

# Your summary of benefits



Anthem® Blue Cross and Blue Shield

Your Plan: Macon-Bibb County: Blue Open Access POS Premier 90 Plan

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
<b>Overall Deductible</b>	\$500 member / \$1,500 family	\$1,000 member / \$3,000 family
<b>Out-of-Pocket Limit</b>	\$5,000 member / \$10,000 family	Unlimited member / Unlimited family
<p>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.</p> <p>Your copays, coinsurance and deductible count toward your out of pocket amount(s).</p> <p>In-network and out-of-network deductibles and out-of-pocket maximum amounts are separate and do not accumulate toward each other.</p>		
<b>Preventive Care / Screening / Immunization</b>	No charge	50% coinsurance after deductible is met
<b>Preventive Care for Chronic Conditions</b> <i>per IRS guidelines</i>	No charge	50% coinsurance after deductible is met
<p><b><u>Virtual Care (Telemedicine / Telehealth Visits)</u></b></p> <p><b>Virtual Visits - Online visits with Doctors who also provide services in person</b></p> <p>Primary Care (PCP)</p> <p>Mental Health and Substance Abuse care</p>		
	\$25 copay per visit deductible does not apply	50% coinsurance after deductible is met
	\$25 copay per visit deductible does not apply	50% coinsurance after deductible is met

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Questions: (855) 397-9267 or visit us at [www.anthem.com](http://www.anthem.com)

GA/LG/Macon-Bibb County: Blue Open Access POS Premier 90 Plan/Q8L8/01-01-2022 (NGF) Modified T. Foster 10/18/21

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Specialist	\$50 copay per visit deductible does not apply	50% coinsurance after deductible is met
<b>Medical Chats and Virtual (Video) Visits for Primary Care</b> from our Online Provider K Health, through its affiliated Provider groups	No charge	
<b>Virtual Visits from Online Provider LiveHealth Online</b> via <a href="http://www.livehealthonline.com">www.livehealthonline.com</a> ; our mobile app, website or Anthem-enabled device  Primary Care (PCP) and Mental Health and Substance Abuse  Specialist Care	No charge   \$50 copay per visit deductible does not apply	
<u><b>Visits in an Office</b></u>  <b>Primary Care (PCP)</b>  <b>Specialist Care</b>	\$25 copay per visit deductible does not apply  \$50 copay per visit deductible does not apply	50% coinsurance after deductible is met  50% coinsurance after deductible is met
<u><b>Other Practitioner Visits</b></u>  <b>Routine Maternity Care</b> (Prenatal and Postnatal)  <b>Retail Health Clinic Visit</b>  <b>Manipulation Therapy</b> <i>Coverage is limited to 30 visits per benefit period.</i>  <b>Acupuncture</b>	\$300 copay per pregnancy deductible does not apply  \$25 copay per visit deductible does not apply  \$50 copay per visit deductible does not apply  Not covered	50% coinsurance after deductible is met  50% coinsurance after deductible is met  50% coinsurance after deductible is met  Not covered
<u><b>Other Services in an Office</b></u>  <b>Allergy Testing</b>	\$50 copay per visit deductible does not apply <sup>†</sup>	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
<b>Chemo/Radiation Therapy</b>  <b>Dialysis/Hemodialysis</b>  <b>Prescription Drugs</b> <i>Dispensed in the office</i>  <b>Surgery</b>	10% coinsurance after deductible is met  10% coinsurance after deductible is met  10% coinsurance after deductible is met  10% coinsurance after deductible is met	50% coinsurance after deductible is met  50% coinsurance after deductible is met  50% coinsurance after deductible is met  50% coinsurance after deductible is met
<b><u>Diagnostic Services</u></b> <b>Lab</b> Office  Freestanding Lab/Reference Lab  Outpatient Hospital	No charge  10% coinsurance after deductible is met  10% coinsurance after deductible is met	50% coinsurance after deductible is met  50% coinsurance after deductible is met  50% coinsurance after deductible is met
<b>X-Ray</b> Office  Freestanding Radiology Center  Outpatient Hospital	No charge  10% coinsurance after deductible is met  10% coinsurance after deductible is met	50% coinsurance after deductible is met  50% coinsurance after deductible is met  50% coinsurance after deductible is met
<b>Advanced Diagnostic Imaging</b> <i>for example: MRI, PET and CAT scans</i>  Office  Freestanding Radiology Center  Outpatient Hospital	10% coinsurance after deductible is met  10% coinsurance after deductible is met  10% coinsurance after deductible is met	50% coinsurance after deductible is met  50% coinsurance after deductible is met  50% coinsurance after deductible is met
<b><u>Emergency and Urgent Care</u></b> <b>Urgent Care</b>	\$35 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
<b>Emergency Room Facility Services</b> <i>Cost share waived if admitted.</i>	\$150 copay per visit deductible does not apply	Covered as In-Network
<b>Emergency Room Doctor and Other Services</b>	10% coinsurance deductible does not apply	Covered as In-Network
<b>Ambulance</b>	10% coinsurance after deductible is met	Covered as In-Network
<u><b>Outpatient Mental Health and Substance Abuse</b></u> <b>Doctor Office Visit</b>  <b>Facility Visit</b> Facility Fees  Doctor Services	\$25 copay per visit deductible does not apply  10% coinsurance after deductible is met  10% coinsurance after deductible is met	50% coinsurance after deductible is met  50% coinsurance after deductible is met  50% coinsurance after deductible is met
<u><b>Outpatient Surgery</b></u> <b>Facility Fees</b> Hospital  Freestanding Surgical Center  <b>Doctor and Other Services</b> Hospital  Freestanding Surgical Center	10% coinsurance after deductible is met  10% coinsurance after deductible is met  10% coinsurance after deductible is met  10% coinsurance after deductible is met	50% coinsurance after deductible is met  50% coinsurance after deductible is met  50% coinsurance after deductible is met  50% coinsurance after deductible is met
<u><b>Hospital (Including Maternity, Mental Health and Substance Abuse)</b></u>  <b>Facility Fees</b>  <b>Doctor and other services</b>	10% coinsurance after deductible is met  10% coinsurance after deductible is met	50% 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
<p><b>Recovery &amp; Rehabilitation</b></p> <p><b>Home Health Care</b>  <i>Coverage is limited to 120 visits per benefit period.</i></p>	10% coinsurance after deductible is met	50% coinsurance after deductible is met
<p><b>Rehabilitation services</b>  <i>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.</i></p> <p>Office</p> <p>Outpatient Hospital</p>	<p>\$50 copay per visit deductible does not apply</p> <p>10% coinsurance after deductible is met</p>	<p>50% coinsurance after deductible is met</p> <p>50% coinsurance after deductible is met</p>
<p><b>Cardiac rehabilitation</b></p> <p>Office</p> <p>Outpatient Hospital</p>	<p>10% coinsurance after deductible is met</p> <p>10% coinsurance after deductible is met</p>	<p>50% coinsurance after deductible is met</p> <p>50% coinsurance after deductible is met</p>
<p><b>Skilled Nursing Care (facility)</b>  <i>Coverage is limited to 150 days per benefit period.</i></p>	10% coinsurance after deductible is met	50% coinsurance after deductible is met
<p><b>Inpatient Hospice</b></p>	No charge	No charge
<p><b>Durable Medical Equipment</b></p>	10% coinsurance after deductible is met	50% coinsurance after deductible is met
<p><b>Prosthetic Devices</b></p>	10% 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
<p><b>Pharmacy Deductible</b></p>	Not applicable	Not applicable

Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use a Non-Network Pharmacy
<b>Pharmacy Out-of-Pocket Limit</b>	Combined with In-Network medical out-of-pocket limit	Combined with Non-Network medical out-of-pocket limit
<p><b>Prescription Drug Coverage</b> 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.</p>		
<p><b>Home Delivery Pharmacy</b> 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.</p>		
<b>Tier 1 - Typically Generic</b> <i>Per 30 day supply (retail pharmacy and Retail 90 pharmacy). Per 90 day supply (home delivery).</i>	\$10 copay per prescription, after deductible is met (retail) and \$25 copay per prescription, after deductible is met (home delivery)	\$10 copay per prescription, after deductible is met (retail only)
<b>Tier 2 – Typically Preferred Brand</b> <i>Per 30 day supply (retail pharmacy and Retail 90 pharmacy). Per 90 day supply (home delivery).</i>	\$30 copay per prescription, after deductible is met (retail) and \$75 copay per prescription, after deductible is met (home delivery)	\$30 copay per prescription, after deductible is met (retail only)
<b>Tier 3 - Typically Non-Preferred Brand</b> <i>Per 30 day supply (retail pharmacy and Retail 90 pharmacy). Per 90 day supply (home delivery).</i>	\$50 copay per prescription, after deductible is met (retail) and \$125 copay per prescription, after deductible is met (home delivery)	\$50 copay per prescription, after deductible is met (retail only)
<b>Tier 4 - Typically Specialty (brand and generic)</b> <i>Per 30 day supply (specialty pharmacy).</i>	20% coinsurance up to \$200 per prescription, after deductible is met (retail and home delivery)	20% coinsurance up to \$200 per prescription, after deductible is met (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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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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