The Local Choice 2022-2023 Comparison of Statewide Plans

Covered Services

Covered Services	Key Advantage 500			Key Advantage 1000			High Deductible Plan		
Copays **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** $25/Routine/$40 Specialist			**In network** $25/Routine/$40 Specialist			**In network** Subject to the Deductible, then paid 80%		
	One Person	Two People	Family	One Person	Two People	Family	One Person	Two People	Family
	$500	$1,000	$1,000	$1,000	$2,000	$2,000	$2,800	$5,600	$5,600
	Out of Network			**Out of Network**			**Out of Network**		
	$1,000	$2,000	$2,000	$2,000	$4,000	$4,000	Deductible is combined for In-Network and Out of Network services.		
Plan Year Out of Pocket **Expense Limit**	**In-Network**						**In-Network**		
	One Person	Two People	Family	One Person	Two People	Family	One Person	Two People	Family
	$4,000	$8,000	$8,000	$5,000	$10,000	$10,000	$5,000	$10,000	$10,000
Out of Network Benefits	**Out of Network**			**Out of Network**			**Out of Network**		
	$7,000	$14,000	$14,000	$9,000	$18,000	$18,000	$10,000	$20,000	$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		
Medical Care When Traveling (Blue Card)	Included			Included			Included		
Lifetime Maximum	Unlimited			Unlimited			Unlimited		
Ambulance Travel	20% coinsurance after the Deductible			20% coinsurance after deductible			20% coinsurance after deductible		
Autism Spectrum Disorder	Copayment/coinsurance determined by service received			Copayment/coinsurance determined by service received			20% coinsurance after deductible		

The Local Choice 2022-2023 Comparison of Statewide Plans continued

Covered Services			
Behavioral Health and EAP ***			
Inpatient Treatment	20% Coinsurance after Deductible	20% Coinsurance after Deductible	20% Coinsurance after Deductible
Facility Services	20% Coinsurance after Deductible	20% Coinsurance after Deductible	20% Coinsurance after Deductible
Outpatient Treatment	20% Coinsurance after Deductible	20% Coinsurance after Deductible	20% Coinsurance after Deductible
Outpatient Professional Provider Visits	$25	$25	20% Coinsurance after Deductible
Chiropractic Care/Spinal Manipulations and other Medical Interventions	Primary $25 Specialty $40	$25 $40	20% Coinsurance after Deductible
Employee Assistance Program (EAP) 4 visits per issue (per plan year)	$0	$0	$0
Diabetic Supplies (Mail Order)	20% coinsurance after deductible	20% Coinsurance no Deductible	20% coinsurance after deductible
Diabetic Education	$0	$0	20% coinsurance after deductible
Diabetic Equipment	20% coinsurance after deductible	20% coinsurance after deductible	20% Coinsurance after Deductible
Diabetic Supplies - See Outpatient Prescription Drugs			
Diagnostic Test and X-Rays (for specific conditions or diseases at a doctor's office, emergency room or outpatient hospital department)	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible
Doctor Visits - on an Outpatient Basis			
Primary Care Physicians	$25 Copayment	$25 Copayment	20% coinsurance after deductible
Specialty Care Providers	$40 Copayment	$40 Copayment	20% coinsurance after deductible
Employee Assistance Program Up to four Visits per issue	$0		
Early Intervention Services	Copay/coinsurance determined by service	Copay/coinsurance determined by service	20% coinsurance after deductible
Emergency Room Visits			
Facility Services	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible
Professional Provider Services			
Primary Care Physician	$25 Copayment	$25 Copayment	20% coinsurance after deductible
Specialty Care Providers	$40 Copayment	$40 Copayment	20% coinsurance after deductible
Diagnostic Tests, Labs and X-Rays	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible
Live Health On Lin	$0		
Home Health Services (90 visit plan year limit per member)	$0	$0	20% coinsurance after deductible
Home Private Duty Nurse's Services	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible
Hospice Care Services	$0	$0	20% coinsurance after deductible

*** No Limit on Behavioral Health (Medical Necessity Criteria must be met, and Prior Authorization is Recommended, EAP expanded, Child and Elder Care Resources, Legal/Financial Services/Identity Protection. Work/Life Services/ EAP website www.AnthemEAP.com . Monthly Webinar. For more information visit: http://www.thelocalchoice.virginia.gov/

The Local Choice 2022-2023 Comparison of Statewide Plans continued

Covered Services	Key Advantage 500	Key Advantage 1000	High Deductible Plan
Hospital Services			
Inpatient Treatment			
Facility Services	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible
Professional Provider Services			
- Primary Care Physicians	$0	$0	20% coinsurance after deductible
- Specialty Care Providers	$0	$0	20% coinsurance after deductible
Hospital Services Continued			
Outpatient Treatment			
Facility Services	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible
Professional Provider Services			
-Primary Care Physicians	$25	$25	20% coinsurance after deductible
-Specialty Care Providers	$40	$40	20% coinsurance after deductible
Diagnostic Test and X-Rays	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible
Infusion Therapy	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible
Maternity			
Professional Provider Services (Prenatal Post Natal Care)	If your doctor submits one bill for delivery, prenatal and postnatal care services, there is no		20% coinsurance after deductible
- Primary Care Physicians	$25	$25	20% coinsurance after deductible
- Specialty Care Provider	$40	$40	20% coinsurance after deductible
Delivery			
- Primary Care Physicians	$0	$0	20% coinsurance after deductible
- Specialty Care Provider	$0	$0	20% coinsurance after deductible
Hospital Services for Delivery (Delivery Room, Anesthesia Routine Nursing Care for Newborn)	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible

The Local Choice 2022-2023 Comparison of Statewide Plans continued

Covered Services	Key Advantage 500	Key Advantage 1000	High Deductible Plan
Outpatient Prescription Drugs **Mandatory Generic ****** Retail up to 34-day supply *You may purchase up to a 90-day supply at a retail pharmacy by paying multiple copayments, or the coinsurance after the deductible	Tier 1 - $10 Copayment Tier 2 - $30 Copayment Tier 3 - $45 Copayment Tier 4 - $55 Copayment	Tier 1 - $10 Copayment Tier 2 - $30 Copayment Tier 3 - $45 Copayment Tier 4 - $55 Copayment	20% coinsurance after deductible
Home Delivery Services (Mail Order) Covered Drugs for up to a 90 day Supply	Tier 1 - $20 Copayment Tier 2 - $60 Copayment Tier 3 - $90 Copayment Tier 4 - $110 Copayment	Tier 1 - $20 Copayment Tier 2 - $60 Copayment Tier 3 - $90 Copayment Tier 4 - $110 Copayment	20% coinsurance after deductible
Diabetic Equipment	20% coinsurance no deductible	20% coinsurance no deductible	20% coinsurance after deductible
Shots - Allergy & Therapeutic Injections (At Doctor's Office, Emergency Room or Outpatient Hospital Department)	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible
Skilled Nursing Facility Stays (180 Day Per Stay Limit Per Member)			
Facility Services	$0	$0	20% coinsurance after deductible
Professional Provider Services	$0	$0	20% coinsurance after deductible
Spinal Manipulation (Chiropractic) and Other Manual Medical Interventions			
Primary Care Providers	$25 Copayment	$25 Copayment	20% coinsurance after deductible
Specialty Care Providers	$40 Copayment	$40 Copayment	20% coinsurance after deductible
Surgery - See Hospital Services			
Therapy Services *Cardiac Rehabilitation Therapy, Chemotherapy, Radiation Therapy, Respiratory Therapy, Physical Therapy and Speech Therapy*	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible
Facility Services	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible
Professional Provider Services - Specialty Care Providers	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible

*** Price of compound drugs will be based on

-2023 Comparison of Statewide Plans continued

Covered Services	Key Advantage 500	Key Advantage 1000	High Deductible Plan
Wellness Services *Well Child (Office Visits at Specified intervals through Age Birth - Age 18* - Primary Care Physicians - Specialty Care Providers -Immunizations and Screening Tests	No copayment, coinsurance, or deductible	No copayment, coinsurance, or deductible	No copayment, coinsurance, or deductible
Routine Wellness - Age 19 & Older Annual Check-Up Visit (One per Plan Year	No copayment, coinsurance, or deductible	No copayment, coinsurance, or deductible	No copayment, coinsurance, or deductible
- Primary Care Physicians -Specialty Care Providers -Immunizations and Screening Tests Routine Screenings, Immunizations, Lab and X-Ray Services (Outside of Annual Check Up Visit)	No copayment, coinsurance, or deductible	No copayment, coinsurance, or deductible	No copayment, coinsurance, or deductible
Preventive Care (One of Each Per Plan Year, 18 and Older *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

Covered Services	Key Advantage 500	Key Advantage 1000	High Deductible Plan
Routine Vision - Blue View Vision Network (Once Every Plan Year)			
Routine Eye Exam	$40 Copayment	$40 Copayment	$15 Copayment
Eyeglass Lenses	$20 Copayment	$20 Copayment	$20 Copayment
Eyeglass Frames	Up to $100 retail allowance*	Up to $100 retail allowance*	Up to $100 retail allowance*
Contact Lenses (In Lieu of Eyeglass Lenses)			
-Elective	Up to $100 retail allowance	Up to $100 retail allowance	Up to $100 retail allowance
-Non-Elective	Up to $250 retail allowance	Up to $250 retail allowance	Up to $250 retail allowance
Upgrade Eyeglass Lenses (Available for Additional Cost)			
UV Coating, Tints, Standard Scratch-Resistant	$15	$15	$15
Standard Poly	$40	$40	$40
Standard Progressive	$65	$65	$65
Standard Anti-Reflective	$45	$45	$45
Other Add-Ons	20% off Retail	20% off Retail	20% off Retail

*You may select a frame greater than the covered allowance and receive a 20% discount for any additional cost over the allowance.

The Local Choice 2022-2023 Comparison of Statewide Plans continued

Comprehensive Dental Care Option	Key Advantage 500			Key Advantage 1000			High Deductible Plan*		
	One Person	Two People	Family	One Person	Two People	Family	One Person	Two People	Family
Dental Plan Year Deductible	$25	$50	$75	$25	$50	$75	$25	$50	$75
Diabetic Eduction	$0	$0	$0						
Diabetic Equipment	20% AD	20% AD	20% AD						
Plan Year Maximum (Except Orthodontics)	$1,500			$1,500			$1,500		
Preventive Dental Care	$0			$0			$0		
Primary Dental Care	20% coinsurance after dental deductible			20% coinsurance after dental deductible			20% coinsurance after dental deductible		
Major Dental Care	50% coinsurance after dental deductible			50% coinsurance after dental deductible			50% coinsurance after dental deductible		
Orthodontic Services (Includes Adult Ortho)	50% coinsurance no dental deductible with $1500 lifetime maximum			50% coinsurance no dental deductible with $1500 lifetime maximum			50% coinsurance no dental deductible with $1500 lifetime maximum		

	Key Advantage 500 Premium	Key Advantage 500 Your Cost	Key Advantage 1000 Premium	Key Advantage 1000 Your Cost	High Deductible Plan* Premium	High Deductible Plan* Your Cost
Employee Only Cost	$670.00	$37.50	$636.00	$8.34	$524.00	$8.34
Employee Plus Child	$1,240.00	$375.00	$1,177.00	$320.84	$969.00	$229.17
Employee Plus Spouse	$1,240.00	$375.00	$1,177.00	$320.84	$969.00	$229.17
Employee Plus Children	$1,809.00	$615.00	$1,717.00	$584.00	$1,415.00	$481.10
Employee Plus Family	$1,809.00	$615.00	$1,717.00	$584.00	$1,415.00	$481.10

***Hospital Indemnity Policy is**

High Deductible Health Plan with Hospital Indemnity

Plan Benefits Summary-Hospital/ICU Admission $1,000 per day to a maximum of 1 day(s) per year per insured, max of 3 day(3) per year per covered family

Health Screens-$50 per/of screening to a maximum of 1/insured

	HDHP Plan Your Cost	Hospital Ind.	Medical and Hospital Indemnity Cost Your Total Cost
Employee Only Cost	$8.34	$0.00	$8.34
Employee Plus Child	$229.17	$5.94	$235.11
Employee Plus Spouse	$229.17	$10.77	$239.94
Employee Plus Children	$481.10	$7.13	$488.23
Employee Plus Family	$481.10	$16.71	$497.81

Preventive Only Dental Option (diagnostic and preventive services only for lower premiums)	$500 Deductible Plan Your Cost	$1,000 Deductible Plan Your Cost	HDHP Plan Your Cost
Employee Only Cost	$35.84	$8.34	$8.34
Employee Plus Child	$365.84	$312.50	$222.50
Employee Plus Spouse	$365.84	$312.50	$222.50
Employee Plus Children	$599.42	$568.14	$465.46
Employee Plus Family	$599.42	$568.14	$465.46

Plan Selection Help

All comparisons are based on the Comprehensive Dental Option

Maximum Out of Pocket	Key Advantage 500	Key Advantage 1000	High Deductible Plan
Single	$4,000	$5,000	$5,000
Family	$8,000	$10,000	$10,000

Annual Employee Cost

	Key Advantage 500	Key Advantage 1000	High Deductible Plan
Employee Only	$450.00	$100.08	$100.08
EE+ Child	$4,500.00	$3,850.08	$2,750.04
EE+ Spouse	$4,500.00	$3,850.08	$2,750.04
EE+ Children	$7,380.00	$7,008.00	$5,773.20
EE + Family	$7,380.00	$7,008.00	$5,773.20

Maximum Out of Pocket + Premiums

	Key Advantage 500	Key Advantage 1000	High Deductible Plan
Employee Only (less employer contributions to HSA)	$4,450	$5,100	$5,100.08
Employee Cost - H.S.A Contribution $1,192.80 (Only applicable to Employee Only HDHP Plan)			
EE+ Child	$12,500	$13,850	$12,750.00
EE+ Spouse	$12,500	$13,850	$12,750.00
EE+ Children	$15,380	$17,008	$15,773.00
EE + Family	$15,380	$17,008	$15,773.00

WORKSHEET for The Local Choice Elections

ealth Insurance complete the Local Choice Enrollment form and waive coverage
inue waive coverage for the 2021-2022 School year, you do not have to complete another form
ed in the Guardian Dental Plan, Employee Only coverage is provided at not cost to you.

electing Health Insurance Coverage

Plan Name	Key Advantage 500		Key Advantage 1000		High Deductible Plan	
	Preventive	Comprehensive	Preventive	Comprehensive	Preventive	Comprehensive
Employee Only						
Employee & Child						
Employee & Spouse						
Employee Children						
Employee & Family						

aiving Health Insurance Coverage

*Waive Health Coverage	

WHO NEEDS TO COMPLETE A NEW ENROLLMENT FORM

All New Employees have to submit an Enrollment Form, you elect coverage or waive on the same form

All Current Employees who are making Changes to their Current Elections

ALL FORMS MUST BE SENT TO RHONDA HOUCHENS IN THE CENTRAL OFFICE

No Later Than August 12th, The Local Choice WILL NOT ACCEPT Any Open Enrollment Forms After the Cut Off Date

Our Contact Information

Darla Rose - Benefits Consultant - 434-327-1652

drose@bankersinsurance.net

Linda Cotton - Account Manager - 434-977-5313 and ask to be transferred to Linda Cotton

lcotton@bankersinsurance.net