Your Benefits

Anthem HealthKeepers

Anthem HealthKeepers 20/10/100 Plan
Suffolk Public Schools

In-Plan 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**
Routine Vision	
o annual routine eye exam ***Plus – valuable discounts on eyewear***	**$15** for each visit
Doctor Visits	
o office visits o home visits o voluntary family planning o in-office surgery 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
o mental health and substance abuse visits	**$20** for each visit
Labs, Diagnostic X-rays and Other Outpatient Diagnostic Test	
o lab work o diagnostic tests o diagnostic x-rays ***A copay does not apply when these services are provided by the same provider on the same day as the office visit.***	**$20** for each visit to your PCP **$40** for each visit to a specialist
o advanced diagnostic imaging services	**$100** for each visit
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.
Therapy Services	
o physical and occupational therapy (30 combined visits)* o speech therapy (30 visit limit)* ****Limit does not apply Autism Spectrum Disorder***	**$40** for each visit
o chemotherapy, radiation, cardiac and respiratory therapy	**$40** for each visit
o spinal manipulations and manual medical therapy services (30 visit limit)	**$35** for each visit
Maternity	
o all routine outpatient pre- and postnatal care (excluding inpatient stays)	**$50** per pregnancy
o diagnostic testing (such as ultrasound, non-stress tests and other fetal monitor procedures)	**$40** for each visit

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Other Outpatient Services	
o hospice services o home health care services o mental health and substance abuse partial-day treatment programs	**No charge**
o dialysis	**$40** for each calendar month
Outpatient Infusion Services	
o facility	**$40** for each visit
o ambulatory infusion centers	**No charge**
o home services	**No charge**
Outpatient Surgery in a Hospital or Facility	
o surgery	**$100** then **10%** for each visit
Emergency Room	
o urgent care visits	**$40** for each visit
o emergency room visits	**$150** then **10%** for each visit
Inpatient Stays in a Plan Hospital or Facility	
o semi-private room, intensive care or similar unit o physician, nursing and other medically necessary professional services in the hospital including anesthesia, surgical and maternity delivery services	**$250** per admission

All Other In-Plan Services

You will pay all the costs associated with your care until you have paid **$100** in one calendar 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 **$100** of the cost of your care **($200** total).
- o If three or more people are covered under your plan, together you will pay the first **$200** of the cost of your care. However, the most one family member will pay is **$100**.

Once you reach your deductible you pay:

Other Outpatient Services	
o prosthetic devices o injectable medication* (*excluding chemotherapy medications, immunizations, preventive care, allergy injections and serum dispensed in a physician's office) ***You will also 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
o ambulance travel o durable medical equipment, medical appliances, and supplies	**10%** of the amount the health care professionals in our network have agreed to accept for their services
Other Inpatient Services	
o skilled nursing facility care (100 days per each admission)	**10%** of the amount the health care professionals in our network have agreed to accept for their services

Out-of-Pocket Maximums

What you will pay for covered services in one calendar year

When using in-plan professionals

If you are the only one covered by your plan, you will pay $6,000 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 $6,000 ($13,000 total).
- o If three or more people are covered under your plan, together you will pay $13,000. However, no family member will pay more than $6,000 toward the limit.

***The following do not count toward the calendar or plan year out-of-pocket maximum:**

- o your share of the cost of 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 Anthem HealthKeepers
- o the additional amount health care professionals not in our plan may bill you when their charge is more than what we pay

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

For benefits listed with specific limits all services received in the calendar year for that benefit are applied to that limit.

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.