

Your benefits



Henrico County General Government and Public Schools Anthem KeyCare PPO Plan

Covered services (not subject to deductible)	IN-NETWORK you pay
Preventive care services	
<p>Preventive care services that meet the requirements of federal and state law, including certain screenings, immunizations, and physician visits.</p> <p>* 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 may result in a member cost share.</p>	*No charge
Outpatient services	
<ul style="list-style-type: none"> • Mammograms 	No charge
<ul style="list-style-type: none"> • Maternity services for all routine outpatient pre-and postnatal care (excluding inpatient stays) 	\$50 copay
Routine vision	
<ul style="list-style-type: none"> • Annual routine eye exam (<i>Administered by Blue View Vision</i>) 	\$15 for each visit
All other services (subject to deductible)	
<p>You will pay all the costs associated with your care until you have paid \$400 per individual/\$800 per family in one plan year. This is known as your deductible. Once you reach your deductible you pay:</p>	
Doctor visits	
<ul style="list-style-type: none"> • Office visits • Urgent care visits • Wisdom teeth extractions (bony impacted only) • In-office surgery • Voluntary family planning • Allergy testing 	20% after deductible of the amount the healthcare professionals in our network have agreed to accept for their services
<ul style="list-style-type: none"> • Allergy serum and allergy injections (if actual cost of serum and injection is less than the allowable charge, you are only charged actual cost) 	20% after deductible of the amount the healthcare professionals in our network have agreed to accept for their services
Labs, diagnostic X-rays	
<ul style="list-style-type: none"> • Diagnostic tests • Diagnostic x-rays • Lab work 	20% after deductible of the amount the healthcare professionals in our network have agreed to accept for their services
<ul style="list-style-type: none"> • Advanced diagnostic imaging services (includes MRI, MRA, MRS, CTA, PET scans, and CT scans) 	20% after deductible of the amount the healthcare professionals in our network have agreed to accept for their services
Emergency care	
<ul style="list-style-type: none"> • True emergency care visits in or out of the service area 	20% after deductible of the amount the healthcare professionals in our network have agreed to accept for their services
Early intervention – for children from birth through age two	
<ul style="list-style-type: none"> • Early intervention services 	Member cost shares will be dependent on the services rendered after deductible

Your benefits *(continued)*

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Autism Spectrum Disorder (ASD)	
<ul style="list-style-type: none"> Diagnosis and treatment of autism spectrum disorder including: <ul style="list-style-type: none"> Behavioral health treatment* Psychological care Psychiatric care Therapeutic care** <p>* Mental health services **Unlimited physical, occupational, and speech therapy.</p>	Member cost shares will be dependent on the services rendered after deductible
<ul style="list-style-type: none"> Applied behavioral analysis 	20% of the amount the healthcare professionals in our network have agreed to accept for their services (after deductible, except for services related to preventive care)
Other outpatient services	
<ul style="list-style-type: none"> Ambulance travel 	20% after deductible of the amount the healthcare professionals in our network have agreed to accept for their services
<ul style="list-style-type: none"> Physical, occupational, and speech therapy Spinal manipulation and manual medical therapy services (<i>Limited to 30 visits per plan year</i>) 	20% after deductible of the amount the healthcare professionals in our network have agreed to accept for their services
<ul style="list-style-type: none"> Infusion therapy Chemotherapy Radiation therapy Dialysis Cardiac rehab therapy 	20% after deductible of the amount the healthcare professionals in our network have agreed to accept for their services
<ul style="list-style-type: none"> Surgery in a hospital or facility (including bony impacted wisdom teeth extractions) 	20% after deductible of the amount the healthcare professionals in our network have agreed to accept for their services
<ul style="list-style-type: none"> Hospice care Home healthcare (<i>Limited to 90 visits per plan year</i>) 	20% after deductible of the amount the healthcare professionals in our network have agreed to accept for their services
<ul style="list-style-type: none"> Diabetic supplies, equipment, and education 	Member cost shares will be dependent on the services rendered
<ul style="list-style-type: none"> Durable medical equipment Medical supplies 	20% after deductible of the amount the healthcare professionals in our network have agreed to accept for their services
<ul style="list-style-type: none"> Prosthetic devices 	20% after deductible of the amount the healthcare professionals in our network have agreed to accept for their services
<ul style="list-style-type: none"> Mental health and substance abuse visits 	20% after deductible of the amount the healthcare professionals in our network have agreed to accept for their services

Your benefits *(continued)*

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Inpatient stays in a hospital or facility	
<ul style="list-style-type: none"> • Semi-private room • Private room when approved in advance • Intensive or coronary care unit • Maternity services • Mental health and substance abuse services • Occupational, speech, and physical therapy • Skilled nursing facility (100 days for each admission) 	<p>20% after deductible of the amount the healthcare professionals in our network have agreed to accept for their services</p>

Out-of-network services

Using doctors, hospitals and other healthcare professionals not contracted to provide benefits

It's important to remember that healthcare professionals not in our network can charge whatever they want for their services. If what they charge is more than the fee our network healthcare 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 \$1,000 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 \$1,000 of the cost of your care (\$2,000 total).
- If three or more people are covered under your plan, together you will pay the first \$2,000 of the cost of your care. However, the most one family member will pay is \$1,000.

Once you have reached this amount, when you receive covered services you will pay 30% and we will pay 70% of the fee our network healthcare professionals have agreed to accept for the same service. What you pay includes the difference between the fee our network healthcare professionals have agreed to accept for the same service and the amount the healthcare professional not in our network charges (this is referred to as balance billing). 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 \$1,000 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 year (January 1 – December 31)

When using in-plan professionals
 If you are the only one covered by your plan, you will pay \$2,500 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 \$2,500 (\$5,000 total).
- If three or more people are covered under your plan, together you will pay \$5,000. However, no family member will pay more than \$2,500 toward the limit.

When not using out-of-plan professionals
 If you are the only one covered by your plan, you will pay \$2,500 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 \$2,500 (\$5,000 total).
- If three or more people are covered under your plan, together you will pay \$5,000. However, no family member will pay more than \$2,500 toward the limit.

When using in-plan professionals and out-of-plan professionals
 The amounts referenced above for in-plan and out-of-plan professionals do not cross accumulate. Therefore, you are responsible for the separate amounts for in-plan and out-of-plan based on the providers you are using.

The following do not count toward the calendar year out-of-pocket maximum. You will still need to pay:

- the costs associated with vision benefits
- the cost of care received when the benefit limits have been reached
- the cost associated with prescription drugs

Under the Affordable Care Act, medical and behavioral costs all count toward one combined out of pocket maximum. Other 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 benefits overview insert is only one piece of your entire enrollment package.

This summary of benefits has been updated to comply with federal and state requirements, including applicable provisions of the recently enacted federal healthcare reform laws. As we receive additional guidance and clarification on the new healthcare 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.