Your summary of benefits

Anthem® Blue Cross and Blue Shield

Your Plan: DeKalb County, Ga: CUSTOM PY OAH5

Your Network: Blue Open Access HMO

Visits with Virtual Care-Only Providers	Cost through our mobile app and website
Primary Care, and medical services for urgent/acute care	**K Health:** No charge **LiveHealth Online:** $25 copay per visit deductible does not apply
Mental Health & Substance Use Disorder Services	$40 copay per visit deductible does not apply
Specialist care	$40 copay per visit deductible does not apply

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Overall Deductible	$500 member / $1,500 family	Not covered
Overall Out-of-Pocket Limit	$6,900 member / $13,800 family	Not covered
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 drug deductibles, copayments and coinsurance apply to the out-of-pocket limit.		
Doctor Visits (virtual and office) *You are encouraged to select a Primary Care Physician (PCP).*		
Primary Care (PCP) *virtual and office*	**virtual-**Not covered **office-**$25 copay per visit deductible does not apply	Not covered
Mental Health and Substance Use Disorder Services *virtual and office*	**virtual-**Not covered **office-**$40 copay per visit deductible does not apply	Not covered
Specialist Care *virtual and office*	**virtual-**Not covered **office-**$40 copay per visit deductible does not apply	Not covered

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Other Practitioner Visits		
Routine Maternity Care (Prenatal and Postnatal)	10% coinsurance after deductible is met	Not covered
Retail Health Clinic Visit *for routine care and treatment of common illnesses; usually found in major pharmacies or retail stores.*	$25 copay per visit deductible does not apply	Not covered
Manipulation Therapy *Coverage is limited to 20 visits per benefit period.*	$25 copay per visit deductible does not apply	Not covered
Acupuncture	Not covered	Not covered
Other Services in an Office		
Allergy Testing	$40 copay per visit deductible does not apply‡	Not covered
Prescription Drugs *Dispensed in the office*	$40 copay per visit deductible does not apply‡	Not covered
Surgery	$40 copay per visit deductible does not apply‡	Not covered
Preventive care / screenings / immunizations	No charge	Not covered
Preventive Care for Chronic Conditions *per IRS guidelines*	No charge	Not covered
Diagnostic Services **Lab**		
Office	$40 copay per visit deductible does not apply‡	Not covered
Freestanding Lab/Reference Lab	10% coinsurance after deductible is met	Not covered
Outpatient Hospital	10% coinsurance after deductible is met	Not covered
X-Ray		
Office	$40 copay per visit deductible does not apply‡	Not covered

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Freestanding Radiology Center	10% coinsurance after deductible is met	Not covered
Outpatient Hospital	10% coinsurance after deductible is met	Not covered
Advanced Diagnostic Imaging *for example: MRI, PET and CAT scans*		
Office	10% coinsurance after deductible is met	Not covered
Freestanding Radiology Center	10% coinsurance after deductible is met	Not covered
Outpatient Hospital	10% coinsurance after deductible is met	Not covered
Emergency and Urgent Care		
Urgent Care *includes doctor services. Additional charges may apply depending on the care provided.*	$75 copay per visit and 10% coinsurance after deductible is met	Not covered
Emergency Room Facility Services *Your copay, coinsurance and deductible will be waived if admitted.*	$300 copay per visit and 10% coinsurance after deductible is met	Covered as In-Network
Emergency Room Doctor and Other Services	10% coinsurance after deductible is met	Covered as In-Network
Ambulance	10% coinsurance after deductible is met	Covered as In-Network
Outpatient Mental Health and Substance Use Disorder Services at a Facility		
Facility Fees	10% coinsurance after deductible is met	Not covered
Doctor Services	10% coinsurance after deductible is met	Not covered
Outpatient Surgery		
Facility Fees		
Hospital	10% coinsurance after deductible is met	Not covered
Ambulatory Surgical Center	10% coinsurance after deductible is met	Not covered

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Physician and other services *including surgeon fees*		
Hospital	10% coinsurance after deductible is met	Not covered
Ambulatory Surgical Center	10% coinsurance after deductible is met	Not covered
Hospital (Including Maternity, Mental Health and Substance Use Disorder Services) *If readmitted within 72 hours for the same condition, no additional facility copay is required. If transferred between facilities, only one copay will apply.*		
Facility Fees	$250 copay per admission and 10% coinsurance after deductible is met	Not covered
Physician and other services *including surgeon fees*	10% coinsurance after deductible is met	Not covered
Home Health Care *Coverage is limited to 120 visits per benefit period and 4 hours per visit. Limits are combined for all home health services.*	10% coinsurance after deductible is met	Not covered
Rehabilitation and Habilitation services *including physical, occupational and speech therapies.* *Coverage for physical, occupational and speech therapies is limited to 90 visits combined per benefit period.*		
Office	$25 copay per visit deductible does not apply	Not covered
Outpatient Hospital	10% coinsurance after deductible is met	Not covered
Pulmonary rehabilitation *office and outpatient hospital*	10% coinsurance after deductible is met	Not covered
Cardiac rehabilitation *Coverage is limited to 36 visits per benefit period.*		
Office	$25 copay per visit deductible does not apply	Not covered
Outpatient Hospital	10% coinsurance after deductible is met	Not covered
Dialysis/Hemodialysis *office and outpatient hospital*	10% coinsurance after deductible is met	Not covered

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Chemo/Radiation Therapy *office and outpatient hospital*	10% coinsurance after deductible is met	Not covered
Skilled Nursing Care (facility) *Coverage is limited to 60 days per benefit period.*	10% coinsurance after deductible is met	Not covered
Inpatient Hospice *Life expectancy up to 12 months.*	10% coinsurance after deductible is met	Not covered
Durable Medical Equipment	10% coinsurance after deductible is met	Not covered
Prosthetic Devices *Coverage for wigs is limited to 1 item after cancer treatment per benefit period.*	10% coinsurance after deductible is met	Not covered
Hearing Aids *Coverage is limited to 1 item per hearing-impaired ear up to $3,000 per ear, every 48 months for members through age 18.*	10% coinsurance after deductible is met	Not covered

Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use a Non-Network Pharmacy
Pharmacy Deductible	Not covered	Not covered
Pharmacy Out-of-Pocket Limit	Not covered	Not covered
Prescription Drug Coverage **Network:** **Drug List:**		
Day Supply Limits:		
Tier 1 - Typically Generic	Not covered (retail and home delivery)	Not covered (retail only)
Tier 2 – Typically Preferred Brand	Not covered (retail and home delivery)	Not covered (retail only)
Tier 3 - Typically Non-Preferred Brand	Not covered (retail and home delivery)	Not covered (retail only)

Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use a Non-Network Pharmacy
Tier 4 - Typically Specialty (brand and generic)	Not covered (retail and home delivery)	Not covered (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.
- 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.

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.

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

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(TTY/TDD: 711)

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