Your Benefits

Anthem

Anthem KeyCare 20
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
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 spinal manipulations and other manual medical intervention visits (30 visit limit) o urgent care visits o in office surgery	$25 for each visit to a PCP $50 for each visit to a specialist
o online visits (https://livehealthonline.com)	$15 for each visit
o physical and occupational therapy in an office setting (30 combined visits)* o speech therapy visits in an office setting (30 visit limit)* **Limit does not apply to Early Intervention and Autism Spectrum Disorder.*	$10 for each visit
Other Outpatient Services	
o ambulance travel	$150 per transport
Mental Health and Substance Use Outpatient Services	
o office visits	$25 for each visit
Outpatient Visits in a Hospital or Facility	
o physical therapy and occupational therapy (30 combined visits)* o speech therapy (30 visit limit)* **Limit does not apply to Autism Spectrum Disorder.*	$10 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.*	$200 plus 20% of the amount the health care professionals in our network have agreed to accept for their services*
Emergency Care	
o emergency room	$200 plus 20% of the amount the health care professionals in our network have agreed to accept for their services*
Care at Home	
o hospice care	No charge
Maternity	
o all routine pre- and postnatal care (excluding inpatient stays)	$200 per pregnancy
Inpatient Stays in a Network Hospital or Facility	
o semi-private room, intensive care or similar unit **You do not have to pay another inpatient copay if you are readmitted for the same or related condition within 90 days of the day you went home.*	$400 plus 20% of the amount the health care professionals in our network have agreed to accept for their services*

All Other In-Network Services	You Pay
You will pay all the costs associated with 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:	
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 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
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.
Labs, Diagnostic X-rays and Other Outpatient Services	
o diagnostic lab services o diagnostic x-rays o advanced diagnostic imaging services o dialysis o durable medical equipment o infusion services o shots and therapeutic injections, including infusion medications o medical appliances, supplies and medications o chemotherapy (not given orally), radiation, cardiac and respiratory therapy	20% of the amount the health care professionals in our network have agreed to accept for their services
o diabetic supplies, equipment and education	Member cost shares will be dependent on the services rendered.
Emergency Care	
o emergency room physician services	20% of the amount the health care professionals in our network have agreed to accept for their services
Mental Health and Substance Use Outpatient Services	
o outpatient facility (including partial day mental health and substance use services) o outpatient facility professional provider services	20% 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)	20% of the amount the health care professionals in our network have agreed to accept for their services
o private duty nursing 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*	20% of the amount the health care professionals in our network have agreed to accept for their services
Maternity	
o diagnostic test o non-stress tests and other fetal monitor procedures o ultrasounds	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	
○ physician, nursing and other medically necessary professional services in the hospital including anesthesia, surgical and maternity delivery services ○ 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

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 $500 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 $500 of the cost of your care ($1,000 total).
- If three or more people are covered under your plan, together you will pay the first $1,000 of the cost of your care. However, the most one family member will pay is $500.

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 $500 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 $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 not using network 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*.

- If two people are covered under your plan, each of you will pay $5,500 ($11,000 total).
- 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:

- 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

For the 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-network).

This benefits overview insert is only one piece of your entire enrollment package.
See the enrollment brochure for a list of your plan's exclusions and limitations and applicable policy form numbers.

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* (833) 592-9956

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

(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。

Language Access Services:

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.