

Rockingham County and Rockingham County Public Schools KeyCare 20 with \$500 Deductible

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 <i>your</i> 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 <i>your</i> provider, which will result in a member cost share.	No charge*
Doctor Visits <ul style="list-style-type: none"> ○ office visits ○ urgent care visits ○ home visits ○ pre- and postnatal office visits** ○ mental health and substance abuse visits ○ in-office surgery ○ physical and occupational therapy in an office setting (30 combined visits)* ○ speech therapy visits in an office setting (30 visit limit)* ○ spinal manipulations and other manual medical intervention visits (30 visit limit)* ○ impacted wisdom teeth * Limited to 30 combined visits per plan year for physical therapy and occupational therapy services, and 30 separate visits each per plan year for speech therapy and spinal manipulation services. **If your physician submits one bill for prenatal, delivery, and postnatal care, services are covered as maternity delivery services (see Inpatient stay section).	\$20 for each visit to a family or general practitioner, internist or pediatrician \$40 for each visit to a specialist
Labs and X-rays <ul style="list-style-type: none"> ○ diagnostic lab services ○ diagnostic x-rays 	No charge
Emergency Room <ul style="list-style-type: none"> ○ emergency room facility services (copayment waived if admitted) 	\$100 copayment per visit
All Other In-Network Services	You Pay
You will pay all the costs associated with your care until you have paid \$500 in one plan year. This is known as your deductible. <ul style="list-style-type: none"> ○ 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 reach your deductible you pay:	
Other Outpatient Services <ul style="list-style-type: none"> ○ dialysis ○ chemotherapy (not given orally) ○ ground or air ambulance services ○ medical appliances, supplies and medications, ○ advanced diagnostic imaging services (including but not limited to MRI, MRA, MRS, CTA, PET scans and CT Scans) ○ respiratory therapy ○ infusion services ○ shots and therapeutic injections, including infusion medications ○ radiation therapy 	20% of the amount the health care professionals in our network have agreed to accept for their services (Allowable Charge) after deductible
<ul style="list-style-type: none"> ○ durable medical equipment 	No charge after deductible
Outpatient Visits in a Hospital or Facility <ul style="list-style-type: none"> ○ physical therapy and occupational therapy* ○ speech therapy* ○ surgery * Limited to 30 combined visits per plan year for physical therapy and occupational therapy services, and 30 visits per plan year for speech therapy services.	20% of the amount the health care professionals in our network have agreed to accept for their services (Allowable Charge) after deductible
Mental Health and Substance Abuse Outpatient Services <ul style="list-style-type: none"> ○ outpatient facility (including partial day treatment and intensive outpatient programs) ○ outpatient facility professional provider services 	20% of the amount the health care professionals in our network have agreed to accept for their services (Allowable Charge) after deductible

Your benefit period is a plan year. A plan year runs from the effective date of the plan through a 12-month period (e.g. October 1 through September 30).

In-Network Services	You Pay
Care at Home	
<ul style="list-style-type: none"> ○ hospice care 	No charge
<ul style="list-style-type: none"> ○ home health care visits by a nurse or aide (90 visits) ○ private duty nursing (\$500 maximum)* <i>*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.</i> 	20% of the amount the health care professionals in our network have agreed to accept for their services (Allowable Charge) after deductible
Inpatient Stays in a Network Hospital or Facility	
<ul style="list-style-type: none"> ○ semi-private room, intensive care or similar unit ○ 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 (Allowable Charge) after deductible

Out-of-Network Services
Using Doctors, Hospitals and Other Health Care Professionals not Contracted to Provide Benefits
<p>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 or plan year. This is called your in and out-of-network deductible.</p> <ul style="list-style-type: none"> ○ 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. <p>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.</p>

Out-of-Pocket Maximums
What You Will Pay for Covered Services in One Plan Year
<p>When using providers in or out of network If you are the only one covered by your plan, you will pay \$3,000 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.*</p> <ul style="list-style-type: none"> ○ If two people are covered under your plan, each of you will pay \$3,000 (\$6,000 total). ○ If three or more people are covered under your plan, together you will pay \$6,000. However, no family member will pay more than \$3,000 toward the limit. <p>The following do not count toward the plan year out-of-pocket maximum:</p> <ul style="list-style-type: none"> ○ your share of the cost of prescription drugs and 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 20 w/\$500 Deductible plan ○ the additional amount health care professionals not in our network may bill you when their charge is more than what we pay

*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.