Your summary of benefits

Anthem® BlueCross and BlueShield

Your Plan: Jim Ellis Atlanta Inc.-Anthem Blue Open Access POS OAP6 2500/30%/7900 AE

Your Network: Blue Open Access POS -**Draft**

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.

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Overall Deductible *See notes section to understand how your deductible works. Your plan may also have a separate Prescription Drug Deductible. See Prescription Drug Coverage section.*	$2,500 member / $7,500 family	$7,500 member / $15,000 family
Out-of-Pocket Limit *When you meet your out-of-pocket limit, you will no longer have to pay cost-shares during the remainder of the year. See notes section for additional information regarding your out of pocket maximum.*	$7,900 member / $15,800 family	$23,700 member / $47,400 family
Preventive care/screening/immunization *In-network preventive care is not subject to deductible, if your plan has a deductible. Non-Network preventive care services for children prior to their 6th birthday have no deductible.*	No charge	50% coinsurance after deductible is met
Doctor Home and Office Services		
Primary Care Office Visit to treat an injury or illness	$30 copay per visit deductible does not apply	50% coinsurance after deductible is met
Surgery Performed by a Primary Care Physician/Specialist	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Specialist Care Visit	$60 copay per visit deductible does not apply	50% coinsurance after deductible is met
Maternity Physician Services	30% coinsurance	50% coinsurance

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Global obstetrical care (prenatal, delivery, and postpartum services).	after deductible is met	after deductible is met
Other Practitioner Visits:		
Retail Health Clinic Visit	$30 copay per visit deductible does not apply	50% coinsurance after deductible is met
On-line Medical Visit	No charge for the first 12 visits and then $30 copay per visit deductible does not apply	50% coinsurance after deductible is met
Chiropractic/Manipulation Therapy *Coverage is limited to 20 visits per year. Limit is combined In-Network and Non-Network. Visit limits are combined both across outpatient and other professional visits.*	$60 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	$30 copay per visit deductible does not apply	50% coinsurance after deductible is met
Allergy Testing Performed by a Primary Care Physician	$30 copay per visit deductible does not apply	50% coinsurance after deductible is met
Allergy Testing Performed by a Specialist	$60 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

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Prescription Drugs	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Diagnostic Services		
Lab:		
Office *All services performed in the office are included in the office copay.*	$30 copay per visit deductible does not apply	50% coinsurance after deductible is met
Freestanding Lab/Reference Lab	No charge	50% coinsurance after deductible is met
Outpatient Hospital	30% coinsurance after deductible is met	50% coinsurance after deductible is met
X-Ray:		
Office *All services performed in the office are included in the office copay.*	$30 copay per visit deductible does not apply	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/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

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Outpatient Hospital	$500 copay per visit and then 30% coinsurance after deductible is met	50% coinsurance after deductible is met
Emergency and Urgent Care		
Urgent Care (Office Setting)	$75 copay per visit deductible does not apply	50% coinsurance after deductible is met
Emergency Room Facility Services *Cost share waived if admitted. Non-emergency use of Emergency Room Services is Not Covered.*	$350 copay per visit and 30% coinsurance deductible does not apply	Covered as In-Network
Ambulance (Air, Ground, and Water)	30% coinsurance after deductible is met	Covered as In-Network
Outpatient Mental Health and Substance Use Disorder		
Doctor Office Visit	$30 copay per visit deductible does not apply	50% coinsurance after deductible is met
Facility visit:		
Facility Fees	30% coinsurance deductible does not apply	50% coinsurance after deductible is met
Doctor Services	30% coinsurance deductible does not apply	50% coinsurance after deductible is met

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Outpatient Surgery		
Facility Fees:		
Hospital	$500 copay per visit and then 30% coinsurance after deductible is met	50% coinsurance after deductible is met
Freestanding Surgical Center	$150 copay per visit and 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 Stay (all inpatient stays including Maternity, Mental / Behavioral Health, and Substance Abuse)		
Facility fees (for example, room & board) *Coverage for Inpatient Rehabilitation and Skilled Nursing services is limited to 60 days combined per benefit period. Limit is combined In-Network and Non-Network.*	$500 copay per admission and then 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

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Recovery & Rehabilitation		
Home Care Visits *Coverage is limited to 100 visits per year. Limit is combined In-Network and Non-Network. Limit does not apply to separate Physical or Occupational or Speech Therapy limits, when performed as part of Home Health.*	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Rehabilitation services (for example, physical/speech/occupational therapy):		
Office *Coverage for rehabilitative and habilitative physical therapy and occupational therapy combined is limited to 20 visits per year. Limit is combined for In-Network and Non-Network. Visit limits are combined both across outpatient and other professional visits. Coverage for rehabilitative and habilitative speech therapy is limited to 20 visits per year. Visit limits are combined both across outpatient and other professional visits. Limit is combined for In-Network and Non-Network.*	$60 copay per visit deductible does not apply	50% coinsurance after deductible is met
Outpatient Hospital *Limit is combined for In-Network and Non-Network.*	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 (in a facility) *Coverage for Inpatient rehabilitation and skilled nursing services is limited to 60 days combined per benefit period. Limit is combined In-Network and Non-Network.*	$500 copay per admission and then 30% coinsurance after deductible is met	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
Hospice	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Durable Medical Equipment *Wearable hearing aids limited to a single purchase for one or both ears (including repair/replacement) once every 3 years. Coverage for hearing aids services is limited to $3000 per ear every 48 months. Covered for all ages.*	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Prosthetic Devices *Coverage for wigs after cancer treatment is limited to 1 item per year. Limit is combined In-Network and Non-Network.*	30% coinsurance after deductible is met	50% coinsurance after deductible is met

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Covered Prescription Drug Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Pharmacy Deductible	Not applicable	Not applicable
Pharmacy Out of Pocket	Combined with medical out of pocket maximum	Combined with medical out of pocket maximum
Prescription Drug Coverage *Essential Drug List*		
Tier 1 - Typically Generic *Covers up to a 30 day supply (retail pharmacy). Covers up to a 90 day supply (home delivery program). Covers up to 90 day supply (retail maintenance pharmacy).*	$15 copay per prescription, deductible does not apply (retail and home delivery)	$15 copay per prescription, deductible does not apply (retail only)
Tier 2 – Typically Preferred Brand *Covers up to a 30 day supply (retail pharmacy). Covers up to a 90 day supply (home delivery program). Covers up to 90 day supply (retail maintenance pharmacy).*	$35 copay per prescription, deductible does not apply (retail) and $70 copay per prescription, deductible does not apply (home delivery)	$35 copay per prescription, deductible does not apply (retail only)
Tier 3 - Typically Non-Preferred Brand *Covers up to a 30 day supply (retail pharmacy). Covers up to a 90 day supply (home delivery program). Covers up to 90 day supply (retail maintenance pharmacy).*	$60 copay per prescription, deductible does not apply (retail) and $180 copay per prescription, deductible does not apply (home delivery)	$60 copay per prescription, deductible does not apply (retail only)

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Covered Prescription Drug Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Tier 4 - Typically Specialty (brand and generic) *Covers up to a 30 day supply (retail pharmacy). Covers up to a 30 day supply (home delivery program).*	25% coinsurance up to $350 per prescription, deductible does not apply (retail and home delivery)	25% coinsurance up to $350 per prescription, deductible does not apply (retail only)

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Notes:

- For additional information on this plan, please visit www.sbc.anthem.com to obtain a "Summary of Benefit Coverage".
- If your plan includes an emergency room facility copay and you are directly admitted to a hospital, your emergency room facility copay is waived.
- The family deductible and out-of-pocket maximum are embedded meaning the cost shares of one family member will be applied to the individual deductible and individual out-of-pocket maximum; in addition, amounts for all family members apply to the family deductible and family out-of-pocket maximum. No one member will pay more than the individual deductible and individual out-of-pocket maximum.
- If your plan includes out of network benefits, all services with calendar/plan year limits are combined both in and out of network.
- When using out-of-network providers, members are responsible for any difference between the Maximum Allowed Amount and the amount the provider actually charges, as well as any copayments, deductibles and/or applicable coinsurance.
- Human Organ and Tissues Transplants require precertification and are covered as any other service in your summary of benefits. Facilities considered In-Network are BDC/CME facilities; all others would apply as plan Out-of-Network benefits according to the plan design.
- Your copays, coinsurance and deductible count toward your out of pocket amount.
- Routine Physical examinations necessitated by employment, foreign travel or participation in school athletic program are not covered.
- Removal/extraction of impacted teeth is not covered.
- Private Duty Nursing is not covered.
- Care of treatment that is not medically necessary is not covered.
- Cosmetic surgery is not covered, except to restore function altered by disease or trauma.
- Dental care and oral surgery; except for accidental injury to natural teeth, treatment of TMJ and radiation for head and neck cancer are not covered.
- Occupational related illness or injury is not covered.
- Treatment, drugs or supplies considered experimental or investigational are not covered.

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Language Access Services:

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