Your Benefits

Anthem HealthKeepers

Anthem HealthKeepers 20 Point of Service/Open Access
Chesapeake 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
Doctor Visits	
○ office visits ○ urgent care visits ○ home visits ○ in-office surgery ○ voluntary family planning	$25 for each visit to your PCP $50 for each visit to a specialist
○ online visits (https://livehealthonline.com)	$15 for each visit
Labs, Diagnostic X-rays and Other Outpatient Diagnostic Tests	
○ diagnostic tests ○ diagnostic x-rays ○ lab work *A copay does not apply when these services are provided by the same provider on the same day as the office visit.*	$25 for each visit to your PCP $50 for each visit to a specialist
Other Outpatient Services	
○ hospice care	No Charge
○ ambulance travel	$150 per transport
Therapy Services	
○ physical and occupational therapy (30 combined visits)* ○ speech therapy (30 visit limit)* **Limit does not apply to Autism Spectrum Disorder.*	$10 for each visit
○ spinal manipulation and manual medical therapy services (30 visit limit)	$25 for each visit
○ chemotherapy, radiation, cardiac and respiratory therapy	$50 for each visit
Outpatient Infusion Services	
○ facility ○ ambulatory infusion centers ○ home services	$50 for each visit
Outpatient Services in a Hospital or Facility	
○ surgery	$250 for each visit
Inpatient Stays in a Hospital or Facility	
○ semi-private room ○ private room when approved when approved in advance ○ intensive or coronary care unit **You do not have to pay another inpatient copay if you are readmitted for the same or related condition within less than 72 hours from when you went home.*	$300 per day (not to exceed $1,500) for an admission*
Maternity	
○ all routine outpatient pre- and postnatal care (excluding inpatient stays)	$200 per pregnancy
○ diagnostic testing (such as ultrasound, non-stress tests and other fetal monitor procedures)	$50 for each visit
Outpatient Mental Health and Substance Use	
○ outpatient facility(partial day mental health and substance use services)	No charge
○ office visit	$25 for each visit
○ outpatient facility professional provider services	$30 for each visit
Routine Vision	
○ annual routine eye exam *Plus valuable discounts on eyewear*	$15 for each visit

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Emergency Care and Out of the Service Area Urgent Care	
o urgent care visits	**$50** for each visit
o emergency care visits in or out of the service area **Waived if admitted directly to the hospital.*	**$200** for each visit to an emergency room*
Outpatient Services in a Hospital or Facility	
o surgery	**$250** for each visit
All Other In Network Services	**You Pay**
You will pay all the costs associated with your care until you have paid $200 in one calendar 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:**	
Diagnostic X-rays and Other Outpatient Diagnostic Tests	
o advanced diagnostic imaging services	**20%** of the amount the health care professionals in our network have agreed to accept for their services
Other Outpatient Services	
o diabetic supplies, equipment and education	Member cost shares will be dependent on the services rendered.
Autism Spectrum Disorder (ASD) – For children from age 2 through 10	
o diagnosis and treatment of autism spectrum disorder including: o behavioral health treatment* o pharmacy care o psychiatric care o psychological care o therapeutic care** * ***Mental Health Services*** ****Unlimited physical, occupational and speech therapy.***	Member cost shares will be dependent on the services rendered.
o applied behavioral analysis – unlimited per member annual maximum	**20%** 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.
Other Outpatient Services	
o prosthetic devices o durable medical equipment o home health care (100 visits) o injectable medication* (excluding immunizations, preventive care, allergy injections and serum dispensed in a physician's office) ****You will also pay an additional $25 or $50 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
Therapy Services	
o dialysis	**20%** of the amount health care professionals in our network have agreed to accept for their services
Inpatient Stays in a Facility	
o skilled nursing facility (100 days for each admission)	**20%** of the amount health care professionals in our network have agreed to accept for their services

Out-of-Network 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 $750 in one calendar year. If two or more people are covered under your health plan, each member will be responsible for paying the first $750 toward covered services within a calendar year.

- If two people are covered under your plan, each of you will pay the first $750 of the cost of your care ($1,500 total).
- If three or more people are covered under your plan, together you will pay the first $1,500 of the cost of your care. However, the most one family member will pay is $750.

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 $750 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 $3,500 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 $3,500 ($7,000 total).
- If three or more people are covered under your plan, together you will pay $7,000. However, no family member will pay more than $3,500 toward the limit.

When using out-of-plan professionals

If you are the only one covered by your plan, 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.

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 benefits
- the additional amount health care professionals not in our network may bill you when their charge is more than what we pay

For benefits listed with specific limits all services received during the calendar year from January 1 to December 31 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.

Language Access Services:

Get help in your language

Curious to know what all this says? We would be too. Here's the English version:
If you have any questions about this document, you have the right to get help and information in your language at no cost. To talk to an interpreter, call (833) 592-9956.

Separate from our language assistance program, we make documents available in alternate formats for members with visual impairments. If you need a copy of this document in an alternate format, please call the customer service telephone number on the back of your ID card.

(TTY/TDD: 711)

(Arabic) العربية: إذا كان لديك أي استفسارات بشأن هذا المستند، فيحق لك الحصول على المساعدة والمعلومات بلغتك دون مقابل. للتحدث إلى مترجم، اتصل على 592-9956 (833)

Armenian (*հայերեն*). *Եթե այս փաստաթղթի հետ կապված հարցեր ունեք, դուք իրավունք ունեք անվճար ստանալ օգնություն և տեղեկատվություն ձեր լեզվով: Թարգմանչի հետ խոսելու համար զանգահարեք հետևյալ հեռախոսահամարով՝* (833) 592-9956

Chinese

(中文)：如果您對本文件有任何疑問，您有權使用您的語言免費獲得協助和資訊。如需與譯員通話，請致電 (833) 592-9956

(Farsi) فارسي: در صورتی که سؤالی پیرامون این سند دارید، این حق را دارید که اطلاعات و کمک را بدون هیچ هزینه‌ای به زبان مادری‌تان دریافت کنید. برای گفتگو با یک مترجم شفاهی، با شماره (833) 592-9956 تماس بگیرید.

French (Français): Si vous avez des questions sur ce document, vous avez la possibilité d'accéder gratuitement à ces informations et à une aide dans votre langue. Pour parler à un interprète, appelez le (833) 592-9956.

Haitian Creole (Kreyòl Ayisyen): Si ou gen nenpòt kesyon sou dokiman sa a, ou gen dwa pou jwenn èd ak enfòmasyon nan lang ou gratis. Pou pale ak yon entèprèt, rele (833) 592-9956.

Italian (Italiano): In caso di eventuali domande sul presente documento, ha il diritto di ricevere assistenza e informazioni nella sua lingua senza alcun costo aggiuntivo. Per parlare con un interprete, chiami il numero (833) 592-9956

Language Access Services:

(Japanese) (日本語):
この文書についてなにかご不明な点があれば、あなたにはあなたの言語で無料で支援を受け情報を得る権利があります。通訳と話すには、(833) 592-9956 にお電話ください。

Korean (한국어): 본 문서에 대해 어떠한 문의사항이라도 있을 경우, 귀하에게는 귀하가 사용하는 언어로 무료 도움 및 정보를 얻을 권리가 있습니다. 통역사와 이야기하려면 (833) 592-9956 로 문의하십시오.

(Navajo) (Din4): D77 naaltsoos bik1'7g77 [ahgo b7na'7d7[kidgo n1 boh0n4edz3 d00 bee ah00t'i' t'11 ni nizaad k'ehj7 bee ni[hodoonih t'1adoo b33h 7l7n7g00. Ata' halne'7g77 [a' bich'8' hadeesdzih n7n7zingo koj8' hod77lnih (833) 592-9956.

Polish (polski): W przypadku jakichkolwiek pytań związanych z niniejszym dokumentem masz prawo do bezpłatnego uzyskania pomocy oraz informacji w swoim języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer (833) 592-9956.

(Punjabi) (ਪੰਜਾਬੀ): *ਜੇ ਤੁਹਾਡੇ ਇਸ ਦਸਤਾਵੇਜ਼ ਬਾਰੇ ਕੋਈ ਸਵਾਲ ਹਨ ਤਾਂ ਤੁਹਾਡੇ ਕੋਲ ਮੁਫ਼ਤ ਵਿੱਚ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮਦਦ ਅਤੇ ਜਾਣਕਾਰੀ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੈ। ਇੱਕ ਦੁਭਾਸ਼ੀਏ ਨਾਲ ਗੱਲ ਕਰਨ ਲਈ,* (833) 592-9956 *ਤੇ ਕਾਲ ਕਰੋ।*

(Russian) (Русский): *если у вас есть какие-либо вопросы в отношении данного документа, вы имеете право на бесплатное получение помощи и информации на вашем языке. Чтобы связаться с устным переводчиком, позвоните по тел. (833) 592-9956.*

Spanish (Español): Si tiene preguntas acerca de este documento, tiene derecho a recibir ayuda e información en su idioma, sin costos. Para hablar con un intérprete, llame al (833) 592-9956.

Tagalog (Tagalog): Kung mayroon kang anumang katanungan tungkol sa dokumentong ito, may karapatan kang humingi ng tulong at impormasyon sa iyong wika nang walang bayad. Makipag-usap sa isang tagapagpaliwanag, tawagan ang (833) 592-9956.

Vietnamese (Tiếng Việt): Nếu quý vị có bất kỳ thắc mắc nào về tài liệu này, quý vị có quyền nhận sự trợ giúp và thông tin bằng ngôn ngữ của quý vị hoàn toàn miễn phí. Để trao đổi với một thông dịch viên, hãy gọi (833) 592-9956.

It's important we treat you fairly
That's why we follow federal civil rights laws in our health programs and activities. We don't discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, we offer free aids and services. For people whose primary language isn't English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711). If you think we failed to offer these services or discriminated based on race, color, national origin, age, disability, or sex, you can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator in writing to Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279. Or you can file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201 or by calling 1-800-368-1019 (TDD: 1- 800-537-7697) or online at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf. Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.