

2016-17 COMPARISON OF BENEFITS—STATE, TLC & OTHER PLANS

Health Plans	COVA Care	COVA HDHP	SB 364 COVA Care Model	SB 364 COVA HDHP Model
In-Network Benefits	You Pay	You Pay	You Pay	You Pay
Deductible – per plan year				
•One person	\$300	\$1,750	\$300	\$1,750
•Two or more persons	\$600	\$3,500	\$600	\$3,500
Out-of-pocket expense limit – per plan year				
•One person	\$1,500	\$5,000	\$1,500	\$5,000
•Two or more persons	\$3,000	\$10,000	\$3,000	\$10,000
Doctor’s visits				
•Primary care physician	\$25	20% after deductible	\$25	20% after deductible
•Specialist	\$40	20% after deductible	\$40	20% after deductible
Hospital services				
•Inpatient	\$300 per stay	20% after deductible	\$300 per stay	20% after deductible
•Outpatient	\$125 per visit	20% after deductible	\$125 per visit	20% after deductible
Emergency room visits	\$150 per visit (waived if admitted)	20% after deductible	\$150 per visit (waived if admitted)	20% after deductible
Ambulance travel	20% after deductible	20% after deductible	20% after deductible	20% after deductible
Outpatient diagnostic, laboratory, tests, injections and x-rays	20% after deductible	20% after deductible	20% after deductible	20% after deductible
Infusion services (includes IV or injected chemotherapy)	20% after deductible	20% after deductible	20% after deductible	20% after deductible
Outpatient therapy visits				
•Occupational, and speech therapy	\$25 PCP/\$35 specialist	20% after deductible	\$25 PCP/\$35 specialist	20% after deductible
•Physical therapy	\$15	20% after deductible	\$15	20% after deductible
•Chiropractic (30-visit plan year limit per member)	\$35	20% after deductible	\$35	20% after deductible
Applied behavior analysis (ABA) for autism spectrum disorder—ages 2 through 10	\$25 per service	20% after deductible	\$25 per service	20% after deductible
Behavioral health				
•Medical and non-medical professional visits	\$25	20% after deductible	\$25	20% after deductible
•Inpatient residential treatment	\$300 per stay	20% after deductible	\$300 per stay	20% after deductible
•Intensive outpatient treatment (IOP)	\$125 per episode of care	20% after deductible	\$125 per episode of care	20% after deductible
Employee Assistance Program (EAP)				
Up to 4 visits per incident	\$0	\$0	\$0	\$0
Prescription drugs – mandatory generic				
Retail Pharmacy	<i>Up to 34-day supply</i> \$15/\$30/\$45/\$55	<i>Up to 34-day supply</i> 20% after deductible	<i>Up to 34-day supply</i> \$15/\$30/\$45/\$55	<i>Up to 34-day supply</i> 20% after deductible
Home Delivery Pharmacy	<i>Up to 90-day supply</i> \$30/ \$60/\$90/\$110	<i>Up to 90-day supply</i> 20% after deductible	<i>Up to 90-day supply</i> \$30/\$60/\$90/\$110	<i>Up to 90-day supply</i> 20% after deductible
Dental Services				
•Diagnostic and preventive	\$0	\$0	\$0	\$0
Annual Routine Vision Exam	Optional benefit	Not available	Optional benefit	Not available
Annual Routine Hearing Exam	Optional benefit	Not available	Optional benefit	Not available

2016-17 COMPARISON OF BENEFITS—STATE, TLC & OTHER PLANS

The Local Choice Health Plans	Key Advantage 250	Key Advantage 500	Key Advantage 1000	Key Advantage Expanded
In-Network Benefits	You Pay	You Pay	You Pay	You Pay
Deductible – per plan year				
•One person	\$250	\$500	\$1,000	\$100
•Two or more persons	\$500	\$1,000	\$2,000	\$200
Out-of-pocket expense limit – per plan year				
•One person	\$3,000	\$4,000	\$5,000	\$2,000
•Two or more persons	\$6,000	\$8,000	\$10,000	\$4,000
Doctor's visits				
•Primary care physician	\$20	\$25	\$25	\$15
•Specialist	\$35	\$40	\$40	\$25
Hospital services				
•Inpatient	\$300 per stay	20% after deductible	20% after deductible	\$200 per stay
•Outpatient	\$150 per visit	20% after deductible	20% after deductible	\$100 per visit
Emergency room visits	\$150 per visit (waived if admitted)	20% after deductible	20% after deductible	\$100 (waived if admitted)
Ambulance travel	20% after deductible	20% after deductible	20% after deductible	20% after deductible
Outpatient diagnostic, laboratory, tests, injections and x-rays	10% after deductible	20% after deductible	20% after deductible	10%, no deductible
Infusion services (includes IV or Injected chemotherapy)	10% after deductible	20% after deductible	20% after deductible	10% after deductible
Outpatient therapy visits				
•Occupational and speech therapy	10% after deductible	20% after deductible	20% after deductible	10% after deductible
•Physical therapy	10% after deductible	20% after deductible	20% after deductible	10% after deductible
•Chiropractic (30-visit plan year limit per member)	\$20/\$35	\$25/\$40	\$25/\$40	\$15/\$25
Applied behavior analysis (ABA) for autism spectrum disorder—ages 2 through 10	Determined by services received			
Behavioral health				
•Medical and non-medical professional visits	\$20	\$25	\$25	\$15
•Inpatient residential treatment	\$300 per stay	20% after deductible	20% after deductible	\$200 per stay
•Intensive outpatient treatment (IOP)	\$150 per episode of care	20% after deductible	20% after deductible	\$100 per episode of care
Employee Assistance Program (EAP)				
Up to 4 visits per incident	\$0	\$0	\$0	\$0
Prescription drugs – mandatory generic				
Retail Pharmacy	<i>Up to 34-day supply</i> \$10/\$30/\$45/\$55			
Home Delivery Pharmacy	<i>Up to 90-day supply</i> \$20/\$60/\$90/\$110			
Dental Services				
•Diagnostic and preventive	\$0	\$0	\$0	\$0
Annual Routine Vision Exam	\$35	\$40	\$40	\$25
Annual Routine Hearing Exam	Not available	Not available	Not available	Not available

2016–17 COMPARISON OF BENEFITS—STATE, TLC & OTHER PLANS

Health Plans In-Network Benefits	COVA Care You Pay	COVA HDHP You Pay	SB 364 COVA Care Model You Pay	SB 364 COVA HDHP Model You Pay
Wellness & preventive services	\$0	\$0	\$0	\$0
	<i>Office visits at specified intervals, immunizations, lab and x-rays Annual check-up visit (primary care physician or specialist), immunizations, lab and x-rays Routine gynecological exam, Pap test, mammography screening, prostate exam (digital rectal exam), prostate specific antigen (PSA) test, and colorectal cancer screening</i>			
Expanded Dental •Maximum benefit – per member •Deductible •Primary (basic) care •Complex restorative (inlays, onlays, crowns, dentures, bridgework) •Orthodontic –Lifetime maximum benefit	Optional Benefit*: \$2,000 \$50/\$100/\$150 20% after deductible 50% after deductible 50% no deductible \$2,000	Optional Benefit*: \$2,000 \$50/\$100/\$150 20% after deductible 50% after deductible 50% no deductible \$2,000	Optional Benefit*: \$2,000 \$50/\$100/\$150 20% after deductible 50% after deductible 50% no deductible \$2,000	Optional Benefit*: \$2,000 \$50/\$100/\$150 20% after deductible 50% after deductible 50% no deductible \$2,000
Routine Vision <i>(once every plan year)</i> •Routine eye exam	Optional Benefit* : \$40	Not available	Optional Benefit*: \$40	Not available
•Eyeglass frames •Lenses –Eyeglass lenses (<i>standard plastic, single, bifocal or trifocal</i>) or –Contact lenses – •Conventional**or disposable** •Non-elective**	20% off balance after plan pays first \$100 \$20 15% after plan pays \$100 Balance after plan pays \$250	Not available	20% off balance after plan pays first \$100 \$20 15% after plan pays \$100 Balance after plan pays \$250	Not available
Routine Hearing •Routine hearing exam •Hearing aids and other hearing-aid related services •Benefit maximum	Optional Benefit*: \$40 (once every plan year) Balance after plan pays \$1,200 \$1,200	Not available	Optional Benefit*: \$40 (once every plan year) Balance after plan pays \$1,200 \$1,200	Not available
Out-of-Network	Optional Benefit*: Plan payment reduced by 25%. Balance billing may apply.	Not available except in an emergency.	Optional Benefit*: Plan payment reduced by 25%. Balance billing may apply.	Not available except in an emergency.

*Options are offered for an additional premium, and may be purchased in combinations as shown on the monthly premiums chart. **Elective contact lenses are in lieu of eyeglass lenses. Non-elective lenses are covered when eyeglasses are not an option for vision correction.

This is only an overview of your health care benefits. For details, see the appropriate Member Handbook, or plan document, or visit www.dhrm.virginia.gov.

2016-17 COMPARISON OF BENEFITS—STATE, TLC & OTHER PLANS

The Local Choice Health Plans In-Network Benefits	Key Advantage 250 You Pay	Key Advantage 500 You Pay	Key Advantage 1000 You Pay	Key Advantage Expanded You Pay
Wellness & preventive services	\$0	\$0	\$0	\$0
	<i>Office visits at specified intervals, immunizations, lab and x-rays Annual check-up visit (primary care physician or specialist), immunizations, lab and x-rays Routine gynecological exam, Pap test, mammography screening, prostate exam (digital rectal exam), prostate specific antigen (PSA) test, and colorectal cancer screening</i>			
Expanded Dental •Maximum benefit – per member •Deductible •Primary (basic) care •Complex restorative (inlays, onlays, crowns, dentures, bridgework) •Orthodontic –Lifetime maximum benefit	\$1,500 \$25/\$50/\$75 20% after deductible 50% after deductible 50% no deductible \$1,500	\$1,500 \$25/\$50/\$75 20% after deductible 50% after deductible 50% no deductible \$1,500	\$1,500 \$25/\$50/\$75 20% after deductible 50% after deductible 50% no deductible \$1,500	\$1,500 \$25/\$50/\$75 20% after deductible 50% after deductible 50% no deductible \$1,500
Routine Vision <i>(once every 12 months)</i> •Routine eye exam	\$35	\$40	\$40	\$25
•Eyeglass frames	20% off balance after plan pays first \$100	20% off balance after plan pays first \$100	20% off balance after plan pays first \$100	20% off balance after plan pays first \$100
•Lenses –Eyeglass lenses (<i>standard plastic, single, bifocal or trifocal</i>) or –Contact lenses – •Conventional**or disposable**	\$20 15% off balance after plan pays \$100	\$20 15% off balance after plan pays \$100	\$20 15% off balance after plan pays \$100	\$20 15% off balance after plan pays \$100
•Non-elective**	Balance after plan pays \$250	Balance after plan pays \$250	Balance after plan pays \$250	Balance after plan pays \$250
Out-of-Network	Additional deductible and out-of-pocket limits apply. 30% coinsurance after deductible. Balance billing may apply.	Additional deductible and out-of-pocket limits apply. 30% coinsurance after deductible. Balance billing may apply.	Additional deductible and out-of-pocket limits apply. 30% coinsurance after deductible. Balance billing may apply.	Additional deductible and out-of-pocket limits apply. 30% coinsurance after deductible. Balance billing may apply.

*Options are offered for an additional premium, and may be purchased in combinations as shown on the monthly premiums chart.

**Elective contact lenses are in lieu of eyeglass lenses. Non-elective lenses are covered when eyeglasses are not an option for vision correction.

This is only an overview of your health care benefits. For details, see the appropriate Member Handbook, benefits summaries or plan document, or visit The Local Choice website at www.thelocalchoice.virginia.gov.