TOWN OF ALTAVISTA

HEALTH INSURANCE

REQUEST FOR BID PROPOSAL

Sealed bids for group health insurance will be received by the town of Altavista, Virginia until July 8th, 2014 at the office of Town Treasurer located at 510 7th Street, Altavista, Virginia 24517. Bids received after the stated date, postmarks notwithstanding, shall be rejected. The insurance to be provided will include coverage as shown in plan benefits or as requested in the bid specifications.

Bid specification packages are available at the town Office of the Treasurer, Tobie Shelton, located at 510 7th Street, Altavista, Virginia 24517 or at the offices of Business Solutions located at 303 East Burwell Street, Salem, VA 24153 or by calling 434-369-5001. All bidders are encouraged to call the offices of Business Solutions, Rebecca Pollard, at 540-444-4000 if they have questions concerning the bid process.

Bids are to be submitted in accordance with specifications stipulated in the bid documents. The bids will not be sealed but must be marked "BIDS FOR GROUP HEATLH INSURANCE". The town reserves the right to accept or reject any or all bids received.

BID SPECIFICATIONS:

I. General bid specifications and Requirements for Health Insurance

A. Coverage shall be effective September 1, 2014. Coverage shall be guaranteed for a minimum of 12 months from the effective date at the same premium quoted in the bid or as negotiated. It would be the town's intent to renew the coverage after the initial coverage period by negotiation with the bidder. Such renewal process may be conducted annually. The town must be notified of their renewal 90 days in advance of the contract anniversary date of any premium increase.

B. If exceptions from coverage are made, exceptions must be clearly stated on each proposal.

C. Envelopes containing the bids shall be marked… "**Bids for Group Health Insurance – RFP #06-11-2014.**

D. The bidder is required to examine carefully the specifications and risks to be covered. It will be assumed that the bidder has made such investigations and is fully informed as to the extent and character of the hazards and requirements of the specifications. No warranty is made or implied as to information contained in these specifications.

E. All bids shall show or conform to the following, in addition to other information required on the bid form:

1. Name of the proposed insurance company
2. Insurance company rating from A.M. Best's Insurance Guide or appropriate financial documents to assure that the bidder is a stable, sound responsible company.

3. Insurance companies must be authorized to do business in the state of Virginia

F. All bids shall contain an attachment thereto giving a description of services to be supplied as part of the insurance coverage. A brief description of claims service shall be included.
G. Cancellation, termination or expiration of the policy by the insurer shall require 90 days notice.
H. All bidders must agree in writing to furnish the town with quarterly claims reports and claims over $10,000.
I. All policies are to cover any new employees under the same conditions as provided under initial implementation of the coverage.
J. All inquiries as to the meaning of the bid specifications must be put in writing and sent to the email address of Rebecca Pollard, Business Solutions: BPollard@BusinessSolutionsInc.net.
K. No bid shall be withdrawn for a period of 90 days subsequent to the opening of the bids.
L. The successful bidder shall be required to provide on-site training and a question and answer session for town employees. Also the successful bidder shall be required to furnish monthly on-site visits by a customer service representative or at requested intervals by the Town of Altavista. On-line enrollment must be made available to the Town of Altavista.
M. The governing body will make the award as soon as practical to the best bidder considering prices and other factors as determined by the town. The governing body reserves the right to reject any and all bids received.
N. For additional information contact Rebecca Pollard with Business Solutions who is acting as consultant for the Town of Altavista. The phone number for Business Solutions is 540-444-4000.
O. Summary of Benefits, claims information and large claims information will be provided in additional attachments as required by the bidders.
P. Census may be obtained electronically from Business Solutions.
Q. Bidders shall identify their provider network by name, supplying a geo-access report regarding networks available to each employee and specify whether the benefit design is an HMO or a PPO.
R. All bids will be net of commissions.
S. A BID PROPOSAL FORM will be returned will all proposals… see enclosed form.

INTRUCTIONS TO BIDDERS

TOWN OF ALTAVISTA

I. All bids are to match current benefits as outlined in the bid proposal.
II. Please provide the following benefit design and rates::

HSA and HRA: 100% and 80/20 Co-Insurance where it is applicable
$2,000 Deductible
$3,000 Deductible
$4,000 Deductible

III. All questions should be directed in writing and follow up by phone to Rebecca Pollard, Business Solutions, 540-444-4000 or at BPollard@BusinessSolutionsInc.net
IV. Current carrier: Coventry Healthcare
Current Dental Carrier: Ameritas
V. Carriers are to provide dental quotes to match current dental benefit design (Perio and Endo paid at 80%) / Claims paid in 90th percentile
VI. Provide a "free standing" vision quote with several variations of coverage. "Materials only" if possible ad they have coverage for routine office exam already
VII. The Town would like to continue to cover retirees until age 65

Note: Please send a copy of the final Bid to Becky Pollard at Business Solutions either by mail, at 303 East Burwell Street, Salem, VA 24153 or by email at BPollard@BusinessSolutionsInc.net

TO BE RETURNED WITH PROPOSALS

BID PROPOSAL FORM

The undersigned is familiar with the specifications and other information as supplied in this invitation to present proposals and understands that the Town of Altavista will not be responsible for any errors or omission on the part of the undersigned in making up the proposal. Any deviations or exceptions must be fully explained in writing by the undersigned.

It is understood that the Town of Altavista reserves the right to reject any or all proposals or any part thereof, or to accept any proposal or any part thereof, and to waive any formalities in any proposal deemed to be for the best interest of the Town of Altavista.

The undersigned is willing to discuss all proposals with the Town of Altavista's insurance consultant and to negotiate with the consultant as required.

BY _____

Signed Authorized Representative

_____

Authorized Representative (Typed or Printed)

_____

Name of Firm

_____

Address

_____

Phone Number (Include Area Code)

CURRENT COVENTRY INFORMATION

(RATES AND BENEFITS)

COVENTRY
Health Care of Virginia, Inc.

Proposal Exhibit - Medical

Revised

TOWN OF ALTAVISTA

County/Region: Lynchburg
Zip Code: 24517
SIC Code: 9111
Case Status: UW Approved - Final
Broker Pass-Through: ☐

Agent: Pollard, Rebecca
Agency: Business Solutions, Inc.
Account Manager: Carel, Nick
Association: None
Broker Pass-Through Fee: N/A

Quote ID: 226647
Effective Date: 7/1/2014
Next Ren. Date: 7/1/2015
Eligible Employees: 99
Covered Employees: 48

Option Summary	Option - 4	Option - 5	Option - 6
Segment	1	1	1
Package	B	B	B
Current Plan	False	False	False
Product	POS	PPO	PPO
Medical Plan	Care POS 25/50/350 p/d 0 Ded (14Q1)	Value PPO 30/50/20% 1000 Ded (14Q1)	Value PPO 25/50/20% 500 Ded (14Q1)
Rx Plan	3/10/20/45/45<20%<300/30% 1-2-3 $4K MOOP (Select)	3/10/20/45/45<20%<300/30% 1-2-3 $5K MOOP (Select)	3/10/20/45/45<20%<300/30% 1-2-3 $4K MOOP (Select)
Riders	VA POS VISION 9758, HMO/POS (incl CHDP) VA MENTAL HEALTH RIDER, Autism Rider	VA PPO VISION 9759, PPO (incl CDHP) VA MENTAL HEALTH RIDER, Autism Rider	VA PPO VISION 9759, PPO (incl CDHP) VA MENTAL HEALTH RIDER, Autism Rider
Domestic Partner	N/A	N/A	N/A
Network	CHC-VA HMO/POS Network	CHC-VA PPO Network	CHC-VA PPO Network

In-Network Benefit Summary			
Deductible	$0 / $0	$1000 / $2000	$500 / $1000
Coinsurance	0%	20%	20%
OOP Max	$4000 / $8000	$5000 / $10000	$4000 / $8000
PCP/SCP	$25/$50	$30/$50	$25/$50
HIP	$350 / Day	20%	20%
HOP	$300	20%	20%
ER/Urgent Care	$75 / $200	$75 / $250	$75 / $200

Enrollment and Tier Ratios	Subscribers	Members	Tier Ratio	Subscribers	Members	Tier Ratio	Subscribers	Members	Tier Ratio
EE Only	14	14	1.00	9	9	1.00	6	6	1.00
EE/SP	4	8	1.85	3	6	1.85	3	6	1.85
EE/CH	1	2	1.85	1	2	1.85	1	2	1.85
EE/Chr	0	0	2.70	0	0	2.70	0	0	2.70
Family	3	12	2.70	2	10	2.70	1	4	2.70
Total Est. Enrollment	**22**	**36**		**15**	**27**		**11**	**18**	

Rates + PPACA Fees	Tier Rate	PPACA Fee	Rate + Fee	Tier Rate	PPACA Fee	Rate + Fee	Tier Rate	PPACA Fee	Rate + Fee
EE Only	$526.85	$21.67	$548.52	$454.22	$18.68	$472.90	$478.55	$19.68	$498.23
EE/SP	$975.24	$40.11	$1,015.35	$840.78	$34.58	$875.36	$885.83	$36.43	$922.26
EE/CH	$975.24	$40.11	$1,015.35	$840.78	$34.58	$875.36	$885.83	$36.43	$922.26
EE/Chr	$1,422.50	$58.50	$1,481.00	$1,226.38	$50.43	$1,276.81	$1,292.09	$53.14	$1,345.23
Family	$1,422.50	$58.50	$1,481.00	$1,226.38	$50.43	$1,276.81	$1,292.09	$53.14	$1,345.23
Est. Total Monthly Premium	$16,519.60			$9,903.86			$7,706.71		
Aggregate Change*	15.8 %			15.8 %			15.8 %		
Est. Monthly PPACA Fee	$679.43			$407.30			$316.94		
Est. Total Monthly Charge:	$17,199.03			$10,311.16			$8,023.65		
Aggregate Change w/ PPACA*	20.6 %			20.6 %			20.6 %		

*The Aggregate Change is compared to Current Premium Rates.

Subject to attached contingencies and disclaimers.

The PPACA Fees shall apply effective 7/1/2014 and shall be owed by TOWN OF ALTAVISTA in addition to the Rates.

Please see your plan documents** for complete benefit descriptions for the above plan.
**Group Policy, Certificate/Evidence of Coverage, Booklet, Group Agreement, Schedule of Benefits, and/or Group Insurance Certificate

Accepted by_____ Title_____ Date_____

Quote Created by nccarel at 9:11 AM on 5/22/2014 (us)
RIDN: 491-9320480, Quote ID: 226647, Ver.: 3.0.77.4

COVENTRY
Health Care of Virginia, Inc.

Renewal Summary Report

Group Name: TOWN OF ALTAVISTA/SP

Super Group Number: 9320480000

Renewal Date: 7/1/2014 ✔

High Dollar Claimants during prior twelve month period (Claimants over $10,000)

$105,737.95

$16,342.19

$11,557.59

Note: $105,737.95 (deceased)

Active Condition

Please note that Renewal Year Active Conditions do not necessarily relate to Current Year High Dollar Claimants

Malignant neoplasm of breast/female genital tract with active management, with significant complication/comorbidity

Unspecified Immunity Deficiency

Adult rheumatoid arthritis

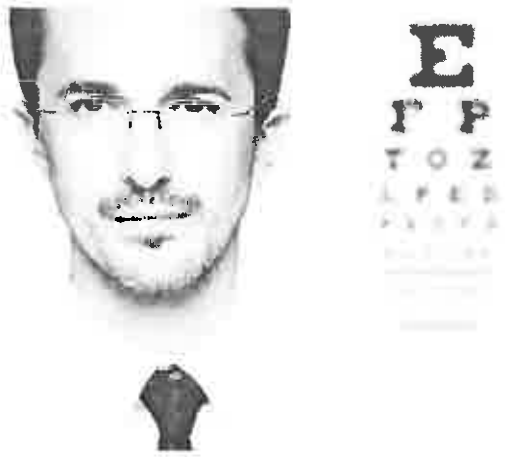
Other higher cost hepatology

Other higher cost hepatology

Malignant neoplasm, gastroenterology, I

COVENTRY
Health Care of Virginia, Inc.

Your Vision Benefits Explained



Our members have access to a network of contracted eye doctors throughout Virginia, many of whom offer evening and weekend appointments.

Vision benefits allow for a comprehensive refractive eye exam for eyeglasses every 12 months. Contact lens exams are not covered as part of this visit. Call to make an appointment for these services and to verify the vision provider you have selected is still in the network.

LOOKING FOR AN EYE DOCTOR?

To search for an eye doctor, visit **www.chcva.com - Find a Doctor - Vision Providers**. By logging in to the VSP website, you will access only the doctors who participate in your plan. To login or register, use your Coventry Health Care of Virginia, Inc. member ID number which is found on your member ID card. For more information, contact VSP at 800-877-7195.

VISION SERVICES

Exams:

Spectacle	$0 copayment
Out-of-Network	$35 benefit*

*HMO members have in-network benefits only

VISION DISCOUNT PROGRAM**

Coventry Health Care of Virginia, Inc. members enjoy additional savings through a VSP discount program.

- Discount on prescription and non-prescription glasses, including sunglasses. This discount is available from any participating provider within 12 months of the last covered eye exam from a participating provider.
- Discount on cosmetic options, including anti-reflective coatings and tinted lenses.
- Discount on contact lens exam.
- Savings off contracted laser center prices for laser vision correction surgery or an additional discount off the center's promotional price.
- There are no claim forms to complete and no waiting for rebates.

Treatment of diseases and injuries of the eye are covered under your medical benefits and are not part of your vision benefits. The specialist office visit copayment listed in your Schedule of Benefits will apply to these medical visits.

**These services are being offered by a third-party vendor and Coventry Health Care of Virginia, Inc. is not liable for the provision of these services, the failure to provide services, or the negligent provision of these services. These services are subject to modification or discontinuance without notice.

PPO products are underwritten by Coventry Health and Life Insurance Company and administered by Coventry Health Care of Virginia, Inc. This is a summary of your vision benefits. For a complete description of your vision benefits, refer to VA.VIS-HMO.14, VA.VIS-POS.14 and VA.VIS-PPO.14.

Data Classification: Public CHC-VA.VSP.08-13

Your Prescription Benefits

COVENTRY Health Care of Virginia, Inc.

Tier	Retail Pharmacy 31-day Supply[1]	Mail Order 1-2-3 90-day Supply[1]
One-A	$3	One Copayment
One	$10	One Copayment
Two	$20	Two Copayments
Three	$45	Three Copayments
Four	$45 or 20% up to $300	Not Applicable[2]
Five	30%	Not Applicable[2]
Deductible	$0 individual	
Prescription expenses contribute to the medical Out-of-Pocket Maximum.		

Things to Remember

- Use your member ID card when filling a prescription. You may only file a claim for reimbursement for a prescription in a true emergency.
- Your prescription may not be covered if you do not have a prior authorization when one is required.
- If you take a specific medicine on a regular basis, you may be eligible for the mail order program.
- You may call Customer Service at 800-627-4872 or the Pharmacy Help Desk at 800-378-7040.

Retail Maintenance Benefit If you take a medication on a regular basis (maintenance drug), you may be eligible to get a 90-day supply of your medication either through the mail order program described above or through the retail maintenance program. If you obtain your maintenance medications at a retail pharmacy instead of through the mail order, you will pay one copayment for up to a 31-day supply[1], two copayments for up to a 60-day supply[1] and three copayments for up to a 90-day supply[1]. To take advantage of either the mail order benefit or the retail maintenance benefit, ask your doctor to write your prescription for a 90-day supply.

Access to National Pharmacy Network - Designed to provide maximum geographic coverage, the pharmacy network consists of more than 67,000 stores in the United States, Puerto Rico and the Virgin Islands. The national network includes national chains and independent drug stores. You can find participating pharmacies on our website, **www.chcva.com**. Retail prescriptions must be filled at a participating pharmacy or a non-participating pharmacy that has agreed to accept the Express Scripts reimbursement rate as payment in full.

Online Drug List - Our online Prescription Drug List will provide you with important information such as generic and preferred drug alternatives, quantity limits and prior authorization requirements. You can also access the mail order program. To use the online formulary, visit the Services and Support section of **www.chcva.com** and click on the link for Prescription Coverage on the right side of the page. Your plan coverage may vary slightly from the searchable formulary results. Once you have been enrolled, we encourage you to use the pharmacy tools which can be accessed through My Online Services.

Transition Rx Program - This program provides new members with a transition service for the first 90 days of coverage beginning on your effective date. You may obtain a one-time fill or refill of certain covered prescription drugs, up to a 31-day supply, at the applicable copayment without being subject to prior authorization, step therapy and/or quantity limit requirements that normally apply to those drugs. We will then send a letter to your prescribing provider advising that the one-time fill or refill was made available. Most commonly used prior authorization, step therapy and once-daily quantity limit drugs are eligible under the Transition Rx program. Specialty injectables and other quantity limits are excluded from the program. To find out what drugs are subject to prior authorization, step therapy, quantity limits or other requirements, you may call Customer Service at **800-627-4872** or visit **www.chcva.com**.

Generic Drugs - Our program requires "mandatory" generic substitution if the FDA has determined the generic to be equivalent to the brand-name product. Effective January 1, 2013, all brand drugs that have multi-source generics are Tier Three drugs. If your physician requires that you take the brand-name drug instead of the generic drug, or if you elect the brand-name rather than the generic at the point of sale, you will pay the Tier Three copayment plus the difference (ancillary charge) in cost between the generic and the brand. The ancillary charge does not apply to any deductible or maximum out-of-pocket.

Quantity Limits - Some medications on the Prescription Drug List have restrictions on the quantity that we will cover. Prior authorization may be required if the dosage of the medication being prescribed varies from the FDA and manufacturer's recommended dose.

Health Care Reform - Coverage for preventive drug products will be provided at 100% of the allowable charge/allowed amount consistent with provisions of the Affordable Care Act.

The following services are not covered under your prescription drug benefits:

- Drugs which are not Medically Necessary
- Drugs obtained from non-participating pharmacies in a non-emergency situation when such pharmacies have not previously notified Us, by facsimile or otherwise, of their agreement to accept as payment in full reimbursement for their services at rates available to pharmacies that are Participating Providers, including any Copayment, Coinsurance and/or Deductible consistently imposed by Us
- Any Prescription Drug which is to be administered, in whole or in part while a Member is in a hospital, medical office or other health care facility (this is covered under Your medical benefit according to the place of service)
- Medication used for travel prophylaxis
- Growth Hormone for adults
- Any Prescription Drug that is being used or abused in a manner that is determined to be furthering an addiction to a habit-forming substance
- Over-the-counter drugs and products that do not, by federal or state law, require a prescription to be dispensed, such as antacids, herbal products, medicated soaps, and bandages, unless recommended by the US Preventive Task Force and prescribed by a physician or as part of an over-the-counter (OTC) program sponsored by Us.
- Contraceptive implant systems and intrauterine devices (IUDs). (This is covered under Your medical benefit)
- Dietary supplements, appetite suppressants, drugs used to treat obesity or assist in weight reduction or weight gain, and malabsorption agents
- Drugs and products for smoking cessation, including Prescription Drugs such as Zyban and Chantix, with the exception of OTC or wellness programs sponsored by Us
- Medications prescribed for cosmetic purposes, including but not limited to, tretinoin for aging skin and minoxidil lotion
- Drugs and products used to promote conception
- Injectable medications, with the exception of Self-Administered Injectable Drugs
- Medications for treatment of diseases of teeth and gums, except fluoride tablets or drops
- Devices or supplies of any type, regardless of having a Prescription Order, unless specifically listed as covered under the outpatient prescription coverage section. These include, but are not limited to tubing for insulin pumps; ostomy supplies, including bags, adhesives, tubing, therapeutic devices, support garments, corrective appliances, non-disposable hypodermic needles, or other devices regardless of their intended use. Insulin pumps and ostomy supplies as well as other durable medical equipment and medical supplies are covered under the medical benefit as stated in the Covered Services section.
- Allergy supplies, including syringes (this is covered under the medical benefit)
- Experimental and Investigational Drugs; products not approved by the FDA; drugs with no FDA-approved indications, medications prescribed at dosages in excess of FDA approval; drugs prescribed for purposes other than the FDA approved use, unless a drug is recognized for treatment of the covered indication in one of the Standard Reference Compendia or in substantially accepted Peer-Reviewed Medical Literature. Cancer drugs that are FDA approved for a certain cancer type may be used for treatment of other types of cancer provided the drug has been recognized as safe and effective for treatment of that specific type of cancer in any of the Standard Reference Compendia. Any drug approved by the FDA for use in the treatment of cancer pain shall not be denied for coverage on the basis that the dosage is in excess of the recommended dosage of the pain relieving agent, if the prescription in excess of the recommended dosage has been prescribed in compliance with Virginia law for a patient with intractable cancer pain.
- Vitamins and minerals (both OTC and legend), except legend prenatal vitamins for pregnant and nursing females, liquid or chewable legend pediatric vitamins for children under age 13, and potassium supplements to prevent/treat low potassium
- Biological sera and Hemophilia blood factors (this is covered under the medical benefit)
- Medications used to enhance athletic performance, including but not limited to, anabolic steroids
- Medications related to sexual transformation or transgender
- Medications for a condition or injury related to a Worker's Compensation claim

[1] Or the appropriate prescribing unit as described in your pharmacy rider
[2] Tier Four medications are limited to a 31-day supply per fill.

PPO products are underwritten by Coventry Health and Life Insurance Company and administered by Coventry Health Care of Virginia, Inc. This brochure is intended to be used with prospective and renewing members. This brochure refers to form numbers VA.HMORX.14, VA.POSRX.14, and VA.PPORX.14.

Coventry Health Care of Virginia, Inc.: Care POS 25/50/350 Per Day

Coverage Period : 07/01/2014 - 06/30/2015

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: EE, EE/Sp., EE/1Ch., EE/Children, Fam. | **Plan Type:** POS

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.chcva.com or by calling 1-800-627-4872.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-network: $0 person/family Out-of-network: $300 person $600 family. Applies to all out-of-network services	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?	In-network: Yes $4,000 person $8,000 family Out-of-network: Yes $4,000 person $8,000 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?	Premiums, balance-billed charges, health care this plan does not cover	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 For a list of in-network providers, see www.chcva.com or call 1-800-627-4872.	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**.
Do I need a referral to see a specialist?	No	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 4. See your policy or plan document for additional information about **excluded services**.

SNO: 1227292 **SBC Name:** 002_90461 002_46003 002_9758

Questions: Call 1-800-627-4872 or visit us at www.chcva.com. If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at http://www.cms.gov/CCIIO/resources/files/downloads/uniform-glossary-final.pdf or call 1-800-627-4872 to request a copy.

- **Co-payments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** 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 **co-insurance** 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 a		Limitations & Exceptions
		In-network Provider	Out-of-network Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 co-payment (co-pay)/visit	30% co-insurance (co-ins)	----------none----------
	Specialist visit	$50 co-pay/visit	30% co-ins	----------none----------
	Other practitioner office visit	$50 co-pay/visit chiropractor	30% co-ins	Limited: 10 visits/year
	Preventive care/ Screening/Immunization	No Charge	30% co-ins	----------none----------
If you have a test	Diagnostic test (x-ray, blood work)	$0 co-pay/service x-ray $0 co-pay/service lab	30% co-ins x-ray 30% co-ins lab	----------none----------
	Imaging (CT/PET scans, MRIs)	$200 co-pay/visit	30% co-ins	Not covered without preauthorization (preauth)
If you need drugs to treat your illness or condition. More information about prescription drug coverage is available at www.chcva.com.	Generic drugs	$10 co-pay/fill retail/mail	Not Covered	Select generics $3 co-pay/fill retail/mail. 30-day supply retail, 90-day supply mail. May require preauth for coverage
	Preferred brand drugs	$20 co-pay/fill retail, $40 co-pay/fill mail	Not Covered	30-day supply retail, 90-day supply mail. May require preauth for coverage
	Non-preferred brand drugs	$45 co-pay/fill retail, $135 co-pay/fill mail	Not Covered	30-day supply retail, 90-day supply mail. May require preauth for coverage
	Specialty drugs	Preferred: $45 co-pay/fill or 20% co-ins up to $300 max, Non-preferred: 30% co-ins	Not Covered	Limited: 30-day supply/fill, not covered without preauth

Questions: Call 1-800-627-4872 or visit us at www.chcva.com. If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at http://www.cms.gov/CCIIO/resources/files/downloads/uniform-glossary-final.pdf or call 1-800-627-4872 to request a copy.

Common Medical Event	Services You May Need	Your cost if you use a In-network Provider	Your cost if you use a Out-of-network Provider	Limitations & Exceptions
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$300 co-pay/visit	30% co-ins	Not covered without preauth
	Physician/surgeon fees	$0 co-pay/visit	30% co-ins	Not covered without preauth
If you need immediate medical attention	Emergency room services	$200 co-pay/visit facility, $50 co-pay/visit providers	$200 co-pay/visit facility, $50 co-pay/visit providers	----------none----------
	Emergency medical transportation	$100 co-pay/service ground, $500 co-pay/service air/water	$100 co-pay/service ground, $500 co-pay/service air/water	----------none----------
	Urgent care	$75 co-pay/visit	$75 co-pay/visit	----------none----------
If you have a hospital stay	Facility fee (e.g., hospital room)	$350 co-pay/day up to $1,750 co-pay/stay	30% co-ins	Not covered without preauth
	Physician/surgeon fee	$0 co-pay/stay	30% co-ins	Not covered without preauth
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$25 co-pay/visit	30% co-ins	Some services require preauth for coverage
	Mental/Behavioral health inpatient services	$350 co-pay/day up to $1,750 co-pay/stay	30% co-ins	Not covered without preauth
	Substance use disorder outpatient services	$25 co-pay/visit	30% co-ins	Some services require preauth for coverage
	Substance use disorder inpatient services	$350 co-pay/day up to $1,750 co-pay/stay	30% co-ins	Not covered without preauth
If you are pregnant	Prenatal and postnatal care	No Charge	30% co-ins	----------none----------
	Delivery and all inpatient services	$350 co-pay/day up to $1,750 co-pay/stay	30% co-ins	----------none----------
If you need help recovering or have other special health needs	Home health care	$0 co-pay/visit	30% co-ins	Limited: 90 visits/year, not covered without preauth
	Rehabilitation services	Inpatient $350 co-pay/day up to $1,750 co-pay/stay Outpatient $50 co-pay/visit	Inpatient 30% co-ins Outpatient 30% co-ins	Outpatient: limited 30 PT/OT & Speech visits/year, Inpatient: not covered without preauth

Questions: Call 1-800-627-4872 or visit us at www.chcva.com. If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at http://www.cms.gov/CCIIO/resources/files/downloads/uniform-glossary-final.pdf or call 1-800-627-4872 to request a copy.

Common Medical Event	Services You May Need	Your cost if you use a In-network Provider	Your cost if you use a Out-of-network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Habilitation services	Not Covered	Not Covered	Not Covered
	Skilled nursing care	$0 co-pay/stay	30% co-ins	Limited: 100 days/year, not covered without preauth
	Durable medical equipment	$0 co-pay/service	30% co-ins	Purchase over $500/all rentals require preauth for coverage
	Hospice Service	$0 co-pay/service	30% co-ins	Not covered without preauth
If your child needs dental or eye care	Eye exam	No Charge	$35 benefit payable	---------none---------
	Glasses	Not Covered	Not Covered	Not Covered
	Dental check-up	Not Covered	Not Covered	Not Covered

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
- Child/Glasses
- Habilitation services
- Long-Term Care
- Weight Loss Programs
- Bariatric Surgery
- Cosmetic Surgery
- Hearing Aids
- Private-Duty Nursing
- Child/Dental Check-up
- Dental Care (Adult)
- Infertility Treatment
- Routine Foot Care

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.)

- Chiropractic Care
- Non-Emergency Care when Traveling Outside the U.S.
- Routine Eye Care (Adult)

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 1-800-627-4872. 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:

For group health coverage subject to ERISA, you may contact 1-800-627-4872. You may also contact, the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform , or your state department of insurance at Office of the Managed Care Ombudsman Bureau of Insurance P.O. Box 1157 Richmond, VA 23218 877-310-6560 (Toll Free) E-Mail: ombudsman@scc.virginia.gov.

For non-federal governmental group health plans and church plans that are group health plans, you may contact 1-800-627-4872 or your state department of insurance at Office of the Managed Care Ombudsman Bureau of Insurance P.O. Box 1157 Richmond, VA 23218 877-310-6560 (Toll Free) E-Mail: ombudsman@scc.virginia.gov.

Additionally, a consumer assistance program can help you file your appeal. Contact Virginia State Corporation Commission Life & Health Division, Bureau of Insurance P.O. Box 1157 Richmond, VA 23218 (877) 310-6560 http://www.scc.virginia.gov/boi bureauofinsurance@scc.virginia.gov

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:

Spanish (Espanol): Para obtener asistencia en Espanol, llame al 1-800-627-4872.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-627-4872.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-627-4872.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-627-4872.

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 insurance protection you might get from 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:	$6,670
You pay:	$870
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**
You pay:	
Deductibles	$0
Co-pays	$800
Coinsurance	$0
Limits or exclusions	$70
Total	**$870**

Managing type 2 diabetes

(routine maintenance of a well-controlled condition)

Amount owed to providers:	$5,400
Plan pays:	$3,640
You pay:	$1,760
Sample care costs:	
Prescriptions	$2,900
Medical equipment and supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccine, other preventive	$100
Total	**$5,400**
You pay:	
Deductibles	$0
Co-pays	$1,700
Coinsurance	$0
Limits or exclusions	$60
Total	**$1,760**

Note: These numbers assume the patient is participating in our diabetes wellness program. If you have diabetes and do not participate in the wellness program, your costs may be higher. For more information about the diabetes wellness program, please contact: 1-800-627-4872

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?

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?

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?

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?

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.

Questions: Call 1-800-627-4872 or visit us at www.chcva.com. If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at http://www.cms.gov/CCIIO/resources/files/downloads/uniform-glossary-final.pdf or call 1-800-627-4872 to request a copy.

Coventry Health and Life Insurance Company: Value PPO 25/50/20% 500 Deductible

Coverage Period : 07/01/2014 - 06/30/2015

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: EE, EE/Sp., EE/1Ch., EE/Children, Fam. | **Plan Type:** PPO

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.chcva.com or by calling 1-800-627-4872.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-network: $500 person $1,000 family. Doesn't apply: office visits, preventive, labs/x-rays, urgent care, ER, outpatient rehabilitation, prescriptions, vision Out-of-network: $500 person $1,000 family. Applies to all out-of-network services	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?	In-network: Yes $4,000 person $8,000 family Out-of-network: Yes $4,000 person $8,000 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?	Premiums, balance-billed charges, health care this plan does not cover	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 For a list of in-network providers, see www.chcva.com or call 1-800-627-4872.	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**.
Do I need a referral to see a specialist?	No	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 4. See your policy or plan document for additional information about **excluded services**.

SNO: 1227294 **SBC Name:** 002_75639 002_46003 002_9759

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- **Co-payments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** 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 **co-insurance** 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 a		Limitations & Exceptions
		In-network Provider	Out-of-network Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 co-payment (co-pay)/visit	30% co-insurance (co-ins)	----------none----------
	Specialist visit	$50 co-pay/visit	30% co-ins	----------none----------
	Other practitioner office visit	$50 co-pay/visit chiropractor	30% co-ins	Limited: 10 visits/year
	Preventive care/ Screening/Immunization	No Charge	30% co-ins	----------none----------
If you have a test	Diagnostic test (x-ray, blood work)	20% co-ins x-ray 20% co-ins lab	30% co-ins x-ray 30% co-ins lab	----------none----------
	Imaging (CT/PET scans, MRIs)	20% co-ins	30% co-ins	Not covered without preauthorization (preauth)
If you need drugs to treat your illness or condition. More information about prescription drug coverage is available at www.chcva.com.	Generic drugs	$10 co-pay/fill retail/mail	Not Covered	Select generics $3 co-pay/fill retail/mail. 30-day supply retail, 90-day supply mail. May require preauth for coverage
	Preferred brand drugs	$20 co-pay/fill retail, $40 co-pay/fill mail	Not Covered	30-day supply retail, 90-day supply mail. May require preauth for coverage
	Non-preferred brand drugs	$45 co-pay/fill retail, $135 co-pay/fill mail	Not Covered	30-day supply retail, 90-day supply mail. May require preauth for coverage
	Specialty drugs	Preferred: $45 co-pay/fill or 20% co-ins up to $300 max, Non-preferred: 30% co-ins	Not Covered	Limited: 30-day supply/fill, not covered without preauth

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Common Medical Event	Services You May Need	Your cost if you use a In-network Provider	Your cost if you use a Out-of-network Provider	Limitations & Exceptions
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% co-ins	30% co-ins	Not covered without preauth
	Physician/surgeon fees	20% co-ins	30% co-ins	Not covered without preauth
If you need immediate medical attention	Emergency room services	$200 co-pay/visit facility, 20% co-ins providers	$200 co-pay/visit facility, 20% co-ins providers	----------none----------
	Emergency medical transportation	$100 co-pay/service ground, 20% co-ins air/water	$100 co-pay/service ground, 20% co-ins air/water	----------none----------
	Urgent care	$75 co-pay/visit	$75 co-pay/visit	----------none----------
If you have a hospital stay	Facility fee (e.g., hospital room)	20% co-ins	30% co-ins	Not covered without preauth
	Physician/surgeon fee	20% co-ins	30% co-ins	Not covered without preauth
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$25 co-pay/visit	30% co-ins	Some services require preauth for coverage
	Mental/Behavioral health inpatient services	20% co-ins	30% co-ins	Not covered without preauth
	Substance use disorder outpatient services	$25 co-pay/visit	30% co-ins	Some services require preauth for coverage
	Substance use disorder inpatient services	20% co-ins	30% co-ins	Not covered without preauth
If you are pregnant	Prenatal and postnatal care	No Charge	30% co-ins	----------none----------
	Delivery and all inpatient services	20% co-ins	30% co-ins	----------none----------
If you need help recovering or have other special health needs	Home health care	20% co-ins	30% co-ins	Limited: 90 visits/year, not covered without preauth
	Rehabilitation services	Inpatient 20% co-ins Outpatient $50 co-pay/visit	Inpatient 30% co-ins Outpatient 30% co-ins	Outpatient: limited 30 PT/OT & Speech visits/year, Inpatient: not covered without preauth
	Habilitation services	Not Covered	Not Covered	Not Covered

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Common Medical Event	Services You May Need	Your cost if you use a In-network Provider	Your cost if you use a Out-of-network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Skilled nursing care	20% co-ins	30% co-ins	Limited: 100 days/year, not covered without preauth
	Durable medical equipment	20% co-ins	30% co-ins	Purchase over $500/all rentals require preauth for coverage
	Hospice Service	20% co-ins	30% co-ins	Not covered without preauth
If your child needs dental or eye care	Eye exam	No Charge	$35 benefit payable	----------none----------
	Glasses	Not Covered	Not Covered	Not Covered
	Dental check-up	Not Covered	Not Covered	Not Covered

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
- Child/Glasses
- Habilitation services
- Long-Term Care
- Weight Loss Programs
- Bariatric Surgery
- Cosmetic Surgery
- Hearing Aids
- Private-Duty Nursing
- Child/Dental Check-up
- Dental Care (Adult)
- Infertility Treatment
- Routine Foot Care

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.)

- Chiropractic Care
- Non-Emergency Care when Traveling Outside the U.S.
- Routine Eye Care (Adult)

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 1-800-627-4872. 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:

For group health coverage subject to ERISA, you may contact 1-800-627-4872. You may also contact, the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform , or your state department of insurance at Office of the Managed Care Ombudsman Bureau of Insurance P.O. Box 1157 Richmond, VA 23218 877-310-6560 (Toll Free) E-Mail: ombudsman@scc.virginia.gov.

For non-federal governmental group health plans and church plans that are group health plans, you may contact 1-800-627-4872 or your state department of insurance at Office of the Managed Care Ombudsman Bureau of Insurance P.O. Box 1157 Richmond, VA 23218 877-310-6560 (Toll Free) E-Mail: ombudsman@scc.virginia.gov.

Additionally, a consumer assistance program can help you file your appeal. Contact Virginia State Corporation Commission Life & Health Division, Bureau of Insurance P.O. Box 1157 Richmond, VA 23218 (877) 310-6560 http://www.scc.virginia.gov/boi bureauofinsurance@scc.virginia.gov

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:

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Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-627-4872.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-627-4872.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-627-4872.

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 insurance protection you might get from 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:** $5,920
- **You pay:** $1,620

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**
You pay:	
Deductibles	$500
Co-pays	$20
Coinsurance	$900
Limits or exclusions	$200
Total	**$1,620**

Managing type 2 diabetes

(to the standards of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays:** $3,610
- **You pay:** $1,790

Sample care costs:	
Prescriptions	$2,900
Medical equipment and supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccine, other preventive	$100
Total	**$5,400**
You pay:	
Deductibles	$300
Co-pays	$1,400
Coinsurance	$30
Limits or exclusions	$60
Total	**$1,790**

Note: These numbers assume the patient is participating in our diabetes wellness program. If you have diabetes and do not participate in the wellness program, your costs may be higher. For more information about the diabetes wellness program, please contact: 1-800-627-4872

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?

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?

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?

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?

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.

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Coventry Health and Life Insurance Company: Value PPO 30/50/20% 1,000 Deductible

Coverage Period : 07/01/2014 - 06/30/2015

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: EE, EE/Sp., EE/1Ch., EE/Children, Fam. | **Plan Type:** PPO

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.chcva.com or by calling 1-800-627-4872.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-network: $1,000 person $2,000 family. Doesn't apply: office visits, preventive, labs/x-rays, urgent care, ER, outpatient rehabilitation, prescriptions, vision Out-of-network: $1,000 person $2,000 family. Applies to all out-of-network services	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?	In-network: Yes $5,000 person $10,000 family Out-of-network: Yes $5,000 person $10,000 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?	Premiums, balance-billed charges, health care this plan does not cover	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 For a list of in-network providers, see www.chcva.com or call 1-800-627-4872.	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**.
Do I need a referral to see a specialist?	No	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 4. See your policy or plan document for additional information about **excluded services**.

SNO: 1227293 **SBC Name:** 002_75645 002_46005 002_9759

Questions: Call 1-800-627-4872 or visit us at www.chcva.com. If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at http://www.cms.gov/CCIIO/resources/files/downloads/uniform-glossary-final.pdf or call 1-800-627-4872 to request a copy.

- **Co-payments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** 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 **co-insurance** 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 a In-network Provider	Your cost if you use a Out-of-network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$30 co-payment (co-pay)/visit	30% co-insurance (co-ins)	----------none----------
	Specialist visit	$50 co-pay/visit	30% co-ins	----------none----------
	Other practitioner office visit	$50 co-pay/visit chiropractor	30% co-ins	Limited: 10 visits/year
	Preventive care/ Screening/Immunization	No Charge	30% co-ins	----------none----------
If you have a test	Diagnostic test (x-ray, blood work)	20% co-ins x-ray 20% co-ins lab	30% co-ins x-ray 30% co-ins lab	----------none----------
	Imaging (CT/PET scans, MRIs)	20% co-ins	30% co-ins	Not covered without preauthorization (preauth)
If you need drugs to treat your illness or condition. More information about prescription drug coverage is available at www.chcva.com.	**Generic drugs**	**$10 co-pay/fill** retail/mail	**Not Covered**	**Select generics $3 co-pay/fill retail/mail. 30-**day supply retail, 90-day supply mail. May require preauth for coverage
	Preferred brand drugs	$20 co-pay/fill retail, $40 co-pay/fill mail	Not Covered	30-day supply retail, 90-day supply mail. May require preauth for coverage
	Non-preferred brand drugs	$45 co-pay/fill retail, $135 co-pay/fill mail	Not Covered	30-day supply retail, 90-day supply mail. May require preauth for coverage
	Specialty drugs	Preferred: $45 co-pay/fill or 20% co-ins up to $300 max, Non-preferred: 30% co-ins	Not Covered	Limited: 30-day supply/fill, not covered without preauth

Questions: Call 1-800-627-4872 or visit us at www.chcva.com. If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at http://www.cms.gov/CCIIO/resources/files/downloads/uniform-glossary-final.pdf or call 1-800-627-4872 to request a copy.

Common Medical Event	Services You May Need	Your cost if you use a In-network Provider	Your cost if you use a Out-of-network Provider	Limitations & Exceptions
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% co-ins	30% co-ins	Not covered without preauth
	Physician/surgeon fees	20% co-ins	30% co-ins	Not covered without preauth
If you need immediate medical attention	Emergency room services	$250 co-pay/visit facility, 20% co-ins providers	$250 co-pay/visit facility, 20% co-ins providers	----------none----------
	Emergency medical transportation	$100 co-pay/service ground, 20% co-ins air/water	$100 co-pay/service ground, 20% co-ins air/water	----------none----------
	Urgent care	$75 co-pay/visit	$75 co-pay/visit	----------none----------
If you have a hospital stay	Facility fee (e.g., hospital room)	20% co-ins	30% co-ins	Not covered without preauth
	Physician/surgeon fee	20% co-ins	30% co-ins	Not covered without preauth
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$30 co-pay/visit	30% co-ins	Some services require preauth for coverage
	Mental/Behavioral health inpatient services	20% co-ins	30% co-ins	Not covered without preauth
	Substance use disorder outpatient services	$30 co-pay/visit	30% co-ins	Some services require preauth for coverage
	Substance use disorder inpatient services	20% co-ins	30% co-ins	Not covered without preauth
If you are pregnant	Prenatal and postnatal care	No Charge	30% co-ins	----------none----------
	Delivery and all inpatient services	20% co-ins	30% co-ins	----------none----------
If you need help recovering or have other special health needs	Home health care	20% co-ins	30% co-ins	Limited: 90 visits/year, not covered without preauth
	Rehabilitation services	Inpatient 20% co-ins Outpatient $50 co-pay/visit	Inpatient 30% co-ins Outpatient 30% co-ins	Outpatient: limited 30 PT/OT & Speech visits/year, Inpatient: not covered without preauth
	Habilitation services	Not Covered	Not Covered	Not Covered

Questions: Call 1-800-627-4872 or visit us at www.chcva.com. If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at http://www.cms.gov/CCIIO/resources/files/downloads/uniform-glossary-final.pdf or call 1-800-627-4872 to request a copy.

Common Medical Event	Services You May Need	Your cost if you use a In-network Provider	Your cost if you use a Out-of-network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Skilled nursing care	20% co-ins	30% co-ins	Limited: 100 days/year, not covered without preauth
	Durable medical equipment	20% co-ins	30% co-ins	Purchase over $500/all rentals require preauth for coverage
	Hospice Service	20% co-ins	30% co-ins	Not covered without preauth
If your child needs dental or eye care	Eye exam	No Charge	$35 benefit payable	----------none----------
	Glasses	Not Covered	Not Covered	Not Covered
	Dental check-up	Not Covered	Not Covered	Not Covered

Excluded Services & Other Covered Services:

Services You Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Child/Glasses
- Habilitation services
- Long-Term Care
- Weight Loss Programs
- Bariatric Surgery
- Cosmetic Surgery
- Hearing Aids
- Private-Duty Nursing
- Child/Dental Check-up
- Dental Care (Adult)
- Infertility Treatment
- Routine Foot Care

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.)

- Chiropractic Care
- Non-Emergency Care when Traveling Outside the U.S.
- Routine Eye Care (Adult)

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 1-800-627-4872. 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:

For group health coverage subject to ERISA, you may contact 1-800-627-4872. You may also contact, the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform , or your state department of insurance at Office of the Managed Care Ombudsman Bureau of Insurance P.O. Box 1157 Richmond, VA 23218 877-310-6560 (Toll Free) E-Mail: ombudsman@scc.virginia.gov.

For non-federal governmental group health plans and church plans that are group health plans, you may contact 1-800-627-4872 or your state department of insurance at Office of the Managed Care Ombudsman Bureau of Insurance P.O. Box 1157 Richmond, VA 23218 877-310-6560 (Toll Free) E-Mail: ombudsman@scc.virginia.gov.

Additionally, a consumer assistance program can help you file your appeal. Contact Virginia State Corporation Commission Life & Health Division, Bureau of Insurance P.O. Box 1157 Richmond, VA 23218 (877) 310-6560 http://www.scc.virginia.gov/boi bureauofinsurance@scc.virginia.gov

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:

Spanish (Espanol): Para obtener asistencia en Espanol, llame al 1-800-627-4872.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-627-4872.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-627-4872.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-627-4872.

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

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?

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?

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?

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?

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.

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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 insurance protection you might get from 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:	$5,520	
You pay:	$2,020	
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**
You pay:		
Deductibles		$1,000
Co-pays		$20
Coinsurance		$800
Limits or exclusions		$200
Total		**$2,020**

Managing type 2 diabetes

(routine maintenance of a well-managed condition)

Amount owed to providers:		$5,400
Plan pays:	$3,610	
You pay:	$1,790	
Sample care costs:		
Prescriptions		$2,900
Medical equipment and supplies		$1,300
Office Visits and Procedures		$700
Education		$300
Laboratory tests		$100
Vaccine, other preventive		$100
Total		**$5,400**
You pay:		
Deductibles		$300
Co-pays		$1,400
Coinsurance		$30
Limits or exclusions		$60
Total		**$1,790**

Note: These numbers assume the patient is participating in our diabetes wellness program. If you have diabetes and do not participate in the wellness program, your costs may be higher. For more information about the diabetes wellness program, please contact: 1-800-627-4872

TOWN OF ALTAVISTA

RATE HISTORY
2010, 2011, 2012 & 2013

BENEFIT DESIGNS

COVENTRY
Health Care of Virginia, Inc.

Proposal Exhibit - Medical

TOWN OF ALTAVISTA

County/Region: Lynchburg
Zip Code: 24517
SIC Code: 9111
Case Status: UW Approved - Final
Broker Pass-Through: ☐

Agent: Pollard, Rebecca
Agency: Business Solutions, Inc.
Account Executive Roberts, Lori
Association: None
Broker Pass-Through Fee: N/A

Quote ID: 200078
Effective Date: 7/1/2013
Next Ren. Date: 7/1/2014
Eligible Employees: 58
Covered Employees: 47

Option Summary	Option 31	Option 32	Option 33	Option 34
Segment	1	1	1	1
Package	Q	R	R	R
Current Plan	False	False	False	False
Product	POS	PPO	PPO	POS
Medical Plan	Care POS 25/50/350 p/d 0 Ded (12Q4)	Value PPO 30/50/20% 1000 Ded (12Q4)	Value PPO 25/50/20% 500 Ded (12Q4)	Care POS 25/50/350 p/d 0 Ded (12Q4)
Rx Plan	10/20/35/35<20%<300 3500 OPM	10/20/35/35<20%<300 3500 OPM	10/20/35/35<20%<300 3500 OPM	10/20/35/35<20%<300 3500 OPM
Riders	VA POS VISION 9634 15/35/40, HMO/POS VA MENTAL HEALTH RIDER, Autism Rider	VA PPO VISION 9635 15/35/40, PPO VA MENTAL HEALTH RIDER, Autism Rider	VA PPO VISION 9635 15/35/40, PPO VA MENTAL HEALTH RIDER, Autism Rider	VA POS VISION 9634 15/35/40, HMO/POS VA MENTAL HEALTH RIDER, Autism Rider
Domestic Partner	N/A	N/A	N/A	N/A
Network	CHC-VA HMO/POS Network	CHC-VA PPO Network	CHC-VA PPO Network	CHC-VA HMO/POS Network
In-Network Benefit Summary				
Deductible	$0 / $0	$1000 / $2000	$500 / $1000	$0 / $0
Coinsurance	0%	20%	20%	0%
OOP Max	$3000 / $6000	$3000 / $6000	$3000 / $6000	$3000 / $6000
PCP/SCP	$25/$50	$30/$50	$25/$50	$25/$50
HIP	$350 / Day	20%	20%	$350 / Day
HOP	$300	20%	20%	$300
ER/Urgent Care	$75 / $200	$75 / $250	$75 / $200	$75 / $200

Enrollment	Subscribers	Members	Subscribers	Members	Subscribers	Members	Subscribers	Members
EE Only	14	14	9	9	9	9	9	9
EE/SP	4	8	4	8	4	8	3	6
EE/CH	1	2	1	2	1	2	0	0
EE/Chr	0	0	0	0	0	0	0	0
Family	2	8	3	12	2	8	2	8
Total Est. Enrollment	**21**	**32**	**17**	**31**	**16**	**27**	**14**	**23**

Tier Ratios and Rates	Tier Ratios	Tier Rate	Tier Ratios	Tier Rate	Tier Ratios	Tier Rate	Tier Ratios	Tier Rate
EE Only	1.00	$438.25	1.00	$408.96	1.00	$423.21	1.00	$438.25
EE/SP	1.85	$811.23	1.85	$757.01	1.85	$783.39	1.85	$811.23
EE/CH	1.85	$811.23	1.85	$757.01	1.85	$783.39	1.85	$811.23
EE/Chr	2.70	$1,183.27	2.70	$1,104.19	2.70	$1,142.67	2.70	$1,183.27
Family	2.70	$1,183.27	2.70	$1,104.19	2.70	$1,142.67	2.70	$1,183.27
Est. Total Monthly Premium	$12,558.19		$10,773.26		$10,011.18		$8,744.48	
Aggregate Change*	-8.5 %		-10.2 %		-10.2 %		-10.2 %	

*The Aggregate Change is compared to Current Premium Rates.

Subject to attached contingencies and disclaimers.

Please see your plan documents** for complete benefit descriptions for the above plan.
**Group Policy, Certificate/Evidence of Coverage, Booklet, Group Agreement, Schedule of Benefits, and/or Group Insurance Certificate

Accepted by_____ Title_____ Date_____

Quote Created by lmjohnson at 11:00 AM on 3/26/2013 (us)
RIDN: 190652, Quote ID: 200078, Ver.: 3.0.67.1

COVENTRY
Health Care of Virginia, Inc.

Proposal Exhibit - Medical

TOWN OF ALTAVISTA

County/Region: Lynchburg
Zip Code: 24517
SIC Code: 9111
Case Status: UW Approved - Final
Broker Pass-Through: ☐

Agent: Pollard, Rebecca
Agency: Business Solutions, Inc.
Account Executive Roberts, Lori
Association: None
Broker Pass-Through Fee: N/A

Quote ID: 200078
Effective Date: 7/1/2013
Next Ren. Date: 7/1/2014
Eligible Employees: 58
Covered Employees: 47

Plan/Network Name	Value PPO 30/50/20% 1000 Ded (12Q4)/CHC-VA PPO Network	
Benefit Category	**In-Network Provider**	**Out-of-Network Provider**
DEDUCTIBLE Individual/Family (Aggregate)	$1000 / $2000	$1000 / $2000
OUT-OF-POCKET MAXIMUM Individual/Family	$3000 / $6000	$4000 / $8000
PHYSICIAN SERVICES Office Visits/Specialty Visits	$30/$50	40%
INPATIENT HOSPITAL CARE Unlimited Hospital Days (semi-private) Private Room When Medically Necessary	20%	40%
OUTPATIENT FACILITY SERVICES Lab MRI, MRA, CT & PET All Other X-Ray Ambulatory/Outpatient Surgery	 20% 20% 20% 20%	 40% 40% 40% 40%
EMERGENCY CARE At Physician's Office/Urgent Care At a Hospital Emergency Room (Waived if admitted)	$75 / $250	$75 / $250
LIFETIME BENEFIT	NA	NA
RIDERS INCLUDED:	VA PPO VISION 9635 15/35/40, PPO VA MENTAL HEALTH RIDER, Autism Rider	

PHARMACY BENEFITS	RETAIL	MAIL SERVICE
Copayments	$10/$20/$35/$35 < 20% < $300 $3500 MOOP	$10/$40/$105/$35 < 20% < $300 $3500 MOOP
Deductible	NA	
Out-of-Pocket Maximum	NA	
Formulary	Open	
Generic Substitution	Mandatory	

PACKAGE: P (Options 27, 28, 29) OPTION: 27 SEGMENT: 1

CONTRACT TYPE	SUBSCRIBERS	RATES	PREMIUM
Employee Only	9	$408.96	$3,680.64
Employee / Spouse	4	$757.01	$3,028.04
Employee / Child	1	$757.01	$757.01
Employee / Children	0	$1,104.19	$0.00
Employee / Family	3	$1,104.19	$3,312.57
Totals	**17**		**$10,778.26**

Subject to attached contingencies and disclaimers.

Please see your plan documents* for complete benefit descriptions for the above plan.
*Group Policy, Certificate/Evidence of Coverage, Booklet, Group Agreement, Schedule of Benefits, and/or Group Insurance Certificate

Accepted by_____ Title_____ Date_____

Quote Created at 2:17 PM on 3/26/2013

COVENTRY
Health Care of Virginia, Inc.

Proposal Exhibit - Medical

TOWN OF ALTAVISTA

County/Region: Lynchburg
Zip Code: 24517
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Covered Employees: 47

Plan/Network Name	Value PPO 25/50/20% 500 Ded (12Q4)/CHC-VA PPO Network	
Benefit Category	**In-Network Provider**	**Out-of-Network Provider**
DEDUCTIBLE Individual/Family (Aggregate)	$500 / $1000	$1000 / $2000
OUT-OF-POCKET MAXIMUM Individual/Family	$3000 / $6000	$4000 / $8000
PHYSICIAN SERVICES Office Visits/Specialty Visits	$25/$50	40%
INPATIENT HOSPITAL CARE Unlimited Hospital Days (semi-private) Private Room When Medically Necessary	20%	40%
OUTPATIENT FACILITY SERVICES Lab MRI, MRA, CT & PET All Other X-Ray Ambulatory/Outpatient Surgery	 20% 20% 20% 20%	 40% 40% 40% 40%
EMERGENCY CARE At Physician's Office/Urgent Care At a Hospital Emergency Room (Waived if admitted)	$75 / $200	$75 / $200
LIFETIME BENEFIT	NA	NA
RIDERS INCLUDED:	VA PPO VISION 9635 15/35/40, PPO VA MENTAL HEALTH RIDER, Autism Rider	

PHARMACY BENEFITS	RETAIL	MAIL SERVICE
Copayments	$10/$20/$35/$35 < 20% < $300 $3500 MOOP	$10/$40/$105/$35 < 20% < $300 $3500 MOOP
Deductible	NA	
Out-of-Pocket Maximum	NA	
Formulary	Open	
Generic Substitution	Mandatory	

PACKAGE: Q (Options 30, 31) OPTION: 30 SEGMENT: 1

CONTRACT TYPE	SUBSCRIBERS	RATES	PREMIUM
Employee Only	13	$423.21	$5,501.73
Employee / Spouse	7	$783.39	$5,483.73
Employee / Child	1	$783.39	$783.39
Employee / Children	0	$1,142.67	$0.00
Employee / Family	5	$1,142.67	$5,713.35
Totals	**26**		**$17,482.20**

Subject to attached contingencies and disclaimers.

Please see your plan documents* for complete benefit descriptions for the above plan.
*Group Policy, Certificate/Evidence of Coverage, Booklet, Group Agreement, Schedule of Benefits, and/or Group Insurance Certificate

Accepted by_____ Title_____ Date_____

Quote Created at 2:17 PM on 3/26/2013

COVENTRY
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Proposal Exhibit - Medical

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Next Ren. Date: 7/1/2014
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Covered Employees: 47

Plan/Network Name	Care POS 25/50/350 p/d 0 Ded (12Q4)/CHC-VA HMO/POS Network	
Benefit Category	**In-Network Provider**	**Out-of-Network Provider**
DEDUCTIBLE Individual/Family (Aggregate)	$0 / $0	$300 / $600
OUT-OF-POCKET MAXIMUM Individual/Family	$3000 / $6000	$3000 / $6000
PHYSICIAN SERVICES Office Visits/Specialty Visits	$25/$50	30%
INPATIENT HOSPITAL CARE Unlimited Hospital Days (semi-private) Private Room When Medically Necessary	$350 / Day	30%
OUTPATIENT FACILITY SERVICES Lab MRI, MRA, CT & PET All Other X-Ray Ambulatory/Outpatient Surgery	 $0 $200 $0 $300	 30% 30% 30% 30%
EMERGENCY CARE At Physician's Office/Urgent Care At a Hospital Emergency Room (Waived if admitted)	$75 / $200	$75 / $200
LIFETIME BENEFIT	NA	NA
RIDERS INCLUDED:	VA POS VISION 9634 15/35/40, HMO/POS VA MENTAL HEALTH RIDER, Autism Rider	

PHARMACY BENEFITS	RETAIL	MAIL SERVICE
Copayments	$10/$20/$35/$35 < 20% < $300 $3500 MOOP	$10/$40/$105/$35 < 20% < $300 $3500 MOOP
Deductible	NA	
Out-of-Pocket Maximum	NA	
Formulary	Open	
Generic Substitution	Mandatory	

PACKAGE: P (Options 27, 28, 29) OPTION: 29 SEGMENT: 1

CONTRACT TYPE	SUBSCRIBERS	RATES	PREMIUM
Employee Only	9	$438.25	$3,944.25
Employee / Spouse	3	$811.23	$2,433.69
Employee / Child	0	$811.23	$0.00
Employee / Children	0	$1,183.27	$0.00
Employee / Family	2	$1,183.27	$2,366.54
Totals	**14**		**$8,744.48**

Subject to attached contingencies and disclaimers.

Please see your plan documents* for complete benefit descriptions for the above plan.
*Group Policy, Certificate/Evidence of Coverage, Booklet, Group Agreement, Schedule of Benefits, and/or Group Insurance Certificate

Accepted by_____ Title_____ Date_____

FY YEAR	TYPE	FULL PREMIUM EXPANDED	CHANGE	TOWN	EMPLOYEE	FULL PREMIUM 250 / 200	CHANGE	TOWN	EMPLOYEE
2013	S	Only offered one plan this FY.				470.00		376.00	94.00
	D					870.00	+7.5%	536.00	334.00
	F					1269.00		695.60	573.40
2012	S	470.00		376.00	94.00	437.00		362.80	74.20
	D	870.00	0	536.00	334.00	*808.00	0	511.20	296.80
	F	1269.00		695.60	573.40	*1180.00		660.00	520.00
2011	S	470.00		376.00	94.00	*437.00		362.80	74.20
	D	870.00	+6%	536.00	334.00	*808.00	+2.5%	511.20	296.80
	F	1269.00		695.60	573.40	*1180.00		660.00	520.00
2010	S	444.00		355.20	88.80	426.00		340.80	85.20
	D	821.00	+6%	506.00	315.00	788.00	+5.5%	485.60	302.40
	F	1199.00		657.20	541.80	1150.00		630.40	519.60
2009	S	419.00		335.20	83.80	404.00		323.20	80.80
	D	775.00	-7.5%	477.60	297.40	747.00	-7%	460.40	286.60
	F	1131.00		620.00	511.00	1091.00		598.00	493.00
2008	S	453.00		362.40	90.60	435.00		348.00	87.00
	D	838.00	+2.7%	516.40	321.60	805.00	+4.5%	496.00	309.00
	F	1223.00		670.40	552.60	1175.00		644.00	531.00
2007	S	441.00		352.80	88.20	416.00		332.80	83.20
	D	816.00	+10%	502.80	313.20	770.00	+10.6%	474.40	295.60
	F	1191.00		652.80	538.20	1123.00		615.60	507.40
2006	S	400.00		320.00	80.00	376.00		300.80	75.20
	D	740.00	+14.3%	456.00	284.00	696.00		428.80	267.20
	F	1080.00		592.00	488.00	1015.00		556.40	458.60

*The Local Choice Program no longer offered Key Advantage 200, the town made the change to Key Advantage 250 effective 7/01/2010.

**The Town began offering two play types in FY 2006. The Local Choice no longer offered the plan type we were offering to our employees, which required us to change.

YEAR	TYPE	FULL PREMIUM	CHANGE	TOWN	EMPLOYEE	
2005	S	350.00		280.00	70.00	
	D	648.00	+9%	399.20	248.80	
	F	945.00		518.00	427.00	
2004	S	321.00		256.80	64.20	
	D	594.00	+26%	366.00	228.00	
	F	867.00		475.20	391.80	
2003	S	255.00		204.00	51.00	
	D	472.00	+20.3%	290.80	181.20	
	F	689.00		377.60	311.40	
2002	S	212.00		169.60	42.40	

	D	392.00		241.60	150.40	
	F	572.00		313.60	258.40	

The Local Choice Health Benefits Program

Town Of Altavista

Proposed Rates Effective from
July 1, 2012 through June 30, 2013

	Single	Dual	Family
ACTIVE EMPLOYEES			
* Key Advantage Expanded	$505	$934	$1,364
* Key Advantage 250	$470	$870	$1,269
Key Advantage 500	$434	$803	$1,172
Key Advantage 1000	$409	$757	$1,104
High Deductible Health Plan	$359	$664	$969

*** 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.

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

April 12, 2012

Mr. Tobi C. Shelton
Treasurer
Town of Altavista
P. O. Box 420
Altavista, VA 24517

Dear Mr. Shelton:

We have received your Employer Data Sheet to renew with THE LOCAL CHOICE program for the 2012 - 2013 plan year. Thank you for your continued participation in the program.

According to our records, the Town of Altavista will renew its group in THE LOCAL CHOICE program as follows:

Effective Date of coverage: July 1, 2012

Plan(s) to be offered with premium(s):

Active Employees	Statewide Plan I Key Advantage 250
Single	$470.00
Dual	$870.00
Family	$1,269.00

Retirees

* No coverage offered.

The employer contribution shown on your Employer Data Sheet meets the minimum contributions required by the program.

Please make sure to order your enrollment materials from the Carriers by using the materials form provided in your renewal packet. For specific plan information, please contact the member services for the plans chosen at the telephone number shown on the Benefits Highlights Brochures sheets provided in your renewal proposal.

The Local Choice program support staff is always available to answer questions and assist your benefits administrators during the upcoming plan year. The Program Manager Walt Norman may be reached at (804) 786-6460 or you may also contact Dana Hollins, TLC Benefits Specialist at (804) 371-6211.

Again, we are pleased to continue our relationship with you as a member of THE LOCAL CHOICE. Working together, we will be able to continue the solid performance that the program has shown over the past 20 years. If our office can be of any assistance to you or your staff, please give us a call.

Sincerely,

George J. Gibbs, Jr., CPA
Chief Financial Officer
State and Local Health Benefits Programs

cc: Gene Raney
Anthem
CommonHealth

Employer Data Sheet

Return this Data Sheet to

The Local Choice Health Benefits Program
Commonwealth of Virginia
Department of Human Resource Management
101 North 14th Street – 13th Floor
Richmond, VA 23219
Phone (804) 786 6460 · Fax (804) 371 0231

You must order your enrollment materials using the Materials Order Form included in your renewal/ proposal notebook. Fax your order to the number shown on the Materials Order Form. Do not send order forms to TLC offices.

Please complete all applicable information and return this sheet to the address shown above. You will receive a letter confirming the plan(s) to be offered and the monthly premiums for each plan. It is important that you complete each section and sign the completed form.

1. Group Name: Town of Altavista

2. Effective Date: 7/01/2012 **To** 6/30/2013

3. Number of Employees Eligible/Participating

	# Eligible Employees	# Participating Employees
Active Full Time Employees	56	47
Active Part Time Employees	0	0
COBRA Eligibles		0
Retirees Not Eligible for Medicare		0
Retirees Eligible for Medicare		0

4. List your definition of participating Full-Time Employee (including minimum hours):

Employees who work 40 hours per week

5. Do you cover Part-Time Employees? ☐ **Yes, our definition of Part-Time is:**

☒ **No, we do not cover Part-Time Employees.**

6. Are elected members of your Governing Body eligible?

☐ Yes, as FT ☐ Yes, as PT ☒ No

GROUP NAME Town of Altavista

7. Have any of your definitions changed since your last renewal?

☐ Yes ☒ No

If yes, please list changes: _____

8. You must have an Open Enrollment of no longer than 30 days between April 1 and May 15 for 7/1 effective groups and between July 28 and September 10 for 10/1 effective groups. Our OE dates will be:

April 2, 2012 through May 2, 2012

9. Employers with fewer than 20 employees on a typical business day during the preceding calendar year are not allowed to offer COBRA. This exclusion is based on the actual number of employees rather than plan participants. Employers must consider all full-time and part-time employees. Is your Group eligible for COBRA?

☒ Yes ☐ No

10. For Groups that cannot offer COBRA, we want to continue coverage for survivors of deceased employees until the end of the month following our employee's death. Full premium with continued employer and dependent contribution is required. Survivors must participate and no plan changes are permitted.

☒ Yes ☐ No

11. Please check the plan name and list rates for Benefit Plan(s) to be offered and Monthly Rate(s) for each Employee/Retiree. Enter the premium rates from your proposal/renewal rate sheet for each selected plan. Do not list the total monthly premium for your group.

	PPO Plans				HDHP	Regional Plan (if available in your area)
	☐ Key Advantage Expanded	☒ Key Advantage 250	☐ Key Advantage 500	☐ Key Advantage 1000	☐ High Deductible Health Plan	☐ Kaiser Permanente
Active Employees – Insert Rates from Proposal/Renewal						
Single		470.00				
Employee +1		870.00				
Family		1,269.00				
Retirees NOT Eligible for Medicare – Insert Rates from Proposal/Renewal						
Single						
Employee +1						
Family						

Retirees Eligible for Medicare	
Insert monthly Rates from Proposal/Renewal	
Advantage 65	$
Advantage 65 with Dental/Vision	$
Medicare Complementary	$

GROUP NAME Town of Altavista

12. List Contributions

Minimum Employer Contribution:

- Full-Time: 80% of average single cost
- No employer contribution is required for dependents if more than 75% of eligible employees enroll
- If less than 75% enroll, the employer must pay at least 20% of the cost of Dependent Coverage
- If Part-Time coverage is offered the employer must pay a minimum of 50% of the amount contributed toward Full Time employee coverage at all membership levels
- HDHP contributions are calculated separately from other contribution calculations
- Minimum employer contributions for HDHP are 80% F/T single employee cost and 20% of dependent cost
- Higher contributions are permitted.

	Single		Dual		Family	
	Employer Contribution	Employee Contribution	Employer Contribution	Employee Contribution	Employer Contribution	Employee Contribution
Active Full Time	$ 376.00	$ 94.00	$ 536.00	$ 334.00	$ 695.60	$ 573.40
Active Part Time	$	$	$	$	$	$
Retiree Not Eligible for Medicare	$	$	$	$	$	$
Retiree with Medicare	$	$	$	$	$	$

If you offer multiple plans, please copy and submit this page for each plan you endorse.

13. I hereby certify that the above information is correct to renew The Local Choice Program.

Tobie C. Shelton — 3/28/2012

▲ GROUP EXECUTIVE ADMINISTRATOR (SIGNATURE REQUIRED) ▲ DATE

Tobie C. Shelton / Treasurer

▲ PRINT NAME & TITLE

434/369-5001 — 434/369-4369 — tcshelton@ci.altavista.va.us

▲ TELEPHONE ▲ FAX ▲ EMAIL

Comparison of Statewide Plans 2012

Effective July 1, 2012 or October 1, 2012

The Local Choice 2012 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 $100 **Out-of-Network:** $200	Two People *See Family* *See Family*	Family $200 $400	**In-Network:** One Person $250 **Out-of-Network:** $500	Two People *See Family* *See Family*	Family $500 $1,000
Plan Year Out-of-pocket expense limit	**In-Network:** One Person $1,000 **Out-of-Network:** $2,000	Two People *See Family* *See Family*	Family $2,000 $4,000	**In-Network:** One Person $2,000 **Out-of-Network:** $4,000	Two People *See Family* *See Family*	Family $4,000 $8,000
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.		
Medical care when traveling	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 2 years to 6 years $35,000 Annual Limit	Copayment/coinsurance determined by service received			Copayment/coinsurance determined by service received		
Behavioral health and EAP *Inpatient treatment* • Facility services • Professional provider services *Outpatient professional provider visits*	 $200 copayment per stay $0 $15 copayment			 $300 copayment per stay $0 $20 copayment		
Employee Assistance Program (EAP) 4 visits per incident (per rolling 12 months)	$0			$0		
Dental *Dental plan year deductible* *Plan year maximum (except Orthodontics)* *Diagnostic and preventive services* *Basic dental care* *Major dental care* *Orthodontic services*	One Person $25 $1,500 $0, no deductible 20% coinsurance after dental deductible 50% coinsurance after dental deductible 50% coinsurance, no dental deductible, with $1,500 lifetime maximum	Two People $50	Family $75	One Person $25 $1,200 $0, no deductible 20% coinsurance after dental deductible 50% coinsurance after dental deductible 50% coinsurance, no dental deductible, with $1,200 lifetime maximum	Two People $50	Family $75
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)	10% coinsurance, no deductible			10% coinsurance after deductible		
Doctor visits – on an outpatient basis *Primary care physicians* *Specialty care providers*	 $15 copayment $25 copayment			 $20 copayment $35 copayment		
Early Intervention Services	Copayment/coinsurance determined by service received			Copayment/coinsurance determined by service received		

Key Advantage 500			Key Advantage 1000			High Deductible Health Plan		
In-Network:			**In-Network:**					
One Person	Two People	Family	One Person	Two People	Family	One Person	Two People	Family
$500	*See Family*	$1,000	$1,000	*See Family*	$2,000	$1,500	See Family	$3,000
Out-of-Network:			**Out-of-Network:**					
$1,000	*See Family*	$2,000	$2,000	*See Family*	$4,000			
In-Network:			**In-Network:**					
One Person	Two People	Family	One Person	Two People	Family	One Person	Two People	Family
$3,000	*See Family*	$6,000	$4,000	*See Family*	$8,000	$5,000	See Family	$10,000
Out-of-Network:			**Out-of-Network:**					
$6,000	*See Family*	$12,000	$8,000	*See Family*	$16,000			
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.			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.			No coverage, except in emergency.		
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 per stay after deductible			20% coinsurance per stay after deductible			20% coinsurance after deductible		
$0			$0			20% coinsurance after deductible		
$25 copayment			**$25 copayment**			20% coinsurance after deductible		
$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
$1,200			$1,200			$1,500		
$0, no deductible			$0, no deductible			$0, no deductible		
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 $1,200 lifetime maximum			50% coinsurance, no dental deductible, with $1,200 lifetime maximum			50% coinsurance, no dental deductible, with $1,500 lifetime maximum		
$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		
[illegible] copayment			$25 copayment			20% coinsurance after deductible		
$40 copayment			$40 copayment			20% coinsurance after deductible		
Copayment/coinsurance determined by service received			Copayment/coinsurance determined by service received			20% coinsurance after deductible		

The Local Choice 2012 Comparison of Statewide Plans (continued)

Covered Services	Key Advantage Expanded In-Network You Pay	Key Advantage 250 In-Network You Pay
Emergency room visits		
Facility services	$100 copayment per visit (waived if admitted to hospital)	$150 copayment per visit (waived if admitted to hospital)
Professional provider services		
• Primary care physicians	$15 copayment	$20 copayment
• Specialty care providers	$25 copayment	$35 copayment
Diagnostic tests and x-rays	10% coinsurance, no deductible	10% 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		
Inpatient treatment		
• Facility services	$200 copayment per stay	$300 copayment per stay
• Professional provider services		
– Primary care physicians	$0	$0
– Specialty care providers	$0	$0
Outpatient treatment		
• Facility services	$100 copayment	$150 copayment
• Professional provider services		
– Primary care physicians	$15 copayment	$20 copayment
– Specialty care providers	$25 copayment	$35 copayment
• Diagnostic tests and x-rays	10% coinsurance, no deductible	10% coinsurance after deductible
Infusion services		
Facility services	10% coinsurance after deductible	10% coinsurance after deductible
Professional provider services	10% coinsurance after deductible	10% coinsurance after deductible
Home services	10% coinsurance after deductible	10% coinsurance after deductible
Infusion medications -		
• Outpatient settings	10% coinsurance after deductible	10% coinsurance after deductible
• Home settings	10% coinsurance after deductible	10% coinsurance after deductible
Maternity		
Professional provider services (prenatal & postnatal care)		
• Primary care physicians	$15 copayment	$20 copayment
• Specialty care providers	$25 copayment	$35 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.	
Delivery		
• Primary care physicians	$0	$0
• Specialty care providers	$0	$0
Hospital services for delivery (delivery room, anesthesia, routine nursing care for newborn)	$200 copayment per stay*	$300 copayment per stay*
Outpatient diagnostic tests	10% coinsurance, no deductible	10% coinsurance after deductible
Medical equipment, appliances, formulas, prosthetics and supplies	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
*You may purchase up to a 90-day supply at a retail pharmacy by paying multiple copayments, or the coinsurance after the deductible	Tier 2 – $20 copayment Tier 3 – $35 copayment	Tier 2 – $20 copayment Tier 3 – $35 copayment
Home Delivery Services (Mail Order) Covered drugs for up to a 90-day supply	Tier 1 – $20 copayment Tier 2 – $40 copayment Tier 3 – $70 copayment	Tier 1 – $20 copayment Tier 2 – $40 copayment Tier 3 – $70 copayment
Diabetic Supplies	20% coinsurance, no deductible	20% coinsurance, no deductible

*This plan will waive the hospital copayment if the member enrolls in the maternity management pre-natal program within the first trimester 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
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 per stay after deductible	20% coinsurance per stay 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
20% coinsurance after deductible [illegible] coinsurance after deductible [illegible] 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	20% coinsurance after deductible 20% coinsurance after deductible
$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.	$25 copayment $40 copayment	20% coinsurance after deductible 20% coinsurance after deductible
$0 $0	$0 $0	20% coinsurance after deductible 20% coinsurance after deductible
20% coinsurance per stay after deductible	20% coinsurance per stay 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 - $20 copayment Tier 3 - $35 copayment	Tier 1 - $10 copayment Tier 2 - $20 copayment Tier 3 - $35 copayment	20% coinsurance after deductible
Tier 1 - $20 copayment Tier 2 - $40 copayment [illegible] - $70 copayment [illegible] coinsurance, no deductible	Tier 1 - $20 copayment Tier 2 - $40 copayment Tier 3 - $70 copayment 20% coinsurance, no deductible	20% coinsurance after deductible 20% coinsurance after deductible

The Local Choice 2012 Comparison of Statewide Plans (continued)

Covered Services	Key Advantage Expanded In-Network You Pay	Key Advantage 250 In-Network You Pay
Routine vision - Blue View Vision Network (once every 12 months)		
Routine eye exam	$25 copayment	$35 copayment
Eyeglass lenses	$20 copayment	$20 copayment
Eyeglass frames	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
• Non-Elective	Up to $250 retail allowance	Up to $250 retail allowance
Lens Options		
• UV coating, tints, standard scratch-resistant	$15	$15
• Standard polycarbonate	$40	$40
• Standard progressive	$65	$65
• Standard anti-reflective	$45	$45
• Other add-ons	20% off retail	20% off retail
Shots – allergy & therapeutic injections (at doctor's office, emergency room or outpatient hospital department)	10% coinsurance, no deductible	10% coinsurance after deductible
Skilled nursing facility stays (180-day per stay limit per member)		
Facility services	$0	$0
Professional provider services	$0	$0
Spinal manipulations and other manual medical interventions (30 visits per plan year limit per member)		
Primary care physicians	$15 copayment	$20 copayment
Specialty care providers	$25 copayment	$35 copayment
Surgery – see Hospital services		
Therapy services *Cardiac Rehabilitation therapy, Chemotherapy, Radiation therapy, Respiratory therapy Occupational therapy, Physical therapy, and Speech therapy*		
Facility services	10% coinsurance after deductible	10% coinsurance after deductible
Professional provider services		
• Primary care physicians	10% coinsurance after deductible	10% coinsurance after deductible
• Specialty care providers	10% coinsurance after deductible	10% coinsurance after deductible
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
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
• Routine screenings, immunizations, lab and x-ray services (outside of Annual check-up visit)	No copayment, coinsurance, or deductible	No copayment, coinsurance, or deductible
Preventive care (one of 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

Key Advantage 500 In-Network You Pay	Key Advantage 1000 In-Network You Pay	High Deductible Health Plan In-Network You Pay
$40 copayment $20 copayment Up to $100 retail allowance**	$40 copayment $20 copayment Up to $100 retail allowance**	Not covered Not covered Not covered
Up to $100 retail allowance Up to $250 retail allowance	Up to $100 retail allowance Up to $250 retail allowance	Not covered Not covered
$15 $40 $65 $45 20% off retail	$15 $40 $85 $45 20% off retail	Not covered Not covered Not covered Not covered Not covered
20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible
$0 $0	$0 $0	20% coinsurance after deductible 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	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
No copayment, coinsurance, or deductible	No copayment, coinsurance, or deductible	No copayment, coinsurance, or deductible

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

April 12, 2011

Tobie C. Shelton
Treasurer
Town of Altavista
P. O. Box 420
Altavista, VA 24517

Dear Mr. Shelton:

We have received your Employer Data Sheet to renew with THE LOCAL CHOICE program for the 2011 - 2012 plan year. Thank you for your continued participation in the program.

According to our records, the Town of Altavista will renew its group in THE LOCAL CHOICE program as follows:

Effective Date of coverage: July 1, 2011

Plan(s) to be offered with premium(s):

Active Employees	Statewide	
	Key Advantage Expanded	Key Advantage 250
Single	$470.00	$437.00
Dual	$870.00	$808.00
Family	$1,269.00	$1,180.00

Retirees Not Eligible for Medicare

*No Coverage Offered

Retirees Eligible for Medicare

*No Coverage Offered

The employer contribution shown on your Employer Data Sheet meets the minimum contributions required by the program.

Please make sure to order your enrollment materials from the Carriers by using the materials form provided in your renewal packet. For specific plan information, please contact the member services for the plans chosen at the telephone number shown on the Benefits Highlights Brochures sheets provided in your renewal proposal.

The Local Choice program support staff is always available to answer questions and assist your benefits administrators during the upcoming plan year. The Program Manager Walt Norman may be reached at (804) 786-6460 or you may also contact Dana Hollins, TLC Benefits Specialist at (804) 371-6211.

Again, we are pleased to continue our relationship with you as a member of THE LOCAL CHOICE. Working together, we will be able to continue the solid performance that the program has shown over the past 20 years. If our office can be of any assistance to you or your staff, please give us a call.

Sincerely,

George J. Gibbs, Jr., CPA
Chief Financial Officer
State and Local Health Benefits Programs

cc: Mary Habel
Anthem
CommonHealth

Employer Data Sheet

Rec

RETURN BY APRIL 1, 2011 3/30/11

Return this Data Sheet to:
The Local Choice Health Benefits Program
Commonwealth of Virginia
Department of Human Resource Management
101 North 14th Street – 13th Floor
Richmond, VA 23219
Phone (804) 786.6460 • Fax (804) 371.0231

OK
DCH
2/16/11

You must order your enrollment materials using the Materials Order Form included in your proposal notebook. Fax your order to the number shown on the Materials Order Form. Do not send your order form to TLC offices.

Please complete all applicable information and return this sheet to the address shown above. You will receive a letter confirming the plan(s) to be offered and the monthly premiums for each plan. It is important that you complete each section and sign the completed form.

1. **Group Name:** Town of Altavista
2. **Effective Date:** 7/01/2011 **To** 6/30/2012
3. **Number of Persons Eligible/Participating**

	# Eligible Employees	# Participating Employees
Active Full Time Employees	57	49
Active Part Time Employees	0	0
COBRA Eligibles		0
Retirees Not Eligible for Medicare		0
Retirees Eligible for Medicare		0

85%

4. **List your definition of participating Full-Time Employee:**
   Employees who work 40 hours per week
5. **Do you cover Part-Time Employees? If yes, provide your definition of Part-Time:**
   No
6. **Are elected members of your Governing Body eligible?** ☐Yes, as FT ☐Yes, as PT ☒No
7. **Have any of your definitions changed since your last renewal?** ☐Yes ☒No
   If yes, please list changes:
8. **Our 30 day Open Enrollment dates will be:** 4/4/11-5/13/11 **(between April 1 and May 15 for 7/1 effective groups and between July 28 and September 10 for 10/1 effective groups)**
9. **We want to continue coverage for survivors of deceased employees until the end of the month following our employee's death. Full premium with continued employer and dependent contribution is required. Survivors must participate and not plan changes are permitted.** ☒Yes ☐No

GROUP NAME: Town of Altavista

10. **Please check the plan name and list rates for Benefit Plan(s) to be offered and Monthly Premium for each Employee/Retiree. Enter the premium rates for each participant from your proposal for all selected plans, not the total monthly premium for your group.**

PPO Plans				
	☒ Key Advantage Expanded	☒ Key Advantage 250	☐ Key Advantage 500	☐ Key Advantage 1000
Active Employees – Rates from Proposal				
Single	470.00	437.00		
Employee +1	870.00	808.00		
Family	1,269.00	1,180.00		
Retirees Not Eligible for Medicare – Rates from Proposal				
Single				
Employee +1				
Family				

	High Deductible Health Plan	Regional Plan (If available in your area)
	☐ High Deductible Health Plan	☐ Kaiser Permanente
Active Employees- Rates from Proposal		
Single	$	$
Employee +1	$	$
Family	$	$
Retirees Not Eligible for Medicare -Rates from Proposal		
Single	$	$
Employee +1	$	$
Family	$	$

Retirees Eligible for Medicare	
Retirees Eligible for Medicare – Rates from Proposal	
☐ Advantage 65	$
☐ Advantage 65 with Dental/Vision	$
☐ Medicare Complementary	$

11. **List Contributions – Minimum Employer Contribution for KA and Regional Plans:** Full-Time: 80% of average single cost • Part-Time: 40% of average single cost • Additional cost of Dependent Coverage (if required): Full-Time: 20% of average cost • Part-Time: 10% of average cost • Although permitted, no employer contribution is required for dependents if more than 75% of all eligible employees are enrolled.

HDHP contributions are calculated separately from other contribution calculations. Minimum employer contributions for HDHP are 80% F/T single employee cost and 20% of dependent cost (P/T 40%/10%). Higher contributions are permitted.

	Single Employer/Employee		Dual Employer/Employee		Family Employer/Employee	
Active Full Time EXP	$ 376.00	$ 94.00	$ 536.00	$ 334.00	$ 695.60	$ 573.40
Active Part-Time 250	$ 362.80	$ 74.20	$ 511.20	$ 296.80	$660.00	$520.00
Retiree Not Eligible for Medicare	$	$	$	$	$	$
Retiree with Medicare	$	$	$	$	$	$

12. **I hereby certify that the above information is correct to renew The Local Choice Program.**

Tobie C. Shelton 3/29/2011 Tobie C. Shelton / Treasurer

Group Executive Administrator (Signature Required) / Date / Print Name & Title

Telephone: 434/369-5002 Fax: 434/369-4369

2

Employer Data Sheet

RETURN BY APRIL 1, 2011

Return this Data Sheet to:
The Local Choice Health Benefits Program
Commonwealth of Virginia
Department of Human Resource Management
101 North 14th Street – 13th Floor
Richmond, VA 23219
Phone (804) 786.6460 • Fax (804) 371.0231

You must order your enrollment materials using the Materials Order Form included in your proposal notebook. Fax your order to the number shown on the Materials Order Form. Do not send your order form to TLC offices.

Please complete all applicable information and return this sheet to the address shown above. You will receive a letter confirming the plan(s) to be offered and the monthly premiums for each plan. It is important that you complete each section and sign the completed form.

1. **Group Name:** Town of Altavista

2. **Effective Date:** 7/01/2011 **To** 6/30/2012

3. **Number of Persons Eligible/Participating**

	# Eligible Employees	# Participating Employees
Active Full Time Employees	57	49
Active Part Time Employees	0	0
COBRA Eligibles		0
Retirees Not Eligible for Medicare		0
Retirees Eligible for Medicare		0

4. **List your definition of participating Full-Time Employee:**
Employees who work 40 hours per week

5. **Do you cover Part-Time Employees? If yes, provide your definition of Part-Time:**
No

6. **Are elected members of your Governing Body eligible?** ☐Yes, as FT ☐Yes, as PT ☒No

7. **Have any of your definitions changed since your last renewal?** ☐Yes ☒No
If yes, please list changes:

8. **Our 30 day Open Enrollment dates will be:** 4/4/11-5/13/11 **(between April 1 and May 15 for 7/1 effective groups and between July 28 and September 10 for 10/1 effective groups)**

9. **We want to continue coverage for survivors of deceased employees until the end of the month following our employee's death. Full premium with continued employer and dependent contribution is required. Survivors must participate and not plan changes are permitted.** ☒Yes ☐No

The Local Choice Health Benefits Program

Town Of Altavista

Proposed Rates Effective from
July 1, 2011 through June 30, 2012

	Single	Dual	Family
ACTIVE EMPLOYEES			
* Key Advantage Expanded	$470	$870	$1,269
* Key Advantage 250	$437	$808	$1,180
Key Advantage 500	$404	$747	$1,091
Key Advantage 1000	$381	$705	$1,029
High Deductible Health Plan	$334	$618	$902

*** 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.

Comparison of Statewide Plans 2011

Effective July 1, 2011 or October 1, 2011

The LOCAL CHOICE

The Local Choice 2011 Comparison of Statewide Plans

	Key Advantage Expanded			Key Advantage 250		
Plan year deductible (Key Advantage applies to certain medical services as indicated on chart)	**In-Network:**			**In-Network:**		
	One Person	Two People	Family	One Person	Two People	Family
	$100	*See Family*	$200	$250	*See Family*	$500
(HDHP: applies to medical, behavioral health, and prescription drug services)	**Out-of-Network:**			**Out-of-Network:**		
	$200	*See Family*	$400	$500	*See Family*	$1,000
Out-of-pocket expense limit	**In-Network:**			**In-Network:**		
	One Person	Two People	Family	One Person	Two People	Family
	$1,000	*See Family*	$2,000	$2,000	*See Family*	$4,000
	Out-of-Network:			**Out-of-Network:**		
	$2,000	*See Family*	$4,000	$4,000	*See Family*	$8,000
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.		
Medical care when traveling	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		
Behavioral health and EAP						
Inpatient treatment						
• Facility services	$200 copayment per stay			$300 copayment per stay		
• Professional provider services	$0			$0		
Outpatient professional provider visits	$15 copayment			$20 copayment		
Employee Assistance Program (EAP) (up to 4 visits per incident)	$0			$0		
Dental	One Person	Two People	Family	One Person	Two People	Family
Dental plan year deductible	$25	$50	$75	$25	$50	$75
Plan year maximum (except orthodontics)	$1,500			$1,200		
Diagnostic and preventive services	$0, no deductible			$0, no deductible		
Primary services	20% coinsurance after dental deductible			20% coinsurance after dental deductible		
Complex restorative services	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 $1,200 lifetime maximum		
Diagnostic tests and x-rays (for specific conditions or diseases at a doctor's office, emergency room or outpatient hospital department)	10% coinsurance, no deductible			10% coinsurance after deductible		
Doctor visits – on an outpatient basis						
Primary care physicians	$15 copayment			$20 copayment		
Specialty care providers	$25 copayment			$35 copayment		
Emergency room visits						
Facility services	$100 copayment per visit (waived if admitted)			$150 copayment per visit (waived if admitted)		
Professional provider services						
• Primary care physicians	$15 copayment			$20 copayment		
• Specialty care providers	$25 copayment			$35 copayment		
Diagnostic tests and x-rays	10% coinsurance, no deductible			10% coinsurance after deductible		
Home health services (90 visit plan year limit)	$0			$0		
Home private duty nurse's services	20% coinsurance after deductible			20% coinsurance after deductible		
Hospice care services	$0			$0		

y Advantage 500			Key Advantage 1000			High Deductible Health Plan		
In-Network:			In-Network:					
One Person	Two People	Family	One Person	Two People	Family	One Person	Two People	Family
$500	*See Family*	$1,000	$1,000	*See Family*	$2,000	$1,500	See Family	$3,000
Out-of-Network:			Out-of-Network:					
$1,000	*See Family*	$2,000	$2,000	*See Family*	$4,000			
In-Network:			In-Network:					
One Person	Two People	Family	One Person	Two People	Family	One Person	Two People	Family
$3,000	*See Family*	$6,000	$4,000	*See Family*	$8,000	$5,000	See Family	$10,000
Out-of-Network:			Out-of-Network:					
$6,000	*See Family*	$12,000	$8,000	*See Family*	$16,000			
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.			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.			No coverage, except in emergency.		
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		
% coinsurance per stay after deductible			20% coinsurance per stay after deductible			20% coinsurance after deductible		
			$0			20% coinsurance after deductible		
$25 copayment			**$25 copayment**			20% coinsurance after deductible		
$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
$1,200			$1,200			$1,500		
$0, no deductible			$0, no deductible			$0, no deductible		
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 $1,200 lifetime maximum			50% coinsurance, no dental deductible, with $1,200 lifetime maximum			50% coinsurance, no dental deductible, with $1,500 lifetime maximum		
20% coinsurance after deductible			20% coinsurance after deductible			20% coinsurance after deductible		
$25 copayment			$25 copayment			20% coinsurance after deductible		
$40 copayment			$40 copayment			20% coinsurance after deductible		
20% coinsurance after deductible			20% coinsurance after deductible			20% coinsurance after deductible		
$25 copayment			$25 copayment			20% coinsurance after deductible		
$40 copayment			$40 copayment			20% coinsurance after deductible		
20% coinsurance after deductible			20% coinsurance after deductible			20% coinsurance after deductible		
			$0			20% coinsurance after deductible		
20% coinsurance after deductible			20% coinsurance after deductible			20% coinsurance after deductible		
$0			$0			20% coinsurance after deductible		

The Local Choice 2011 Comparison of Statewide Plans (continued)

Covered Services	Key Advantage Expanded In-Network You Pay	Key Advantage 250 In-Network You Pay
Hospital services		
Inpatient treatment:		
• Facility services	$200 copayment per stay	$300 copayment per stay
• Professional provider services		
– Primary care physicians	$0	$0
– Specialty care providers	$0	$0
Outpatient treatment		
• Facility services	$100 copayment	$150 copayment
• Professional provider services		
– Primary care physicians	$15 copayment	$20 copayment
– Specialty care providers	$25 copayment	$35 copayment
• Diagnostic tests and x-rays	10% coinsurance, no deductible	10% coinsurance after deductible
Infusion services		
Facility services	10% coinsurance after deductible	10% coinsurance after deductible
Professional provider services	10% coinsurance after deductible	10% coinsurance after deductible
Home services	10% coinsurance after deductible	10% coinsurance after deductible
Infusion medications -		
• Outpatient settings	10% coinsurance after deductible	10% coinsurance after deductible
• Home settings	10% coinsurance after deductible	10% coinsurance after deductible
Maternity		
Professional provider services (prenatal & postnatal care)		
• Primary care physicians	$15 copayment	$20 copayment
• Specialty care providers	$25 copayment	$35 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.	
Delivery		
• Primary care physicians	$0	$0
• Specialty care providers	$0	$0
Hospital services for delivery (delivery room, anesthesia, routine nursing care for newborn)	$200 copayment per stay*	$300 copayment per stay*
Outpatient diagnostic tests	10% coinsurance, no deductible	10% coinsurance after deductible
Medical equipment, appliances, formulas and supplies	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
*You may purchase up to a 90-day supply at a retail pharmacy by paying multiple copayments, or the coinsurance after the deductible	Tier 2 - $20 copayment	Tier 2 - $20 copayment
	Tier 3 - $35 copayment	Tier 3 - $35 copayment
Mail Service up to 90-day supply	Tier 1 - $20 copayment	Tier 1 - $20 copayment
	Tier 2 - $40 copayment	Tier 2 - $40 copayment
	Tier 3 - $70 copayment	Tier 3 - $70 copayment
Routine vision - Blue View Vision Network (once every 12 months)		
Routine eye exam	$25 copayment	$35 copayment
Eyeglass lenses	$20 copayment	$20 copayment
Eyeglass frames	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
• Non-Elective	Up to $250 retail allowance	Up to $250 retail allowance
Lens Options		
• UV coating, tints, standard scratch-resistant	$15	$15
• Standard polycarbonate	$40	$40
• Standard progressive	$65	$65
• Standard anti-reflective	$45	$45
• Other add-ons	20% off retail	20% off retail

**This plan will waive the hospital copayment if the member enrolls in the maternity management pre-natal program within the first trimester 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
20% coinsurance per stay after deductible	20% coinsurance per stay after deductible	20% coinsurance after deductible
$0	$0	20% coinsurance after deductible
$0	$0	20% coinsurance after deductible
20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible
$25 copayment	$25 copayment	20% coinsurance after deductible
$40 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	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
$25 copayment	$25 copayment	20% coinsurance after deductible
$40 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 received.		
	$0	20% coinsurance after deductible
$0	$0	20% coinsurance after deductible
20% coinsurance per stay after deductible	20% coinsurance per stay 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 - $20 copayment Tier 3 - $35 copayment	Tier 1 - $10 copayment Tier 2 - $20 copayment Tier 3 - $35 copayment	20% coinsurance after deductible
Tier 1 - $20 copayment Tier 2 - $40 copayment Tier 3 - $70 copayment	Tier 1 - $20 copayment Tier 2 - $40 copayment Tier 3 - $70 copayment	20% coinsurance after deductible
$40 copayment	$40 copayment	Not covered
$20 copayment	$20 copayment	Not covered
Up to $100 retail allowance**	Up to $100 retail allowance**	Not covered
Up to $100 retail allowance	Up to $100 retail allowance	Not covered
Up to $250 retail allowance	Up to $250 retail allowance	Not covered
$15	$15	Not covered
$40	$40	Not covered
$65	$65	Not covered
$45	$45	Not covered
% off retail	20% off retail	Not covered

The Local Choice 2011 Comparison of Statewide Plans (continued)

Covered Services	Key Advantage Expanded In-Network You Pay	Key Advantage 250 In-Network You Pay
Shots – allergy & therapeutic injections (at doctor's office, emergency room or outpatient hospital department)	10% coinsurance, no deductible	10% coinsurance after deductible
Skilled nursing facility stays (180-day per stay limit)		
Facility services	$0	$0
Professional provider services	$0	$0
Spinal manipulations and other manual medical interventions (30 visits per plan year limit)		
Primary care physicians	$15 copayment	$20 copayment
Specialty care providers	$25 copayment	$35 copayment
Surgery – see Hospital services		
Therapy services *Cardiac Rehabilitation therapy, Chemotherapy, Radiation therapy, Respiratory therapy Occupational therapy, Physical therapy, and Speech therapy*		
Facility services	10% coinsurance after deductible	10% coinsurance after deductible
Professional provider services		
• Primary care physicians	10% coinsurance after deductible	10% coinsurance after deductible
• Specialty care providers	10% coinsurance after deductible	10% coinsurance after deductible
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
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
• Routine screenings, immunizations, lab and x-ray services (outside of Annual check-up visit)	No copayment, coinsurance, or deductible	No copayment, coinsurance, or deductible
Preventive care (one of 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

' / Advantage 500 In-Network You Pay	Key Advantage 1000 In-Network You Pay	High Deductible Health Plan In-Network You Pay
20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible
$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 ' coinsurance after deductible	20% coinsurance after deductible 20% coinsurance after deductible	20% coinsurance after deductible 20% coinsurance after 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	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

VISION INFORMATION

I. ***Note:** Coventry was providing enhanced vision and is no longer offering that product.
II. Please provide a "Materials Only" freestanding vision product
III. Please provide at least 3 different choices of vision designs

DENTAL INFORMATION

Town of Altavista

Covered Procedure Summary

AMERITAS GROUP

	Plan 1	Plan 2
Plan Design Summary	100/80 $25/Calendar Year Waived Type 1 3 Family Maximum $1,000	100/80/50 $25/Calendar Year Waived Type 1 3 Family Maximum $1,250
Type 1 Procedure (Frequency)	• Routine Exam (2 per benefit period) • Bitewing X-rays (2 per benefit period) • Full Mouth/Panoramic X-rays (1 in 3 years) • Periapical X-rays • Cleaning (2 per benefit period) • Fluoride for Children 18 and under (1 per benefit period) • Sealants (age 16 and under) • Space Maintainers	• Routine Exam (2 per benefit period) • Bitewing X-rays (2 per benefit period) • Full Mouth/Panoramic X-rays (1 in 3 years) • Periapical X-rays • Cleaning (2 per benefit period) • Fluoride for Children 18 and under (1 per benefit period) • Sealants (age 16 and under) • Space Maintainers
Type 2 Procedure (Frequency)	• Restorative Amalgams • Restorative Composites • Endodontics (nonsurgical) • Endodontics (surgical) • Periodontics (nonsurgical) • Periodontics (surgical) • Denture Repair • Simple Extractions • Complex Extractions • Anesthesia	• Restorative Amalgams • Restorative Composites • Endodontics (nonsurgical) • Endodontics (surgical) • Periodontics (nonsurgical) • Periodontics (surgical) • Denture Repair • Simple Extractions • Complex Extractions • Anesthesia
Type 3 Procedure (Frequency)	• None	• Onlays • Crowns (1 in 5 years per tooth) • Crown Repair • Prosthodontics (fixed bridge; removable complete/partial dentures) (1 in 5 years)

Current Dental Terminology © American Dental Association.

* adult ortho included

John Tschantre
Regional Group Manager
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April 15, 2014

Tobie Shelton
Town Of Altavista
510 7Th St
Altavista, VA 24517

Subject: Town Of Altavista renewal effective July 1, 2014 Policy Number 010.039749

Thank you for choosing an Ameritas Dental Plan.

We're proud to provide plans that help employees get the dental coverage they need for good health, and we'll work hard to keep earning the privilege of insuring Town Of Altavista.

A team of associates with actuarial, administrative, marketing, and sales experience has prepared this renewal for the year beginning July 1, 2014. To predict your plan's future performance, we analyzed Town Of Altavista's claims history and combined this with the historical data of all groups insured for similar benefits.

Beginning in 2014, health insurers are required to pay an annual Health Insurer Assessment Fee (HIAF) in accordance with Section 9010 of the Patient Protection and Affordable Care Act (PPACA). The amount due from each insurer is based on the insurer's market share of health premiums, including dental and vision insurance premiums. **Rates in this renewal notification are adjusted to reflect the estimated cost of this fee.** We reserve the right to adjust rates based on PPACA fees or assessments imposed by any governmental authority or agency. For more information on health care reform, please visit ameritasgroup.com.

Based on this analysis, your Dental and Orthodontia rates will be adjusted. Effective 7/1/2014 through 6/30/2015, the following rates will apply:

DENTAL RATES	CURRENT	RENEWAL
Employee	$ 30.56	$ 33.32
Employee + Spouse	$ 62.92	$ 68.60
Employee + Child(ren)	$ 84.08	$ 91.68
Employee + Spouse + Child(ren)	$ 116.44	$ 126.96

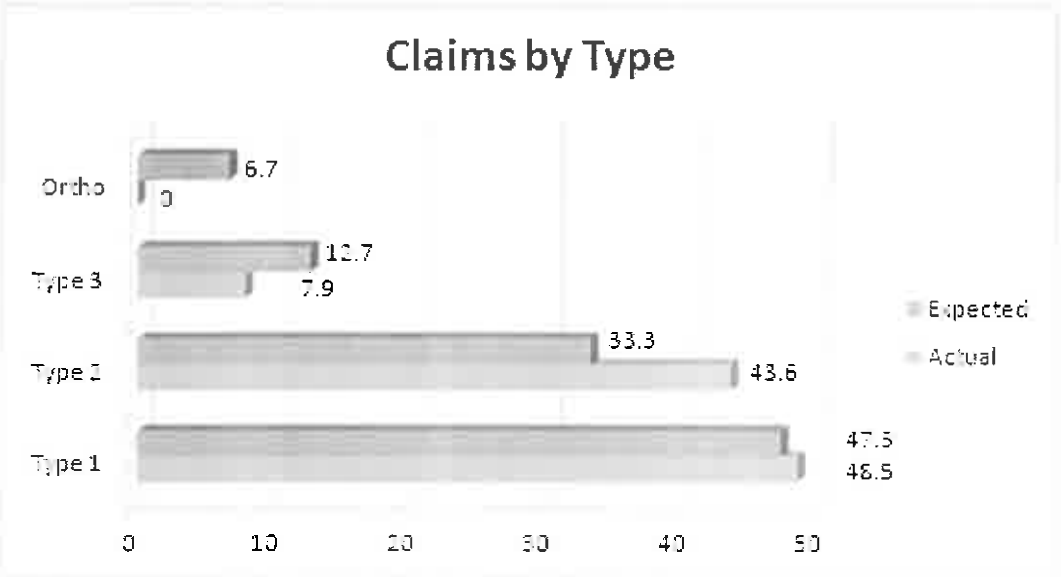
Our product flexibility enables us to package solutions balanced between benefits and premium to help maximize the plan's effectiveness. At your request, we can research alternatives that may better meet the needs of your company and its employees.

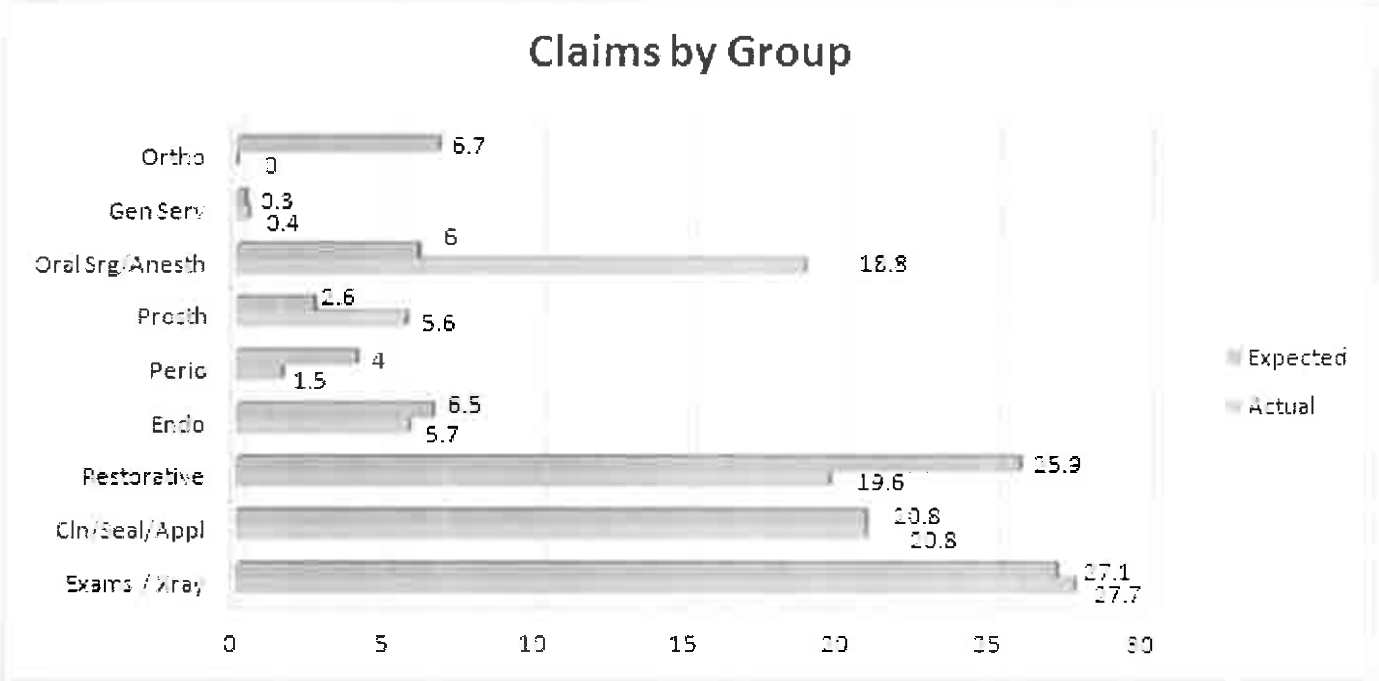
Thank you again for your business. I welcome the opportunity to discuss this renewal. We appreciate the opportunity to continue providing fast and accurate claims processing, exceptional administration, and excellent customer service in the years to come.

Sincerely,

John Tschantre

John Tschantre
Regional Group Manager





John A. Tschantre | Regional Group Manager | **Ameritas**

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Town of Altavista
Dental Highlight Sheet

Ameritas.

Dental Plan Summary

Coinsurance	
Type 1	100%
Type 2	80%
Type 3	50%
Deductible	$25/Calendar Year Type 2 & 3 Waived Type 1 3 Family Maximum
Maximum *(per person)*	$1,250 per calendar year
Allowance	90th U&C
Waiting Period	None
Annual Open Enrollment	None

Orthodontia Summary - Adult and Child Coverage

Allowance	U&C
Coinsurance	50%
Lifetime Maximum *(per person)*	$1,250
Waiting Period	None

Sample Procedure Listing (*Current Dental Terminology* © American Dental Association.)

Type 1	Type 2	Type 3
• Routine Exam (2 per benefit period)	• Restorative Amalgams	• Onlays
• Bitewing X-rays (2 per benefit period)	• Restorative Composites	• Crowns (1 in 5 years per tooth)
• Full Mouth/Panoramic X-rays (1 in 3 years)	• Endodontics (nonsurgical)	• Crown Repair
• Periapical X-rays	• Endodontics (surgical)	• Prosthodontics (fixed bridge, removable complete/partial dentures) (1 in 5 years)
• Cleaning (2 per benefit period)	• Periodontics (nonsurgical)	
• Fluoride for Children 18 and under (1 per benefit period)	• Periodontics (surgical)	
• Sealants (age 16 and under)	• Denture Repair	
• Space Maintainers	• Simple Extractions	
	• Complex Extractions	
	• Anesthesia	

Ameritas Information

We're Here to Help

This plan was designed specifically for the associates of **Town of Altavista.** At Ameritas Group, we do more than provide coverage - we make sure there's always a friendly voice to explain your benefits, listen to your concerns, and answer your questions. Our customer relations associates will be pleased to assist you 7 a.m. to midnight (Central Time) Monday through Thursday, and 7 a.m. to 6:30 p.m. on Friday. You can speak to them by calling toll-free: 800-487-5553. For plan information any time, access our automated voice response system or go online to ameritasgroup.com/member.

Rx Savings

Our valued plan members and their covered dependents (even their pets) can save on prescription medications through any Walmart or Sam's Club pharmacy across the nation. This Rx discount is offered at no additional cost, and it is not insurance.

To receive the Walmart Rx discount, Ameritas plan members just need to visit us at ameritasgroup.com and sign into (or create) a secure member account where they can access and print an online-only Rx discount savings ID card.

Eyewear Savings

Ameritas plan members may receive up to 15% off eyewear frames and lenses purchased at any Walmart Vision Center nationwide. Members may also bring in their current vision prescription from any vision care provider and purchase eyewear at Walmart. This savings arrangement is not insurance: it is available to members at no additional cost to their plan premium.

To receive the eyewear savings identification card, Ameritas plan members can visit ameritasgroup.com and sign-in (or create) a secure member account. Members must present the Ameritas Eyewear Savings Card at time of purchase to receive the discount.

Town of Altavista

Dental Highlight Sheet

Ameritas.

PPO Information

To find a provider, visit ameritasgroup.com and select **FIND A PROVIDER,** then **DENTAL**. Enter your criteria to search by location or for a specific dentist or practice. California Residents: When prompted to select your network, choose **PPO Dental Network**.

Pretreatment

While we don't require a pretreatment authorization form for any procedure, we recommend them for any dental work you consider expensive. As a smart consumer, it's best for you to know your share of the cost up front. Simply ask your dentist to submit the information for a pretreatment estimate to our customer relations department. We'll inform both you and your dentist of the exact amount your insurance will cover and the amount that you will be responsible for. That way, there won't be any surprises once the work has been completed.

Late Entrant Provision

We strongly encourage you to sign up for coverage when you are initially eligible. If you choose not to sign up during this initial enrollment period, you will become a late entrant. Late entrants will be eligible for only exams, cleanings, and fluoride applications for the first 12 months they are covered.

Section 125

This plan is provided as part of the Policyholder's Section 125 Plan. Each employee has the option under the Section 125 Plan of participating or not participating in this plan. If an employee does not elect to participate when initially eligible, he/she may elect to participate at the Policyholder's next Annual Election Period.

Worldwide Support

When our members travel abroad, they'll have peace of mind knowing that should a dental or vision need arise, help is just a phone call away. Through AXA Assistance, Ameritas offers its dental and vision plan members 24-hour access to dental or vision provider referrals when traveling outside the U.S.

Immediately after a call is made to AXA, an assistance coordinator assesses the situation, provides credible provider referrals and can even assist with making the appointment. Within 48 hours following the appointment, the coordinator calls the member to find out if additional assistance is needed. If all is well, the case is closed. Then, the plan member may submit a claim to Ameritas for reimbursement consideration based on applicable plan benefits.

This document is a highlight of plan benefits provided by Ameritas Life Insurance Corp. as selected by your employer. It is not a certificate of insurance and does not include exclusions and limitations. For exclusions and limitations, or a complete list of covered procedures, contact your benefits administrator.