

Your summary of benefits



City of South Fulton

Anthem® Blue Cross and Blue Shield

Your Plan: Anthem Blue Open Access POS OAP5 1500/20% /2500 AE – **OAP Mid**

Your Network: Blue Open Access POS

Visits with Virtual Care-Only Providers	Cost through our mobile app and website
Primary Care, and medical services for urgent/acute care	No charge medical deductible does not apply
Mental Health & Substance Use Disorder Services	No charge medical deductible does not apply
Specialist care	\$40 copay per visit medical deductible does not apply

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Overall Deductible	\$1,500 member / \$3,000 family	\$3,000 member / \$6,000 family
Overall Out-of-Pocket Limit	\$2,500 member / \$5,000 family	\$5,000 member / \$10,000 family

The family deductible and out-of-pocket limit are embedded, meaning the cost shares of one family member will be applied to the per member deductible and per member out-of-pocket limit; in addition, amounts for all covered family members apply to both the family deductible and family out-of-pocket limit. No one member will pay more than the per member deductible or per member out-of-pocket limit.

All medical and prescription drug deductibles, copayments and coinsurance apply to the out-of-pocket limit (excluding Out-of-Network Human Organ and Tissue Transplant (HOTT), Cellular and Gene Therapy services).

In-Network and Out-of-Network deductibles and out-of-pocket limit amounts are separate and do not accumulate toward each other.

Doctor Visits (virtual and office) You are encouraged to select a Primary Care Physician (PCP).		
Primary Care (PCP) and Mental Health and Substance Use Disorder Services <i>virtual and office</i>	\$25 copay per visit medical deductible does not apply	40% coinsurance after medical deductible is met
Specialist Care <i>virtual and office</i>	virtual -\$40 copay per visit medical deductible does not apply office -\$50 copay per visit medical deductible does not apply	40% coinsurance after medical deductible is met
Other Practitioner Visits		
Maternity Doctor services (prenatal/postnatal care and delivery)	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Retail Health Clinic Visit for routine care and treatment of common illnesses; usually found in major pharmacies or retail stores.	\$25 copay per visit medical deductible does not apply	40% coinsurance after medical deductible is met
Manipulation Therapy Coverage is limited to 20 visits per year.	\$40 copay per visit medical deductible does not apply	40% coinsurance after medical deductible is met
Acupuncture	Not covered	Not covered
<u>Other Services in an Office</u>		
Allergy Testing	\$50 copay per visit medical deductible does not apply [‡]	40% coinsurance after medical deductible is met
Prescription Drugs Dispensed in the office	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Surgery	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Preventive care / screenings / immunizations	No charge	40% coinsurance after medical deductible is met
Preventive Care for Chronic Conditions per IRS guidelines	No charge	40% coinsurance after medical deductible is met
<u>Diagnostic Services</u>		
Lab Office	\$50 copay per visit medical deductible does not apply [‡]	40% coinsurance after medical deductible is met
Freestanding Lab/Reference Lab	No charge	40% coinsurance after medical deductible is met
Outpatient Hospital	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
X-Ray Office	\$50 copay per visit medical deductible does not apply [‡]	40% coinsurance after medical deductible is met
Freestanding Radiology Center	20% coinsurance medical deductible does not apply	40% coinsurance after medical deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Outpatient Hospital	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Advanced Diagnostic Imaging for example: <i>MRI, PET and CAT scans</i>		
Office	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Freestanding Radiology Center	20% coinsurance medical deductible does not apply	40% coinsurance after medical deductible is met
Outpatient Hospital	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Emergency and Urgent Care		
Urgent Care includes doctor services. Additional charges may apply depending on the care provided.	\$50 copay per visit	40% coinsurance after medical deductible is met
medical deductible does not apply		
Emergency Room Facility Services	\$150 copay per visit	Covered as In-Network
Your copay, coinsurance will be waived if admitted.	medical deductible does not apply	
Emergency Room Doctor and Other Services	20% coinsurance	Covered as In-Network
medical deductible does not apply		
Ambulance	20% coinsurance after	Covered as In-Network
medical deductible is met		
Outpatient Mental Health and Substance Use Disorder Services at a Facility		
Facility Fees	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Doctor Services	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Outpatient Surgery		
Facility Fees		
Hospital	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Ambulatory Surgical Center	\$200 copay per visit	40% coinsurance after medical deductible is met
medical deductible does not apply		

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Physician and other services <i>including surgeon fees</i> Hospital Ambulatory Surgical Center	20% coinsurance after medical deductible is met 20% coinsurance medical deductible does not apply	40% coinsurance after medical deductible is met 40% coinsurance after medical deductible is met
<u>Hospital (Including Maternity, Mental Health and Substance Use Disorder Services)</u>		
Facility Fees	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Physician and other services <i>including surgeon fees</i>	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Home Health Care <i>Coverage is limited to 120 visits per benefit period. Limits are combined for all home health services.</i>	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Rehabilitation and Habilitation services <i>including physical, occupational and speech therapies.</i> <i>Coverage for physical and occupational therapies is limited to 20 visits combined per year. Coverage for speech therapy is limited to 20 visits per year.</i> Office Outpatient Hospital	\$40 copay per visit medical deductible does not apply 20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met 40% coinsurance after medical deductible is met
Pulmonary rehabilitation office and outpatient hospital	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Cardiac rehabilitation office and outpatient hospital	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Dialysis/Hemodialysis office and outpatient hospital	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Chemo/Radiation Therapy office and outpatient hospital	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Skilled Nursing Care (facility) <i>Coverage for Inpatient rehabilitation and skilled nursing services is limited to 100 days combined per benefit period.</i>	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Inpatient Hospice	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Durable Medical Equipment	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Prosthetic Devices <i>Coverage for wigs is limited to 1 item after cancer treatment per benefit period.</i>	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Hearing Aids <i>Coverage is limited to 1 item per hearing-impaired ear up to \$3,000 per ear, every 48 months for members through age 18.</i>	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met

Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use an Out-of-Network Pharmacy
Pharmacy Deductible	Not applicable	Not applicable
Pharmacy Out-of-Pocket Limit	Combined with In-Network medical out-of-pocket limit	Combined with Out-of-Network medical out-of-pocket limit

Prescription Drug Coverage Network: Base Network Drug List: National Direct Plus

Day Supply Limits: Retail Pharmacy 30 day supply (cost shares noted below) Retail 90 Pharmacy 90 day supply (follow home delivery cost share amounts noted below) Home Delivery Pharmacy 90 day supply (maximum cost shares noted below). Maintenance medications are available through our 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. Specialty Pharmacy 30 day supply (cost shares noted below for retail and home delivery apply). We may require certain drugs with special handling, provider coordination or patient education be filled by our designated specialty pharmacy or an In-Network Pharmacy that carries your specialty drug.

Tier 1 - Typically Generic	\$10 copay per prescription (retail) and \$20 copay per prescription (home delivery)	40% coinsurance per prescription (retail only)
Tier 2 - Typically Preferred Brand	\$30 copay per prescription (retail) and \$60 copay per prescription (home delivery)	40% coinsurance per prescription (retail only)

Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use an Out-of-Network Pharmacy
Tier 3 - Typically Non-Preferred Brand	\$50 copay per prescription (retail) and \$100 copay per prescription (home delivery)	40% coinsurance per prescription (retail only)
Tier 4 - Typically Specialty (brand and generic)	\$75 copay per prescription (retail) and \$150 copay per prescription (home delivery)	40% coinsurance per prescription (retail only)

Covered Vision Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
<i>This is a brief outline of your vision coverage. To receive the In-Network benefit, you must use a Blue View Vision Provider. Only children's vision services count towards your out-of-pocket limit.</i>		
Children's Vision exam (up to age 19) <i>Limited to 1 exam per benefit period.</i>	No charge	\$0 copayment up to plan's Maximum Allowed Amount
Adult Vision exam (age 19 and older) <i>Limited to 1 exam per benefit period.</i>	No charge	Reimbursed Up to \$42

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.
- Screening and diagnostic imaging for the detection of breast cancer, including diagnostic mammograms, 3D mammography, breast ultrasounds and MRIs are covered in full as required by state mandate.
- The limits for physical, occupational, and speech therapy, if any apply to this plan, will not apply if you get care as part of the Mental Health and Substance Use Disorder benefit.
- * You will pay the PCP's office visit copay when services are provided in their office.
- When using an Out-of-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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Questions: (855) 397-9267 or visit us at www.anthem.com

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We're here for you – in many languages

The law requires us to include a message in all of these different languages. Curious what they say? Here's the English version: "You have the right to get help in your language for free. Just call the Member Services number on your ID card." Visually impaired? You can also ask for other formats of this document

Spanish

Usted tiene derecho a obtener asistencia en su idioma sin cargo. Llame al número de Servicios para Miembros que figura en su tarjeta de identificación. ¿Tiene alguna deficiencia visual? También puede solicitar este documento en otros formatos.

Chinese

您有權免費獲得使用您的語言提供的協助。只需撥打印於您的ID卡上的會員服務部電話號碼即可。視力障礙？您也可以索取本文件的其他格式。

Vietnamese

Quý vị có quyền nhận trợ giúp bằng ngôn ngữ của mình, miễn phí. Quý vị chỉ cần gọi đến số điện thoại của Ban Dịch vụ Thành viên trên thẻ ID của quý vị. Quý vị bị khiếm thị? Quý vị cũng có thẻ yêu cầu các định dạng khác của tài liệu này.

Korean

귀하는 귀하의 언어로 된 도움을 무료로 받을 권리가 있습니다. 귀하의 ID 카드에 있는 가입자 서비스 번호로 전화하십시오. 시각 장애인이신가요? 다른 형식으로 된 이 문서를 요청하실 수 있습니다.

Tagalog

May karapatan kang makakuha ng tulong na nasa iyong wika nang libre. Tawagan lang ang numero ng Member Services na nasa iyong ID card. May kapansanan sa paningin? Maaari ka ring humingi ng iba pang mga format ng dokumentong ito.

Russian

У вас есть право на бесплатное получение помощи на вашем родном языке. Просто позвоните в отдел обслуживания участников по номеру, указанному на вашей идентификационной карте. У вас проблемы со зрением? Вы также можете запросить этот документ в других форматах.

French Creole

Ou gen dwa jwenn èd nan lang ou gratis. Jis rele nimewo Sèvis Manm ki sou Kat ID ou a gratis Gen pwoblèm vizyèl? Ou ka mande tou pou lòt fòma nan dokiman sa a.

Arabic

الحق في الحصول على هذه المعلومات والحصول على المساعدة بلغتك مجاناً.
فقط اتصل برقم خدمات الأعضاء الموجود على بطاقة هويتك. هل تعاني من ضعف البصر؟ يمكنك أيضاً طلب تنسيرات أخرى لهذه الوثيقة.

French

Vous avez le droit d'obtenir de l'aide dans votre langue gratuitement. Appelez simplement le numéro du Services membres figurant sur votre carte d'identité. Vous êtes une personne malvoyante ? Vous pouvez également demander à accéder à ce document dans d'autres formats.

Persian

شما حق دارید به زبان خود به صورت رایگان کمک بگیرید. فقط با شماره خدمات اعضاء مدرج در کارت عضویت خود تماس بگیرید. آیا دچار اختلال بینایی هستید؟ همچنین میتوانید فرمتهای دیگر این سند را درخواست کنید.

Armenian

Դուք իրավունք ունեք անվճար օգնություն ստանալու ձեր լեզվով: Դարպասեն զանգահարեք ձեր ID քարտի վրա գտնվող Անդամների սպասարկման համարին: Տեսողության խանգարում ունեցն եք: Կարող եք նաև խնդրել այս փաստաթղթի այլ ձևաչափեր:

Japanese

あなたにはあなたの言語で無料で支援を受ける権利があります。IDカードに記載されている会員サービス番号にお電話ください」視覚障害をお持ちですか？他の形式でこの文書を要求することもできます。

Italian

Hai il diritto di ricevere assistenza gratuita nella tua lingua. Basta chiamare il numero del Servizio Membri presente sulla tua tessera identificativa. Hai problemi di vista? È possibile richiedere anche altri formati di questo documento.

German

Sie haben das Recht, kostenlose Hilfe in Ihrer Sprache zu erhalten. Rufen Sie einfach die Nummer des Mitgliederservices auf Ihrer ID-Karte an. Sehbehindert? Sie können dieses Dokument auch in anderen Formaten anfordern.

Polish

Masz prawo do bezpłatnej pomocy w swoim języku. Wystarczy zadzwonić pod numer Biura Obsługi Klienta podany na karcie identyfikacyjnej. Masz wadę wzroku? Możesz również poprosić o inne formaty tego dokumentu.

Pennsylvania Dutch

Du hoscht's Recht fer Hilf griege in dei Schprooch fer nix. Duh yuscht die Member Services Number uffrufe uff dei ID Card. Hoscht Druwwel fer sehne? Du kannscht des do Schreiwas in en differnter Weg griege so as du's besser sehne kannscht.

TTY/TDD:711

It's important we treat you fairly

We follow federal civil rights laws in our health programs and activities. Members can get reasonable modifications as well as free auxiliary aids and services if you have a disability. We don't discriminate, on the basis of race, color, national origin, sex, age or disability. For people whose primary language isn't English (or have limited proficiency), we offer free language assistance services like interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711) or visit our website. If you think we failed in any areas or to learn more about grievance procedures, you can mail a complaint to: Compliance Coordinator, P.O. Box 27401, Richmond, VA 23279, or directly to the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201. You can also call 1-800- 368-1019 (TDD: 1-800-537-7697) or visit <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>