Suffolk Public Schools

Anthem HealthKeepers

Anthem HealthKeepers 20/20/500 POS Open Access

Your Anthem HealthKeepers Plan	
Care rendered in a health care professional's office:	
Typically when you receive your care in a health care professional's office you will pay a set fee as noted below. Some professional services are paid once your deductible is satisfied (see below). Once you reach your deductible, you pay 20% of the amount that health care professionals in our network have agreed to accept for their services with the exception of home health care.	
Inpatient facility and select outpatient services:	
You will pay all of the costs associated with your care until you have paid $500 in one calendar year or plan year. This is known as your deductible. o If two people are covered under your plan, each of you will pay the first $500 of the cost of your care ($1,000 total). o If three or more people are covered under your plan, together you will pay the first $1,000 of your care. However, the most one family member will pay is $500. Once you reach your deductible you pay 20% of the amount that health care professionals in our network have agreed to accept for their services:	
Covered Services	**You Pay**
Preventive Care Services	
Preventive care services that meet the requirements of federal and state law, including certain screenings, immunizations and physician visits. *During the course of a routine screening procedure, abnormalities or problems may be identified that require immediate intervention or additional diagnosis. If this occurs, and your provider performs additional necessary procedures, the service will be considered diagnostic and/or surgical, rather than screening, depending on the claim for the services submitted by your provider, which will result in a member cost share.	***No Charge**
Doctor Visits	
o office visits o home visits o in-office surgery o voluntary family planning o urgent care visits	**$20** for each visit to your PCP **$40** for each visit to a specialist
o online visits (https://livehealthonline.com)	**$0** for each visit
Labs, Diagnostic X-rays and Other Outpatient Diagnostic Tests	
o diagnostic x-rays o diagnostic tests o lab work ****This fee is not required when these services are provided by the same professional on the same day as the office visit.***	**$20** for each visit to your PCP* **$40** for each visit to a specialist* **20%** for each visit to a hospital or facility (after meeting deductible, except for services related to preventive care)
o advanced diagnostic imaging services	**20%** of the amount the health care professionals in our network have agreed to accept for their services (after meeting deductible, except for services related to preventive care)
Autism Spectrum Disorder (ASD)	
o diagnosis and treatment of autism spectrum disorder including: o behavioral health treatment* o psychiatric care o therapeutic care** o pharmacy care o psychological care * ***Mental Health Services*** ****Unlimited physical, occupational and speech therapy.***	Member cost shares will be dependent on the services rendered.
o applied behavioral analysis o unlimited per member annual maximum	**20%** of the amount the health care professionals in our network have agreed to accept for their services (after meeting deductible, except for services related to preventive care)
Early Intervention – For children from birth up to age 3	
o unlimited per member per calendar year up to age 3	Member cost shares will be dependent on the services rendered.

For the benefits listed with specific limits, all services received during the calendar year or plan year for that benefit are applied to that limit (whether received in or out-of-plan).

Covered Services	You Pay
Other Outpatient Services	
o hospice care	**No Charge**
o diabetic supplies, equipment and education	Member cost shares will be dependent on the services rendered.
o ambulance travel	**$150** per transport
o home health care (100 visits)	**20%** of the amount the health care professionals in our network have agreed to accept for their services
o prosthetic devices o durable medical equipment o injectable medication*(excluding immunizations, preventive care, allergy injections and serum dispensed in a physician's office) ***You will pay an additional $20 or $40 office visit copayment depending on the type of provider who treats you.***	**20%** of the amount the health care professionals in our network have agreed to accept for their services (after meeting deductible)
Therapy Services	
o chemotherapy, radiation, cardiac and respiratory therapy o speech therapy (30 visit limit)* o physical and occupational therapy (30 combined visits)* o spinal manipulation and manual medical therapy services (30 visit limit) ***Limit does not apply to Autism Spectrum Disorder.*** o infusion o dialysis	**20%** of the amount the health care professionals in our network have agreed to accept for their services (after meeting deductible)
Outpatient Surgery in a Hospital or Facility	
o surgery	**20%** of the amount the health care professionals in our network have agreed to accept for their services (after meeting deductible)
Inpatient Stays in a Hospital or Facility	
o semi-private room o private room when approved when approved in advance o intensive or coronary care unit o skilled nursing facility (100 days for each admission)	**20%** of the amount the health care professionals in our network have agreed to accept for their services (after meeting deductible)
Maternity	
o all routine pre- and postnatal care (excluding inpatient stays)	**$200** per pregnancy
o diagnostic tests o non-stress tests and other fetal monitor procedures o ultrasounds	**$40** for each visit to a specialist office **20%** for each visit to a hospital or facility (after meeting deductible)
Outpatient Mental Health and Substance Use Services	
o office visits	**$20** for each visit
o outpatient facility (including partial day mental health and substance use services) o outpatient facility professional provider services	**No Charge**
Routine Vision	
o an annual routine eye exam ***Plus valuable discounts on eyewear***	**$15** for each visit
Emergency Care and Out of the Service Area Urgent Care	
o urgent care visits	**$40** for each visit

o emergency care visits in or out of the service area	**20%** of the amount the health care professionals in our network have agreed to accept for their services (after meeting deductible)

Out-of-Plan Services
Deductible for services received from out-of-plan health care professionals
You will pay all of the costs associated with covered services until you pay $1,000 in one calendar year. If two or more people are covered under your health plan, each member will be responsible for paying the first $1,000 toward covered services within a calendar year. o If two people are covered under your plan, each of you will pay the first $1,000 of the cost of your care ($2,000 total). o If three or more people are covered under your plan, together you will pay the first $2,000 of the cost of your care. However, the most one family member will pay is $1,000.
Once this amount has been reached, we will pay 70% of the amount doctors, hospitals and other health care professionals have agreed to accept for the same covered services.
If you go to an eye care professional not in our network for your routine eye examination, we will pay $30 (whether or not you have reached the $1,000 calendar year out-of-plan deductible) and you will pay the rest of what the professional charges.
In addition, you may seek spinal manipulation and manual medical therapy services (chiropractic care) from a provider not in our network without first meeting the out-of-plan deductible.
Out-of-Pocket Maximums
What You Will Pay for Covered Services in One Calendar Year (January 1 - December 31)
When using in-plan professionals If you are the only one covered by your plan, you will pay $4,500 for covered services outlined in this insert. Once you have reached this amount, your payment for covered services is $0, except for those services listed below that do not count toward the annual out-of-pocket maximum. o If two people are covered under your plan, each of you will pay $4,500 ($9,000 total). o If three or more people are covered under your plan, together you will pay $9,000. However, no family member will pay more than $4,500 toward the limit. **When using out-of-plan professionals** If you are the only one covered by your plan, you will pay $5,500 for covered services outlined in this insert. Once you have reached this amount, your payment for covered services is $0, except for those services listed below that do not count toward the annual out-of-pocket maximum. o If two people are covered under your plan, each of you will pay $5,500 ($11,000 total). o If three or more people are covered under your plan, together you will pay $11,000. However, no family member will pay more than $5,500 toward the limit. **The following do not count toward the calendar year out-of-pocket maximum:** o your share of the cost of adult routine vision care o the cost of care received when the benefit limits have been reached o the cost of services and supplies not covered under your benefits o the additional amount health care professionals not in our network may bill you when their charge is more than what we pay

Your benefit period is on calendar year. A calendar year means your benefit period runs from January through December.

For the benefits listed with specific limits, all services received during the calendar year or plan year for that benefit are applied to that limit (whether received in or out-of-plan).

Some benefits may be subject to balance billing, if provided by a non-participating provider. For more information on balance billing, see the enrollment brochure.

This summary of benefits is a brief outline of coverage, designed to help you with the selection process. This policy has exclusions and limitations to benefits and terms under which the policy may be continued in force or discontinued. For costs and complete details of the coverage, contact your insurance agent or contact us. *If there is a difference between this summary and the contract of coverage, the contract of coverage will prevail.*

This summary of benefits has been updated to comply with federal and state requirements, including applicable provisions of the recently enacted federal health care reform laws. As we receive additional guidance and clarification on the new health care reform laws from the U.S. Department of Health and Human Services, Department of Labor and Internal Revenue Service, we may be required to make additional changes to this summary of benefits.