Brunswick County
Local Choice Plan Options July 1, 2019 through June 30, 2020

	Key Advantage Expanded	Key Advantage 500	High Deductible Health Plan
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 $100 / Family $200 **Out-of-Network** $200 / $400	**In-Network:** One Person $500 / Family $1,000 **Out-of-Network** $1,000 / $2,000	One Person $2,800 / Family $5,600 Ded is combined for in and out of network
Out-of-pocket expense limit	**In-Network:** One Person $2,000 / Family $4,000 **Out-of-Network** $3,000 / $6,000	**In-Network:** One Person $4,000 / Family $8,000 **Out-of-Network** $7,000 / $14,000	One Person $5,000 / Family $10,000 **Out-of-Network** $10,000 / $20,000
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.	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.	Yes. Once you meet the combined deductible you pay 40% coinsurance for medical, behavioral health and prescription drug services from Out-of-Network providers
BlueCard® PPO and BlueCard Worldwide® networks when traveling outside Virginia	Included	Included	Included
Lifetime maximum	None	None	None
Covered Services	**In-Network You Pay**	**In-Network You Pay**	**In-Network You Pay**
Ambulance travel	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible
Autism Spectrum Disorder-2 years to 10 years	Copayment/coinsurance determined by service	Copayment/coinsurance determined by service	20% coinsurance after deductible
Behavioral health and EAP			
Inpatient treatment			
• Facility services	$300 copayment per stay	20% coinsurance per stay after deductible	20% coinsurance after deductible
• Professional provider services	$0	$0	20% coinsurance after deductible
Outpatient professional provider visits	$15 copayment	$25 copayment	20% coinsurance after deductible
Employee Assistance Program (EAP) (up to 4 visits per incident)	$0	$0	$0
Dental	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
Plan year maximum (except Orthodontics)	$1,500	$1,500	$1,500
Diagnostic and preventive services	$0, no deductible	$0, no deductible	$0, no deductible
Primary services	20% coinsurance after dental deductible	20% coinsurance after dental deductible	20% coinsurance after dental deductible
Complex restorative	50% coinsurance after dental deductible	50% coinsurance after dental deductible	50% coinsurance after dental deductible
Orthodontic services	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
Diabetic Education	$0	$0	20% coinsurance after deductible
Diabetic Equipment	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible
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	20% coinsurance, after deductible
Doctor visits - on an outpatient basis			
Primary care physicians	$15 copayment	$25 copayment	20% coinsurance after deductible
Specialty care providers	$25 copayment	$40 copayment	20% coinsurance after deductible
Emergency room visits			
Facility services	$250 copayment per visit (waived if admitted)	20% coinsurance after deductible	20% coinsurance after deductible
Professional provider services			
• Primary care physicians	$15 copayment	$25 copayment	20% coinsurance after deductible
• Specialty care providers	$25 copayment	$40 copayment	20% coinsurance after deductible
Diagnostic tests, and x-rays	20% coinsurance, no deductible	20% coinsurance after deductible	20% coinsurance after deductible
Home health services (90 visit plan year limit)	$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
Hospital services			
Inpatient treatment			
• Facility services	$300 copayment per stay	20% coinsurance per stay after deductible	20% coinsurance after deductible
• Professional provider services -	$0	$0	20% coinsurance after deductible
• Primary care physicians	$0	$0	20% coinsurance after deductible
• Specialty care providers			
Outpatient treatment			
• Facility services	$100 copayment	20% coinsurance after deductible	20% coinsurance after deductible
• Professional provider services -			
• Primary care physicians	$15 copayment	$25 copayment	20% coinsurance after deductible
• Specialty care providers	$25 copayment	$40 copayment	20% coinsurance after deductible
• Diagnostic tests and x-rays	20% coinsurance, no deductible	20% coinsurance after deductible	20% coinsurance after deductible
Infusion services			
Facility services	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible
Professional provider services -	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible
Home services	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible
Infusion medications -			
• Outpatient settings	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible
• Home settings	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible

Brunswick County
Local Choice Plan Options July 1, 2019 through June 30, 2020

	Key Advantage Expanded	Key Advantage 500	High Deductible Health Plan
Maternity			
Professional provider services (prenatal & postnatal care)			
• Primary care physicians	$15 copayment	$25 copayment	20% coinsurance after deductible
• Specialty care providers	$25 copayment	$40 copayment	20% coinsurance after deductible
	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 rece		
Delivery			
• Primary care physicians	$0	$0	20% coinsurance after deductible
• Specialty care providers	$0	$0	20% coinsurance after deductible
Hospital services for delivery (delivery room, anesthesia, routine nursing care for newborn)	$300 copayment per stay*	20% coinsurance per stay after deductible	20% coinsurance after deductible
Outpatient diagnostic tests	20% coinsurance, no deductible	20% coinsurance after deductible	20% coinsurance after deductible
*This plan will waive $200 of the hospital copayment if the member enrolls in the Future Moms pre-natal program within the first trimester of pregnancy, has a dental cleaning and satisfactorily completes the entire program. Call Future Moms at **800-828-5891**			
Medical equipment, appliances, formulas and supplies	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible
Outpatient prescription drugs - mandatory generic			
Retail up to 34-day supply	Tier 1 - $10 copayment	Tier 1 - $10 copayment	20% coinsurance after deductible
	Tier 2 - $30 copayment	Tier 2 - $30 copayment	
(You may purchase up to a 90-day supply at a retail pharmacy by paying multiple copayments, or the coinsurance after the deductible)	Tier 3 - $45 copayment Tier 4-$55	Tier 3 - $45 copayment	
Mail Service up to 90-day supply	Tier 1 - $20 copayment	Tier 1 - $20 copayment	20% coinsurance after deductible
	Tier 2 - $60 copayment	Tier 2 - $60 copayment Tier 4-$110	
	Tier 3 - $90 copayment Tier 4-$110	Tier 3 - $90 copayment	
Routine vision - Blue View Vision Network (once every 12 months)			
Routine eye exam	$25 copayment	$40 copayment	$15 copayment
Eyeglass frames	Up to $100 retail allowance**	Up to $100 retail allowance**	Up to $100 retail allowance**
Eyeglass lenses	$20 copayment	$20 copayment	$20 copayment
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
Lens Options			
• UV coating, tints, standard scratch-resistant	$15	$15	$15
• Standard polycarbonate	$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.			
Shots (allergy & therapeutic injections at doctor's office, emergency room or outpatient hospital department)	20% coinsurance, no deductible	20% coinsurance after deductible	20% coinsurance after deductible
Skilled nursing facility stays (180-day per stay limit)			
Facility services	$0	$0	20% coinsurance after deductible
Professional provider services	$0	$0	20% coinsurance after deductible
Spinal manipulations and other manual medical interventions (30 visits per plan year)			
Primary care physicians	$15 copayment	$25 copayment	20% coinsurance after deductible
Specialty care physicians	$25 copayment	$40 copayment	20% coinsurance after deductible
Surgery - see Hospital services			
Therapy services *Cardiac Rehabilitation therapy, Chemotherapy, Radiation therapy, and Respiratory therapy, Occupational therapy, Physical therapy, and Speech therapy*			
• Facility services	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible
• Professional provider services			
• Primary care physicians	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible
• Specialty care providers	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible

Brunswick County
Local Choice Plan Options July 1, 2019 through June 30, 2020

	Key Advantage Expanded	Key Advantage 500	High Deductible Health Plan
Wellness services			
Well child (office visits at specified intervals through age 6)			
• 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 7 & older)			
• Annual check-up visit (one per plan year) - - Primary care physicians; - Specialty care providers; - Immunizations, lab and x-ray services	No copayment, coinsurance, or deductible	No copayment, coinsurance, or deductible	No copayment, coinsurance, or deductible
• 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 each per plan year) • 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
Women's Preventative Care • Well-woman visits • Screening for gestational diabetes • Testing for human papillomavirus (HPV) • Counseling for sexually transmitted infections • Screening and counseling for human immunodeficiency virus (HIV) • FDA-approved contraception methods and contraceptive counseling • Breastfeeding support, supplies and counseling • Screening and counseling for interpersonal and domestic violence	No copayment, coinsurance, or deductible	No copayment, coinsurance, or deductible	No copayment, coinsurance, or deductible

This is a brief benefits comparison for illustrative purposes only. Please refer to your plans Member Handbook for a complete description of the benefits, exclusions, limitations, and reductions for your specific plan.