

Your summary of benefits

Anthem® BlueCross and BlueShield

Your Plan: Jim Ellis Atlanta, Inc.-Anthem Blue Essential Open Access NS POS OAP12 5000/30%/7900 L

Your Network: Blue Open Access POS

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 <i>See notes section to understand how your deductible works. Your plan may also have a separate Prescription Drug Deductible. See Prescription Drug Coverage section.</i>	\$5,000 member / \$10,000 family	\$15,000 member / \$30,000 family
Out-of-Pocket Limit <i>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.</i>	\$7,900 member / \$15,800 family	\$23,700 member / \$47,400 family
Preventive care/screening/immunization <i>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.</i>	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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<i>Global obstetrical care (prenatal, delivery, and postpartum services).</i>	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	Not covered	Not covered
Acupuncture	Not covered	Not covered
Other Services in an Office:		
Allergy Testing	Not covered	Not covered
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
Prescription Drugs	30% coinsurance after deductible is met	50% coinsurance after deductible is met

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<p>Diagnostic Services</p> <p>Lab:</p> <ul style="list-style-type: none"> Office Freestanding Lab/Reference Lab Outpatient Hospital 	<ul style="list-style-type: none"> 30% coinsurance after deductible is met 0% coinsurance, deductible does not apply 30% coinsurance after deductible is met 	<ul style="list-style-type: none"> 50% coinsurance after deductible is met 50% coinsurance after deductible is met 50% coinsurance after deductible is met
<p>X-Ray:</p> <ul style="list-style-type: none"> Office Freestanding Radiology Center Outpatient Hospital 	<ul style="list-style-type: none"> 30% coinsurance after deductible is met 30% coinsurance deductible does not apply 30% coinsurance after deductible is met 	<ul style="list-style-type: none"> 50% coinsurance after deductible is met 50% coinsurance after deductible is met 50% coinsurance after deductible is met
<p>Advanced Diagnostic Imaging (for example, MRI/PET/CAT scans):</p> <ul style="list-style-type: none"> Office Freestanding Radiology Center Outpatient Hospital 	<ul style="list-style-type: none"> 30% coinsurance after deductible is met 30% coinsurance deductible does not apply 30% coinsurance after deductible is met 	<ul style="list-style-type: none"> 50% coinsurance after deductible is met 50% coinsurance after deductible is met 50% coinsurance after deductible is met

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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 <i>Cost share waived if admitted. Non-emergency use of Emergency Room Services is Not Covered.</i>	\$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 Facility visit: Facility Fees Doctor Services	\$30 copay per visit deductible does not apply 30% coinsurance after deductible is met 30% coinsurance after deductible is met	50% coinsurance after deductible is met 50% coinsurance after deductible is met 50% coinsurance after deductible is met

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<p>Outpatient Surgery</p> <p>Facility Fees:</p> <p>Hospital</p> <p>Freestanding Surgical Center</p> <p>Doctor and Other Services:</p> <p>Hospital</p> <p>Freestanding Surgical Center</p>	<p>30% coinsurance after deductible is met</p> <p>\$150 copay per visit and 30% coinsurance deductible does not apply</p> <p>30% coinsurance after deductible is met</p> <p>30% coinsurance deductible does not apply</p>	<p>50% coinsurance after deductible is met</p> <p>50% coinsurance after deductible is met</p> <p>50% coinsurance after deductible is met</p> <p>50% coinsurance after deductible is met</p>
<p>Hospital Stay (all inpatient stays including Maternity, Mental / Behavioral Health, and Substance Abuse)</p> <p>Facility fees (for example, room & board) <i>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.</i></p> <p>Doctor and other services</p>	<p>\$500 copay per admission and 30% coinsurance deductible does not apply</p> <p>30% coinsurance after deductible is met</p>	<p>50% coinsurance after deductible is met</p> <p>50% coinsurance after deductible is met</p>

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Recovery & Rehabilitation Home Care Visits <i>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.</i>	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Rehabilitation services (for example, physical/speech/occupational therapy): Office Outpatient Hospital	Not covered Not covered	Not covered Not covered
Cardiac rehabilitation Office Outpatient Hospital	30% coinsurance after deductible is met 30% coinsurance after deductible is met	50% coinsurance after deductible is met 50% coinsurance after deductible is met
Skilled Nursing Care (in a facility) <i>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.</i>	\$500 copay per admission and 30% coinsurance deductible does not apply	50% coinsurance after deductible is met
Hospice	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Durable Medical Equipment <i>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 through the age of 18.</i>	30% coinsurance after deductible is met	50% coinsurance after deductible is met

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Prosthetic Devices	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	\$500 person / \$1,000 family	\$500 person / \$1,000 family
Pharmacy Out of Pocket	Combined with medical out of pocket maximum	Combined with medical out of pocket maximum
Prescription Drug Coverage <i>Essential Drug List</i>		
Tier 1 - Typically Generic <i>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).</i>	\$15 copay per prescription, Pharmacy deductible does not apply (retail and home delivery)	\$15 copay per prescription, Pharmacy deductible does not apply (retail only)
Tier 2 – Typically Preferred Brand <i>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).</i>	\$40 copay per prescription after Pharmacy deductible is met (retail) and \$80 copay per prescription after Pharmacy deductible is met (home delivery)	\$40 copay per prescription after Pharmacy deductible is met (retail only)
Tier 3 - Typically Non-Preferred Brand <i>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).</i>	\$75 copay per prescription after Pharmacy deductible is met (retail) and \$225 copay per prescription after Pharmacy deductible is met (home delivery)	\$75 copay per prescription after Pharmacy deductible is met (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
<p>Tier 4 - Typically Specialty (brand and generic) <i>Covers up to a 30 day supply (retail pharmacy). Covers up to a 30 day supply (home delivery program).</i></p>	25% coinsurance up to \$350 per prescription after Pharmacy deductible is met (retail and home delivery)	25% coinsurance up to \$350 per prescription after Pharmacy deductible is met (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.

Get help in your language

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