Your summary of benefits

City Of Warner Robins

Anthem® Blue Cross and Blue Shield

Your Plan: Anthem Blue Open Access POS OAP5 500/10%/2500 AE

Your Network: Blue Open Access POS

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Overall Deductible	$200 member / $600 family	$200 member / $600 family
Out-of-Pocket Limit	$1,000 member / $1,000 family	$1,500 member / $1,500 family
The family deductible and out-of-pocket maximum are embedded meaning the cost shares of one family member will be applied to both the individual deductible and individual out-of-pocket maximum; in addition, amounts for all covered family members apply to both 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.		
Preventive Care / Screening / Immunization	No charge	30% coinsurance after deductible is met
Doctor Home and Office Services		
Primary Care Visit	$30 copay per visit deductible does not apply	30% coinsurance after deductible is met
Specialist Care Visit	$30 copay per visit deductible does not apply	30% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Prenatal and Post-natal Care	$100 copayment (first office visitation only)	30% coinsurance after deductible is met
Other Practitioner Visits:		
Retail Health Clinic Visit	$30 copay per visit deductible does not apply	30% coinsurance after deductible is met
On-line Medical Visit	$30 copay per visit deductible does not apply	30% coinsurance after deductible is met
Manipulation Therapy *Coverage is limited to 20 visits per year.*	$30 copay per visit deductible does not apply	30% coinsurance after deductible is met
Acupuncture	10% coinsurance after deductible is met	10% coinsurance after deductible is met
Other Services in an Office:		
Allergy Testing	$30 copay per visit (PCP & Specialist) deductible does not apply	30% coinsurance after deductible is met
Chemo/Radiation Therapy	10% coinsurance after deductible is met	30% coinsurance after deductible is met
Dialysis/Hemodialysis	10% coinsurance after deductible is met	30% coinsurance after deductible is met
Prescription Drugs - *Dispensed in the office*	10% coinsurance after deductible is met	30% coinsurance after deductible is met
Diagnostic Services **Lab:**		
Office	0% coinsurance deductible does not apply	30% coinsurance after deductible is met
Freestanding Lab/Reference Lab	0% coinsurance deductible does not apply	30% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Outpatient Hospital	10% coinsurance after deductible is met	10% coinsurance after deductible is met
X-Ray:		
Office	0% coinsurance deductible does not apply	30% coinsurance after deductible is met
Freestanding Radiology Center	0% coinsurance deductible does not apply	30% coinsurance after deductible is met
Outpatient Hospital	10% coinsurance after deductible is met	30% coinsurance after deductible is met
Advanced Diagnostic Imaging:		
Office	10% coinsurance after deductible is met	30% coinsurance after deductible is met
Freestanding Radiology Center	10% coinsurance deductible does not apply	30% coinsurance after deductible is met
Outpatient Hospital	10% coinsurance after deductible is met	30% coinsurance after deductible is met
Emergency and Urgent Care		
Urgent Care	10% coinsurance deductible does not apply	Covered as In-Network
Emergency Room Facility Services *Cost share waived if admitted.*	$100 copay per visit deductible does not apply	Covered as In-Network
Emergency Room Doctor and Other Services	0% coinsurance deductible does not apply	Covered as In-Network
Ambulance	10% coinsurance after deductible is met	Covered as In-Network

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Outpatient Mental/Behavioral Health and Substance Abuse		
Doctor Office Visit	$30 copay per visit deductible does not apply	50% coinsurance after deductible is met
Facility Visit:		
Facility Fees	0% coinsurance deductible does not apply	30% coinsurance after deductible is met
Doctor Services	10% coinsurance after deductible is met	30% coinsurance after deductible is met
Outpatient Surgery		
Facility Fees:		
Hospital	10% coinsurance after deductible is met	30% coinsurance after deductible is met
Doctor and Other Services:		
Hospital	10% coinsurance after deductible is met	30% coinsurance after deductible is met
Freestanding Surgical Center	10% coinsurance deductible does not apply	30% coinsurance after deductible is met
Hospital (Including Maternity, Mental / Behavioral Health, Substance Abuse):		
Facility Fees	10% coinsurance after deductible is met	30% coinsurance after deductible is met
Doctor and other services	10% coinsurance after deductible is met	30% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Recovery & Rehabilitation **Home Health Care** *Coverage is limited to 120 visits per benefit period. Limits are combined for all home health services.*	10% coinsurance after deductible is met	30% coinsurance after deductible is met
Rehabilitation services: Office *Coverage for rehabilitative and habilitative physical therapy and occupational therapy combined is limited to 30 visits per year. Coverage for rehabilitative and habilitative speech therapy is limited to 30 visits per year.* Outpatient Hospital *Limits are combined with Rehabilitation office visits.*	10% coinsurance after deductible is met 10% coinsurance after deductible is met	30% coinsurance after deductible is met 30% coinsurance after deductible is met
Cardiac rehabilitation Office Outpatient Hospital	0% coinsurance deductible does not apply 10% coinsurance after deductible is met	30% coinsurance after deductible is met 30% coinsurance after deductible is met
Skilled Nursing Care (facility) *Coverage for Inpatient rehabilitation and skilled nursing services is limited to 60 days combined per benefit period.*	10% coinsurance after deductible is met	30% coinsurance after deductible is met
Hospice	0% coinsurance deductible does not apply	0% coinsurance deductible does not apply
Durable Medical Equipment	20% coinsurance after deductible is met	20% coinsurance after deductible is met
Prosthetic Devices	20% coinsurance after deductible is met	20% coinsurance after deductible is met

Notes:

- Your copays, coinsurance and deductible count toward your out of pocket amount.
- If you have a visit with your Primary Care Physician, Specialist or Urgent Care at an Outpatient Facility (e.g., Hospital or Ambulatory Surgical Facility), benefits for Covered Services will be paid under "Outpatient Facility Services" which is generally coinsurance or coinsurance after your deductible is met.
  Costs may also vary by the site of service. Other cost shares may apply depending on services provided. Check your Certificate of Coverage for details.
- Opt-out Home Delivery for Maintenance Drugs (previously known as Home Delivery Choice) – For medications on your benefit plan's maintenance drug list, you may get your first 30-day supply and up to one more 30-day refill of the same Maintenance Medication at an in-network retail pharmacy. Prior to your 3rd fill, you must contact us at 1-833-203-1739 or at www.anthem.com and tell us if you would like to keep getting your Maintenance Medications from the retail pharmacy or if you would like to use Home Delivery. If you do not contact us, you will pay the full retail cost of any Maintenance Medication until you inform us of your decision.

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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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

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(TTY/TDD: 711)

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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 entèprèt, rele (855) 397-9267.

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Language Access Services:

Navajo (Diné): Díí naaltsoos biká'ígíí łahgo bina'idiłkidgo ná bohónéedzą dóó bee ahóót'i' t'áá ni nizaad k'ehjí bee nił hodoonih t'áadoo bą́ą́h ílínígóó. Ata' halne'ígíí ła' bich'į' hadeesdzih ninízingo kojį' hodíilnih (855) 397-9267.

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