# Your summary of benefits

**The Macon Water Authority**

Anthem® Blue Cross and Blue Shield

Your Plan: Anthem Blue Open Access POS OAP5 750/20%/5000 AE

Your Network: Blue Open Access POS

| Visits with Virtual Care-Only Providers | Cost through our mobile app and website |
|---|---|
| **Primary Care, and medical services for urgent/acute care** | No charge medical deductible does not apply |
| **Mental Health & Substance Use Disorder Services** | No charge medical deductible does not apply |
| **Specialist care** | $35 copay per visit medical deductible does not apply |

| Covered Medical Benefits | Cost if you use an In-Network Provider | Cost if you use an Out-of-Network Provider |
|---|---|---|
| **Overall Deductible** | $750 member / $2,250 family | $1,500 member / $4,500 family |
| **Overall Out-of-Pocket Limit** | $5,000 member / $10,000 family | $10,000 member / $20,000 family |
| 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.<br>All medical and prescription drug deductibles, copayments and coinsurance apply to the out-of-pocket limit (excluding Out-of-Network Human Organ and Tissue Transplant (HOTT), Cellular and Gene Therapy services).<br>In-Network and Out-of-Network deductibles and out-of-pocket limit amounts are separate and do not accumulate toward each other. | | |
| **Doctor Visits (virtual and office)** *You are encouraged to select a Primary Care Physician (PCP).* | | |
| **Primary Care (PCP)** *virtual and office* | $25 copay per visit medical deductible does not apply | 30% coinsurance after medical deductible is met |
| **Mental Health and Substance Use Disorder Services** *virtual and office* | $25 copay per visit medical deductible does not apply | 30% coinsurance after medical deductible is met |

| Covered Medical Benefits | Cost if you use an In-Network Provider | Cost if you use an Out-of-Network Provider |
|---|---|---|
| **Specialist Care** *virtual and office* | $35 copay per visit medical deductible does not apply | 30% coinsurance after medical deductible is met |
| **Other Practitioner Visits** | | |
| **Maternity services** | | |
| Prenatal and Postnatal care | $25 copay per visit medical deductible does not apply | 30% coinsurance after medical deductible is met |
| Delivery | 20% coinsurance after medical deductible is met | 30% coinsurance after medical deductible is met |
| **Retail Health Clinic Visit** *for routine care and treatment of common illnesses; usually found in major pharmacies or retail stores.* | $25 copay per visit medical deductible does not apply | 30% coinsurance after medical deductible is met |
| **Manipulation Therapy**<br>*Coverage is limited to 30 visits per benefit period.* | 20% coinsurance after medical deductible is met | 30% coinsurance after medical deductible is met |
| **Acupuncture** | Not covered | Not covered |
| **Other Services in an Office** | | |
| **Allergy Testing** | $35 copay per visit medical deductible does not apply | 30% coinsurance after medical deductible is met |
| **Prescription Drugs** *Dispensed in the office* | 20% coinsurance after medical deductible is met | 30% coinsurance after medical deductible is met |
| **Surgery** | $35 copay per surgery medical deductible does not apply | 30% coinsurance after medical deductible is met |
| **Preventive care / screenings / immunizations** | No charge | 30% coinsurance after medical deductible is met |
| **Preventive Care for Chronic Conditions** *per IRS guidelines* | No charge | 30% coinsurance after medical deductible is met |

| Covered Medical Benefits | Cost if you use an In-Network Provider | Cost if you use an Out-of-Network Provider |
|---|---|---|
| **Diagnostic Services** | | |
| **Lab** | | |
| Office | 20% coinsurance after medical deductible is met | 30% coinsurance after medical deductible is met |
| Freestanding Lab/Reference Lab | 20% coinsurance after medical deductible is met | 30% coinsurance after medical deductible is met |
| Outpatient Hospital | 20% coinsurance after medical deductible is met | 30% coinsurance after medical deductible is met |
| **X-Ray** | | |
| Office | 20% coinsurance after medical deductible is met | 30% coinsurance after medical deductible is met |
| Freestanding Radiology Center | 20% coinsurance medical deductible does not apply | 30% coinsurance after medical deductible is met |
| Outpatient Hospital | 20% coinsurance after medical deductible is met | 30% coinsurance after medical deductible is met |
| **Advanced Diagnostic Imaging** *for example: MRI, PET and CAT scans* | | |
| Office | 20% coinsurance after medical deductible is met | 30% coinsurance after medical deductible is met |
| Freestanding Radiology Center | 20% coinsurance medical deductible does not apply | 30% coinsurance after medical deductible is met |
| Outpatient Hospital | 20% coinsurance after medical deductible is met | 30% coinsurance after medical deductible is met |
| **Emergency and Urgent Care** | | |
| **Urgent Care** *includes doctor services. Additional charges may apply depending on the care provided.* | $75 copay per visit medical deductible does not apply | 30% coinsurance after medical deductible is met |
| **Emergency Room Facility Services** *Your copay, coinsurance will be waived if admitted.* | $250 copay per visit and 20% coinsurance medical deductible does not apply | Covered as In-Network |

| Covered Medical Benefits | Cost if you use an In-Network Provider | Cost if you use an Out-of-Network Provider |
|---|---|---|
| **Emergency Room Doctor and Other Services** | 20% coinsurance medical deductible does not apply | Covered as In-Network |
| **Ambulance**<br>*Authorized Out-of-Network non-emergency ambulance services are limited to an Anthem maximum payment of $50,000 per trip.* | 20% coinsurance after medical deductible is met | Covered as In-Network |
| **Outpatient Mental Health and Substance Use Disorder Services at a Facility** | | |
| Facility Fees | 20% coinsurance after medical deductible is met | 30% coinsurance after medical deductible is met |
| Doctor Services | 20% coinsurance after medical deductible is met | 30% coinsurance after medical deductible is met |
| **Outpatient Surgery** | | |
| **Facility Fees** | | |
| Hospital | 20% coinsurance after medical deductible is met | 30% coinsurance after medical deductible is met |
| Ambulatory Surgical Center | 20% coinsurance after medical deductible is met | 30% coinsurance after medical deductible is met |
| **Physician and other services** *including surgeon fees* | | |
| Hospital | 20% coinsurance after medical deductible is met | 30% coinsurance after medical deductible is met |
| Ambulatory Surgical Center | 20% coinsurance medical deductible does not apply | 30% coinsurance after medical deductible is met |
| **Hospital (Including Maternity, Mental Health and Substance Use Disorder Services)** | | |
| **Facility Fees** | 20% coinsurance after medical deductible is met | $500 copay per admission and then 30% coinsurance after medical deductible is met |
| **Physician and other services** *including surgeon fees* | 20% coinsurance after medical deductible is met | 30% coinsurance after medical deductible is met |

| Covered Medical Benefits | Cost if you use an In-Network Provider | Cost if you use an Out-of-Network Provider |
|---|---|---|
| **Home Health Care**<br>*Coverage is limited to 120 visits per benefit period. Limits are combined for all home health services.* | 20% coinsurance after medical deductible is met | 30% coinsurance after medical deductible is met |
| **Rehabilitation and Habilitation services** *including physical, occupational and speech therapies.*<br>*Coverage for physical is limited to 30 visits per benefit period. Coverage for occupational therapy is limited to 20 visits per benefit period. Coverage for speech therapy is limited to 30 visits per benefit period.* | | |
| Office | 20% coinsurance after medical deductible is met | 30% coinsurance after medical deductible is met |
| Outpatient Hospital | 20% coinsurance after medical deductible is met | 30% coinsurance after medical deductible is met |
| **Pulmonary rehabilitation** *office and outpatient hospital* | 20% coinsurance after medical deductible is met | 30% coinsurance after medical deductible is met |
| **Cardiac rehabilitation** *office and outpatient hospital* | 20% coinsurance after medical deductible is met | 30% coinsurance after medical deductible is met |
| **Dialysis/Hemodialysis** *office and outpatient hospital* | 20% coinsurance after medical deductible is met | 30% coinsurance after medical deductible is met |
| **Chemo/Radiation Therapy** *office and outpatient hospital* | 20% coinsurance after medical deductible is met | 30% coinsurance after medical deductible is met |
| **Skilled Nursing Care (facility)**<br>*Coverage for Inpatient rehabilitation and skilled nursing services is limited to 60 days combined per benefit period.* | 20% coinsurance after medical deductible is met | 30% coinsurance after medical deductible is met |
| **Inpatient Hospice** | 20% coinsurance after medical deductible is met | 30% coinsurance after medical deductible is met |
| **Durable Medical Equipment** | 20% coinsurance after medical deductible is met | 30% coinsurance after medical deductible is met |
| **Prosthetic Devices**<br>*Coverage for wigs is limited to 1 item after cancer treatment per benefit period.* | 20% coinsurance after medical deductible is met | 30% coinsurance after medical deductible is met |

| Covered Medical Benefits | Cost if you use an In-Network Provider | Cost if you use an Out-of-Network Provider |
|---|---|---|
| **Hearing Aids**<br>*Coverage is limited to 1 item per hearing-impaired ear up to $3,000 per ear, every 48 months for members through age 18.* | 20% coinsurance after medical deductible is met | 30% coinsurance after medical deductible is met |

| Covered Prescription Drug Benefits | Cost if you use an In-Network Pharmacy | Cost if you use an Out-of-Network Pharmacy |
|---|---|---|
| **Pharmacy Deductible** *combined for In-Network and Out-of-Network Pharmacies* | Not applicable | Not applicable |
| **Pharmacy Out-of-Pocket Limit** | Combined with In-Network medical out-of-pocket limit | Combined with Out-of-Network medical out-of-pocket limit |
| **Prescription Drug Coverage**<br>**Network:** ***Base Network***<br>**Drug List:** ***National Direct Plus*** | | |
| **Day Supply Limits:**<br>**Retail Pharmacy** *30 day supply (cost shares noted below)*<br>**Retail 90 Pharmacy** *90 day supply (follow home delivery cost share amounts noted below)*<br>**Home Delivery Pharmacy** *90 day supply (maximum cost shares noted below). Maintenance medications are available through our home delivery pharmacy. You will need to call us on the number on your ID card to sign up when you first use the service.*<br>**Specialty Pharmacy** *30 day supply (cost shares noted below for retail and home delivery apply). We may require certain drugs with special handling, provider coordination or patient education be filled by our designated specialty pharmacy or an In-Network Pharmacy that carries your specialty drug.* | | |
| **Tier 1 - Typically Generic** | $10 copay per prescription (retail) and $25 copay per prescription (home delivery) | $10 copay per prescription (retail only) |
| **Tier 2 - Typically Preferred Brand** | $35 copay per prescription (retail) and $88 copay per prescription (home delivery) | $35 copay per prescription (retail only) |
| **Tier 3 - Typically Non-Preferred Brand** | $55 copay per prescription (retail) and $138 copay per prescription (home delivery) | $55 copay per prescription (retail only) |
| **Tier 4 - Typically Specialty (brand and generic)** | $55 copay per prescription (retail and home delivery) | $55 copay per prescription (retail only) |

| Covered Vision Benefits | Cost if you use an In-Network Provider | Cost if you use an Out-of-Network Provider |
|---|---|---|
| *This is a brief outline of your vision coverage. To receive the In-Network benefit, you must use a Blue View Vision Provider. Only children's vision services count towards your out-of-pocket limit.* | | |
| **Children's Vision exam (up to age 19)**<br>*Limited to 1 exam per benefit period.* | No charge | $0 copayment up to plan's Maximum Allowed Amount |
| **Adult Vision exam (age 19 and older)**<br>*Limited to 1 exam per benefit period.* | No charge | Reimbursed Up to $42 |

**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.
- When using an Out-of-Network Pharmacy, members are responsible for the stated copay & costs in excess of the prescription drug maximum allowed amount. Members will pay upfront and submit a claim form.

*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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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)**

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