

The Local Choice

Health Benefits Program

Fiscal Year 2021 Renewal





The Local Choice Health Benefits Program

To: TLC Group Administrators

From: Ann B. Wohl
TLC Program Manager

Date: January 2020

Re: The Local Choice Health Benefits Renewal

Thank you for your continuing support of The Local Choice (TLC) program. We are pleased to share the enclosed fiscal year 2021 renewal for TLC.

The Virginia Department of Human Resource Management (DHRM) and its The Local Choice (TLC) Health Benefits Program are keenly aware of the high priority that TLC groups place on planning and budgeting for health benefits. We are constantly working to find new and innovative ways to add value to our plans and improve our service. We have just completed the process of procuring administrative services contracts for medical, prescription drug, dental and behavioral health benefits, including the employee assistance program, in addition to two fully-insured regional HMOs. Our plan offerings continue to provide choice, competitive pricing, and value-added services that offer opportunities to improve the health of your employees and their families.

The TLC plan administrators have been named as follows:

- Anthem BCBS: Medical, Behavioral Health, EAP and Routine Vision and Outpatient Prescription Drugs for statewide plans
- Delta Dental: Dental for statewide plans
- Kaiser Permanente: regional HMO
- NEW! Optima Vantage: regional HMO

TLC will again offer five statewide plans to all local employer groups along with two regional HMOs available in defined service areas. Employer plan choices include:

Statewide plans

- Key Advantage Expanded Benefits
- Key Advantage 250
- Key Advantage 500
- Key Advantage 1000
- TLC High Deductible Health Plan (HDHP) – HSA compatible

Regional HMO plans

- Kaiser Permanente – available in defined service area
- Optima Vantage – available in defined service area

Retiree Plans

- Key Advantage or Regional Plan coverage (only available to retirees not eligible for Medicare)
- Advantage 65
- Advantage 65 with Dental/Vision
- Medicare Complementary (grandfathered for current participant groups, only)

All active employee TLC plans include the CommonHealth wellness program at no additional cost. CommonHealth features confidential, at-work medical screenings plus other health and wellness programs such as nutrition, stress management and fitness programs.

Your 2020-2021 renewal notebook includes a Comparison of Benefits brochure outlining the proposed benefits to assist you in determining which plan or plans you want to offer your employees.

Rates for all available plan options are listed in Section 2 (Renewal Rate Sheets and Information). Together, the statewide Key Advantage plans, High Deductible Health Plan and the Kaiser Permanente and new Optima Vantage HMO fully-insured regional plans (available in certain service areas) offer you a variety of choices with competitive administrative costs and quality coverage.

We encourage you to attend a TLC regional meeting in March, 2020. I, along with representatives from our program's vendors, will present plan highlights, improvements and changes in more detail. Once the regional meeting schedule for 2020 is finalized, it will be distributed through an eNews.

We value your participation, and we look forward to continuing to build upon our partnership of caring for your employees.

Thank you for selecting The Local Choice.

If you have any questions, please contact me at (804) 371-0185 or ann.wohl@dhrm.virginia.gov.

Sincerely,



Ann B. Wohl
TLC Program Manager

The Local Choice

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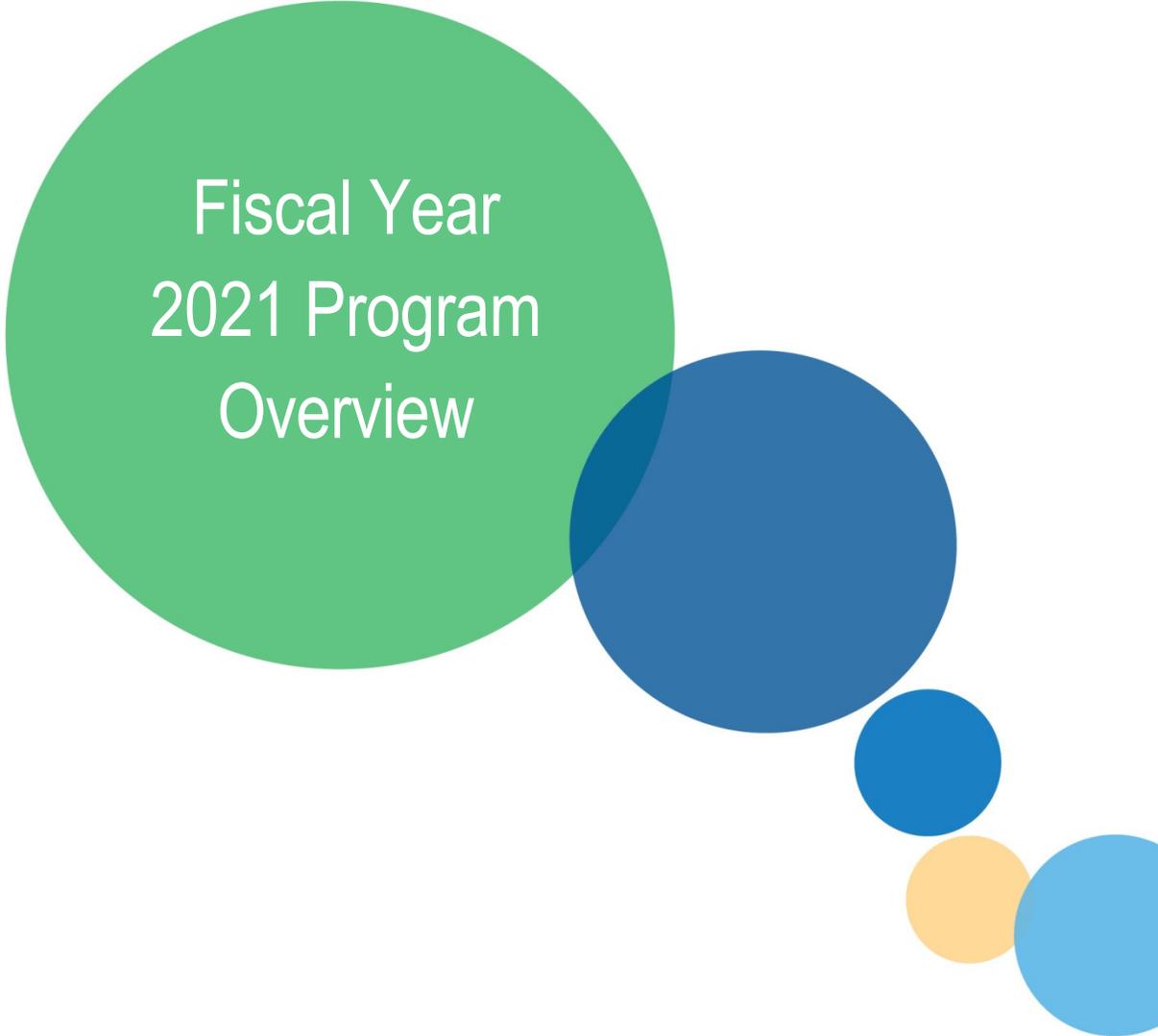
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A decorative graphic consisting of several overlapping circles of various sizes and colors. The largest circle is blue and contains the text 'Overview & Instructions'. Other circles include a green one with 'Section 1', a dark blue one, a light blue one, and an orange one. The circles are arranged in a scattered pattern across the page.

Section 1

Overview & Instructions



Fiscal Year
2021 Program
Overview



Program Overview and Instructions

The Local Choice Health Benefits Program (TLC) is pleased to provide your health care program renewal for July 1, 2020 (October 1, 2020 for certain school groups).

The Local Choice Health Benefits Program Advantage

Thank you for your participation in The Local Choice. Our goal is to provide participating local employer groups with high-quality benefit plans, competitive rates, excellent customer service, and financial stability through rating pools based on group size and stop-loss protection for self-insured plans.

The following self-insured plans can again be chosen as an option by employers for eligible active employees and retirees not eligible for Medicare:

- Key Advantage Expanded
- Key Advantage 250
- Key Advantage 500
- Key Advantage 1000
- TLC HDHP (An HSA compatible High Deductible Health Plan)

The above Key Advantage and HDHP plans are offered with the employee's choice of either Preventive Dental coverage or Comprehensive Dental. Comprehensive Dental includes orthodontics for all participants.

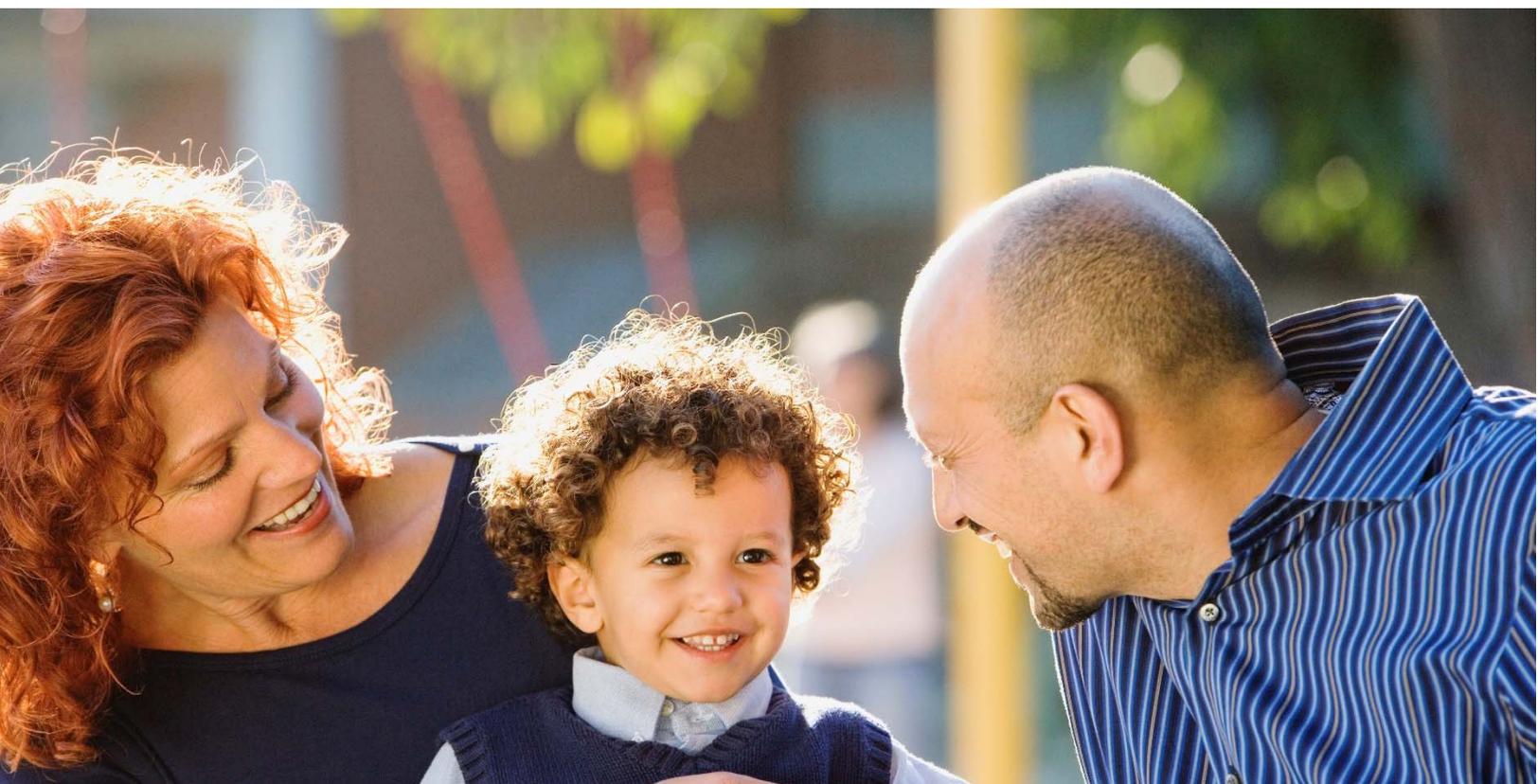
NOTE: To maintain Affordable Care Act compliance, the Preventive Dental option must be offered as indicated on the enrollment form.

The following fully-insured plans can be chosen as an option by employers for eligible active employees and non-Medicare-eligible retirees who live or work in the plan's service area (see Section 5 for more information):

- Kaiser Permanente HMO (available only in the Kaiser service area—contact Kaiser for additional information)
- NEW!! Optima Vantage HMO (available only in the Optima service area – contact Optima for additional information)

For Medicare-Eligible Retirees:

- Advantage 65 Medical Only (does not include outpatient prescription drug/Medicare Part D coverage)
- Advantage 65 Medical Only with Dental/Vision (does not include outpatient prescription drug/Medicare Part D coverage)
- Medicare Complementary (grandfathered plan)





The following is a basic overview of the plans offered by TLC. For more details, see the Comparison of Benefits brochure, specific plan benefit summary or Member Handbook.

Statewide Self-Funded Plans: Key Advantage & HDHP Plans

Medical, behavioral health, prescription drugs, and routine vision are administered by Anthem. Routine dental is administered by Delta Dental.

The following provisions apply to both Key Advantage and HDHP Plans:

- Extensive medical, behavioral health, dental and routine vision benefits (through Blue View Vision) are covered in all Key Advantage and HDHP plans.
- These plans also allow for medical care when traveling outside Virginia through the BlueCard PPO and Blue Cross Blue Shield Global Core programs.
- Under all Key Advantage and TLC HDHP plans, in-network preventive medical care is covered with no deductible or coinsurance.
- Under the Employee Assistance Program (EAP), members receive up to four visits per incident per plan year at no cost. The EAP is only available in-network. Contact Anthem for more information.
- Home Delivery is also available through the plans' outpatient prescription drug benefits.
- Copayment/coinsurance expenses for outpatient prescription drugs are included, along with medical and behavioral health copayments/coinsurance costs, toward the annual out-of-pocket maximum expense limit.
- Dental coverage is provided by Delta Dental with a separate deductible. Members may select either Preventive or Comprehensive Dental.

The following provisions apply only to Key Advantage Plans:

- While members receive the highest level of benefits when visiting an in-network provider, members also receive out-of-network benefits for covered medical and behavioral health services but with higher out-of-pocket costs.
- Under the Key Advantage Plans, if members receive a brand name drug when a generic equivalent is available, they are responsible for the applicable brand copayment plus the cost difference between the allowable charge for the generic equivalent and the brand name.
- Outpatient prescription drugs are divided into 4 tiers based upon the cost and/or type of drug. See the Comparison of Benefits for more information.

The following provisions apply only to HDHP Plans:

- The TLC HDHP plan is an HSA (Health Spending Account) compatible plan. TLC does not provide the HSA account. Each group may choose to offer its own HSA account administrator.
- With the embedded deductible HDHP plan, deductible amounts for each individual member will accumulate toward the family plan year deductible limit. However, no individual family member can contribute more than the single-only deductible amount.
- Under the HDHP plan, covered medical, behavioral health and prescription drug services are subject to the \$2,800 single and \$5,600 family plan year deductible and 20% coinsurance.

Regional Plan: Kaiser Permanente HMO

Kaiser Permanente offers a regional HMO plan in its service area, which includes Northern Virginia, Fredericksburg, Washington D.C., and parts of Maryland and is available only to participants who live or work in those areas as defined by zip code. Kaiser information is only provided in your renewal notebook if your group is eligible for Kaiser benefits.

A detailed outline of the service area and benefits may be found in the Kaiser HMO benefits summary. Medical, behavioral health, EAP, outpatient prescription drug and dental coverage are included in the plan.

Retirees and their dependents eligible for Medicare and Medicare-eligible dependents of retirees who are not eligible for Medicare are not eligible for enrollment in the Kaiser plan. Kaiser does not offer a Medicare supplement option in the TLC Program.

NEW!! Regional Plan: Optima Vantage HMO

Optima Health, a local health plan headquartered in Virginia, is a new TLC regional plan offered in its service area.

Optima Health's open-access style HMO plan does not require participants to select a primary care physician (PCP) and referrals are not required for specialist care. Optima Health encourages a PCP relationship, but it is not required. PCPs can help members with routine medical care and provide guidance when seeking specialist care within the broad Optima Health network of providers.

A detailed outline of the service area and benefits may be found in the Optima Health benefits summary. The TLC plan includes preventive care covered in full, dental and vision benefits, emergency travel assistance and Employee Assistance Program (EAP) services.

In order to enroll in this plan, participants must be eligible for coverage as defined by their employer, employer must select this as a plan option and the participant must live or work in the defined service area.

Retirees and their dependents eligible for Medicare and Medicare-eligible dependents of retirees who are not eligible for Medicare are not eligible for enrollment in the Optima Health plan. Optima Health does not offer a Medicare supplement option in the TLC program.

Retirees Not Eligible for Medicare: Key Advantage and HDHP Coverage

Employers may choose to offer retiree coverage for those retirees who are not eligible for Medicare. Although allowed, no employer contribution is required for retiree coverage. **A local employer may add retiree coverage at renewal by submitting a written request to the Department of Human Resource Management (DHRM) along with an approved resolution from your Board or Governing Body. Adding such coverage may impact your group's renewal rates.** All groups (with exception of groups that have been grandfathered) will receive rates for blended premiums. In a blended premium, active employees and non-Medicare-eligible retirees will have the same rates. Stand-alone rates for non-Medicare-eligible retirees are grandfathered, which means that they are only available for groups who currently offer them. .

Medicare Supplemental Plans for Medicare-Eligible Retirees

If a group offers coverage to non-Medicare retirees, it may also offer coverage for Medicare-eligible retirees. **A local employer may add coverage for Medicare eligible retirees at renewal by submitting a written request to the Department of Human Resource Management (DHRM) along with an approved resolution from their Board or Governing Body.**

For groups currently offering coverage to retirees eligible for Medicare, the Advantage 65 and Advantage 65 with Dental/Vision plans continue to be available. However, Medicare Complementary is a grandfathered plan and not available to groups that do not currently offer it. The Medicare supplement and routine dental and vision (if selected) are administered by Anthem.

Groups adding retiree benefits to their program for the first time may only offer Advantage 65 or Advantage 65 with Dental/Vision for their Medicare-eligible retirees and family members. It is important to remember that a local employer may select only one plan for Retirees Eligible for Medicare.

A local employer may also add Dental/Vision coverage to a current Advantage 65 contract at the group level at renewal. Once added, however, it may not be removed.



Enrollees in TLC Medicare supplement plans must be enrolled in Medicare Parts A and B as the primary payer of Medicare-covered services. Neither Advantage 65 nor Medicare Complementary Plans will pay for any services that would have been covered by Medicare had the participant been properly enrolled.

Outpatient prescription drug coverage is not available in any of the Medicare supplemental plans. If prescription drug coverage is desired, members should seek coverage in Medicare Part D.

To prevent claims denial and/or retraction of claims, it is imperative that you communicate the following information to all covered participants, whether active or retired.

Coverage under a Key Advantage plan, the TLC HDHP or a Regional plan (if available) is only for:

- Active Employees and their Dependents
- Retirees Not Eligible for Medicare and their Dependents Not Eligible for Medicare, and/or
- Dependents of Medicare Eligible Retirees who are not Medicare eligible

ONCE COVERAGE IS BASED ON FORMER EMPLOYMENT, MEDICARE BECOMES THE PRIMARY PAYER FOR THOSE WHO ARE MEDICARE ELIGIBLE. (The only exception is based on End Stage Renal Disease.)

Active employees and dependents of Active employees cannot participate in our Medicare Supplement plans regardless of Medicare status.

Advantage 65

Advantage 65 provides Medicare supplemental medical benefits and some primary benefits for services not covered by Medicare (see TLC Medicare-Coordinating Member Handbook) for retirees eligible for Medicare and their Medicare-eligible covered family members. It does not include outpatient prescription drug coverage. Anthem administers the Advantage 65 plan.

Advantage 65 with Dental/Vision

As a group option, you may elect to add dental and vision coverage to Advantage 65. This product adds dental and vision to the Advantage 65 plan described above. Dental benefits are administered by Anthem and routine vision is administered through Anthem Blue View Vision.

Medicare Complementary

Medicare Complementary is a "grandfathered" plan available only to groups who already offer the product. It provides Medicare supplemental benefits plus routine dental and vision coverage for retirees eligible for Medicare and their Medicare-eligible covered family members. Medical and routine dental benefits are administered by Anthem, and routine vision is administered through Anthem Blue View Vision.

CommonHealth

The CommonHealth Wellness Program is a value-added benefit included at no additional cost for TLC members. CommonHealth features confidential, at-work medical screenings plus other health and wellness programs such as nutrition, stress management and fitness programs.

Since wellness programs foster good health, which often can help to control claims costs, we strongly encourage you to take advantage of all that CommonHealth has to offer. Employees and their dependents covered by any TLC program are eligible to participate.

Choice of Plans - Statewide and Regional

Most employers may select a combination of Key Advantage, HDHP and any available regional plan. **Each employee in a statewide plan has the choice of preventive-only or comprehensive dental.**

- Groups with 14 or fewer eligible employees may offer only one benefit plan with both dental options.
- Groups with 15 to 99 eligible employees may offer two plans, each with both dental options.
- Groups with 100 or more eligible employees may offer two Key Advantage plans plus the HDHP, each with both dental options, and/or one of the Regional plans (if available).

Groups establish their own eligibility (within certain TLC parameters). These may change at renewal. Be sure that any change coincides with your personnel and policy practices. A written request for any changes must be submitted to the Department of Human Resource Management (DHRM) with your electronic renewal Employer Data Sheet (worksheet and instructions will be provided at a later date). DHRM must approve any changes to assure compliance with state regulations.

Group Rating

Totally Pool Rated—no credibility factor - Group size of 1 through 99 employees.

Experience Rating - Group size of 100 or more. A Credibility Factor applies to medical and behavioral health components only. All outpatient prescription drugs and routine dental claims are pooled, based on the combined experience of all current TLC groups, regardless of size.

Group Size	Credibility Factor
100 – 149	58% of the group's medical and behavioral health experience
150 – 199	71% of the group's medical and behavioral health experience
200 - 249	82% of the group's medical and behavioral health experience
250 - 299	91% of the group's medical and behavioral health experience
300 – and above	100% of the group's medical and behavioral health experience

To protect participating employers, TLC provides shared risk/stop loss protection through medical attachment points (Specific Pooling Points) of \$100,000 for groups with fewer than 300 participating employees; \$125,000 for groups between 300 and 999 participating employees; \$175,000 for groups between 1,000 and 1,499 and \$200,000 for groups with 1,500 or more employees.

Monthly rates for employee plus one and family are calculated as a factor of the single employee rate. The relationship between the single, dual, and family rates remains the same as in the current plan year: Single = 1, employee plus one = 1.85 X single rate, and family = 2.70 X single rate.

Employer Contribution

The Virginia Administrative Code requires that, as a condition of local employer participation in TLC, the employer must pay a minimum portion of the plan contribution attributable to an active local employee's coverage. Participating local employers must contribute a minimum of 80% of the cost of single coverage and 20% of the cost of dependent coverage as a condition of participation. In the event that an employer enrolls 75% or more of all eligible employees, the employer will not be required to contribute to the cost of dependent coverage.

Local employers allowing part-time employees to participate in the program must contribute a minimum of 50% of the amount contributed toward active employee coverage (at all membership levels) for their participating part-time employees.

If the local employer elects to offer retiree coverage, contributions toward the cost is permitted but not required.

To provide more flexibility, employers offering multiple plans may choose to determine one minimum premium contribution requirement for all plans except for the HDHP, which must be determined separately (see below).

Premium averaging (if selected) will be based on the average single premium for all included plans. Once the average premium has been determined, the 80% employee minimum contribution and 20% dependent minimum contribution, is applied to all applicable plans.

Minimum employer funding for the HDHP is always determined separately from the Key Advantage and Regional plan requirements. If the HDHP is offered, an employer must pay a minimum of 80% of single premium and 20% of the additional dependent premium. If 75% of all eligible employees enroll and the employer funds an HSA/HRA, the 20% dependent contribution requirement is waived. For part-time participants, the 50% rule above will apply. Groups may make a higher contribution if they wish.

Regulations Governing the Local Choice Program

The section of the Virginia Administrative Code governing The Local Choice Program can be found at <https://law.lis.virginia.gov/admincode/title1/agency55/chapter20/section20/>.

Renewal Acceptance

To renew your coverage with TLC, **you must** complete the Employer Data Sheet through the DHRM on-line portal. **Detailed instructions for the on-line portal will be provided at a later date.**

DHRM must receive the completed Employer Data Sheet via the on-line portal by April 1, 2020 for July renewals and by July 1, 2020 for October renewals. You will receive confirmation from DHRM of your renewal. The renewal confirmation will include benefit plan selections, premiums and employer contribution requirements.



Deadline Extensions

All groups must respond by April 1, 2020, unless granted an extension based on receipt of the group's written request by April 1. An extension is for the return of your Employer Data Sheet only. The Code of Virginia does not permit an extension or waiver of the 90-day written termination request if you plan to leave the TLC Program. Please contact Ann Wohl, TLC Program Manager at (804) 371-0185 to discuss your options if you cannot comply.

Termination of Group Participation in TLC

For information on termination, please reference 1 VAC 55-20-160, 1 VAC 55-20-290 and 1 VAC 55-20-300 of the Virginia Administrative Code. According to these regulations, if you choose to terminate participation in The Local Choice Health Benefits Program, DHRM must receive written notification at least 90 days prior to the date of termination. Please note that the 90-day notification will not be extended by a request to extend the April 1, 2020, renewal response deadline. The department will notify a terminating local employer of any Adverse Experience Adjustment (AEA) within six calendar months of the time the local employer terminates participation in the program. Further, the department reserves the right to modify the amount of the experience adjustment applicable to a terminating local employer for a period not to exceed 12 months from the end of the plan year in which such termination occurred.

The Adverse Experience Adjustment shall be payable by the local employer in 12 equal monthly installments beginning 30 days after the date of notification by the department. A terminated local employer may request, in writing, an extension of the 12-month installment payment period. DHRM may approve an extension up to 36 months provided the local employer agrees to pay interest at the statutory rate on any extended payments. Since AEA is an exact look-back limit of liability, it cannot be estimated.

Renewal & Open Enrollment Process

Employer Data Sheet

- This must be completed through the DHRM on-line portal by April 1, 2020 for July renewals and by July 1, 2020 for October renewals.

Open Enrollment Materials

- After March 15th, Open Enrollment materials may be ordered based on the selected benefit plans and your total enrollment. **It is your responsibility to order and distribute the appropriate materials. Ordering instructions will be provided through eNews at a later date.** Please allow 7-10 business days for delivery.

Enrollment Forms

- **The renewal/open enrollment is not a complete re-enrollment. New enrollment forms are necessary for open enrollment only for new participants or for changes.** Please submit all enrollment forms at least 30 days prior to the July 1 or October 1 effective date. All open enrollment forms must be completed, signed and dated within your group's specified open enrollment period or they will not be processed.
- **If an eligible employee declines coverage, they must complete the waiver section of the Enrollment Form** and the waiver should also be sent to TLC. Originals of all forms should be retained in the employer's personnel files.

Open Enrollment Meetings

- **The Open Enrollment period is critical to allow for employee changes. Groups that renew on July 1 may select an Open Enrollment period between April 1, 2020 and May 15, 2020, but cannot exceed 30 days. School groups that renew on October 1 may select an Open Enrollment period between July 29, 2020, and September 10, 2020.** Representatives from the health plan(s) will be available to assist you with your renewal enrollment process, but you must contact them and make the appropriate scheduling arrangements.

The Local Choice Support

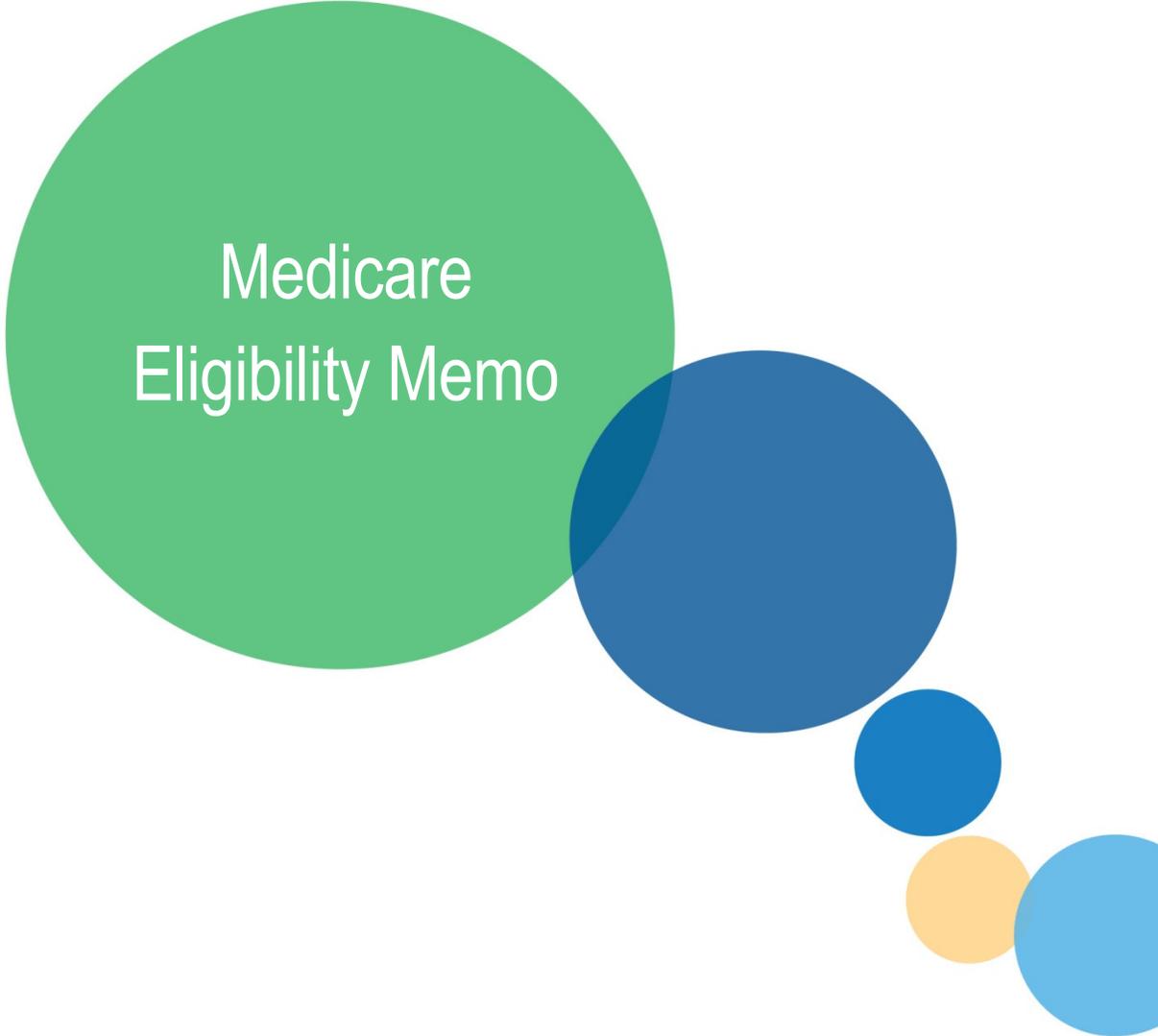
If you have questions about eligibility, renewal process or policy administration, please contact Ann Wohl, TLC Program Manager (ann.wohl@dhrm.virginia.gov) or Freddie Oliver, TLC Senior Specialist (Freddie.oliver@dhrm.virginia.gov).

Thank you for your continued support of The Local Choice program.



Thank You





Medicare Eligibility Memo

URGENT MESSAGE TO TLC GROUPS THAT OFFER RETIREE COVERAGE

Retirees and their covered family members who become eligible for Medicare (due to age or disability) are not eligible to participate in the following TLC plans:

- All Key Advantage plans
- High Deductible Health Plan
- Kaiser HMO
- Optima Health HMO

TLC groups who offer coverage for Medicare eligible retirees must either move the Medicare-eligible retiree to the group's Medicare-primary plan or terminate the retiree coverage. This also applies to their Medicare-eligible family members. Family members who are not eligible for Medicare may remain in their non-Medicare plan until their own Medicare eligibility (or other termination event). However, if the retiree terminates coverage, all family members must also be terminated.

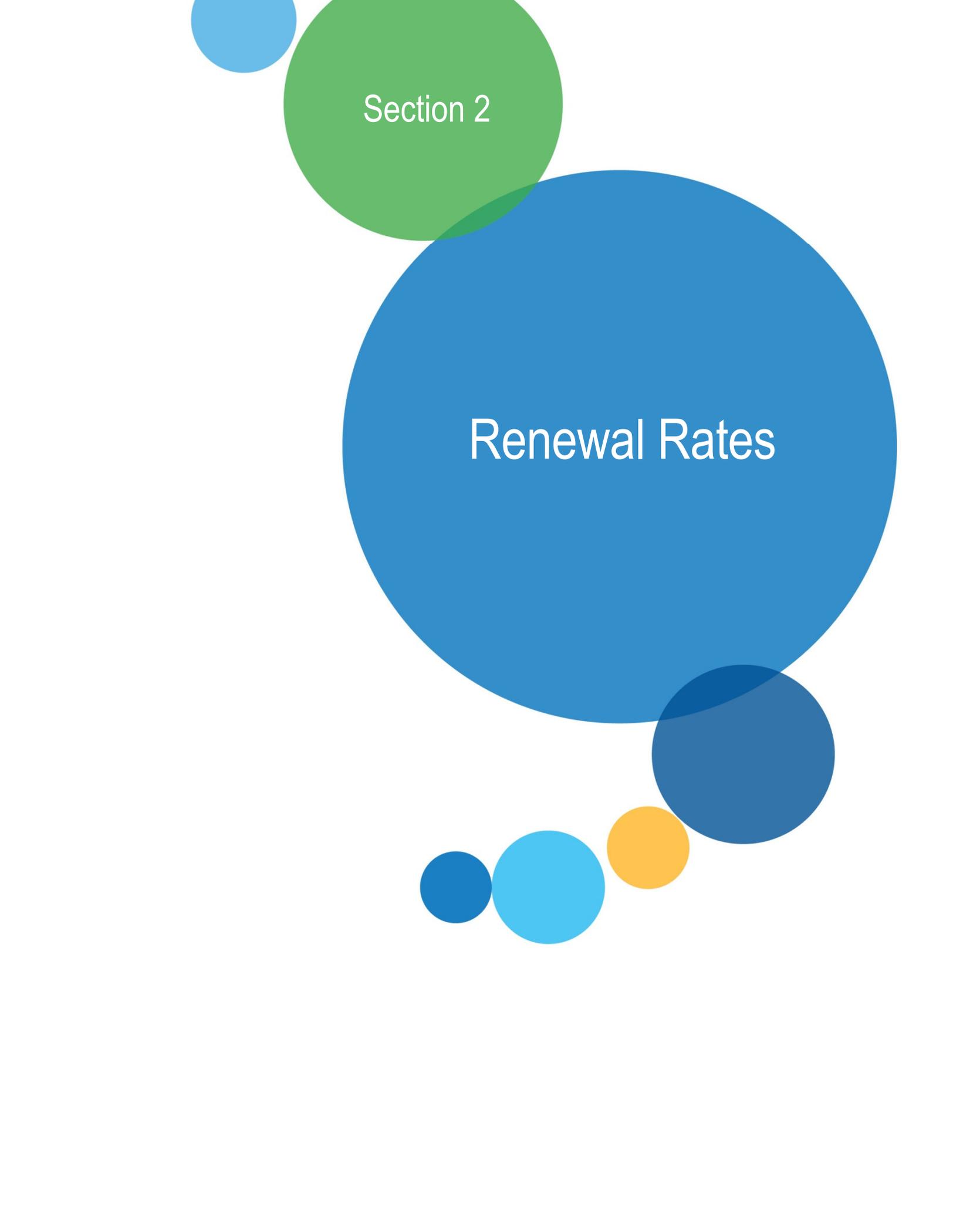
TLC groups who have chosen not to cover Medicare-eligible retirees must terminate the coverage for any retiree or family member of a retiree who becomes eligible for Medicare. When the retiree loses coverage due to Medicare eligibility, all family members will lose coverage, but the family members (not the retiree) should be offered Extended Coverage/COBRA. When a family member becomes eligible for Medicare and the Retiree is not eligible for Medicare, the Retiree (and any other non-Medicare family members) may continue coverage in the non-Medicare plan until the Retiree becomes eligible for Medicare. When that happens, the Retiree should be terminated, but all remaining

family members should be offered Extended Coverage/COBRA. (The family member that was terminated previously due to his/her own Medicare eligibility will not be eligible for Extended Coverage/COBRA. Only Medicare eligibility/entitlement of the employee is a triggering event for Extended Coverage, and only for covered family members.)

TLC tracks Medicare eligibility for groups' retiree population, but it is ultimately the responsibility of the retiree to report their Medicare eligibility to their Benefits Administrator. Retiree participants who have access to TLC Medicare-primary coverage but fail to move to that coverage immediately upon eligibility will be moved to an available TLC Medicare-primary plan back to their Medicare eligibility date or terminated. Any claims paid primary in error will be retracted, and any drug claim payments made in error will need to be paid back to plan.

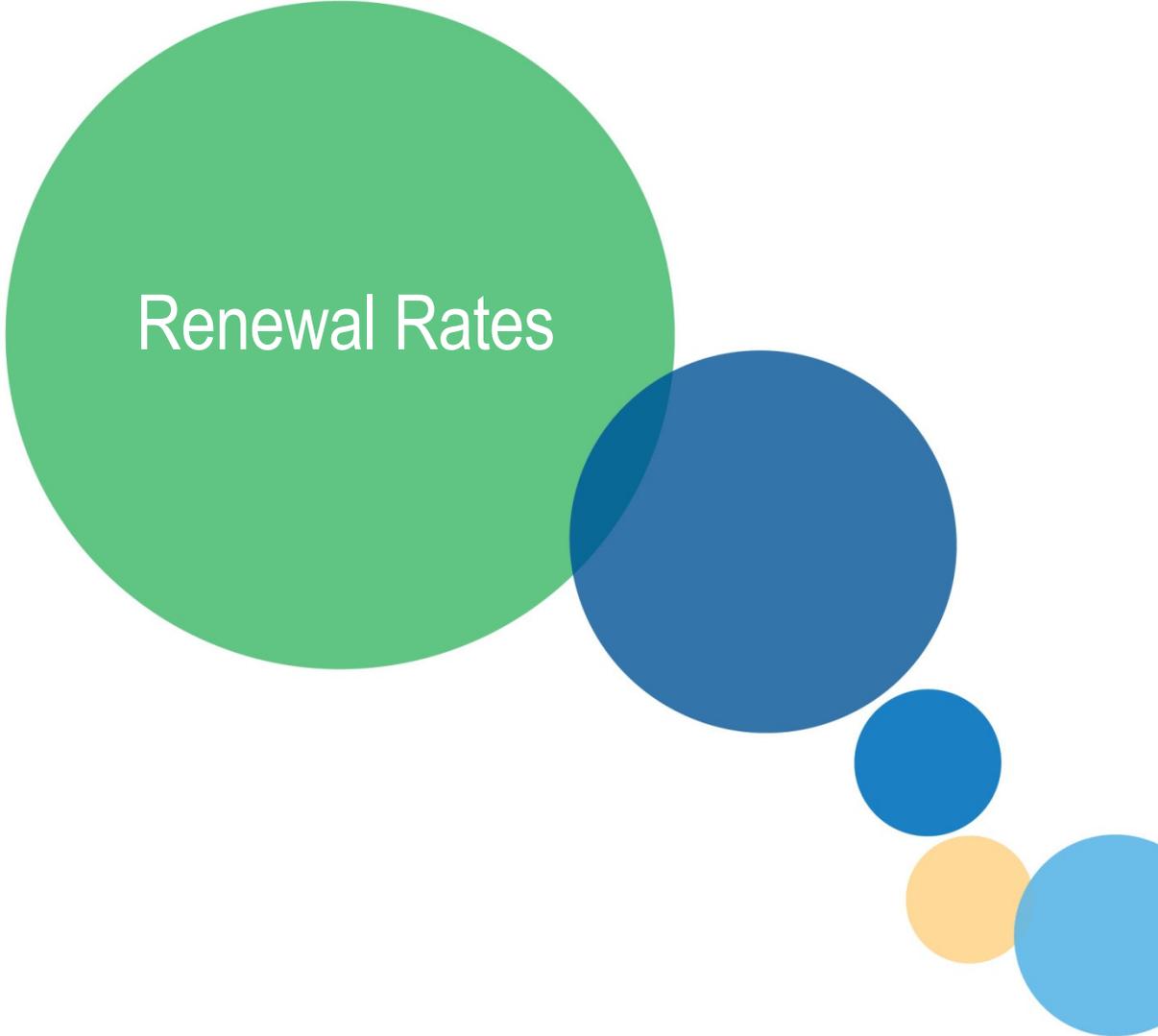
Each group receives a monthly report of participants who are becoming eligible for Medicare. **You may disregard any active employees and their covered family members**, but retirees and their family members need to be addressed as described above.

TLC is in the process of implementing a Medicare identification process. Your retirees have already begun seeing correspondence in this regard.

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Section 2

Renewal Rates



Renewal Rates

The Local Choice Health Benefits Program

Clarke County and Schools

Proposed Rates Effective from
for July 01, 2020 through June 30, 2021

With Comprehensive Dental

	<u>Single</u>	<u>Dual</u>	<u>Family</u>
<u>ACTIVE EMPLOYEES</u>			
Key Advantage Expanded	\$883	\$1,634	\$2,384
* Key Advantage 250	\$810	\$1,499	\$2,187
* Key Advantage 500	\$722	\$1,336	\$1,949
Key Advantage 1000	\$689	\$1,275	\$1,860
* High Deductible Health Plan	\$592	\$1,095	\$1,598
<u>RETIREEES NOT ELIGIBLE FOR MEDICARE</u>			
Key Advantage Expanded	\$883	\$1,634	\$2,384
* Key Advantage 250	\$810	\$1,499	\$2,187
* Key Advantage 500	\$722	\$1,336	\$1,949
Key Advantage 1000	\$689	\$1,275	\$1,860
* High Deductible Health Plan	\$592	\$1,095	\$1,598

With Preventive Dental Only

<u>ACTIVE EMPLOYEES</u>			
Key Advantage Expanded	\$866	\$1,602	\$2,338
* Key Advantage 250	\$793	\$1,467	\$2,141
* Key Advantage 500	\$705	\$1,304	\$1,904
Key Advantage 1000	\$672	\$1,243	\$1,814
* High Deductible Health Plan	\$575	\$1,064	\$1,553
<u>RETIREEES NOT ELIGIBLE FOR MEDICARE</u>			
Key Advantage Expanded	\$866	\$1,602	\$2,338
* Key Advantage 250	\$793	\$1,467	\$2,141
* Key Advantage 500	\$705	\$1,304	\$1,904
Key Advantage 1000	\$672	\$1,243	\$1,814
* High Deductible Health Plan	\$575	\$1,064	\$1,553

* Benefit Plans Currently Offered

Coverage under The Local Choice Key Advantage and HDHP contracts is for:

- Active Employees and their Dependents
- Retirees not eligible for Medicare and their Dependents not eligible for Medicare, and/or
- Dependents of Medicare eligible Retirees who are not Medicare eligible.

If coverage is offered to Medicare eligible retirees and their Medicare eligible Dependents, it must be obtained through one of our Medicare Supplemental contracts which require participation in both Parts A and B of Medicare to receive maximum benefits.

The PCORI fee is the responsibility of the group and payment should be submitted directly to HHS, therefore, this fee has not been included in your rates.

THE LOCAL CHOICE HEALTH BENEFITS PROGRAM

Medicare Retiree Rate

RETIREES WITH MEDICARE

Advantage 65	\$169
* Advantage 65 and Dental/Vision	\$201

* **Benefit Plans Currently Offered**

Coverage under The Local Choice Key Advantage and HDHP contracts is for:

- Active Employees and their Dependents
- Retirees not eligible for Medicare and their Dependents not eligible for Medicare, and/or
- Dependents of Medicare eligible Retirees who are not Medicare eligible.

If coverage is offered to Medicare eligible retirees and their Medicare eligible Dependents, it must be obtained through one of our Medicare Supplemental contracts which require participation in both Parts A and B of Medicare to receive maximum benefits.

THE LOCAL CHOICE HEALTH CARE PROGRAM

Anthem Blue Cross and Blue Shield

Renewal Analysis For:

(Excludes Advantage 65 premiums and claims)

Clarke County and Schools

Group #T05875

for July 01, 2020 through June 30, 2021

I. Income at Current Rates (1)	\$3,791,124
II. Projected Medical Claims Related Charges (2)	
A. Paid Claims for 12/1/2018 through 11/30/2019	\$2,108,707
B. Claims in excess of the \$100,000 pooling limit	<u>(\$239,573)</u>
C. Subtotal	\$1,869,134
D. Change in Incurred But Not Reported Claims	\$18,691
E. Benefit Adjustment	\$0
F. Enrollment Adjustment	\$0
G. Trend	\$198,222
H. Impact of blending	<u>\$20,316</u>
I. Total Medical Projected Incurred claims	\$2,106,362
III. Projected Reinsurance Charges	\$390,520
IV. Projected Medical Administrative Charges, Network Access Fees, and Affordable Care Act(3)	\$153,731
V. Projected Dental Capitation	\$155,542
VI. Projected Drug Capitation	\$808,684
VII. TLC Contingency Reserve or Risk Fee(4)	<u>\$176,286</u>
VIII. Total Income Requirements (II. + III. + IV. + V. + VI. + VII.)	\$3,791,124
Percentage Adjustment	0.0%

¹ Illustrative income is based on current enrollment as follows:

	KA 250	KA 500	HDHP	TOTAL
Single	52	129	14	195
Dual	12	26	4	42
Family	<u>13</u>	<u>38</u>	<u>8</u>	<u>59</u>
TOTAL:	77	193	26	296

² There are 5 claims in excess of the \$100,000 pooling limit.
Medical trends used in the renewal development were 6.5% annual.
For a 19 month projection, this equates to 10.5%

³ Administrative charge as a percent of income requirements is 4.1%

⁴ Includes DHRM Program Administration and CommonHealth

Assumes all have Comprehensive Dental.

**7 PARTICIPANTS WITH LARGE CLAIMS OVER 50000
 FOR CLARKE COUNTY - T05875, 05875
 CLAIMS PROCESSED: '2018-12-01' - '2019-11-30'
 CLAIMS INCURRED: '1900-01-01' - '2019-11-30'
 INCLUDES VISION, EXCLUDES MEDICARE AND DRUGS**

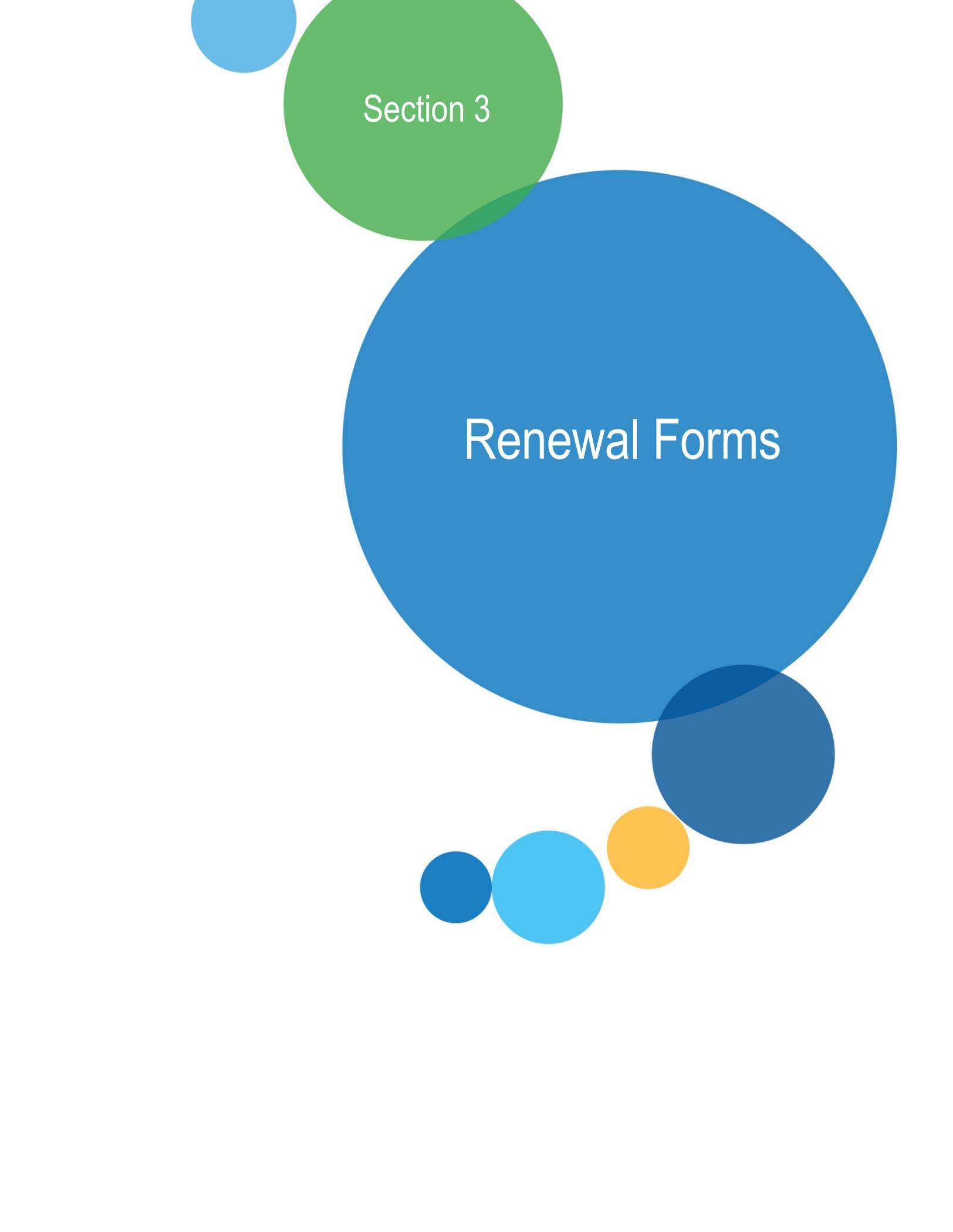
PRODUCT	SEX REL	TIER	MBR-EMP CURRENT		DIAGNOSIS	MEDICAL	VISION	BENEFIT
			CVRG STATUS	EXPENSE AT 100%		EXPENSE	EXPENSE	
PAR-PPO	4	Emp-Family	A - A		BIPOLAR DISORDER	204,127.63	0.00	204,127.63
PAR-PPO	3	Emp-Spouse	A - A		MALIGNANT NEOPLASM OF RECTUM	162,518.12	0.00	162,518.12
PAR-PPO	2	Emp Only	A - A		MALIGNANT NEOPLASM OF BREAST	145,443.57	93.46	145,537.03
PAR-PPO	3	Emp-Family	A - A		INFLAMMATORY POLYNEUROPATHY	117,723.71	58.46	117,782.17
PAR-PPO	3	Emp-Spouse	A - A		HYPERTENSIVE HEART AND CHRONIC KIDNEY DISEASE	109,608.08	0.00	109,608.08
PAR-PPO	6	Emp-Family	A - A		SPECIFIC PERSONALITY DISORDER	66,493.43	0.00	66,493.43
PAR-PPO	3	Emp-Spouse	C - C		OSTEOMYELITIS	62,961.05	0.00	62,961.05
						868,875.59	151.92	869,027.51

SEX_REL CODES

- 1 MALE EMPLOYEE 2 FEMALE EMPLOYEE
- 3 MALE SPOUSE 4 FEMALE SPOUSE
- 5 MALE DEPENDENT 6 FEMALE DEPENDENT
- 7 MALE DEPENDENT 8 FEMALE DEPENDENT

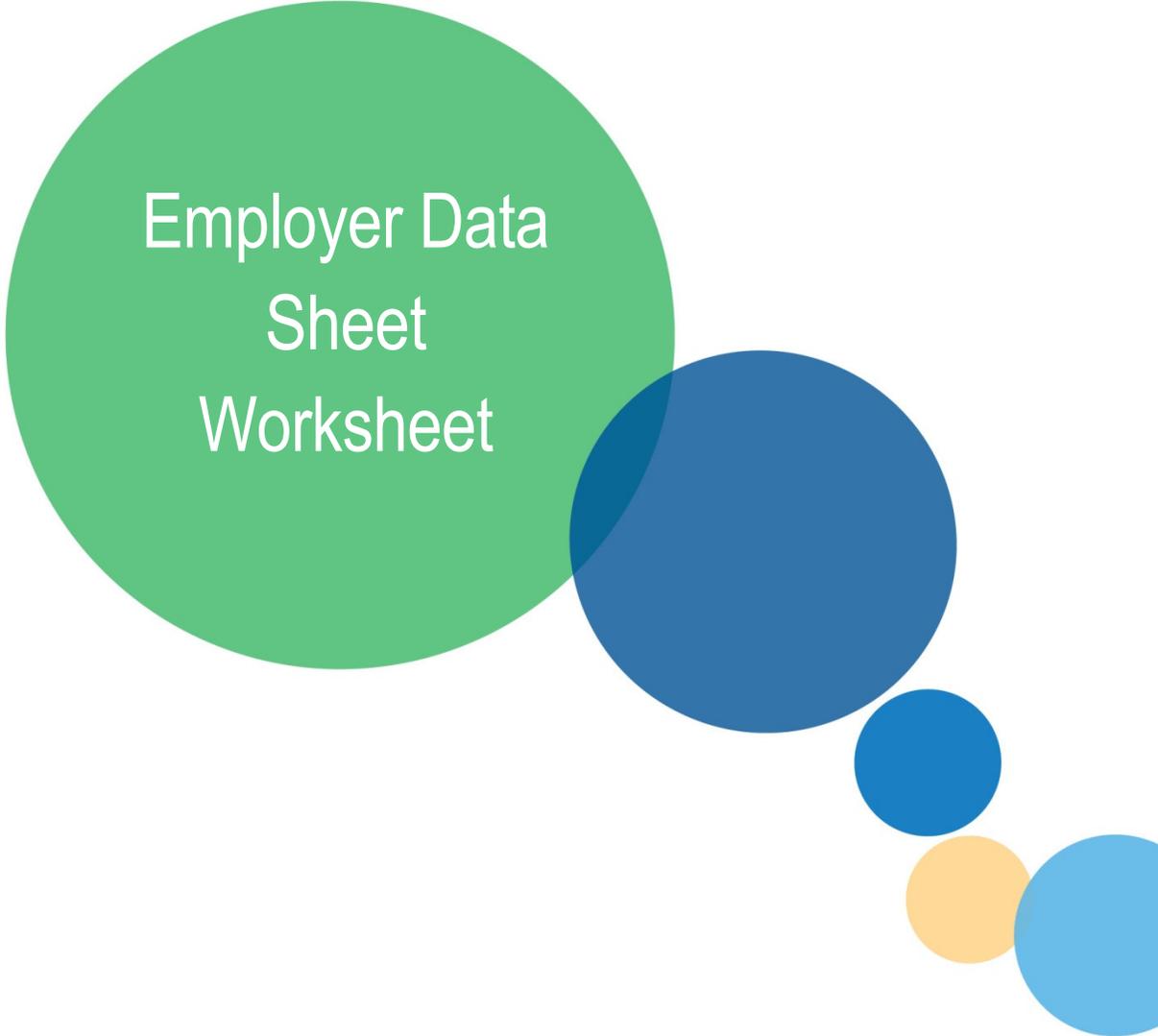
STATUS

- A ACTIVE
- C CANCELLED

A decorative graphic consisting of several overlapping circles in various shades of blue, green, and orange. The largest circle is a medium blue and is centered on the page. Other circles of different sizes and colors are scattered around it, some overlapping it. The text 'Section 3' is located inside a green circle in the upper left, and 'Renewal Forms' is inside the largest blue circle in the center.

Section 3

Renewal Forms



Employer Data
Sheet
Worksheet



Employer Renewal Data Sheet

Instructions for accessing the FY21 Employer Renewal Data Sheet will be provided through an eNews at a later date.



TLC Materials
Order Form



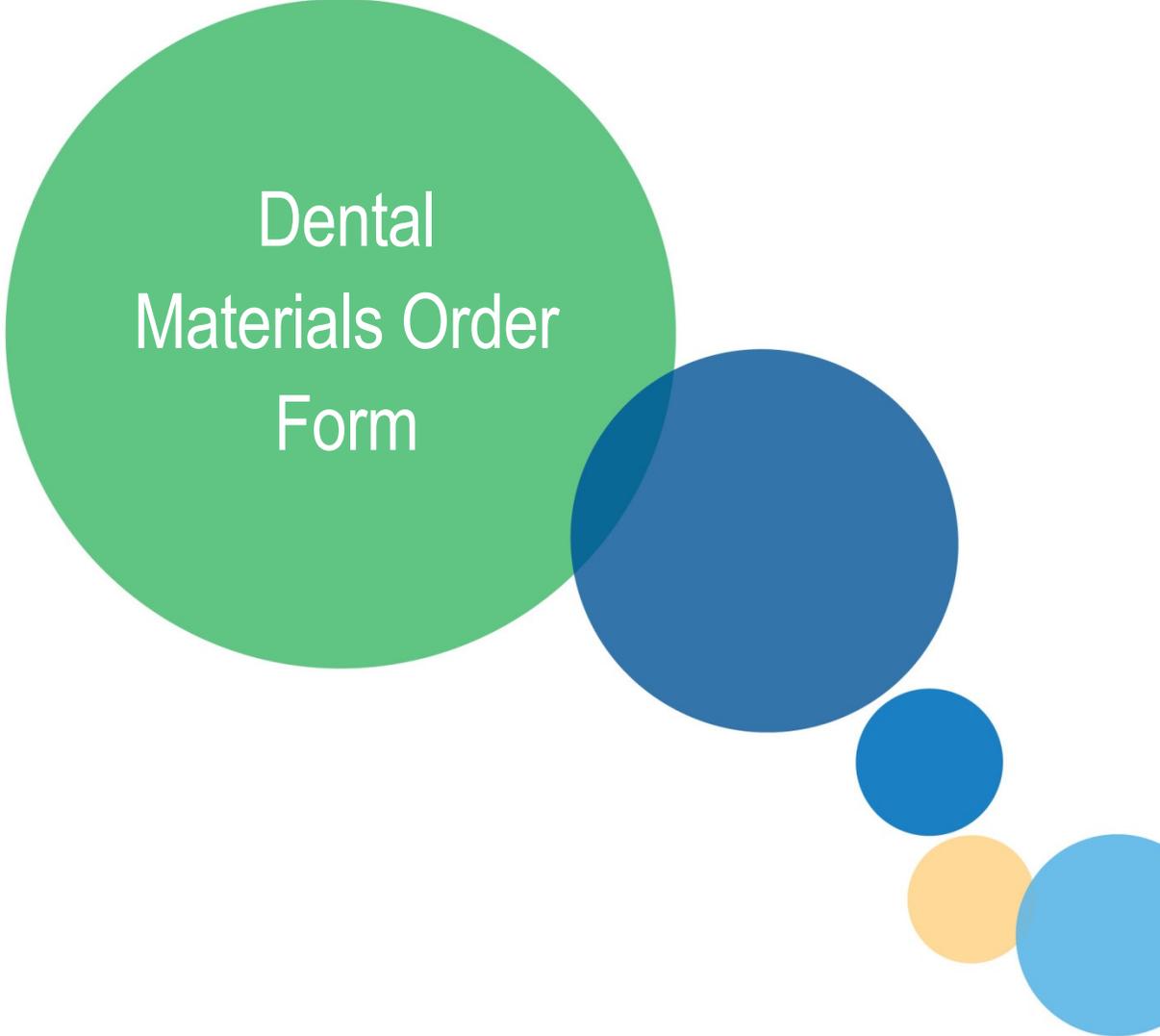
New Online Material Ordering.

2020 Materials should not be ordered before March 1, 2020

To order your enrollment packages, benefit summaries and forms:

- Login to the materials ordering portal at tlcorders.com and enter **tlcorders** as your username and **materials** as your password.
- Select from one of the following tabs to order materials
 - Enrollment Packages
 - Benefit Summaries
 - Forms
- Enrollment Packages:
 1. Select “Order Now” under the appropriate enrollment package
(Select from 2019 or 2020 Materials for Active and Early Retirees.)
 2. Enter the number of enrollment packages to order
(all inserts except for the benefit summaries are automatically included)
 3. Enter a “1” for only the benefit summaries you would like included in the package.
(One of each benefit summary selected will be included in each package.)
 4. Add to Cart, or to add additional materials to your order, select “Continue Shopping” in the lower left.
 5. Once you have ordered all of the materials, select “Continue”.
 6. Enter shipping information and be sure to “Save”, confirm your shipping information then “Continue”.
 7. Confirm the items in your order and “Place My Order”
 8. You will then receive a confirmation of your order. You can either print or save as a PDF for future reference.
- Benefit Summaries (only if you need extra summaries in addition to your enrollment packages) and Forms
 1. Enter the quantity needed for each, select “Order Now” and follow steps 4 – 8 above.

For questions about materials ordered, call or email Janet Browning at janet.browning@anthem.com or (804) 354-3904.



Dental
Materials Order
Form



Delta Dental of Virginia
4818 Starkey Road
Roanoke, VA 24018
888.335.8296

Date: _____

GROUP REQUEST FORM

Group Name: The Local Choice

Group Number: 047000000 & 048000000 Telephone Number: _____

Group Administrator: _____

Group Address: _____

Mail to (If Different from Above): _____

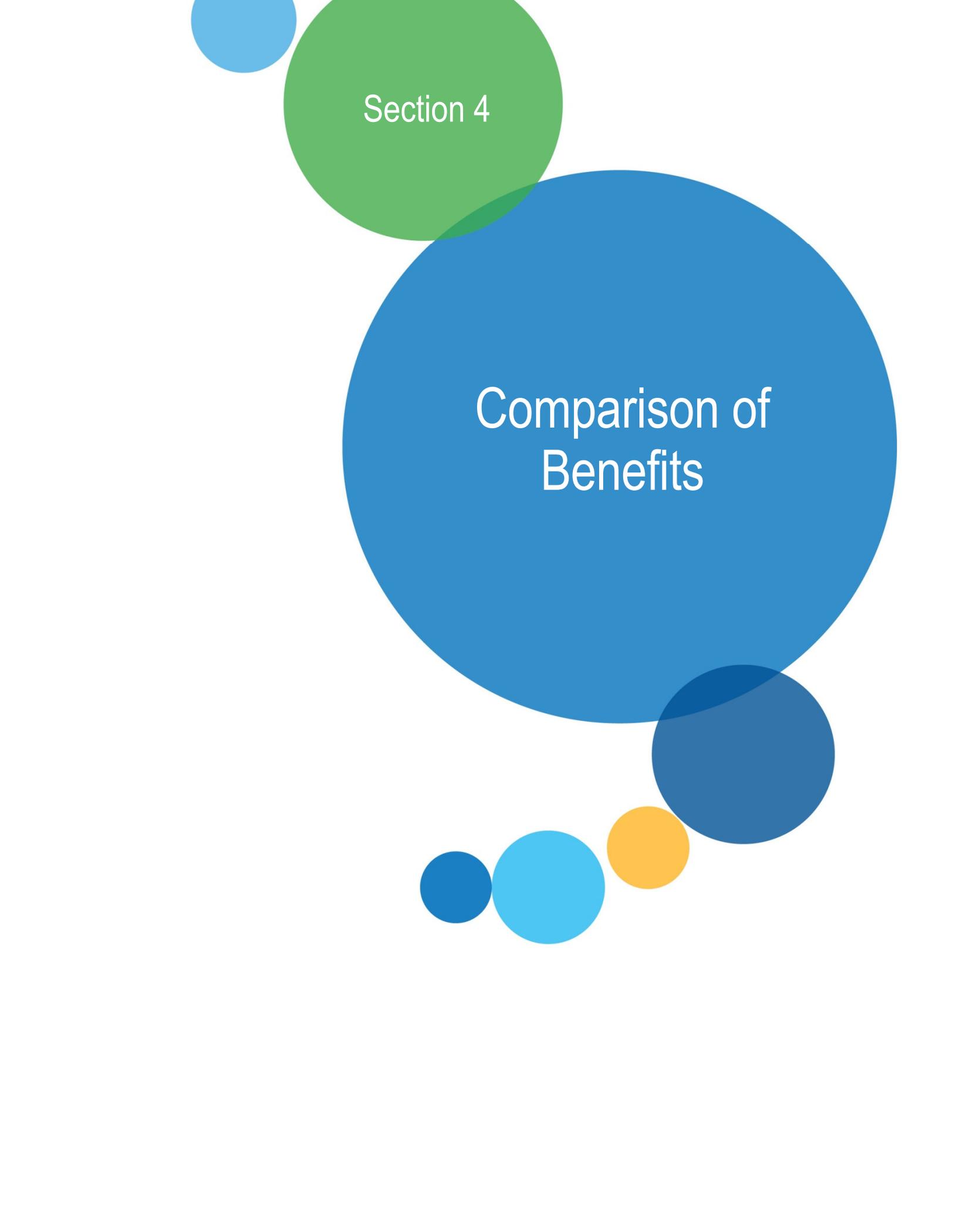
Quantity Needed

_____ Benefits Brochure

Delta Dental of Virginia Use Only	
Date Received:	_____
Date Completed:	_____
Sign off:	_____
Method Sent:	Next Day Air _____ 2nd Day Air _____ UPS Ground _____ Regular Mail _____

Please send request to:
Delta Dental of Virginia
Attn: Marketing Administration
4818 Starkey Road, Roanoke, VA 24018
Fax to 540-774-7574
Email to MktgAdmin@deltadentalva.com

If you have questions or need additional information please contact Allison Gaines at:
804.915.2690 or allison.gaines@deltadentalva.com



Section 4

Comparison of Benefits



2020 Comparison Of Statewide Plans

Effective July 1, 2020 or October 1, 2020

The Local Choice 2020 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: One Person Two People Family \$100 See Family \$200 Out-of-Network: \$200 See Family \$400	In-Network: One Person Two People Family \$250 See Family \$500 Out-of-Network: \$500 See Family \$1,000
Plan Year Out-of-pocket Expense Limit	In-Network: One Person Two People Family \$2,000 See Family \$4,000 Out-of-Network: \$3,000 See Family \$6,000	In-Network: One Person Two People Family \$3,000 See Family \$6,000 Out-of-Network: \$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	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 \$0 \$15 copayment	\$400 copayment per stay \$0 \$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 (for higher premium)	<i>One Person Two People Family</i> \$25 \$50 \$75	<i>One Person Two People Family</i> \$25 \$50 \$75
Dental Plan Year Deductible Plan Year Maximum (Except Orthodontics)	\$1,500 \$0	\$1,500 \$0
• Preventive Dental Care • Primary Dental Care • Major Dental Care • Orthodontic Services (Includes Adult Ortho)	20% coinsurance after dental deductible 50% coinsurance after dental deductible 50% coinsurance, no dental deductible, with \$1,500 lifetime maximum	20% coinsurance after dental deductible 50% coinsurance after dental deductible 50% coinsurance, no dental deductible, with \$1,500 lifetime maximum

Key Advantage 500

Key Advantage 1000

High Deductible Health Plan

Key Advantage 500			Key Advantage 1000			High Deductible Health Plan		
In-Network: One Person \$500	Two People <i>See Family</i>	Family \$1,000	In-Network: One Person \$1,000	Two People <i>See Family</i>	Family \$2,000	One Person \$2,800	Two People <i>See Family</i>	Family \$5,600
Out-of-Network: \$1,000	<i>See Family</i>	\$2,000	Out-of-Network: \$2,000	<i>See Family</i>	\$4,000	Deductible is combined for In-Network and Out-of-Network services.		
In-Network: One Person \$4,000	Two People <i>See Family</i>	Family \$8,000	In-Network: One Person \$5,000	Two People <i>See Family</i>	Family \$10,000	In-Network: One Person \$5,000	Two People <i>See Family</i>	Family \$10,000
Out-of-Network: \$7,000	<i>See Family</i>	\$14,000	Out-of-Network: \$9,000	<i>See Family</i>	\$18,000	Out-of-Network: \$10,000	<i>See Family</i>	\$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

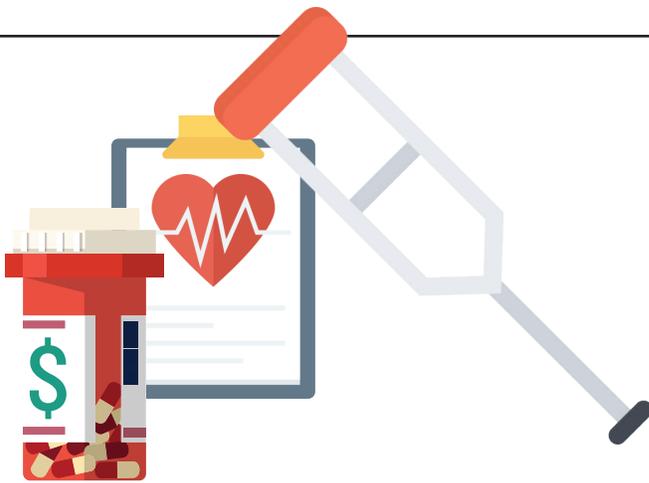
One Person	Two People	Family	One Person	Two People	Family	One Person	Two People	Family
\$25	\$50	\$75	\$25	\$50	\$75	\$25	\$50	\$75
\$1,500			\$1,500			\$1,500		
\$0			\$0			\$0		
20% coinsurance after dental deductible			20% coinsurance after dental deductible			20% coinsurance after dental deductible		
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 2020 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
LiveHealth Online (Online doctor's visits)	\$0	\$0



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
\$0	\$0	Determined by services received



The Local Choice 2020 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

*This plan will waive the hospital copayment if the member enrolls in the maternity management pre-natal program within the first 16 weeks 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.



**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



The Local Choice 2020 Comparison of Statewide Plans (continued)

Covered Services	Key Advantage Expanded In-Network You Pay	Key Advantage 250 In-Network You Pay
Skilled Nursing Facility Stays (180-Day Per Stay Limit Per Member) <i>Facility Services</i> <i>Professional Provider Services</i>	\$0 \$0	\$0 \$0
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>Infusion Services, Cardiac Rehabilitation Therapy, Chemotherapy, Radiation Therapy, Respiratory Therapy, Occupational Therapy, Physical Therapy, and Speech Therapy</i> <i>Facility Services</i> 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



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

\$0

\$0

20% coinsurance after deductible

\$25 copayment
\$40 copayment

\$25 copayment
\$40 copayment

20% coinsurance after deductible
20% coinsurance after deductible

20% coinsurance after deductible

20% coinsurance after deductible

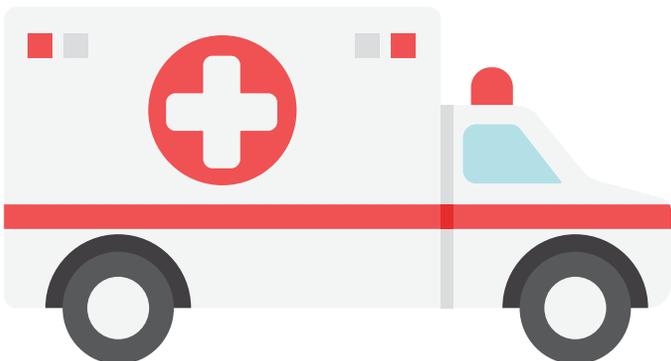
20% coinsurance after deductible

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





Health & Wellness Programs

Be your healthy best! The TLC plans include access to a host of health and wellness programs to help you manage your health issues.

- o **Sydney:** The **Sydney mobile app** acts like a personal health guide, answering your questions and connecting you to the right resources at the right time. And you can use the chatbot to get answers quickly. Download from the App Store (iOS) or Google Play (Android).
 - Find care and check costs
 - View and use digital ID cards
 - Check all benefits and view claims

- o **ConditionCare:** 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

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.

- o **Future Moms:** Enroll and receive pre- and post-natal support. Access a nurse coach and other maternity support specially designed to help women have healthy pregnancies and healthy babies.

- o **MyHealth Advantage:** Receive personalized health-related suggestions, tips, and reminders via mail or email to alert you of potential health risks, care gaps or cost-saving opportunities.
- o **Staying Healthy Reminders:** Receive yearly reminders of important checkups, tests, screenings, immunizations, and other preventive care needs for you and your family.
- o **24/7 NurseLine & Audio Health Tape Library:** Sometimes you need health questions answered right away - even in the middle of the night. Call 24/7 NurseLine (800-337-4770) 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.



See more information on Health & Wellness programs at www.anthem.com/tlc.

We're here for you – in many languages

The law requires us to include a message in all of these different languages. Curious what they say? Here's the English version: "You have the right to get help in your language for free. Just call the Member Services number on your ID card." Visually impaired? You can also ask for other formats of this document.

Spanish

Usted tiene derecho a recibir ayuda en su idioma en forma gratuita. Simplemente llame al número de Servicios para Miembros que figura en su tarjeta de identificación.

Chinese

您有權免費獲得透過您使用的語言提供的幫助。請撥打您的ID卡片上的會員服務電話號碼。若您是視障人士，還可索取本文件的其他格式版本。

Vietnamese

Quý vị có quyền nhận miễn phí trợ giúp bằng ngôn ngữ của mình. Chỉ cần gọi số Dịch vụ dành cho thành viên trên thẻ ID của quý vị. Bị khiếm thị? Quý vị cũng có thể hỏi xin định dạng khác của tài liệu này."

Korean

귀하는 자국어에 무료지원을 받을 권리가 있습니다. ID 카드에 있는 멤버 서비스번호로 연락하십시오.

Tagalog

May karapatan ka na makakuha ng tulong sa iyong wika nang libre. Tawagan lamang ang numero ng Member Services sa iyong ID card. May kapansanan ka ba sa paningin? Maaari ka ring humiling ng iba pang format ng dokumentong ito.

Russian

Вы имеете право на получение бесплатной помощи на вашем языке. Просто позвоните по номеру обслуживания клиентов, указанному на вашей идентификационной карте. Пациенты с нарушением зрения могут заказать документ в другом формате.

Armenian

Դուք իրավունք ունեք ստանալ անվճար օգնություններ լեզվով: Պարզապես զանգահարեք Անդամների սպասարկման կենտրոն, որի հեռախոսահամարը նշված է ձեր ID քարտի վրա:

Farsi

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French

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Arabic

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Japanese

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Haitian

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Punjabi

ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮੁਫਤ ਸੇਵਾਵਾਂ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੈ। ਬਸ ਆਪਣੀ ਆਈਡੀ ਕਾਰਡ ਤੇ ਦਿੱਤੇ ਸਿਰਵਸ ਨੰਬਰ ਤੇ ਕਾਲ ਕਰੋ। ਨਜ਼ਰ ਕਮਜ਼ੋਰ ਹੈ? ਤੁਸ ਇਸ ਦਸਤਾਵੇਜ਼ ਦੇ ਹੋਰ ਰੂਪਾਂਤਰ ਮੰਗ ਸਕਦੇ ਹੋ।

TTY/TTD:711

It's important we treat you fairly

We follow federal civil rights laws in our health programs and activities. By calling Member Services, our members can get free in-language support, and free aids and services if you have a disability. We don't discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people whose primary language isn't English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711). If you think we failed in any of these areas, you can mail a complaint to: Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279, or directly to the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201. You can also call 1-800-368-1019 (TDD: 1-800-537-7697) or visit <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>

Quick Access to Your Plan

[Anthem.com/tlc](https://www.anthem.com/tlc)

Your dedicated website for health benefits documents, no log in needed

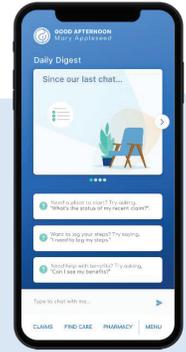
-  Download your health benefits summary and member handbook
-  Find a doctor and urgent care
-  Register for LiveHealth Online video doctor visits
-  Learn about your Employee Assistance Program (EAP)

[Anthem.com](https://www.anthem.com)

Log in to your confidential and secure account

-  View your claims
-  Download your ID card
-  Find a doctor and urgent care
-  Refill prescriptions online
-  Compare costs for hundreds of medical procedures

Sydney mobile app



-  Log in using your anthem.com username and password to:
 -  View your ID card
 -  See all your medical and pharmacy benefits in one place
 -  Use the chatbot to get answers and resources quickly

[thelocalchoice.virginia.gov](https://www.thelocalchoice.virginia.gov)

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



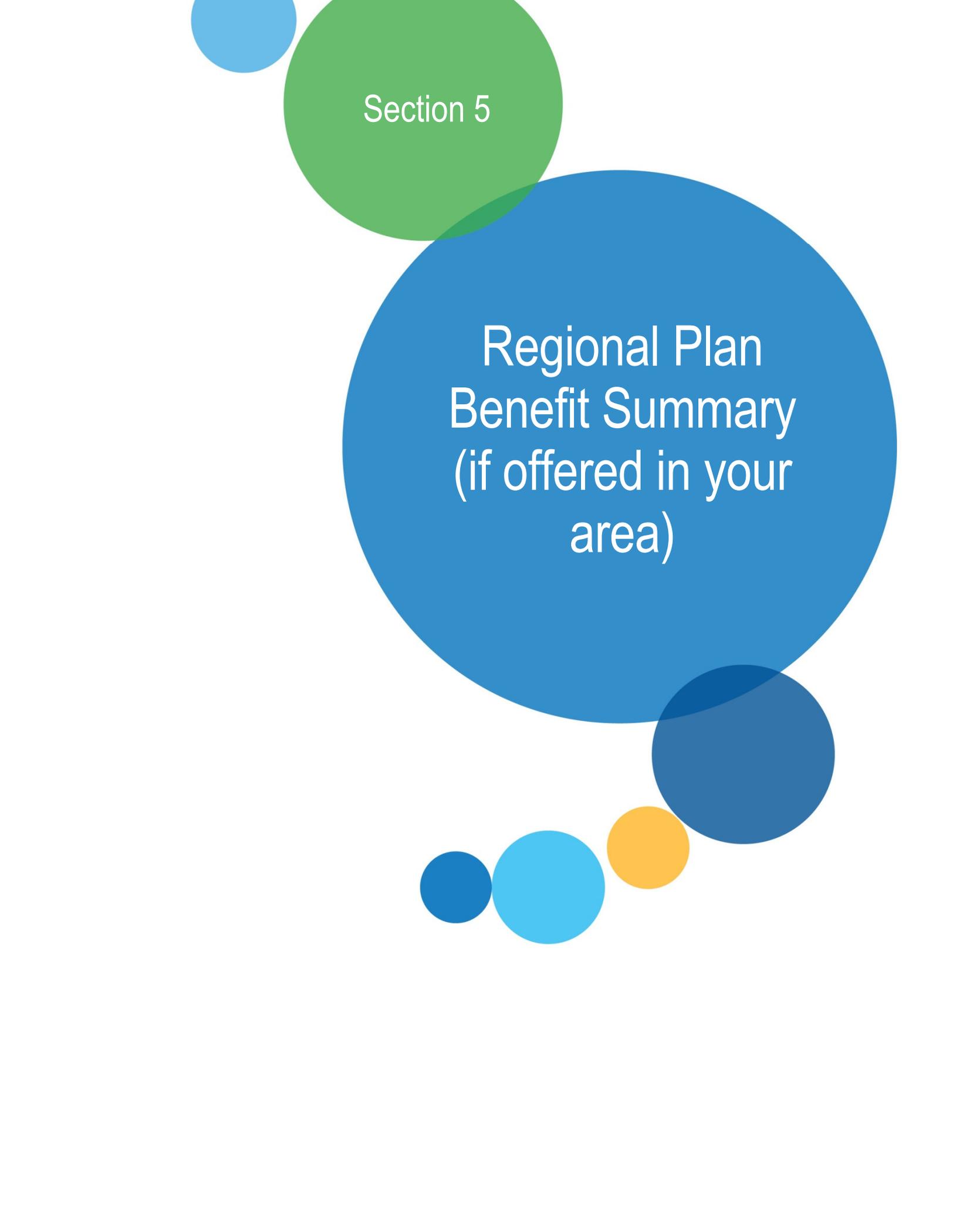
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(Spanish) - Tiene el derecho de obtener esta información y ayuda en su idioma en forma gratuita. Llame al número de Servicios para Miembros que figura en su tarjeta de identificación para obtener ayuda.

(Korean) - 귀하에게는 무료로 이 정보를 얻고 귀하의 언어로 도움을 받을 권리가 있습니다. 도움을 얻으려면 귀하의 ID 카드에 있는 회원 서비스 번호로 전화하십시오.

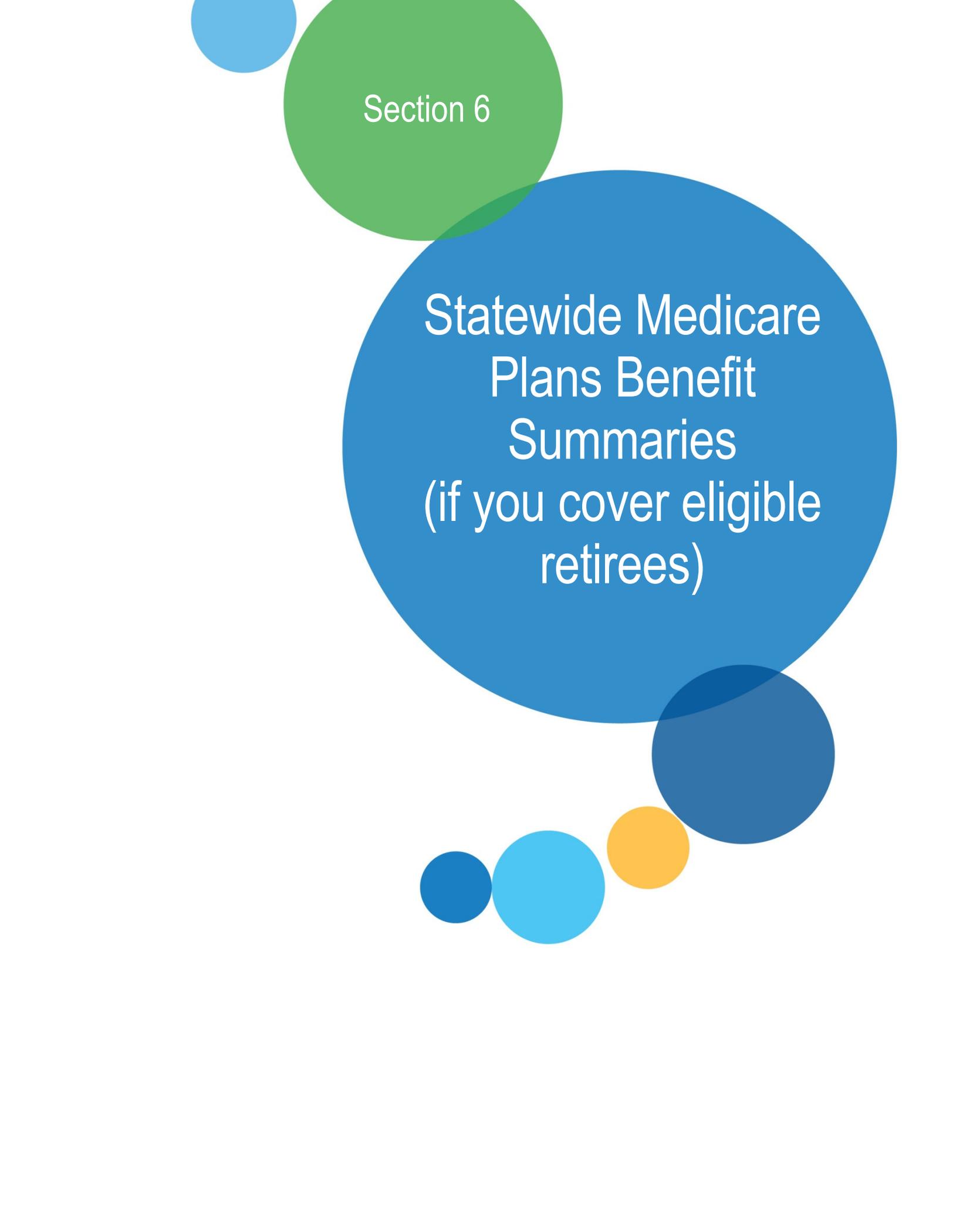
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Section 5

Regional Plan
Benefit Summary
(if offered in your
area)



Section 6

Statewide Medicare
Plans Benefit
Summaries
(if you cover eligible
retirees)



Your Advantage 65 Dental/Vision Benefits

Medical, Dental and Vision administered by
Anthem Blue Cross and Blue Shield

Effective January 1, 2020 - December 31, 2020



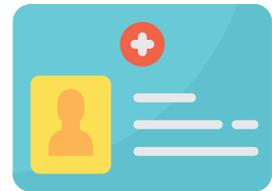
The Local Choice is a unique health benefits program managed by the Commonwealth of Virginia Department of Human Resource Management (DHRM). The Advantage 65 with Dental/Vision plan may be offered to you if you are eligible for Medicare and to your Medicare-eligible family members by your group. Benefits are administered on a calendar year basis to coincide with your Medicare coverage. Changes in your monthly premium are effective July 1 (or October 1 for certain school groups) to coincide with your former employer's The Local Choice (TLC) health plan renewal.

The Advantage 65 with Dental/Vision plan provides medical benefits that work with Medicare Part A and Part B. **It does not provide prescription drug coverage.**

This guide is only an overview. For a complete description of the benefits, exclusions, limitations, and reductions, please see the TLC Medicare Coordinating Plans Member Handbook.

Service Area

Wherever retirees live.



Medical Benefits

To receive full benefits you must be enrolled under both Part A and Part B of Medicare. Always show both your Medicare card and your Anthem identification card when you receive care.

Advantage 65 covers the Medicare Part A hospital deductible (after you pay \$100) and copayment amounts, and the Part B coinsurance for Medicare-approved charges. It also covers out-of-country Major Medical services.

Choose Health Care Providers Carefully



Physicians

Ask your doctor if he or she is a Medicare participating physician. A doctor who participates in Medicare agrees to:

- File claims on your behalf
- Accept Medicare's payment for covered services

This means your coinsurance is limited to a percentage of the Medicare-approved charge. Go to [Medicare.gov](https://www.medicare.gov) for additional information about Medicare-participating physicians.

This brochure describes benefits based on Medicare-approved charges. Doctors who do not accept assignments may not charge you any more than 15% above what Medicare considers a reasonable fee. This applies to all doctors and all services.

Hospitals

Hospitals that participate in the Medicare program are covered. Admissions not approved by Medicare are not covered.



Advantage 65

What The Plan Covers



Plan Pays

PART A SERVICES

Hospital Inpatient

■ Medicare Part A hospital deductible less \$100 per benefit period, days 1-60	In full
■ Medicare Part A daily hospital copayment amount, days 61-90	In full
■ 100% of the allowable charge*, for eligible expenses for an additional 365 days.	In full
■ Copayment amount for Medicare Lifetime Reserve Days (60 days available)	In full

Skilled Nursing Facility

■ Medicare Part A skilled nursing facility copayment, days 21-100 (Medicare covers days 1-20 in full.)	In full
■ A daily amount equal to Medicare skilled nursing home copayment, days 101-180 (Medicare provides no coverage beyond 100 days.)	In full

Plan Pays

PART B SERVICES

Physician And Other Services (after you pay the Medicare Part B calendar year deductible)

■ Part B coinsurance of Medicare-approved charges for services such as: · Doctor's care · Surgical services · Outpatient x-ray and lab services · Professional ambulance service	In full
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AT HOME RECOVERY SERVICES

■ At-home recovery care for an illness or injury approved under a Medicare home health treatment plan. Benefits include: · Home visits up to the number approved by Medicare, not to exceed 7 visits per week (This benefit applies to home health services, certified by a physician, for personal care during the recovery period)	Up to \$40 per visit (limited to \$1,600 per calendar year)
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Plan Pays

OUT-OF-COUNTRY MAJOR MEDICAL SERVICES

(after you pay \$250 calendar year deductible)

■ Lifetime maximum	\$250,000
■ Annual restoration of lifetime maximum (limited to the amount of benefits used in any one year)	\$2,000

Covered Services

■ Medically necessary services received in a foreign country	80% AC*
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Out-Of-Pocket Expense Limit

■ In a calendar year when your out-of-pocket expenses for covered services reach \$1,200, the plan pays 100% of the allowable charge for the rest of the calendar year.	
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* **Allowable Charge (AC)** – The term has two meanings, depending on whether the service is provided by a doctor (or other health care professional) or a hospital. For care by a doctor or other health care professional, the allowable charge is the lesser amount of your plan's allowance for that service, or the provider's charge for that service. For hospital services, the allowable charge is the amount of the negotiated compensation to the facility for the covered service or the facility's charge for that service, whichever is less. For complete information about the allowable charge, please see the Medicare Coordinating Plans Member Handbook.

Dental/Vision Benefits

Dental Benefits

The plan pays up to \$1,500 per member per calendar year. It also pays 100% of the allowable charge for diagnostic and preventive services, such as oral examinations and dental x-rays. It pays 80% of the allowable charge for basic services, such as fillings, re-cementing of crowns, inlays and bridges, or repair of removable dentures. The remaining 20% is your responsibility. The plan also pays 5% for major services such as crowns, **dentures**, and implants.



When you need services, simply present your plan identification card to your dentist. If you go to an Anthem Dental Complete network dentist, you will be responsible only for your coinsurance. If services are provided by a non-network dentist, you pay your coinsurance, plus the difference, if any, between the plan's allowable charge for a covered service and the dentist's charge. Network dentists are listed on the Web at www.anthem.com/tlc, or call Anthem Dental Complete at **1-855-648-1411** to determine if a dentist is in the network.

Plan Pays \$1,500 Maximum Per Person Per Calendar Year		In-Network You Pay
<i>Diagnostic And Preventive Services</i>	Twice-a-year visits to the dentist for oral examinations, x-rays, and cleanings	\$0
<i>Basic Dental Care</i>	Fillings, oral surgery, periodontal services, scaling, repair of dentures, root canals and other endodontic services, and recementing of existing crowns and bridges	20% AC**
<i>Major Dental Care</i>	Crowns (single crowns, inlays and onlays), prosthodontics (partial or complete dentures and fixed bridges) and dental implants.	95% AC**
<i>Out-Of-Network Care</i>	For services by a non-network dentist, you pay the applicable coinsurance plus any amounts above the allowable charge.	

****Allowable Charge (AC)** – The allowable charge is the lesser amount of the Anthem Dental Complete plan allowance for that covered service, or the provider's submitted charge for that covered service. Participating Anthem Dental Complete dentists have agreed to accept Anthem's payment, plus any required coinsurance (if applicable) as payment in full for covered benefits..

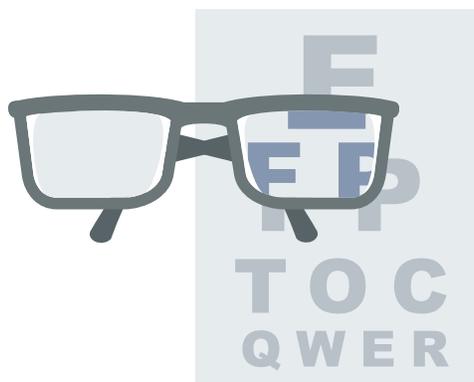
Routine Vision Benefits

Your routine vision benefits are through the Anthem Blue View Vision network. Available once per calendar year, your vision benefits include a routine eye exam, eyewear and special eye accessory discounts. You may receive services from any ophthalmologist, optometrist, optician and/or retail location in the Anthem Blue View Vision network.

To locate an Anthem Blue View Vision provider, select Find A Doctor at www.anthem.com/tlc, or contact Member Services at **800-552-2682** for assistance. To receive vision services, simply present your Anthem identification card to your Blue View Vision provider when you receive your eye exam or purchase covered eyewear. Your Blue View Vision provider will verify eligibility and file your claims.

While some vision benefits are also covered out-of-network, you will receive the most value when you choose a Blue View Vision provider. If you use an out-of-network provider, your benefits will be covered at a lower payment level. You will need to pay for covered services and purchases at the time of your visit and send an out-of-network claim form to Blue View Vision. The claim form is available at anthem.com/tlc under Forms.

Certain non-routine vision care such as eye surgery may be covered under your primary medical coverage under your Medicare plan. Refer to your Medicare and You Handbook or contact Medicare for more information.



Vision Benefits Highlights

Routine vision care services		In-Network You Pay
<i>Routine eye exam (once per calendar year)</i>		\$20 copayment
<i>Eyeglass frames</i> Once per calendar year you may select any eyeglass frame ¹ and receive the following allowance toward the purchase price:		\$100 allowance then 20% off remaining balance
<i>Standard Eyeglass Lenses</i> <i>Polycarbonate lenses included for children under 19 years old.</i> Once per calendar year you may receive any one of the following lenses: <ul style="list-style-type: none"> ■ Standard plastic single vision lenses (1 pair) ■ Standard plastic bifocal lenses (1 pair) ■ Standard plastic trifocal lenses (1 pair) ■ Standard progressive lenses (1 pair) 		\$20 copay; then covered in full \$20 copay; then covered in full \$20 copay; then covered in full \$85 copay; then covered in full
<i>Upgrade Eyeglass Lenses (available for additional cost)</i> When receiving services from a Blue View Vision provider, you may choose to upgrade your new eyeglass lenses at a discounted cost. Eyeglass lenses copayment applies, plus the cost for the upgrade.	<i>Lens options</i> <ul style="list-style-type: none"> ■ UV coating ■ Tint (solid and gradient) ■ Standard scratch resistance ■ Standard polycarbonate ■ Standard anti-reflective coating ■ Other add-ons and services 	<i>Member cost for upgrades</i> \$15 \$15 \$15 \$40 \$45 20% off retail price
<i>Contact lenses</i> Prefer contact lenses over glasses? You may choose to receive contact lenses instead of eyeglasses (frames and lenses) and receive an allowance toward the cost of a supply of contact lenses once per calendar year.	<i>Lens options</i> <ul style="list-style-type: none"> ■ Elective conventional lenses² ■ Elective disposable lenses² ■ Non-elective contact lenses² 	\$100 allowance then 15% off the remaining balance \$100 allowance (no additional discount) \$250 allowance (no additional discount)

¹ Discount is not available on certain frame brands in which the manufacturer imposes a no-discount policy.

² Elective contact lenses are in lieu of eyeglass lenses. Non-elective lenses are covered when glasses are not an option for vision correction.

Options For Prescription Drug Coverage— Medicare Part D

If you want prescription drug coverage, you must enroll in a separate Medicare Part D prescription drug plan.

Several Medicare Part D plan options are being offered. To determine what drug coverage option best meets your needs, consult the Medicare and You Handbook, call **1-800-MEDICARE (1-800-633-4227)** or visit the Medicare Web site at www.medicare.gov.



We're here for you – in many languages

The law requires us to include a message in all of these different languages. Curious what they say? Here's the English version: "You have the right to get help in your language for free. Just call the Member Services number on your ID card." Visually impaired? You can also ask for other formats of this document.

Spanish

Usted tiene derecho a recibir ayuda en su idioma en forma gratuita. Simplemente llame al número de Servicios para Miembros que figura en su tarjeta de identificación.

Chinese

您有權免費獲得透過您使用的語言提供的幫助。請撥打您的 ID 卡片上的會員服務電話號碼。若您是視障人士，還可索取本文件的其他格式版本。

Vietnamese

Quý vị có quyền nhận miễn phí trợ giúp bằng ngôn ngữ của mình. Chỉ cần gọi số Dịch vụ dành cho thành viên trên thẻ ID của quý vị. Bị khiếm thị? Quý vị cũng có thể hỏi xin định dạng khác của tài liệu này."

Korean

귀하는 자국어로 무료 지원을 받을 권리가 있습니다. ID 카드에 있는 멤버 서비스번호로 연락하십시오.

Tagalog

May karapatan ka na makakuha ng tulong sa iyong wika nang libre. Tawagan lamang ang numero ng Member Services sa iyong ID card. May kapansanan ka ba sa paningin? Maaari ka ring humiling ng iba pang format ng dokumentong ito.

Russian

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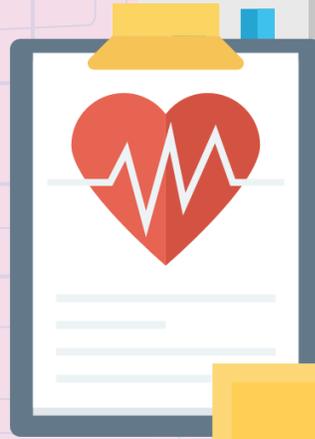
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If You Need Assistance

<p>Anthem Blue Cross and Blue Shield</p>	<p>Medical and Routine Vision Care 1-800-552-2682 Monday through Friday 8:00 a.m. – 6:00 p.m. On the Web at www.anthem.com/tlc</p> <p>Dental Care 1-855-648-1411 Monday - Friday 8:00 a.m. - 9:00 p.m. On the Web at www.anthem.com/tlc</p>
<p>The Local Choice</p>	<p>The Local Choice Health Benefits Program Commonwealth of Virginia Department of Human Resource Management 101 North 14th Street - 13th Floor Richmond, VA 23219 On the Web at www.thelocalchoice.virginia.gov</p>
<p>Medicare</p>	<p>1-800-MEDICARE (1-800-633-4227) On the Web at www.medicare.gov</p>

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(Spanish) - Tiene el derecho de obtener esta información y ayuda en su idioma en forma gratuita. Llame al número de Servicios para Miembros que figura en su tarjeta de identificación para obtener ayuda.
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Your Advantage 65 Benefits

Health Benefits Plan Administered by
Anthem Blue Cross and Blue Shield

Effective January 1, 2020 - December 31, 2020



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This guide is only an overview. For a complete description of the benefits, exclusions, limitations, and reductions, please see the TLC Medicare Coordinating Plans Member Handbook.

Service Area

Wherever retirees live.

How The Plan Works

To receive full benefits you must be enrolled under both Part A and Part B of Medicare. Always show both your Medicare card and your Anthem identification card when you receive care.

Advantage 65 covers the Medicare Part A hospital deductible (after you pay \$100) and copayment amounts, and the Part B coinsurance for Medicare-approved charges. It also covers out-of-country Major Medical services.



Choose Health Care Providers Carefully



Physicians

Ask your doctor if he or she is a Medicare participating physician. A doctor who participates in Medicare agrees to:

- File claims on your behalf
- Accept Medicare's payment for covered services

This means your coinsurance is limited to a percentage of the Medicare-approved charge. Go to [Medicare.gov](https://www.medicare.gov) for additional information about Medicare-participating physicians.

This brochure describes benefits based on Medicare-approved charges. Doctors who do not accept assignments may not charge you any more than 15% above what Medicare considers a reasonable fee. This applies to all doctors and all services.

Hospitals

Hospitals that participate in the Medicare program are covered. Admissions not approved by Medicare are not covered.

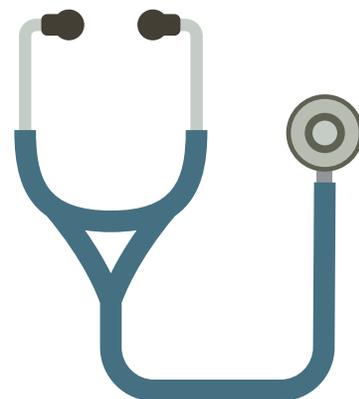


Advantage 65

What The Plan Covers

		Plan Pays
PART A SERVICES		
Hospital Inpatient	■ Medicare Part A hospital deductible less \$100 per benefit period, days 1-60	In full
	■ Medicare Part A daily hospital copayment amount, days 61-90	In full
	■ 100% of the allowable charge*, for eligible expenses for an additional 365 days.	In full
	■ Copayment amount for Medicare Lifetime Reserve Days (60 days available)	In full
Skilled Nursing Facility	■ Medicare Part A skilled nursing facility copayment, days 21-100 (Medicare covers days 1-20 in full.)	In full
	■ A daily amount equal to Medicare skilled nursing home copayment, days 101-180 (Medicare provides no coverage beyond 100 days.)	In full
		Plan Pays
PART B SERVICES		
Physician And Other Services	■ Part B coinsurance of Medicare-approved charges for services such as: (after you pay the Medicare Part B calendar year deductible) <ul style="list-style-type: none"> · Doctor's care · Surgical services · Outpatient x-ray and lab services · Professional ambulance service 	In full
AT HOME RECOVERY SERVICES	■ At-home recovery care for an illness or injury approved under a Medicare home health treatment plan. Benefits include: <ul style="list-style-type: none"> · Home visits up to the number approved by Medicare, not to exceed 7 visits per week (This benefit applies to home health services, certified by a physician, for personal care during the recovery period) 	Up to \$40 per visit (limited to \$1,600 per calendar year)
		Plan Pays
OUT-OF-COUNTRY MAJOR MEDICAL SERVICES		
(after you pay \$250 calendar year deductible)	■ Lifetime maximum	\$250,000
	■ Annual restoration of lifetime maximum (limited to the amount of benefits used in any one year)	\$2,000
Covered Services	■ Medically necessary services received in a foreign country	80% AC*
Out-Of-Pocket Expense Limit	■ In a calendar year when your out-of-pocket expenses for covered services reach \$1,200, the plan pays 100% of the allowable charge for the rest of the calendar year.	

***Allowable Charge (AC)** – The term has two meanings, depending on whether the service is provided by a doctor (or other health care professional) or a hospital. For care by a doctor or other health care professional, the allowable charge is the lesser amount of your plan's allowance for that service, or the provider's charge for that service. For hospital services, the allowable charge is the amount of the negotiated compensation to the facility for the covered service or the facility's charge for that service, whichever is less. For complete information about the allowable charge, please see the Medicare Coordinating Plans Member Handbook.



Options For Prescription Drug Coverage— Medicare Part D

If you want prescription drug coverage, you must enroll in a separate Medicare Part D prescription drug plan.

Several Medicare Part D plan options are being offered. To determine what drug coverage option best meets your needs, consult the Medicare and You Handbook, call **1-800-MEDICARE (1-800-633-4227)** or visit the Medicare Web site at www.medicare.gov.



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Korean

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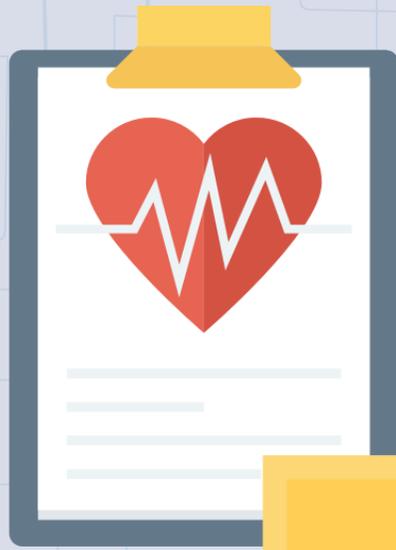
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TTY/TTD:711

It's important we treat you fairly

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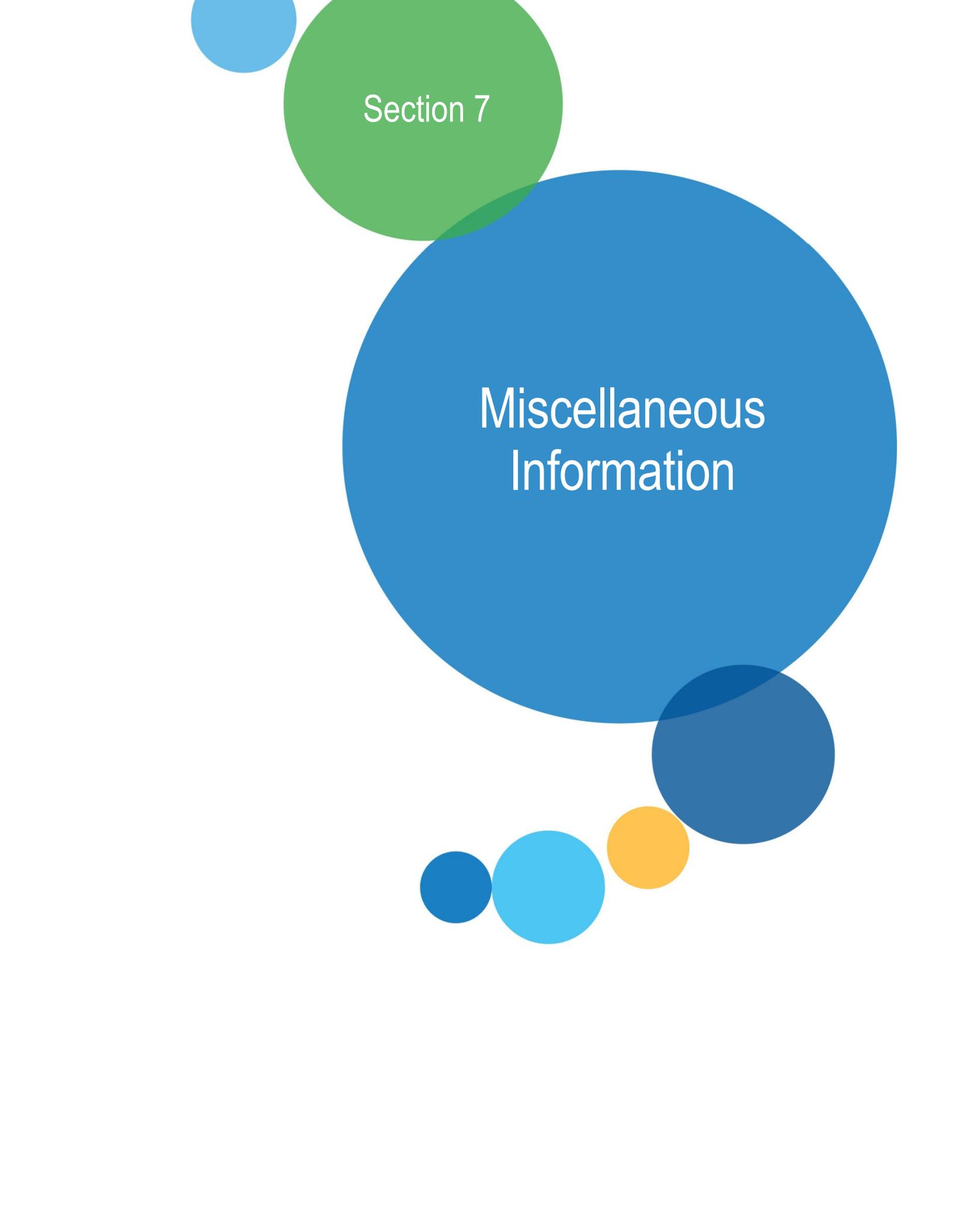
If You Need Assistance

<p>Anthem Blue Cross and Blue Shield</p>	<p>Medical and Routine Vision Care 1-800-552-2682 Monday through Friday 8:00 a.m. – 6:00 p.m. On the Web at www.anthem.com/tlc</p> <p>Dental Care 1-855-648-1411 Monday - Friday 8:00 a.m. - 9:00 p.m. On the Web at www.anthem.com/tlc</p>
<p>The Local Choice</p>	<p>The Local Choice Health Benefits Program Commonwealth of Virginia Department of Human Resource Management 101 North 14th Street - 13th Floor Richmond, VA 23219 On the Web at www.thelocalchoice.virginia.gov</p>
<p>Medicare</p>	<p>1-800-MEDICARE (1-800-633-4227) On the Web at www.medicare.gov</p>

Language Access Services - (TTY/TDD: 711)

(Spanish) - Tiene el derecho de obtener esta información y ayuda en su idioma en forma gratuita. Llame al número de Servicios para Miembros que figura en su tarjeta de identificación para obtener ayuda.
(Korean) - 귀하에게는 무료로 이 정보를 얻고 귀하의 언어로 도움을 받을 권리가 있습니다. 도움을 얻으려면 귀하의 ID 카드에 있는 회원 서비스 번호로 전화하십시오.
The Commonwealth of Virginia complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Anthem Blue Cross and Blue Shield is the trade name of Anthem Health Plans of Virginia, Inc. Serving all of Virginia except for the City of Fairfax, the Town of Vienna, and the area east of State Route 123. Independent licensee of the Blue Cross and Blue Shield Association. Anthem is a registered trademark of Anthem Insurance Companies, Inc.

A decorative graphic consisting of several overlapping circles in various shades of blue, green, and orange. The largest circle is a medium blue and contains the text 'Miscellaneous Information'. Other circles are in shades of light blue, dark blue, and orange, scattered around the main circle.

Section 7

Miscellaneous Information



Language
Assistance
Statement

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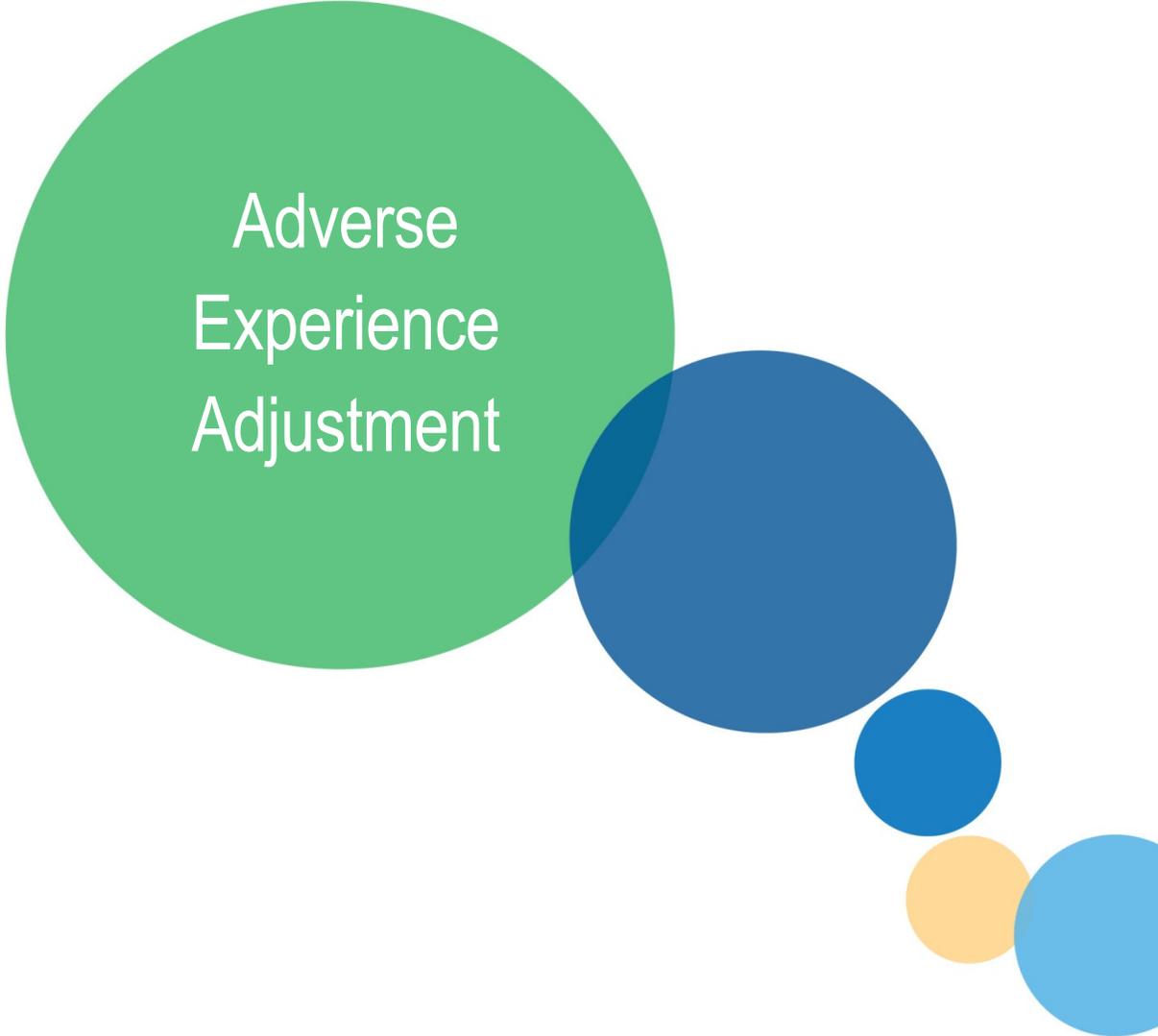
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Adverse
Experience
Adjustment



TLC Procedures for Determining Adverse Experience Adjustment (AEA)

Sections 1VAC55-20-160 D and 1VAC55-20-300 of the Virginia Administrative Code, the regulations under which The Local Choice (TLC) program operates, provide for a potential Adverse Experience Adjustment to withdrawing employers. This adjustment requires any withdrawing employer to contribute their pro rata share of any operating loss experienced during prior plan years. Although the regulations permit a multi-year review of profits and losses, it is the policy of the Department to confine any applicable Adverse Experience Adjustment to the experience of the last plan year during which the employer was a member. The following illustrations have been prepared to assist our members in understanding how an Adverse Experience Adjustment would be calculated.

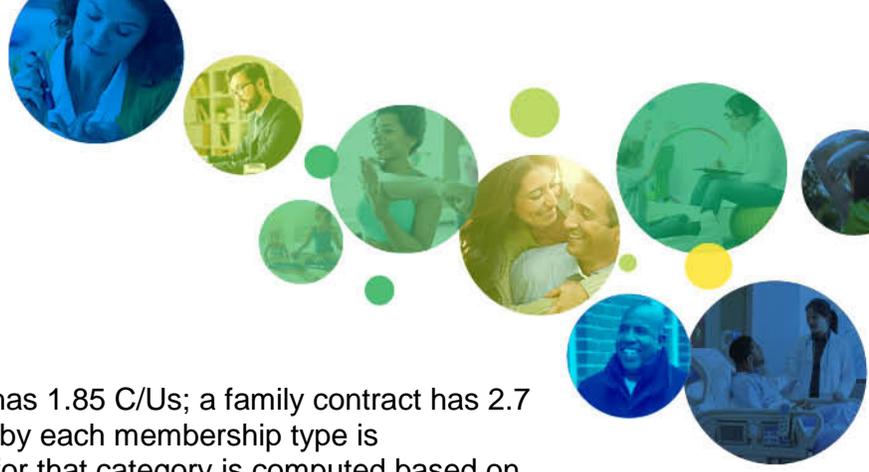
The basis for determining any Adverse Experience Adjustment will be (1) the amount of the program's loss for the most recent plan year, (2) the experience of the employer, and (3) the proportion of the employer's enrollment to the enrollment for the entire category. Employers are divided into three categories.

1. Employers with 1 to 99 enrollees (Pooled)
2. Employers with 100 to 299 enrollees (Blended)
3. Employers with over 299 enrollees (Experience Rated)

A statement of income and expenses is prepared for each category based upon its experience. (The third category is comprised of experience rated employers. Each group is responsible for their own claims, whether or not the entire category of experience rated employers sustains a loss.)

EMPLOYERS WITH FEWER THAN 300 ENROLLEES (CATEGORIES 1 & 2)

The first step in the adjustment process is to determine the total number of contract units (C/Us) for each category for the past plan year. A contract unit is determined by the following factors applied to the type of membership times the number of month's participation for each enrollee: an employee only contract has



one C/U; an employee plus one contract has 1.85 C/Us; a family contract has 2.7 C/Us. Therefore, the number of contracts by each membership type is accumulated, and the total contract units for that category is computed based on the stated factors as follows:

Type of Membership	Total Contracts	C/U Factor	Total C/Us
Employee only x 12 =	4,500	1.0	4,500
Employee + One x 12 =	2,200	1.85	4,070
Family x 12 =	<u>3,300</u>	2.7	<u>8,910</u>
Total	10,000		17,480

The next step is to determine the total number of contract units for the withdrawing employer during the plan year using the same method illustrated above. The withdrawing employer's pro rata share of the contract units is then applied to the category's loss to determine the adverse experience adjustment for the withdrawing employer. The following example illustrates an adverse experience calculation for employers in categories 1 and 2.

EXAMPLE *:

ASSUMPTIONS: Loss for the category is \$1,000,000. Total category contract units equal 17,480. The terminating employer had 1,878 C/Us during the review year.

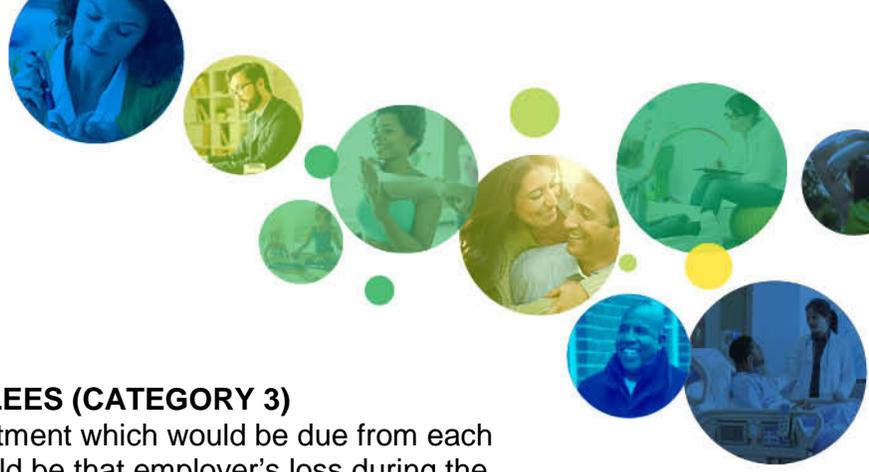
1. Employer's C/Us divided by category's C/Us equals employer's pro rata share.
2. Employer's share times the category's loss equals the employer's Adverse Experience Adjustment.

CALCULATIONS: $1,878 / 17,480 = 10.74\% \times \$1,000,000 = \$107,437$

In the example, the employer would have an Adverse Experience Adjustment of \$107,437 at the time of termination. The terminating employer would be notified of this amount within 6 months of termination, and the employer would be required to pay the adjustment in up to 12 equal installments beginning 30 days after the notification by the Department.

It is possible that one category could experience a loss, subjecting employers in that category to an Adverse Experience Adjustment, while another category could operate at a surplus and require no Adverse Experience Adjustment to a terminating group.

* Examples are for illustration only and have no bearing on the actual experience of a pool/category or individual group.



EMPLOYERS WITH OVER 299 ENROLLEES (CATEGORY 3)

The maximum Adverse Experience Adjustment which would be due from each terminating employer in this category would be that employer’s loss during the immediate past plan year based upon the employer’s plan(s) expenses and its pro rata share of the program overhead. Prior years’ performance during which the employer was experience rated would be taken into consideration, if favorable to the employer, but the Adverse Experience Adjustment would never exceed the last plan year’s loss.

An employer in this category withdrawing at the end of a year in which they did not have a loss would not be assessed an Adverse Experience Adjustment. Another employer that withdrew with a \$100,000 loss during the last plan year would be subject to a maximum Adverse Experience Adjustment of the \$100,000 loss paid in equal installments over a 12-month period. An illustration follows:

SAMPLE ILLUSTRATION *

ANY CATEGORY 3 EMPLOYER
THE LOCAL CHOICE HEALTH CARE PROGRAM
Operating Statement
July 1, 2010 through June 30, 2011

INCOME	\$1,519,543
EXPENSES:	
Incurred Claims	\$1,417,129
Contractor Administration	128,107
Pooled Capitation (Rx, Dental and MISA)	55,290
Program Overhead	<u>19,017</u>
Total Expenses	\$1,619,543
GAIN OR (LOSS)	(\$100,000)

If this employer had withdrawn on June 30, 2011, the maximum Adverse Experience Adjustment would have been the operating loss of \$100,000. However, prior year’s accumulated gains could be applied to reduce any current year loss.

Likewise, if an employer withdraws from the program and the review analysis reflects a gain for the immediate past plan year, there would be no Adverse Experience Adjustment, even if their accumulated experience was a loss.

* Examples are for illustration only and have no bearing on the actual experience of a pool/category or individual group.



Reports
Available on
BES



BES Reports

- **BES Enrollment Report**

Weekly report of total membership in BES for your group – one report shows participants and the other shows corresponding covered dependents. It is available on the 3rd, 10th, 17th and 24th of each month. The reports posted on the 3rd, 10th, and 17th list the membership in BES in effect the first of that month. The report posted on the 24th lists the membership in BES in effect the first of the next month. (For example, the reports posted on April 3rd, 10th, and 17th show membership in effect April 1 and the report posted on April 24th shows membership in effect May 1.)

- **BES Exception Report**

Monthly report listing a variety of discrepancies found in BES that need attention. Note that missing SSNs or TINs are on this report.

- **BES Termination Report**

Monthly report identifying participants and dependents recently terminated (cancelled).

- **BES Turnaround**

Daily report for each successful action made in BES before 5:30 PM. This is the official record of enrollment.

- **BES Turnaround Summary**

Daily report listing all actions that created a BES Turnaround.

- **BES ACA Reconciliation Report**

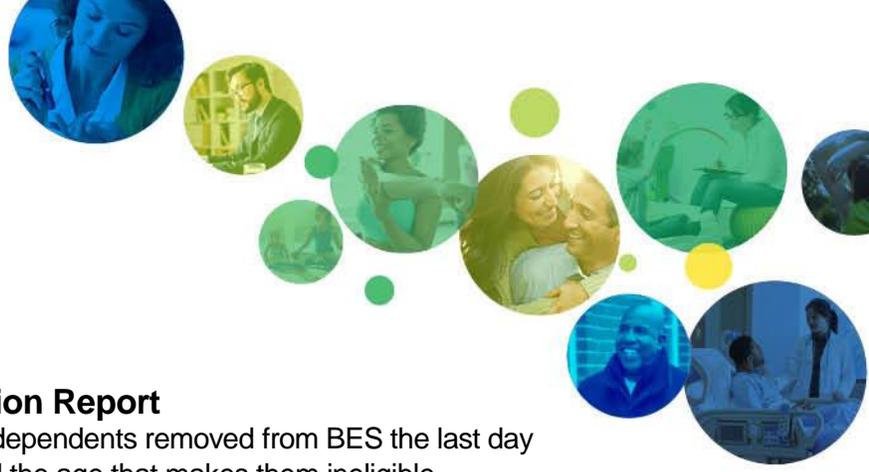
Created in October and December of each year. This report shows calendar year records in BES. This data is used for ACA Reporting.

- **BES Persons Eligible for Medicare**

Monthly report identifying individuals (participants and spouses) approaching Age 65. (Note: This report looks 3 months ahead of the individual's DOB. For example, a person turning Age 65 in April will appear on the January report. The person will not appear on a report after January.)

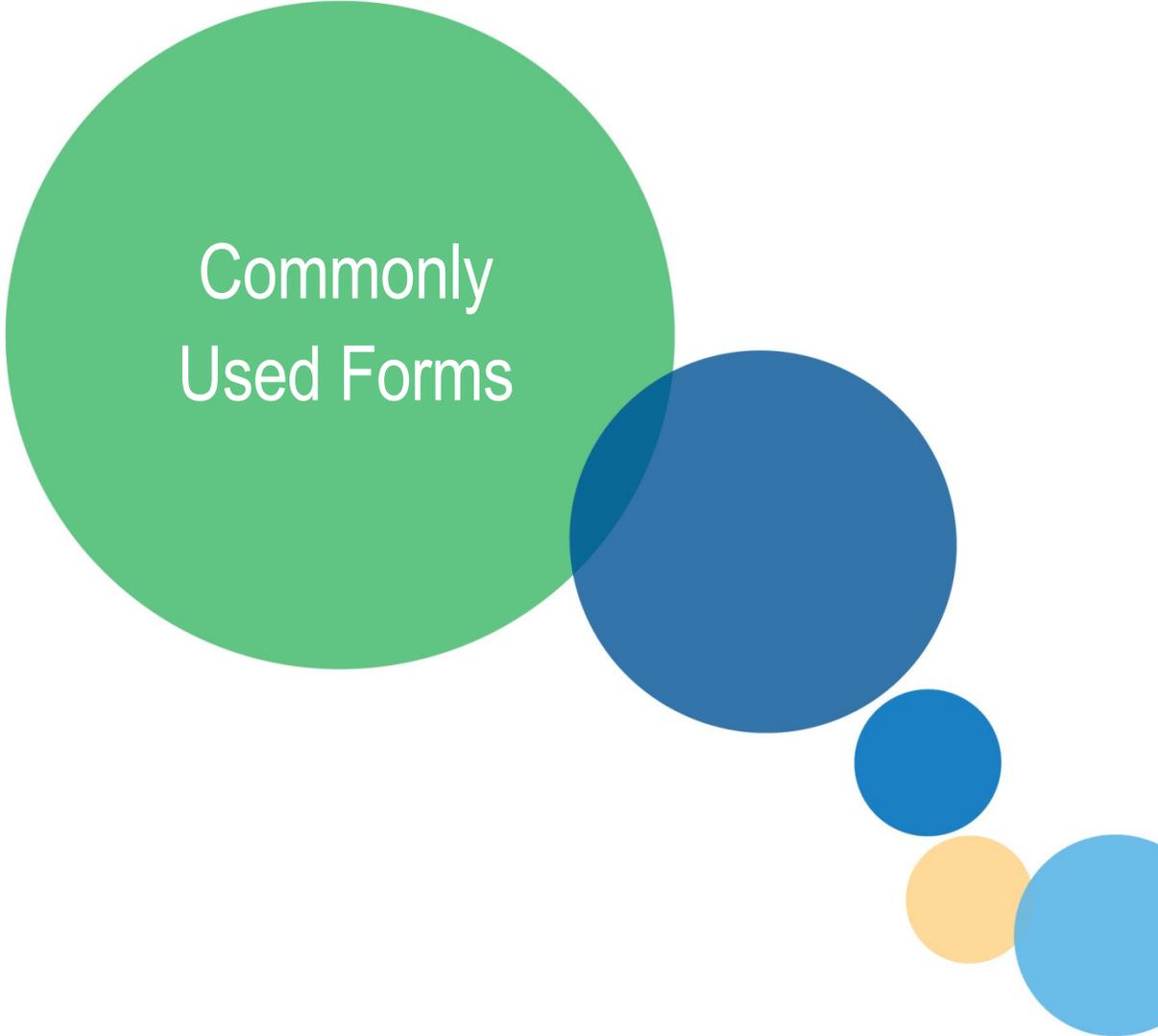
- **BES Dependent Age 26 Approaching Termination Report**

Created in August and October of each year identifying participants who have a covered child reaching Age 26 sometime during the current year. (Note: This report does not include children added to BES after the report's run date.)



- **BES Dependent Age 26 Termination Report**

Created in January of each year showing dependents removed from BES the last day of the previous year because they reached the age that makes them ineligible.



Commonly Used Forms



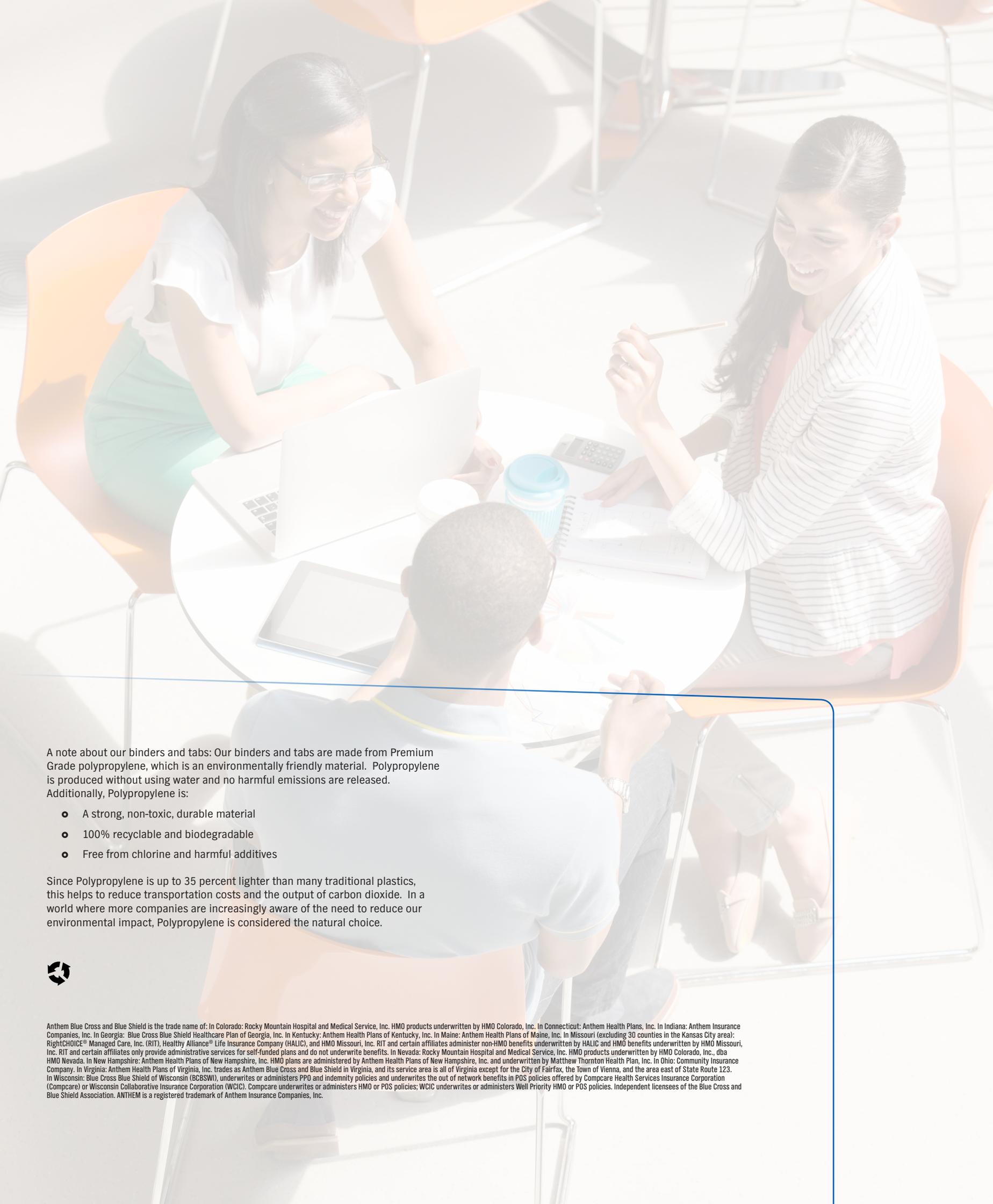
Commonly Used TLC Forms

www.thelocalchoice.virginia.gov

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

The most commonly used TLC forms can be found at this location, including:

- **Enrollment Form**
This form is used for member enrollment and election changes, including initial enrollment, open enrollment and qualifying mid-year events.
- **Group Adjustment Form**
This form is used to cancel coverage and terminate a BES record.
- **Group Data Change Form**
This form is used to change the employer group's contact information (including address and group contact).
- **Personal Data Change Form**
This form is used to update member information.



A note about our binders and tabs: Our binders and tabs are made from Premium Grade polypropylene, which is an environmentally friendly material. Polypropylene is produced without using water and no harmful emissions are released. Additionally, Polypropylene is:

- A strong, non-toxic, durable material
- 100% recyclable and biodegradable
- Free from chlorine and harmful additives

Since Polypropylene is up to 35 percent lighter than many traditional plastics, this helps to reduce transportation costs and the output of carbon dioxide. In a world where more companies are increasingly aware of the need to reduce our environmental impact, Polypropylene is considered the natural choice.



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