after deductible	——————none——————
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance after deductible	40% coinsurance after deductible	——————none——————
	Imaging (CT/PET scans, MRIs)	20% coinsurance after deductible	40% coinsurance after deductible	Pre-authorization may be required.

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at **www.anthem.com**.	Generic drugs	20% coinsurance after deductible	40% coinsurance after deductible	Covers up to a 34-day supply (retail prescription); 90 day supply (home delivery prescription). If you use a non-network pharmacy, you pay the difference between the pharmacy charge and the plan allowable charge.
	Preferred brand drugs	20% coinsurance after deductible	40% coinsurance after deductible	Please see limitations in Generic drugs.
	Non-preferred brand drugs	20% coinsurance after deductible	40% coinsurance after deductible	Please see limitations in Generic drugs.
	Specialty drugs	20% coinsurance after deductible	40% coinsurance after deductible	Please see limitations in Generic drugs.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance after deductible	40% coinsurance after deductible	————————none————————
	Physician/surgeon fees	20% coinsurance after deductible	40% coinsurance after deductible	————————none————————
If you need immediate medical attention	Emergency room services	20% coinsurance after deductible	40% coinsurance after deducible. Emergency services will be considered at the In-Network benefit level; however, balance billing may still occur.	————————none————————
	Emergency medical transportation	20% coinsurance after deductible	40% coinsurance after deducible. Emergency services will be considered at the In-Network benefit level; however, balance billing may still occur.	————————none————————
	Urgent care	20% coinsurance after deductible	40% coinsurance after deductible	————————none————————

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance after deductible	40% coinsurance after deductible	——————none——————
	Physician/surgeon fee	20% coinsurance after deductible	40% coinsurance after deductible	——————none——————
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	20% coinsurance after deductible	40% coinsurance after deductible	——————none——————
	Mental/Behavioral health inpatient services	20% coinsurance after deductible	40% coinsurance after deductible	——————none——————
	Substance use disorder outpatient services	20% coinsurance after deductible	40% coinsurance after deductible	——————none——————
	Substance use disorder inpatient services	20% coinsurance after deductible	40% coinsurance after deductible	——————none——————
	Employee Assistance Program (EAP)	No Charge	40% coinsurance after deductible	Covers up to 4 visits per incident within a 12 month period.
If you are pregnant	Prenatal and postnatal care	20% coinsurance after deductible	40% coinsurance after deductible	——————none——————
	Delivery and all inpatient services	20% coinsurance after deductible	40% coinsurance after deductible	——————none——————
If you need help recovering or have other special health needs	Home health care	20% coinsurance after deductible	40% coinsurance after deductible	Coverage is limited to 90 visits max. per coverage period.
	Rehabilitation services	20% coinsurance after deductible	40% coinsurance after deductible	——————none——————
	Habilitation services	20% coinsurance after deductible	40% coinsurance after deductible	——————none——————
	Skilled nursing care	20% coinsurance after deductible	40% coinsurance after deductible	Coverage is limited to 180 days max. per coverage period.
	Durable medical equipment	20% coinsurance after deductible	40% coinsurance after deductible	——————none——————
	Hospice service	20% coinsurance after deductible	40% coinsurance after deductible	——————none——————

If your child needs dental or eye care	Eye exam	$15 copay	Not Covered	Limit one exam per plan year
	Glasses	$20 copay for lenses, balance over $100 for frames	Not Covered	See your formal contract for complete details
	Dental check-up	No Charge	Provider Charge in excess of plan's contractual rate	Dental coverage administered by Delta Dental of Virginia, **www.deltadentalva.com** or call **1-888-335-8296**.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover **(This isn't a complete list. Check your policy or plan document for other excluded services.)**

- Acupuncture
- Cosmetic surgery
- Hearing aids
- Infertility treatment
- Long-term care
- Routine eye care
- Routine foot care (except for some diabetic treatment – please see your member handbook for complete details)
- Weight loss programs

Other Covered Services **(This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)**

- Bariatric surgery
- Chiropractic care
- Dental care
- Most coverage provided outside the United States. See **www.anthem.com/tlc**
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-888-642-4414. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or **www.dol.gov/ebsa**, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or **www.cciio.cms.gov**.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: Director, Department of Human Resource Management, 101 North 14th Street – 12th Floor, Richmond, Virginia 23219-3657. Mark envelope Confidential-Appeal Enclosed. Telephone: 1-888-642-4414.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

Si no es miembro todavía y necesita ayuda en idioma español, le suplicamos que se ponga en contacto con su agente de ventas o con el administrador de su grupo. Si ya está inscrito, le rogamos que llame al número de servicio de atención al cliente que aparece en su tarjeta de identificación.

如果您是非會員並需要中文協助，請聯絡您的銷售代表或小組管理員。如果您已參保，則請使用您 ID 卡上的號碼聯絡客戶服務人員。

Kung hindi ka pa miyembro at kailangan ng tulong sa wikang Tagalog, mangyaring makipag-ugnayan sa iyong sales representative o administrator ng iyong pangkat. Kung naka-enroll ka na, mangyaring makipag-ugnayan sa serbisyo para sa customer gamit ang numero sa iyong ID card.

Doo bee a'tah ni'liigoo eí dooda'í, shikáa adoołwoł íínízinigo t'áá diné k'éjíígo, t'áá shoodí ba na'ałníhí ya sidáhí bich'į naabídíílkiid. Eí doo biigha daago ni ba'nija'go ho'aałagíí bich'į hodiilní. Hai'dąą iini'taago eíya, t'áá shoodí diné ya atáh halne'ígíí ní béésh bee hane'í wólta' bi'ki si'niilígíí bi'kéhgo bich'į hodiilní.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

- **Amount owed to providers:** $7,540
- **Plan pays** $3,790
- **Patient pays** $3,750

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$2,800
Copays	$0
Coinsurance	$950
Limits or exclusions	$0
Total	**$3,750**

Managing type 2 diabetes

(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $2,100
- **Patient pays** $3,300

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$2,800
Copays	$0
Coinsurance	$500
Limits or exclusions	$0
Total	**$3,300**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

High Deductible Health Plan Employee Monthly Rates

High Deductible Health Plan with Comprehensive Dental	
Employee Only	$0.00
Employee + One	$134.00
Family	$268.00

High Deductible Health Plan with Preventative Dental	
Employee Only	$0.00
Employee + One	$110.00
Family	$233.00