

Your summary of benefits

Anthem® BlueCross and BlueShield

Your Plan: City of Warner Robins

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 Evidence of Coverage (EOC). If there is a difference between this summary and the Certificate of Insurance or Evidence of Coverage (EOC), the Certificate of Insurance or Evidence of Coverage (EOC), will prevail.

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<p>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></p>	<p>\$200 person / \$600 family</p>	<p>\$200 person / \$600 family</p>
<p>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 your benefit period. See notes section for additional information regarding your out of pocket maximum.</i></p>	<p>\$1,000 person / \$3,000 family</p>	<p>\$1,500 person / \$4,500 family</p>
<p>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></p>	<p>No charge</p>	<p>30% coinsurance after deductible is met</p>
<p>Doctor Home and Office Services</p> <p>Primary Care Office Visit to treat an injury or illness</p> <p>Surgery Performed by a Primary Care Physician/Specialist</p>	<p>\$30 copay per visit deductible does not apply</p> <p>10% coinsurance after deductible is met</p>	<p>30% coinsurance after deductible is met</p> <p>30% coinsurance after deductible is met</p>

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<p>Specialist Care Visit <i>All services performed in the office are included in the office copay.</i></p>	\$30 copay per visit deductible does not apply	30% coinsurance after deductible is met
<p>Maternity Physician Services <i>Global obstetrical care (prenatal, delivery and postpartum services.</i></p>	\$100 copayment (first office visitation only)	30% coinsurance after deductible is met
<p>Other Practitioner Visits:</p> <p>Retail Health Clinic Visit</p> <p>On-line Medical Visit</p> <p>Chiropractic/Manipulation Therapy <i>Limit is combined across professional visits and outpatient facilities. Coverage is limited to 20 visit(s) per year. Limit is combined In-Network and Non-Network.</i></p> <p>Acupuncture</p>	<p>\$30 copay per visit deductible does not apply</p> <p>\$30 per visit deductible does not apply</p> <p>Member pays 10% after deductible \$20 copayment</p> <p>Not covered</p>	<p>30% coinsurance after deductible is met</p> <p>30% coinsurance after deductible is met</p> <p>30% coinsurance after deductible is met</p> <p>Not covered</p>
<p>Other Services in an Office:</p> <p>Allergy Testing</p> <p>Chemo/Radiation Therapy</p> <p>Dialysis/Hemodialysis</p>	<p>\$20 copay per visit or \$20 if performed in a specialist office deductible does not apply</p> <p>10% coinsurance after deductible is met</p> <p>10% coinsurance after deductible is met</p>	<p>30% coinsurance after deductible is met</p> <p>30% coinsurance after deductible is met</p> <p>30% coinsurance after deductible is met</p>

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<p>Prescription Drugs <i>For the drugs itself dispensed in the office through infusion/injection.</i></p>	10% coinsurance after deductible is met	30% coinsurance after deductible is met
<p>Diagnostic Services</p> <p>Lab:</p> <p>Office <i>All services performed in the office are included in the office copay.</i></p> <p>Freestanding Lab/Reference Lab</p> <p>Outpatient Hospital</p>	<p>\$30 copay per visit or \$30 if performed in a specialist office</p> <p>10% coinsurance deductible does not apply</p> <p>10% coinsurance after deductible is met</p>	<p>30% coinsurance after deductible is met</p> <p>30% coinsurance after deductible is met</p> <p>30% coinsurance after deductible is met</p>
<p>X-Ray:</p> <p>Office <i>All services performed in the office are included in the office copay.</i></p> <p>Freestanding Radiology Center</p> <p>Outpatient Hospital</p>	<p>\$30 copay per visit or \$30 if performed in a specialist office deductible does not apply</p> <p>10% coinsurance deductible does not apply</p> <p>10% coinsurance after deductible is met</p>	<p>30% coinsurance after deductible is met</p> <p>30% coinsurance after deductible is met</p> <p>30% coinsurance after deductible is met</p>
<p>Advanced Diagnostic Imaging (for example,</p>		

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MRI/PET/CAT scans): Office Freestanding Radiology Center Outpatient Hospital	10% coinsurance after deductible is met 10% coinsurance deductible does not apply 10% coinsurance after deductible is met	30% coinsurance after deductible is met 30% coinsurance after deductible is met 30% coinsurance after deductible is met
Emergency and Urgent Care Urgent Care (Office Setting)	Member pays 10%	30% 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>	\$100 copayment	Covered as In-Network
Ambulance (Air, Ground, and Water)	10% 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	\$20 copay per visit deductible does not apply 10% coinsurance after deductible is met 10% coinsurance after deductible is met	30% coinsurance after deductible is met 30% coinsurance after deductible is met 30% coinsurance after deductible is met
Outpatient Surgery		

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<p>Facility Fees:</p> <p>Hospital</p> <p>Doctor and Other Services:</p> <p>Hospital</p> <p>Freestanding Surgical Center</p>	<p>10% coinsurance after deductible is met</p> <p>10% coinsurance after deductible is met</p> <p>10% coinsurance deductible does not apply</p>	<p>30% coinsurance after deductible is met</p> <p>30% coinsurance after deductible is met</p> <p>30% coinsurance after deductible is met</p>
<p>Hospital Stay (all Inpatient stays including Maternity, Mental and Substance Use Disorder):</p> <p>Facility fees (for example, room & board) <i>Coverage for Inpatient rehabilitation and skilled nursing services combined In-Network Providers and Non-Network Providers combined is limited to 60 days per year.</i></p> <p>Doctor and other services</p>	<p>10% coinsurance after deductible is met</p> <p>10% coinsurance after deductible is met</p>	<p>30% coinsurance after deductible is met</p> <p>30% coinsurance after deductible is met</p>
<p>Recovery & Rehabilitation</p> <p>Home Care Visits <i>Coverage is limited to 120 visit(s) 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></p>	<p>10% coinsurance after deductible is met</p>	<p>30% coinsurance after deductible is met</p>
<p>Rehabilitation services (for example, physical/speech/occupational therapy):</p>		

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<p>Office</p> <ul style="list-style-type: none"> ▪ <i>Physical Therapy and Occupational Therapy: 30-visit benefit period maximum combined</i> ▪ <i>Speech Therapy: 30-visit benefit period maximum.</i> <p>Outpatient Hospital</p> <ul style="list-style-type: none"> ▪ <i>Physical Therapy and Occupational Therapy: 30-visit benefit period maximum combined</i> ▪ <i>Speech Therapy: 30-visit benefit period maximum.</i> 	<p>Member pays 10% after deductible \$20 copayment</p> <p>10% coinsurance after deductible is met</p>	<p>30% coinsurance after deductible is met</p> <p>30% coinsurance after deductible is met</p>
<p>Cardiac rehabilitation</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>30% coinsurance after deductible is met</p> <p>30% coinsurance after deductible is met</p>
<p>Skilled Nursing Care (in a facility) <i>Coverage for Inpatient rehabilitation and skilled nursing services combined In-Network Providers and Non-Network Providers combined is limited to 60 days per year.</i></p>	<p>10% coinsurance after deductible is met</p>	<p>30% coinsurance after deductible is met</p>
<p>Hospice</p>	<p>Member pays 0% (not subject to deductible)</p>	<p>Member pays 0% (not subject to deductible)</p>
<p>Durable Medical Equipment <i>Coverage for hearing aids services is limited to \$3000 every 48 months. Limit is combined In-Network and Non-Network. Covered through the age of 18.</i></p>	<p>20% coinsurance after deductible is met</p>	<p>20% coinsurance after deductible is met</p>
<p>Prosthetic Devices <i>Coverage for Wigs after cancer treatment is limited to 1 item per year. Limit is combined In-Network and Non-Network.</i></p>	<p>20% coinsurance after deductible is met</p>	<p>20% coinsurance after deductible is met</p>

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Notes:

- 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 programs are not covered.
- Removal/extraction of impacted teeth is not covered.
- Private Duty Nursing is not covered.
- Care or 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.
- For additional information on this plan, please visit sbc.anthem.com to obtain a "Summary of Benefit Coverage".

Get help in your language

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

Separate from our language assistance program, we make documents available in alternate formats for members with visual impairments. If you need a copy of this document in an alternate format, please call the customer service telephone number on the back of your ID card.

(TTY/TDD: 711)

Arabic (العربية): إذا كان لديك أي استفسارات بشأن هذا المستند، فيحق لك الحصول على المساعدة والمعلومات بلغتك دون مقابل. للتحدث إلى مترجم، اتصل على (855) 397-9267.

Armenian (հայերեն). Եթե այս փաստաթղթի հետ կապված հարցեր ունեք, դուք իրավունք ունեք անվճար ստանալ օգնություն և տեղեկատվություն ձեր լեզվով: Թարգմանչի հետ խոսելու համար զանգահարեք հետևյալ հեռախոսահամարով՝ (855) 397-9267:

Chinese(中文): 如果您對本文件有任何疑問，您有權使用您的語言免費獲得協助和資訊。如需與譯員通話，請致電(855) 397-9267。

Farsi (فارسی): در صورتی که سؤالی پیرامون این سند دارید، این حق را دارید که اطلاعات و کمک را بدون هیچ هزینه ای به زبان مادریتان دریافت کنید. برای گفتگو با یک مترجم شفاهی، با شماره (855) 397-9267 تماس بگیرید.

French (Français): Si vous avez des questions sur ce document, vous avez la possibilité d'accéder gratuitement à ces informations et à une aide dans votre langue. Pour parler à un interprète, appelez le (855) 397-9267.

Haitian Creole (Kreyòl Ayisyen): Si ou gen nenpòt kesyon sou dokiman sa a, ou gen dwa pou jwenn èd ak enfòmasyon nan lang ou gratis. Pou pale ak yon entèpret, rele (855) 397-9267.

Italian (Italiano): In caso di eventuali domande sul presente documento, ha il diritto di ricevere assistenza e informazioni nella sua lingua senza alcun costo aggiuntivo. Per parlare con un interprete, chiami il numero (855) 397-9267.

Japanese (日本語): この文書についてなにかご不明な点があれば、あなたにはあなたの言語で無料で支援を受け情報を得る権利があります。通訳と話すには、(855) 397-9267 にお電話ください。

Korean (한국어): 본 문서에 대해 어떠한 문의사항이라도 있을 경우, 귀하에게는 귀하가 사용하는 언어로 무료 도움 및 정보를 얻을 권리가 있습니다. 통역사와 이야기하려면(855) 397-9267로 문의하십시오.

Language Access Services:

Navajo (Diné): Dii naaltsoos biká'ígíí lahgo bina'idílkidgo ná bohónéedzá dóó bee ahóót'i' t'áá ni nizaad k'ehjí bee nił hodoonih t'áadoo bą́ąh ilínígóó. Ata' halne'ígíí la' bich'i' hadeesdzih nínizingo kojí' hodiílnih (855) 397-9267.

Polish (polski): W przypadku jakichkolwiek pytań związanych z niniejszym dokumentem masz prawo do bezpłatnego uzyskania pomocy oraz informacji w swoim języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer: (855) 397-9267.

Punjabi (ਪੰਜਾਬੀ): ਜੇ ਤੁਹਾਡੇ ਇਸ ਦਸਤਾਵੇਜ਼ ਬਾਰੇ ਕੋਈ ਸਵਾਲ ਹੁੰਦੇ ਹਨ ਤਾਂ ਤੁਹਾਡੇ ਕੋਲ ਮੁਫਤ ਵਿੱਚ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮਦਦ ਅਤੇ ਜਾਣਕਾਰੀ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੁੰਦਾ ਹੈ। ਇੱਕ ਦੁਭਾਸ਼ੀਏ ਨਾਲ ਗੱਲ ਕਰਨ ਲਈ, (855) 397-9267 ਤੇ ਕਾਲ ਕਰੋ।

Russian (Русский): Если у вас есть какие-либо вопросы в отношении данного документа, вы имеете право на бесплатное получение помощи и информации на вашем языке. Чтобы связаться с устным переводчиком, позвоните по тел. (855) 397-9267.

Spanish (Español): Si tiene preguntas acerca de este documento, tiene derecho a recibir ayuda e información en su idioma, sin costos. Para hablar con un intérprete, llame al (855) 397-9267.

Tagalog (Tagalog): Kung mayroon kang anumang katanungan tungkol sa dokumentong ito, may karapatan kang humingi ng tulong at impormasyon sa iyong wika nang walang bayad. Makipag-usap sa isang tagapagpaliwanag, tawagan ang (855) 397-9267.

Vietnamese (Tiếng Việt): Nếu quý vị có bất kỳ thắc mắc nào về tài liệu này, quý vị có quyền nhận sự trợ giúp và thông tin bằng ngôn ngữ của quý vị hoàn toàn miễn phí. Để trao đổi với một thông dịch viên, hãy gọi (855) 397-9267.

It's important we treat you fairly

That's why we follow federal civil rights laws in our health programs and activities. We don't discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, we offer free aids and services. For people whose primary language isn't English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711). If you think we failed to offer these services or discriminated based on race, color, national origin, age, disability, or sex, you can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator in writing to Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279. Or you can file a complaint with 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 or by calling 1-800-368-1019 (TDD: 1-800-537-7697) or online at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>. Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.