Suffolk Public Schools

Anthem

High Deductible Health Plan (HDHP) with Health Savings Account (HSA)

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
Annual Deductible	
You will pay all the costs associated with your care until you have paid $3,400 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 $3,400 of the cost of your care ($6,800 total). o If three or more people are covered under your plan, together you will pay the first $6,800 of the cost of your care. However, the most one family member will pay is $3,400.	
Once you reach your deductible, you will pay the following for covered in-network services	
All Other In-Network Services	**You Pay**
Doctor Visits	
o office visits o urgent care visits o home visits o pre- and postnatal office visits o mental health and substance use 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 to Autism Spectrum Disorder.***	**10%** of the amount the health care professionals in our network have agreed to accept for their services
Labs, Diagnostic X-rays and Other Outpatient Services	
o diagnostic lab services o shots and therapeutic injections o medical appliances, supplies and medications, including infusion medications o diagnostic x-rays o dialysis o ambulance travel o durable medical equipment o chemotherapy (not given orally), radiation, cardiac and respiratory therapy	**10%** of the amount the health care professionals in our network have agreed to accept for their services

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In-Network Services	You Pay
o diabetic supplies, equipment and education	Member cost shares will be dependent on the services rendered.
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	**10%** of the amount the health care professionals in our network have agreed to accept for their services
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 Visits in a Hospital or Facility	
o physical therapy and occupational therapy (30 combined visits)* o speech therapy (30 visit limit)* o surgery o emergency room o physician services o mental health and substance use partial-day treatment programs * ***Limit does not apply to Autism Spectrum Disorder.***	**10%** of the amount the health care professionals in our network have agreed to accept for their services
Care at Home	
o home health care (100 visits) o private duty nursing is limited to 16 hours per member per calendar year* ****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.***	**10%** of the amount the health care professionals in our network have agreed to accept for their services
o hospice care	**10%** 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 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)	**10%** of the amount the health care professionals in our network have agreed to accept for their services
Retail or Specialty Pharmacy	
o Up to a 30-day medication supply at participating pharmacies *Most specialty medications are limited to up a 30 day supply.*	**See Your Prescription Drug Plan information**
Home Delivery or Specialty Pharmacy	
o Up to a 90-day medication supply delivered to your home *Most specialty medications are limited to up a 30 day supply.*	**See Your Prescription Drug Plan information**
Retail Maintenance	
o Up to a 90-day medication supply at participating pharmacies *Enhanced CVS 90 day benefit - CVS Retail Stores Only = Up to 90 day supply (cost same as Home Delivery)	**See Your Prescription Drug Plan information**

Your benefit period runs on a calendar year. 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 (whether received in or out of network).

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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 $6,000 in one calendar or plan year. This is called your out-of-network deductible.

- If two people are covered under your plan, each of you will pay the first $6,000 of the cost of your care ($12,000 total).
- If three or more people are covered under your plan, together you will pay the first $12,000 of the cost of your care. However, the most one family member will pay is $6,000.

Once you have reached this amount, when you receive covered services we will pay 60% 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 $6,000 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 or Plan Year

When using network professionals

For single coverage, you will pay $5,000 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.

- If two people are covered under your plan, each of you will pay $5,000 ($10,000 total).
- If three or more people are covered under your plan, together you will pay $10,000. However, no family member will pay more than $5,000 toward the limit.

When not using network professionals

For single coverage, you will pay $10,000 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.

- If two people are covered under your plan, each of you will pay $10,000 ($20,000 total).
- If three or more people are covered under your plan, together you will pay $20,000. However, no family member will pay more than $10,000 toward the limit.

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

- your share of the cost of adult 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 benefits
- 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 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

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