2020 BENEFITS AT A GLANCE

Health Plan	LODA
In-Network Benefits	**You Pay**
Deductible – per plan year	
• One person	$300
• Two or more persons	$600
Out-of-pocket expense limit – per plan year	
• One person	$1,500
• Two or more persons	$3,000
Doctor's visits (in person and telemedicine)	
• Primary care physician	$25
• Primary care physician online visit	$0 www.livehealthonline.com
• Specialist	$40
Hospital services	
• Inpatient	$300 per stay
• Outpatient	$125 per visit
Emergency room visits	$150 per visit (waived if admitted)
Ambulance travel	20% after deductible
Outpatient diagnostic laboratory and x-rays	20% after deductible
Infusion services (includes IV or injected chemotherapy)	20% after deductible
Outpatient therapy visits	
• Occupational and speech therapy	$25 PCP/$35 specialist
• Physical therapy only	$15
• Physical therapy and other related services, including manual intervention & spinal manipulation	$25 PCP/$35 specialist
• Chiropractic services (30-visit plan year limit per member)	$25 PCP/$35 specialist
Applied behavior analysis (ABA) for autism spectrum disorder	$25 per service
Behavioral health	
• Medical and non-medical professional visits	$25
• Inpatient residential treatment	$300 per stay
• Intensive outpatient treatment (IOP)	$125 per episode of care
Employee Assistance Program (EAP) Up to 4 visits per incident	$0
Prescription drugs – mandatory generic	
Retail Pharmacy	Up to 34-day supply – $15/$30/$45/$55
Home Delivery Pharmacy	Up to 90-day supply – $30/$60/$90/$110
Wellness & Preventive Services	
• Office visits at specified intervals, immunizations, lab and x-rays	$0
• Annual check-up visit (primary care physician or specialist), immunizations, lab and x-rays	$0
• Routine gynecological exam, Pap test, mammography screening, prostate exam (digital rectal exam), prostate specific antigen (PSA) test, and colorectal cancer screening	$0

[Continued on reverse side]

2020 BENEFITS AT A GLANCE

[Continued from reverse side]

Health Plan	LODA	
In-Network Benefits	**You Pay**	
Expanded Routine Vision	**Adult Member**	**Pediatric Member***
Annual Routine Vision Exam	$15 copay	$15 copay $0 once OOP is met
• Eyeglass frames	80% after plan pays $100	$0 copay; formulary**
• Lenses - Eyeglass lenses (standard plastic, single, bifocal or trifocal) or	$20 copay	$20 copay $0 copay once OOP is met
• Contact lenses*** - Conventional*** - Disposable*** - Non-elective***	 85% after plan pays $100 Balance after plan pays $100 Balance after plan pays $250	 $0 copay; formulary** $0 copay; formulary** Covered in full
Dental Services		
• Maximum benefit – per member	$2,000	
• Deductible	$50/$100/$150	
• Primary (basic) care	20% after deductible	
• Complex restorative (inlays, onlays, crowns, dentures, bridgework)	50% after deductible	
• Orthodontic - Lifetime maximum benefit	50% no deductible $2,000	
Routine Hearing		
• Routine hearing exam (once every plan year)	$40	
• Hearing aids and other hearing-aid related services	Balance after plan pays $1,200 (once every 48 months)	
• Benefit maximum	$1,200	
Out-of-Network	Plan payment reduced by 25%. Balance billing may apply.	

NOTE:

*Dependent children are considered pediatric members through the end of the month they turn 19.

**Members of pediatric vision plans will need to select their covered frames from a specific selection (formulary). Formulary should consist of at least 35 frames with a total of wholesale acquisition cost of at least $19 each. 20% to 40% (or at least 5 units) each of girl, boy and unisex styles.

***Elective contact lenses are in lieu of eyeglasses (frames and lenses). Non-elective lenses are covered when glasses are not an option for vision correction.

This is only an overview of your health care benefits. More information is available at the DHRM website **www.dhrm.virginia.gov**.

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VIRGINIA DEPARTMENT OF
HUMAN RESOURCE MANAGEMENT