Suffolk Public Schools(Revised 3/24/2017)

	Current Healthkeepers 90/10	Current Key Care PPO	High Deductible withHSA 1647 2800/20 Embedded	HealthKeepers 80/20 Plan
IN PLAN BENEFITS	IN PLAN BENEFITS	IN PLAN BENEFITS	IN PLAN BENEFITS	IN PLAN BENEFITS
Current Year DEDUCTIBLE – Individual/Family	$100/$200	$200/$400	$2800/$5600	$500/$1000
Out patient OFFICE VISITS - PCP/SPECIALIST	$20/$40	$25/$50	20% aft DED	$20/$40
LIVE HEALTH ONLINE --Medical			20% aft DED	**$10**
PREVENTIVE CARE	100%	100%	100% before DED	100%
ANNUAL VISION EXAM	$15 $30 OON allowance	$15 $30 OON allowance	$15 $30 OON allowance	$15 $30 OON allowance
DIAGNOSTIC TESTS [1]	$20 PCP/$40 Spec	$25 PCP/$50 Spec	20% aft DED	$20 PCP/$40 Spec 20% aft DED Facility
ADVANCE DIAGNOSTIC IMAGING(ADI)				
· Office & Out Patient Facility	$100 each visit	$50 + 20%	20% aft DED	20% aft DED
CHEMOTHERAPY, INFUSION, CARDIAC, RADIATION AND RESPIRATORY THERAPY				
· Office & Out Patient Facility	$40 each visit	$50 plus 20% aft DED	20% aft DED	20% aft DED
PHYSICAL, OCC., SPEECH THERAPY [2]				
· Office & Out Patient Facility	$40 each visit	$50 each visit with limit	20% aft DED	20% aft DED
SPINAL MANIPULATION & MANUAL MEDICAL THERAPY SERVICES [3]				
· Office & Out Patient Facility	$40 each visit/ 30 per year	$50 each visit with limit	20% aft DED	20% aft DED
STATE MANDATED BENEFITS				
· Early Intervention Services (Unlimited Preventative Maintanence per Current Year up to age 3)	Cost Share Determined by Service Rendered	Cost Share Determined by Service Rendered	Cost Share Determined by Service Rendered	Cost Share Determined by Service Rendered
· Autism Spectrum Disorder (51+ ONLY) - Applied Behavior Analysis (age 2 thru 10); Unlimited	Cost Share Determined by Service Rendered; 10% after DED for ABA Services	Cost Share Determined by Service Rendered; 20% after DED for ABA Services	Cost Share Determined by Service Rendered; 20% after DED for ABA Services	Cost Share Determined by Service Rendered; 20% after DED for ABA Services
DIALYSIS · Office & Out Patient Facility	$40/month	20% after DED	20% aft DED	20% aft DED
Out Patient SURGERY [4]	$100 then 10%/visit	$100 plus 20%	20% aft DED	$20 PCP/$40 Spec/20% aft DED Facility Services
PRE/POST NATAL CARE [5]	$50/pregnancy/ $250/admission	$25PCP/$50 Spec/$300 + 10%	20% aft DED	$200
MENTAL HEALTH/SUBSTANCE ABUSE VISITS				
· Office Visits (including **Live Health Online Psychology**, Nutritional Counseling for eating disorders)	$30	20% aft DED	20% aft DED	$20

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· Out Patient Facility (Partial Day/Intensive Out Patient) · Out Patient Facility (other services/including Nutritional Counseling for eating disorders)	20% after DED	10% in network	20% aft DED	$0
· Residential Treatment Center	$250 copay/visit	$300 plus 10% in network	20% aft DED	20% aft DED
HOME HEALTH CARE [6]	No charge/limit 90 visits	20% aft DED	20% aft DED	20%
INPATIENT HOSP. SERVICES	$250/admission	$300 plus 10% in network	20% aft DED	20% aft DED
SKILLED NURSING [7]	20% aft DED	20% aft DED	20% aft DED	20% aft DED
DURABLE MEDICAL EQUIPMENT [8] CDH only Wigs 1 wig/Per member/per year(In Network & Out of Network combined)	20% aft DED	20% aft DED	20% aft DED	20% aft DED
OTHER SERVICES[9]	20% aft DED	20% aft DED	20% aft DED	20% aft DED
AMBULANCE SERVICES	20% aft DED	20% aft DED	20% aft DED	$150
EMERGENCY ROOM	$150 plus 10%	$150 plus 20%	20% aft DED	20% aft DED
OUT OF PLAN BENEFIT				
· CY Deductible – Individual/Family	**$400/$800**	**$400/$800**	**$5,600/$11,200**	**$1,000/$2,000**
· Co-insurance	30% after DED	30% after DED	40% after DED	30% aft DED
OUT-OF-POCKET				
· In-Network/In-Plan	$6,000/$13,000	$6,500/$13,000	$5,000/$10,000	$4,500/$9,000
· Out of Network/Out of Plan	$6,000/$13,000	$6,500/$13,000	$10,000/$20,000	$5,500/$11,000
PHARMACY[10]	$10/$30/$50+20%	$10/$30/$50+20%	$10/$30/$50+20%	$10/$30/$50+20%

[1] If rendered with an office visit the member will only be responsible for an office visit copayment- (this does not apply to DED/COINS & LUMENOS PLANS)
[2] 30 combined PT/OT visits per CY and 30 ST visits per CY; combined in-plan and out-of-plan; unlimited for autism spectrum disorder and early intervention
[3]30 visits per calendar year
[4] Free standing ambulatory surgery center or hospital based facility
[5] All routine O/P pre- and postnatal care of the mother rendered by the OB/GYN
[6] 100 visits per year
[7] 100 days/per confinement; combined in-plan and out-of-plan
[8] Rental and purchase; Unlimited
[9] Includes prosthetics and specialty drugs (including chemotherapy) in an office setting (excluding immunizations, PC, allergy injections/serum)
[10] Pharmacy cost shares accumulate to the OOP

Revised due to changes made but never implemented by Anthem, described in Handbook at old rates and these will be honored.