David Ash – Chip Schutte – David Weiss - Sharon Keeler – Chuck Bishop

AGENDA
Joint Administrative Services Board
Monday February, 27 2017 1:00 p.m.
Joint Government Center

1. **Call to Order.**

2. **Approval of Minutes. (January 30 Minutes Attached). Pg. 2**

3. **ERP Update.**

   a. **Taxation.**
   b. **Assessment System.**

4. **Health Insurance: Local Choice renewal. Pg. 8.**

5. **Health Insurance: Preliminary COVA Local rates. Pg. 15.**

6. **Next Meeting: Request cancellation of March 27 meeting. Next meeting April 24.**

Joint Administrative Services Board

January 30, 2017 Regular Meeting 1:00 pm

At a regular meeting of the Joint Administrative Services Board held on Monday, January 30, 2017 at 1:00 pm in the Meeting Room AB, Berryville Clarke County Government Center, 101 Chalmers Court, 2nd Floor, Berryville, Virginia.

Members Present

David Ash, Chuck Bishop, Sharon Keeler, Chip Schutte, David Weiss

Members Absent

None

Staff Present

Tom Judge, Gordon Russell

Others Present

None

1. Call To Order - Determination of Quorum

At 1:00 pm, Tom Judge called the meeting to order having determined that a quorum was present.

Selection of Chairperson

Mr. Judge opened the floor for nominations for the position of Joint Administrative Services Board Chair for 2017.

David Ash, seconded by Chuck Bishop, moved to appoint Chip Schutte for Joint Administrative Services Board Chair for 2017.

Tom Judge called for vote from all those in favor of Chip Schutte as Chair for calendar year 2017. The vote carried by the following voice vote:

David Ash	-	Aye
Chuck Bishop	-	Aye
Sharon Keeler	-	Aye

Charles "Chip" Schutte - Aye
David Weiss - Aye

Following the vote, Tom Judge turned the meeting over to Chairman Chip Schutte.

Selection of Vice-Chairperson

Chip Schutte opened the floor for nominations for Vice Chair.

David Ash, seconded by Chuck Bishop, nominated David Weiss for Joint Administrative Services Board Vice Chair for 2017.

Chairman Schutte called for vote from all those in favor of David Weiss as Vice Chair. The vote carried by the following voice vote:

David Ash - Aye
Chuck Bishop - Aye
Sharon Keeler - Aye
Charles "Chip" Schutte - Aye
David Weiss - Aye

Establishment of meeting calendar

Chuck Bishop, seconded by David Ash, moved to approve the calendar as presented. The motion carried as follows:

David Ash - Aye
Chuck Bishop - Aye
Sharon Keeler - Aye
Charles "Chip" Schutte - Aye
David Weiss - Aye

Date	Time	Location	Topic(s)
02/27/17	1:00:00 PM	JGC	Health Ins, Budget, Technology
03/27/17	1:00:00 PM	JGC	Health Insurance, Budget, Technology
04/24/17	1:00:00 PM	JGC	Technology
05/22/17	1:00:00 PM	JGC	Audit, Technology
06/26/17	1:00:00 PM	JGC	*If needed*
07/24/17	1:00:00 PM	JGC	*If needed*
08/28/17	1:00:00 PM	JGC	*If needed*
09/25/17	1:00:00 PM	JGC	Technology
10/23/17	1:00:00 PM	JGC	Director Evaluation
11/27/17	1:00:00 PM	JGC	*If needed*
12/18/17	1:00:00 PM	JGC	*If needed*
01/22/18	1:00:00 PM	JGC	Organization, Budget, Technology

2. Approval of Minutes

David Weiss, seconded by Sharon Keeler, moved to approve the October 24, 2016 minutes as presented. The motion carried by the following vote:

David Ash	-	Aye
Chuck Bishop	-	Aye
Sharon Keeler	-	Aye
Charles "Chip" Schutte	-	Aye
David Weiss	-	Aye

3. ERP

Utility Billing is live:

- Utility bills for the Clarke County Sanitary Authority [CCSA] were issued Friday, January 27.
- Not a smooth implementation:
  - Had to abort in October.
  - Had a week with an implementation consultant.
  - Still "cleaning up" some issues.
  - By in large, module is working.
- Module includes a new rate structure and other changes implemented by the CCSA.
- Staff glad to have on line in one system.
- On line payment is not ready. Gordon Russell dealing with two third-parties to resolve.

Taxation

- Six implementation days.
- Much of the setup is complete.
- Gordon Russell working with Tyler on the conversion; and while complicated, it appears that all needed information is available.
- Implementation is an iterative process first running the conversion, review, tweak, run again, until the data presents as needed.
- Next three-day session with Tyler is scheduled for February 14, 15, 16.

Building Permits:

- Appears to be going well.
- Building Department input FY2018 budget in Munis.
- Processing building permits.
- Gordon Russell instrumental in providing support.
- Munis system is less user-friendly than the old system – WindowWare.
  - More steps.
  - More pass-through screens.
  - More data gathered and integrated into other countywide departments.
  - Process is now less simplified.
  - Takes three to four times longer to issue a permit.
  - Processing delays because of system integration when required data from another department is missing or unavailable.
  - There can be a significant lapse between the time of real estate transaction and input into county records.
  - To reduce pressure on staff, may need to change permit processing time and reduce customer expectation.

Tyler Issues:

- Tyler so busy at times it has difficulty focusing and returning emails.
- Difficult to get attention at times particularly on the implementation side of things.
- New Tyler staff unfamiliar with its system.
- Munis is not an elegant system.

Budgeting of FY2018 Operating Cost

The annual operating cost of the ERP system is $120K. To date, this cost has been budgeted and charged to the capital budget; but in July, the capital project will be complete. There is an estimated surplus in the capital project, which might cover this (it will be close), but there are additional capital expenditures, which should be considered: a new assessment system, and upgrading the ESRI mapping system. There are therefore three options for charging FY 18 ERP operating cost:

i. Charge to Capital knowing it will be close, and supplement for additional expenditures later if necessary.

ii. Charge to General Fund and School Fund 50/50.

iii. Charge to Joint Administrative Services (shown in budget below).

Tom Judge and Gordon Russell reviewed:

- Purchase of new assessment software:
  - Software separate from Munis.
  - Approximate cost of $10,000 to $20,000.
  - Assessment software systems transfers its values into Munis from which Munis generates the tax bills.
  - Implementation of assessment software required prior to AS400 replacement.
- AS400 replacement.
- ESRI mapping priority.

Following review, by consensus, Tom Judge summarized action as follows:

- Subtract $120,000 from JAS budget request,
- Leave $2,000 in the line item for JAS copier,
- Keep balance to cover the FY2018 operating cost, which was part of the initial five-year bid, and to cover an assessment system.
- Use residual funds for mapping system.

4. Joint Administrative Services 2018 Budget

Following review, **David Ash, seconded by Chuck Bishop, moved to approve the Joint Administrative Services budget with the reduction from Tom Judge's budget of the same amount set aside in the Capital Budget for the operation and substituting an assessment program for the map link at the initial outset. The motion carried by the following vote:**

David Ash	-	Aye
Chuck Bishop	-	Aye
Sharon Keeler	-	Aye
Charles "Chip" Schutte	-	Aye
David Weiss	-	Aye

Tom Judge noted that the department's adjusted total budget was $603,817, which takes into account elimination of the $120,000 and the reduction in health insurance.

5. Next Meeting

The next regularly scheduled meeting is set for Monday, February 27, 2017.

6. Adjournment

Being no further business, Chip Schutte adjourned the meeting.

Minutes Recorded by David Ash; Transcribed by Lora B. Walburn

FY 18 Monthly Health Benefit Rates

Effective 5/15/2017

Source: Joint Administrative Services

A. Plan Rates	Cost	Employer	Employee	Employer FY 18 Share*	Employer FY 17 Share*	FY 18 Employer Annual
				Rounding difference shifts year to year in KA 250.		
KA 250 Plan Option						
Regular Full Time						
Single	674.00	569.66	104.34	85%	84%	6,836
Dual	1,247.00	621.58	625.42	50%	50%	7,459
Family	1,820.00	907.28	912.72	50%	50%	10,887
						0
Transportation, Food Service & Other						0
Single	674.00	480.67	193.33	71%	71%	5,768
Dual	1,247.00	524.48	722.52	42%	42%	6,294
Family	1,820.00	765.55	1,054.45	42%	42%	9,187
						0
KA 500 Plan Option						0
						0
Regular Full Time						0
Single	620.00	569.66	50.34	92%	92%	6,836
Dual	1,147.00	621.58	525.42	54%	54%	7,459
Family	1,674.00	907.28	766.72	54%	54%	10,887
						0
Transportation, Food Service & Other						0
Single	620.00	480.67	139.33	78%	78%	5,768
Dual	1,147.00	524.48	622.52	46%	46%	6,294
Family	1,674.00	765.55	908.45	46%	46%	9,187
						0
TLC High Deductible						0
						0
Regular Full Time						0
Single	487.00	487.00	.00	100%	100%	5,844
Dual	901.00	553.75	347.25	61%	61%	6,645
Family	1,315.00	807.05	507.95	61%	61%	9,685
						0
Transportation, Food Service & Other						0
Single	487.00	410.92	76.08	84%	84%	4,931
Dual	901.00	467.25	433.75	52%	52%	5,607
Family	1,315.00	680.98	634.02	52%	52%	8,172
B. Account Contributions						
Regular Full Time						
TLC Health Savings Account Contribution (single)		82.66				992
TLC Health Savings Account Contribution (dual)		67.83				814
TLC Health Savings Account Contribution (family)		100.23				1,203
Transportation, Food Service & Other						
TLC Health Savings Account Contribution (single)		69.75				837
TLC Health Savings Account Contribution (dual)		57.23				687
TLC Health Savings Account Contribution (family)		84.57				1,015
C. Total Employer Cost Per Group Health Member						
Regular Full Time						
Single Health		569.66				
Dual Health		621.58				
Family Health		907.28				
TLC Single Health & "HSA"		569.66				
TLC Dual Health & "HSA"		621.58				
TLC Family Health & "HSA"		907.28				
Transportation & Food Service						
Single Health		480.67				
Dual Health		524.48				
Family Health		765.55				
TLC Single Health & "HSA"		480.67				
TLC Dual Health & "HSA"		524.48			Overall Change	
TLC Family Health & "HSA"		765.55			-3.20%	

Note: Where two employees are married, and they together opt for either a dual or family option, the employer will pay two times the single employer contribution for the plan option selected.

METHOD:
Force TLC employee single contribution to zero.
Force 500 rates to percentage contributions from prior year.
Force 250 employer contribution to same as 500 contribution.
Force "HSA" contribution so total employer equal across plans.

The Local Choice Health Benefits Program

To: TLC Group Administrators

From: Walter E. Norman
Program Manager

Date: January 2017

Re: The Local Choice Health Benefits Renewal

Thank you for your continuing support of The Local Choice program. We are pleased to enclose The Local Choice (TLC) renewal for fiscal year 2018. TLC will again offer five statewide plans to all local employer groups along with a regional plan in certain geographic areas.

For all Statewide plans, medical, behavioral health, outpatient prescription drugs and routine vision is administered by Anthem BCBS. Delta Dental will administer the dental benefits through a separate agreement with Anthem. The regional plan will continue to be administered by Kaiser Permanente. Employer plan choices are:

Statewide plans

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

Regional plan

- Kaiser Permanente – available in certain service areas

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 programs at no additional cost to your employees. CommonHealth programs feature our *Future Moms* prenatal risk management program, our highly acclaimed *Quit For Life* tobacco cessation program, confidential, at work medical screenings plus other health and wellness programs including nutrition, stress management and fitness programs.

Virginia Department of Human Resource Management • 101 North 14th Street • 13th Floor • Richmond, Virginia 23219
(804) 786-6460 • e-mail: tlc@dhrm.state.va.us

Your 2017-2018 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.

There are a few benefit changes this year.

- LiveHealth Online EAP will now be available for accessing member's four free counseling sessions.
- LiveHealth Online will be available for accessing Future Moms with Breastfeeding Support, at no extra cost.

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 HMO fully-insured regional plan (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 of 2017. I, along with representatives from our program's vendors, will present plan highlights, improvements and changes in more detail. The RoadShow meeting schedule for 2017 will be distributed in January 2017.

Our goals are twofold -- first, to help you offer a high quality, affordable health benefits package; and second, to assist you in attracting and retaining the highest quality employees. We value your participation, and we look forward to continuing our partnership in to the future.

Thank you for selecting The Local Choice program.

Sincerely,

Walter E. Norman
Program Manager

COMMONWEALTH OF VIRGINIA
DEPARTMENT OF HUMAN RESOURCE MANAGEMENT

Group Administrator Memo #17-01

To: TLC Group Benefits Administrators
From: State and Local Health Benefits Programs
Date: January 3, 2017
Re: Extended Coverage / COBRA Update

NOTE - THIS INFORMATION REQUIRES YOUR IMMEDIATE ATTENTION.

Effective on January 1, 2017, all The Local Choice groups, regardless of size, must begin offering Extended Coverage/COBRA to health plan participants who experience a COBRA qualifying event on or after December 1, 2016, resulting in a COBRA start date of January 1, 2017. Election Notices must be properly addressed and sent by first class mail within 14 days of the loss of coverage date. Updated Election Notices will be available at www.thelocalchoice.virginia.gov under "Forms" by January 5th.

This change will also require the distribution of new Initial General Notices to all health plan participants in all TLC groups. You will receive the format of this notice and instructions for distribution as soon as possible.

For groups already administering COBRA, please begin using the new Election Form format immediately upon availability. For groups that will be offering COBRA for the first time, you will be provided with an overview of the process; however, if you need immediate assistance related to a December qualifying event, please contact Ann Wohl at Ann.Wohl@dhrm.virginia.gov or 804-371-0185.

THE LOCAL CHOICE HEALTH BENEFITS PROGRAM

Clarke County And Schools

Proposed Rates Effective from
July 1, 2017 through June 30, 2018

With Comprehensive Dental

	Single	Dual	Family
ACTIVE EMPLOYEES			
Key Advantage Expanded	$738	$1,365	$1,993
* Key Advantage 250	$674	$1,247	$1,820
* Key Advantage 500	$620	$1,147	$1,674
Key Advantage 1000	$589	$1,090	$1,590
* High Deductible Health Plan	$487	$901	$1,315
RETIREES NOT ELIGIBLE FOR MEDICARE			
Key Advantage Expanded	$738	$1,365	$1,993
* Key Advantage 250	$674	$1,247	$1,820
* Key Advantage 500	$620	$1,147	$1,674
Key Advantage 1000	$589	$1,090	$1,590
* High Deductible Health Plan	$487	$901	$1,315

With Preventive Dental Only

ACTIVE EMPLOYEES			
Key Advantage Expanded	$724	$1,339	$1,955
* Key Advantage 250	$660	$1,221	$1,782
* Key Advantage 500	$606	$1,121	$1,636
Key Advantage 1000	$575	$1,064	$1,553
* High Deductible Health Plan	$473	$875	$1,277
RETIREES NOT ELIGIBLE FOR MEDICARE			
Key Advantage Expanded	$724	$1,339	$1,955
* Key Advantage 250	$660	$1,221	$1,782
* Key Advantage 500	$606	$1,121	$1,636
Key Advantage 1000	$575	$1,064	$1,553
* High Deductible Health Plan	$473	$875	$1,277

Medicare Retiree Rates

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 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 CARE PROGRAM

Anthem Blue Cross and Blue Shield

Renewal Analysis For:

(Excludes Advantage 65 premiums and claims)

For

Clarke County And Schools

Group #47284

for July 1, 2017 through June 30, 2018

I.	Income at Current Rates (1)	$3,497,112
II.	Projected Medical Claims Related Charges (2)	
	A. Claims Cost (12/01/2015 through 11/30/2016)	$4,105,600
	B. 100% Facility Network Savings	($1,143,980)
	C. 100% Professional Network Savings	($1,008,541)
	D. Claims in excess of the $125,000 pooling limit	($139,301)
	E. Subtotal	$1,813,778
	F. Change in Incurred But Not Reported Claims	$18,138
	G. Benefit Adjustment	$0
	H. Enrollment Adjustment	$0
	I. Trend	$177,696
	J. Total Medical Projected Incurred claims	$2,009,611
III.	Projected Reinsurance Charges	$278,733
IV.	Projected Medical Administrative Charges, Network Access Fees, and Affordable Care Act(3)	$147,266
V.	Projected Dental Capitation	$151,486
VI.	Projected Drug Capitation	$762,838
VII.	TLC Contingency Reserve or Risk Fee(4)	$34,438
VIII.	Total Income Requirements (II.J. + III. + IV. + V. + VI. + VII.)	$3,384,372
	Percent of Current Income	96.8%

[1] Illustrative income is based on current enrollment as follows:

	KA 250	KA 500	HDHP	TOTAL
Single	70	126	16	212
Dual	18	21	4	43
Family	15	38	6	59
TOTAL:	103	185	26	314

[2] There are 2 claims in excess of the $125,000 pooling limit.
Facility and Professional network savings represent 52.4% of medical claims cost.
Medical trends used in the renewal development were 6% annual.
For a 19 month projection, this equates to 9.7%

[3] Administrative charge as a percent of income requirements is 4.4%

[4] Includes DHRM Program Administration and CommonHealth

Assumes all have Comprehensive Dental.

ANTHEM BLUE CROSS AND BLUE SHIELD

CLARKE COUNTY - 05875

MEDICAL PROGRAM EXPENSE REPORT INCLUDES VISION AND EXCLUDES MEDICARE RETIREES

CLAIMS PROCESSED : 201512 - 201611

	Total
COVERED BILLED CHARGES (B)	$4,497,292.78
NETWORK SAVINGS (A)	$2,152,521.38
COST OF BENEFITS	$2,344,771.40
MEMBER PAID AMOUNT/PLAN DESIGN (C)	$391,692.71
MEDICAL EXPENSE	$1,953,078.69
% SAVINGS TO PRE BENFIT DESIGN COVERED CHARGES (CALC A/B)	47.88%
% SAVINGS TO POST BENEFIT DESIGN COVERED CHARGES (CALC A/(B-C))	52.43%

Report Run Date: 01/23/2017

COMMONWEALTH of VIRGINIA

SARA REDDING WILSON
DIRECTOR

Department of Human Resource Management

101 N. 14TH STREET
JAMES MONROE BUILDING, 12TH FLOOR
RICHMOND, VIRGINIA 23219
(804) 225-2131
(TTY) 711

February 22, 2017

RE: Local Option Health Insurance Plan – Preliminary Rates
Senate Bill 364 (Chafin 2016) – COVA Local

Dear Local Employers:

Thank you for being among the groups that submitted their data and expressed preliminary, non-binding interest in the local option health insurance plan (SB 364). In all, 210 groups with 102,390 enrolled employees and a total of 204,029 enrolled members provided the necessary information. As we discussed in our 2016 webinars, a minimum of 5,000 enrolled employees and 10,000 enrolled members is required for the plan to be offered in July 2018.

Preliminary Rates
Based on the experience and demographics of the groups that submitted data, the preliminary rates for COVA Local in FY 2019 are projected to be the same as the rates for the state COVA Care Basic plan, and the buy-ups are projected to be the same or less than the state plans:

COVA Local Plans	FY 2019 Initial Monthly Rates		
	EE Only	EE+1	EE+Family
Basic	$ 794.00	$1,469.00	$2,144.00
OON Buy-Up	$ 19.00	$ 35.00	$ 51.00
Enhanced Dental Buy-up	$ 31.00	$ 57.00	$ 84.00
Vision and Hearing Buy-Up	$ 20.00	$ 37.00	$ 54.00
Basic with All Buy-Ups	$ 864.00	$1,598.00	$2,333.00
HDHP	$ 598.00	$1,106.00	$1,615.00
Enhanced Dental Buy-Up	$ 31.00	$ 57.00	$ 84.00
HDHP with Enhanced Dental	$ 629.00	$1,163.00	$1,699.00

Next Steps
Now that you have seen the preliminary COVA Local option rates based on Round 1 participants, it is time to let us know whether or not you continue to be interested in participating in the program. Your non-binding decision is very important to the rate setting process, so please consider your decision carefully.

The final rates for the COVA Local plan will be published in the fall of 2017. Those rates will be based on the experience and demographics of the groups that express interest to participate and provide the requested data during Round 2.

Round 2 groups will make a binding election to participate in COVA Local at the end of 2017. The COVA Local plan will go live on July 1, 2018.

Election Survey
Below is a link to a survey for you to complete expressing your intent. Please complete this survey no later than March 15, 2017. If you do not complete this survey by March 15, you will not be able to participate in the first year.

http://survey.dhrm.virginia.gov/n/COVALocal.aspx

We appreciate your time and interest. If you have questions, please send an email to Kathryn Brooks at kathryn.brooks@dhrm.virginia.gov.

Sincerely,

Sara R. Wilson

Sara Redding Wilson
Director

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.dhrm.virginia.gov or by calling 1-888-642-4414. You may also select, at an extra cost to you, additional options that offer enhanced coverage for dental, out-of-network, and vision and hearing services.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	For in-network providers **$300** person / **$600** family Doesn't apply to preventive care, outpatient prescription drugs, or copayments	You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the deductible starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the deductible.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses?	Yes. For participating providers **$1,500** person / **$3,000** family	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Dental, routine hearing and vision, premiums, any health care services this plan doesn't cover and balanced-billed charges	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. See www.anthem.com or call 1-800-552-2682 for a list of in-network providers.	If you use an in-network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred, or participating for providers in their network. See the chart starting on page 2 for how this plan pays different kinds of providers.

A10195

Questions: Call 1-888-642-4414 or visit us at www.dhrm.virginia.gov.
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.dhrm.virginia.gov or call 1-888-642-4414 to request a copy.

1 of 12

Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the specialist you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about excluded services.

- Copayments are fixed dollar amounts (for example, $25) you pay for covered health care, usually when you receive the service.
- Coinsurance is *your* share of the costs of a covered service, calculated as a percent of the allowed amount for the service. For example, if the plan's allowed amount for an overnight hospital stay is $1,000, your coinsurance payment of 20% would be $200. This may change if you haven't met your deductible.
- The amount the plan pays for covered services is based on the allowed amount. If an out-of-network provider charges more than the allowed amount, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the allowed amount is $1,000, you may have to pay the $500 difference. (This is called balance billing.)
- This plan may encourage you to use in-network providers by charging you lower deductibles, copayments and coinsurance amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 copay	Not Covered	none
	Specialist visit	$40 copay	Not Covered	none
	Other practitioner office visit	$35 copay for chiropractor	Not Covered	Coverage is limited to 30 visits annual max for chiropractic.
	Preventive care/ screening/immunization	No Charge	Not Covered	none
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance after deductible	Not Covered	none
	Imaging (CT/PET scans, MRIs)	20% coinsurance after deductible	Not Covered	Pre-authorization may be required.

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.anthem.com.	Generic drugs	$15 copay (retail); $30 copay (home delivery)	$15 copay (retail); $30 copay (home delivery)	Covers up to a 34-day supply (retail prescription); 90 day supply (home delivery prescription). If you use a non-network pharmacy, you pay the difference between the pharmacy charge and the plan allowable charge.
	Preferred brand drugs	$30 copay(retail); $60 copay (home delivery)	$30 copay (retail); $60 copay (home delivery)	Please see limitations in Generic drugs.
	Non-preferred brand drugs	$45 copay (retail); $90 copay (home delivery)	$45 copay (retail); $90 copay (home delivery)	Please see limitations in Generic drugs.
	Specialty drugs	$55 copay (retail); $110 copay (home delivery)	$55 copay (retail); $110 copay (home delivery)	Please see limitations in Generic drugs.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$125 copay/visit	Not Covered	——————none——————
	Physician/surgeon fees	$25 copay for primary care physician and $40 copay for specialist	Not Covered	——————none——————
If you need immediate medical attention	Emergency room services	$150 copay/visit	Not Covered. Emergency services will be considered at the In-Network benefit level; however, balance billing may still occur.	Copay waived if admitted.
	Emergency medical transportation	20% coinsurance after deductible	Not Covered. Emergency services will be considered at the In-Network benefit level; however, balance billing may still occur.	——————none——————
	Urgent care	$25 copay for primary care physician and $40 copay for specialist	Not Covered	——————none——————

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you have a hospital stay	Facility fee (e.g., hospital room)	$300 copay/stay	Not Covered	——————none——————
	Physician/surgeon fee	No Charge	Not Covered	——————none——————
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$25 copay/visit	Not Covered	——————none——————
	Mental/Behavioral health inpatient services	$300 copay/stay	Not Covered	——————none——————
	Substance use disorder outpatient services	$25 copay/visit	Not Covered	——————none——————
	Substance use disorder inpatient services	$300 copay/stay	Not Covered	——————none——————
	Employee Assistance Program (EAP)	No Charge	Not Covered	Covers up to 4 visits per incident within a 12 month period.
If you are pregnant	Prenatal and postnatal care	$25 copay for primary care physician and $40 copay for specialist	Not Covered	——————none——————
	Delivery and all inpatient services	$300 copay/stay	Not Covered	——————none——————

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	No Charge	Not Covered	Coverage is limited to 90 visits max. per coverage period.
	Rehabilitation services	$25 copay for primary care physician and $35 copay for specialist	Not Covered	$15 copay for physical therapy services only
	Habilitation services	$25 copay for primary care physician and $35 copay for specialist	Not Covered	——————none——————
	Skilled nursing care	No Charge	Not Covered	Coverage is limited to 180 days max per coverage period.
	Durable medical equipment	20% coinsurance after deductible	Not Covered	——————none——————
	Hospice service	No Charge	Not Covered	——————none——————
If your child needs dental or eye care	Eye exam	Not Covered	Not Covered	——————none——————
	Glasses	Not Covered	Not Covered	——————none——————
	Dental check-up	No Charge	Provider Charge in excess of plan's contractual rate	Dental coverage administered by Delta Dental of Virginia, www.deltadentalva.com. 1-888-335-8296.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)		
• Acupuncture	• Long-term care	• Routine foot care (except for some diabetic treatment – please see your member handbook for complete details)
• Cosmetic surgery	• Routine eye care	
• Infertility treatment	• Hearing aids	• Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)		
• Bariatric surgery	• Dental care (diagnostic and preventive only)	• Most coverage provided outside the United States. See www.anthem.com/cova
• Chiropractic care	• Non-emergency care when traveling outside the U.S.	• Private-duty nursing

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-888-642-4414. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact: Director, Department of Human Resource Management, 101 North 14th Street – 12th Floor, Richmond, Virginia 23219-3657. Mark envelope Confidential-Appeal Enclosed. Telephone: 1-888-642-4414.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." This plan or policy does provide minimum essential coverage.

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). This health coverage does meet the minimum value standard for the benefits it provides.

Language Access Services

Si no es miembro todavía y necesita ayuda en idioma español, le suplicamos que se ponga en contacto con su agente de ventas o con el administrador de su grupo. Si ya está inscrito, le rogamos que llame al número de servicio de atención al cliente que aparece en su tarjeta de identificación.

如果您是非會員並需要中文協助，請聯絡您的銷售代表或小組管理員。如果您已參保，則請使用您 ID 卡上的號碼聯絡客戶服務人員。

Kung hindi ka pa miyembro at kailangan ng tulong sa wikang Tagalog, mangyaring makipag-ugnayan sa iyong sales representative o administrator ng iyong pangkat. Kung naka-enroll ka na, mangyaring makipag-ugnayan sa serbisyo para sa customer gamit ang numero sa iyong ID card.

Doo bee a'tah ni'liigoo eí dooda'í, shikáa adoolwoł íníziníigo t'áá diné k'éjíígo, t'áá shoodí ba na'alníhí ya sidáhí bich'į naabídíilkiid. Eí doo biigha daago ni ba'nija'go ho'aalagíí bich'į hodiilní. Hai'dąą iini'taago eíya, t'áá shoodí díné ya atáh halne'ígíí ní béésh bee haane'í wólta' bi'ki si'niilígíí bi'kéhgo bich'į hodiilní.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

Amount owed to providers: $7,540
Plan pays $7,240
Patient pays $300

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$0
Copays	$300
Coinsurance	$0
Limits or exclusions	$0
Total	**$300**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

Amount owed to providers: $5,400
Plan pays $4,390
Patient pays $1,010

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$300
Copays	$490
Coinsurance	$220
Limits or exclusions	$0
Total	**$1,010**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include premiums.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network providers. If the patient had received care from out-of-network providers, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how deductibles, copayments, and coinsurance can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

FQ FE No. Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

FQ FE No. Coverage Examples are not cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

FQ FE Yes. When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

FQ FE Yes. An important cost is the premium you pay. Generally, the lower your premium, the more you'll pay in out-of-pocket costs, such as copayments, deductibles, and coinsurance. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

This page is intentionally left blank.

This page is intentionally left blank.

This page is intentionally left blank.