Your Anthem Benefits

Anthem

Anthem KeyCare Plan
Suffolk Public Schools

In-Network 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 urgent care visits o home visits o pre- and postnatal office visits** o in office surgery o physical and occupational therapy in an office setting (30 combined visits)* o speech therapy visits in an office setting (30 visit limit)* o spinal manipulations and other manual medical intervention visits (30 visit limit) ***Limit does not apply Autism Spectrum Disorder*** ****If your physician submits one bill for prenatal, delivery, and postnatal care, services are covered as maternity delivery services. (See Inpatient stay section.)***	**$25** for each visit to a family or general practitioner, internist or pediatrician **$50** for each visit to a specialist
o online visits (https://livehealthonline.com)	**$0** for each visit
o mental health and substance abuse visits	**$25** 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.
Outpatient Services in a Hospital or Facility	
o physical therapy and occupational therapy (30 combined visits)* o speech therapy (30 visit limit)* ***Limit does not apply Autism Spectrum Disorder***	**$50 plus 20%** of the amount the health care professionals in our network have agreed to accept for their services
o emergency room ***For the services billed by the doctor, you will pay an additional $25 or $50 depending on the type of doctor who treats you.***	**$150 plus 20%** of the amount the health care professionals in our network have agreed to accept for their services*
o surgery ***For the services billed by the doctor, you will pay an additional $25 or $50 depending on the type of doctor who treats you.***	**$100 plus 20%** of the amount the health care professionals in our network have agreed to accept for their services*

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Care at Home	
o hospice care o home health care visits by a nurse or aide (90 visits)	**No charge**
All Other In-Plan Services	
You will pay all the costs associated with your care until you have paid **$200** 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 **$200** of the cost of your care **($400** total). o If three or more people are covered under your plan, together you will pay the first **$400** of the cost of your care. However, the most one family member will pay is **$200**. **Once you reach your deductible you pay:**	
Labs, X-rays and Other Outpatient Services	
o diagnostic lab services o diagnostic x-rays o dialysis o chemotherapy (not given orally) o professional ground ambulance services o medical appliances, supplies and medications o respiratory therapy o infusion services o shots and therapeutic injections, including infusion medications o durable medical equipment o radiation therapy	**20%** of the amount the health care professionals in our network have agreed to accept for their services
Care at Home	
o home private duty nursing ($500 maximum) ***Since there is no network for this service, you may be billed for the difference between what we pay for this service and the amount the private duty nursing service charged.***	**20%** of the amount the health care professionals in our network have agreed to accept for their services
Mental Health and Substance Abuse Outpatient Services	
o outpatient facility (including partial day treatment and intensive outpatient programs) o outpatient facility professional provider services	**20%** of the amount the health care professionals in our network have agreed to accept for their services
Inpatient Stays in a Network Hospital or Facility	
o semi-private room, intensive care or similar unit ***If your physician submits one bill for prenatal, delivery, and postnatal care, services are covered as maternity delivery services.***	**$300 plus 10%** of the amount the health care professionals in our network have agreed to accept for their services (not subject to deductible)
o physician, nursing and other medically necessary professional services in the hospital including anesthesia, surgical and maternity delivery services o skilled nursing facility care (100 days for each admission)	**20%** of the amount the health care professionals in our network have agreed to accept for their services
o mental health/substance abuse stays - semi-private room, intensive care or similar unit	**$300 plus 10%** of the amount the health care professionals in our network have agreed to accept for their services (not subject to deductible)
o mental health/substance abuse stays - physician, nursing and other medically necessary professional services in the hospital	**10%** of the amount the health care professionals in our network have agreed to accept for their services

Your benefit period is on a calendar year basis. 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 from January 1 to December 31 for that benefit (whether received in-network or out-of-network) are applied to that limit.

Out-of-Network Services

Using Doctors, Hospitals and Other Health Care Professionals not Contracted to Provide Benefits

It's important to remember that health care professionals not in our network can charge whatever they want for their services. If what they charge is more than the fee our network health care professionals have agreed to accept for the same service, they may bill you for the difference between the two amounts. You will pay all the costs associated with the covered services outlined in this insert until you have paid $400 in one calendar year. This is called your **out-of-network deductible**.

- If two people are covered under your plan, each of you will pay the first $400 of the cost of your care ($800 total).
- If three or more people are covered under your plan, together you will pay the first $800 of the cost of your care. However, the most one family member will pay is $400.

Once you have reached this amount, when you receive covered services we will pay 70% of the fee our network health care professionals have agreed to accept for the same service. You will pay the rest, including any difference between the fee our network health care professionals have agreed to accept for the same service and the amount the health care professional not in our network charges. 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 $400 out-of-network deductible) and you will pay the rest of what the professional charges.

Out-of-Pocket Maximums

What You Will Pay for Covered Services in One Calendar Year (January 1 - December 31)

When using network professionals
If you are the only one covered by your plan, you will pay $6,500 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*.

- If two people are covered under your plan, each of you will pay $6,500 ($13,000 total).
- If three or more people are covered under your plan, together you will pay $13,000. However, no family member will pay more than $6,500 toward the limit.

When not using network professionals
If you are the only one covered by your plan, you will pay $6,500 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*.

- If two people are covered under your plan, each of you will pay $6,500 ($13,000 total).
- If three or more people are covered under your plan, together you will pay $13,000. However, no family member will pay more than $6,500 toward the limit.

***The following do not count toward the calendar year out-of-pocket maximum:**
- your share of the cost of routine vision care
- the cost of care received when the benefit limits have been reached
- the cost of services and supplies not covered under your Anthem KeyCare plan
- the additional amount health care professionals not in our network may bill you when their charge is more than what we pay

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.