Your summary of benefits

Anthem® Blue Cross and Blue Shield

Your Plan: Macon-Bibb County: Blue Open Access POS

Your Network: Blue Open Access POS

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Overall Deductible	$2,000 member / $6,000 family	$4,000 member / $12,000 family
Out-of-Pocket Limit	$7,350 member / $14,700 family	Unlimited member / Unlimited family
The family deductible and out-of-pocket maximum are embedded, meaning the cost shares of one family member will be applied to both per member deductible and per member out-of-pocket maximum; in addition, amounts for all covered family members apply to both the family deductible and family out-of-pocket maximum. No one member will pay more than the per member deductible or per member out-of-pocket maximum. Your copays, coinsurance and deductible count toward your out of pocket amount(s). In-network and out-of-network deductibles and out-of-pocket maximum amounts are separate and do not accumulate toward each other.		
Preventive Care / Screening / Immunization	No charge	50% coinsurance after deductible is met
Preventive Care for Chronic Conditions *per IRS guidelines*	No charge	50% coinsurance after deductible is met
Virtual Care (Telemedicine / Telehealth Visits) **Virtual Visits - Online visits with Doctors who also provide services in person**		
Primary Care (PCP)	$40 copay per visit deductible does not apply	50% coinsurance after deductible is met
Mental Health and Substance Abuse care	$40 copay per visit deductible does not apply	50% coinsurance after deductible is met
Specialist	$80 copay per visit deductible does not apply	50% coinsurance after deductible is met

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Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Medical Chats and Virtual (Video) Visits for Primary Care from our Online Provider K Health, through its affiliated Provider groups	No charge	
Virtual Visits from Online Provider LiveHealth Online *via www.livehealthonline.com; our mobile app, website or Anthem-enabled device*		
Primary Care (PCP) and Mental Health and Substance Abuse	No charge	
Specialist Care	$80 copay per visit deductible does not apply	
Visits in an Office		
Primary Care (PCP)	$40 copay per visit deductible does not apply	50% coinsurance after deductible is met
Specialist Care	$80 copay per visit deductible does not apply	50% coinsurance after deductible is met
Other Practitioner Visits		
Routine Maternity Care (Prenatal and Postnatal)	$300 copay per pregnancy deductible does not apply	50% coinsurance after deductible is met
Retail Health Clinic Visit	$40 copay per visit deductible does not apply	50% coinsurance after deductible is met
Manipulation Therapy *Coverage is limited to 30 visits per year.*	$80 copay per visit deductible does not apply	50% coinsurance after deductible is met
Acupuncture	Not covered	Not covered
Other Services in an Office		
Allergy Testing	$80 copay per visit deductible does not apply‡	50% coinsurance after deductible is met
Chemo/Radiation Therapy	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Dialysis/Hemodialysis	30% coinsurance after deductible is met	50% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Prescription Drugs *Dispensed in the office*	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Surgery	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Diagnostic Services **Lab**		
Office	No charge	50% coinsurance after deductible is met
Freestanding Lab/Reference Lab	30% coinsurance deductible does not apply	50% coinsurance after deductible is met
Outpatient Hospital	30% coinsurance after deductible is met	50% coinsurance after deductible is met
X-Ray		
Office	No charge	50% coinsurance after deductible is met
Freestanding Radiology Center	30% coinsurance deductible does not apply	50% coinsurance after deductible is met
Outpatient Hospital	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Advanced Diagnostic Imaging *for example: MRI, PET and CAT scans*		
Office	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Freestanding Radiology Center	30% coinsurance deductible does not apply	50% coinsurance after deductible is met
Outpatient Hospital	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Emergency and Urgent Care		
Urgent Care	$60 copay per visit deductible does not apply	50% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Emergency Room Facility Services *Cost share waived if admitted.*	$350 copay per visit deductible does not apply	Covered as In-Network
Emergency Room Doctor and Other Services	30% coinsurance deductible does not apply	Covered as In-Network
Ambulance	30% coinsurance after deductible is met	Covered as In-Network
Outpatient Mental Health and Substance Abuse		
Doctor Office Visit	$40 copay per visit deductible does not apply	50% coinsurance after deductible is met
Facility Visit		
Facility Fees	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Doctor Services	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Outpatient Surgery		
Facility Fees		
Hospital	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Freestanding Surgical Center	30% coinsurance deductible does not apply	50% coinsurance after deductible is met
Doctor and Other Services		
Hospital	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Freestanding Surgical Center	30% coinsurance deductible does not apply	50% coinsurance after deductible is met
Hospital (Including Maternity, Mental Health and Substance Abuse)		
Facility Fees	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Doctor and other services	30% coinsurance after deductible is met	50% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Recovery & Rehabilitation **Home Health Care** *Coverage is limited to 120 visits per benefit period.*	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Rehabilitation services *Coverage for rehabilitative and habilitative physical therapy and occupational therapy combined is limited to 40 visits per benefit period. Coverage for rehabilitative and habilitative speech therapy is limited to 40 visits per benefit period.* Office	$80 copay per visit deductible does not apply	50% coinsurance after deductible is met
Outpatient Hospital	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Cardiac rehabilitation Office	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Outpatient Hospital	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Skilled Nursing Care (facility) *Coverage is limited to 150 days per benefit period.*	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Inpatient Hospice	No charge	No charge
Durable Medical Equipment	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Prosthetic Devices	30% coinsurance after deductible is met	50% coinsurance after deductible is met

Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use a Non-Network Pharmacy
Pharmacy Deductible	Not applicable	Not applicable

Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use a Non-Network Pharmacy
Pharmacy Out-of-Pocket Limit	Combined with In-Network medical out-of-pocket limit	Combined with Non-Network medical out-of-pocket limit
Prescription Drug Coverage *Cost shares for drugs included on the Essential drug list appear below. Drugs not included on the Essential drug list will not be covered. Your plan uses the Base Network. You may receive up to a 90 day supply of medication at Retail 90 pharmacies. Drug cost share assistance programs may be available for certain specialty drugs.*		
Home Delivery Pharmacy *Maintenance medication are available through IngenioRx Home Delivery Pharmacy. You will need to call us on the number on your ID card to sign up when you first use the service.*		
Tier 1 - Typically Generic *Per 30 day supply (retail pharmacy and Retail 90 pharmacy). Per 90 day supply (home delivery).*	$15 copay per prescription, deductible does not apply (retail) and $37 copay per prescription, deductible does not apply (home delivery)	$15 copay per prescription, deductible does not apply (retail only)
Tier 2 – Typically Preferred Brand *Per 30 day supply (retail pharmacy and Retail 90 pharmacy). Per 90 day supply (home delivery).*	$55 copay per prescription, deductible does not apply (retail) and $137 copay per prescription, deductible does not apply (home delivery)	$55 copay per prescription, deductible does not apply (retail only)
Tier 3 - Typically Non-Preferred Brand *Per 30 day supply (retail pharmacy and Retail 90 pharmacy). Per 90 day supply (home delivery).*	$70 copay per prescription, deductible does not apply (retail) and $175 copay per prescription, deductible does not apply (home delivery)	$70 copay per prescription, deductible does not apply (retail only)
Tier 4 - Typically Specialty (brand and generic) *Per 30 day supply (specialty pharmacy).*	20% coinsurance up to $300 per prescription, deductible does not apply (retail and home delivery)	20% coinsurance up to $300 per prescription, deductible does not apply (retail only)

Notes:

- If you have an office visit with your Primary Care Physician or Specialist at an Outpatient Facility (e.g., Hospital or Ambulatory Surgical Facility), benefits for Covered Services will be paid under “Outpatient Facility Services”.
- Costs may vary by the site of service. Other cost shares may apply depending on services provided. Check your Certificate of Coverage for details.
- ‡ Your cost share will be reduced when services are provided in a PCP's office.
- When using a non-network pharmacy, members are responsible for the stated copay & costs in excess of the prescription drug maximum allowed amount. Members will pay upfront and submit a claim form.

This summary of benefits is a brief outline of coverage, designed to help you with the selection process. This summary does not reflect each and every benefit, exclusion and limitation which may apply to the coverage. For more details, important limitations and exclusions, please review the formal Certificate of Coverage. If there is a difference between this summary and the Certificate of Coverage the Certificate of Coverage will prevail.

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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 (855) 397-9267

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(TTY/TDD: 711)

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Language Access Services:

Navajo (Diné): Díí naaltsoos biká'ígíí łahgo bina'idiłkidgo ná bohónéedzą dóó bee ahóót'i' t'áá ni nizaad k'ehjí bee nił hodoonih t'áadoo bą́ą́h ílínígóó. Ata' halne'ígíí łą' bich'į' hadeesdzih ninízingo kojį' hodíilnih (855) 397-9267.

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