


PEGHP/City Of Albany: Anthem Blue Choice PPO PPO5 Buy Up Plan



The Summary of Benefits and Coverage (SBC) document will help you choose a health [plan](#). The SBC shows you how you and the [plan](#) would share the cost for covered health care services. **NOTE: Information about the cost of this [plan](#) (called the [premium](#)) will be provided separately. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, <https://eoc.anthem.com/eocdps/aso>. For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other underlined terms, see the Glossary. You can view the Glossary at [www.healthcare.gov/sbc-glossary/](http://www.healthcare.gov/sbc-glossary/) or call (855) 397-9267 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall deductible?</b>	\$1,000/member or \$3,000/family for In- <u>Network Providers</u> . \$1,000/member or \$3,000/family for <u>Out-of-Network Providers</u> .	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
<b>Are there services covered before you meet your deductible?</b>	Yes. Primary Care. <u>Specialist Visit</u> . <u>Preventive Care</u> . For more information see below.	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <a href="#">plan</a> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other deductibles for specific services?</b>	No.	You don't have to meet <u>deductibles</u> for specific services.
<b>What is the out-of-pocket limit for this plan?</b>	\$9,100/member or \$18,200/family for In- <u>Network Providers</u> . \$18,200/member or \$36,400/family for <u>Out-of-Network Providers</u> .	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
<b>What is not included in the out-of-pocket limit?</b>	<u>Premiums</u> , <u>balance-billing</u> charges, health care this <a href="#">plan</a> doesn't cover, and <u>Out-of-Network Transplants</u> .	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
<b>Will you pay less if you use a network provider?</b>	Yes. See <a href="http://www.anthem.com/find-care/?alphaprefix=ZRX">www.anthem.com/find-care/?alphaprefix=ZRX</a> or call (855) 397-9267 for a list of <u>network providers</u> . Costs may	This <a href="#">plan</a> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <a href="#">plan's</a> <u>network</u> . You will pay the most if you use an <u>Out-of-Network Provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <a href="#">plan</a> pays ( <u>balance billing</u> ). Be aware, your <u>network provider</u> might use an <u>Out-of-Network Provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.

	vary by site of service and how the <u>provider</u> bills.	
<b>Do you need a <u>referral</u> to see a <u>specialist</u>?</b>	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .

 All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$35/visit, <u>deductible</u> does not apply	30% <u>coinsurance</u>	Virtual visits (Telehealth) benefits available.
	<u>Specialist</u> visit	\$45/visit, <u>deductible</u> does not apply	30% <u>coinsurance</u>	Virtual visits (Telehealth) benefits available.
	<u>Preventive care</u> / <u>screening</u> /immunization	No charge	30% <u>coinsurance</u>	<u>Out-of-Network preventive care</u> services for children prior to their 6th birthday have no <u>deductible</u> . You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	No charge	30% <u>coinsurance</u>	-----none-----
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u>	30% <u>coinsurance</u>	-----none-----
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at <a href="http://www.[insert]">www.[insert]</a> .	Typically Generic (Tier 1)	Not covered (retail and home delivery)	Not covered (retail and home delivery)	Carved out to ESI
	Typically Preferred Brand & Non-Preferred Generic Drugs (Tier 2)	Not covered (retail and home delivery)	Not covered (retail and home delivery)	
	Typically Non-Preferred Brand and Generic drugs (Tier 3)	Not covered (retail and home delivery)	Not covered (retail and home delivery)	
	Typically Preferred <u>Specialty</u> (brand and generic) (Tier 4)	Not covered (retail and home delivery)	Not covered (retail and home delivery)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	30% <u>coinsurance</u>	-----none-----
	Physician/surgeon fees	20% <u>coinsurance</u>	30% <u>coinsurance</u>	-----none-----

\* For more information about limitations and exceptions, see the plan or policy document at <https://eoc.anthem.com/eocdps/aso>.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	<u>Emergency room care</u>	\$200/visit, then 20% <u>coinsurance</u>	Covered as In- <u>Network</u>	<u>Copayment</u> , <u>coinsurance</u> and <u>deductible</u> waived if admitted.
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	Covered as In- <u>Network</u>	Non-emergency <u>Out-of-Network</u> Ambulance Services are limited to \$50,000 per trip.
	<u>Urgent care</u>	\$60/visit, <u>deductible</u> does not apply	30% <u>coinsurance</u>	-----none-----
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	30% <u>coinsurance</u>	30 days/benefit period for Inpatient rehabilitation and skilled nursing services combined.
	Physician/surgeon fees	20% <u>coinsurance</u>	30% <u>coinsurance</u>	-----none-----
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visit \$35/visit, <u>deductible</u> does not apply Other Outpatient 20% <u>coinsurance</u>	Office Visit 30% <u>coinsurance</u> Other Outpatient 30% <u>coinsurance</u>	Office Visit Virtual visits (Telehealth) benefits available. Other Outpatient -----none-----
	Inpatient services	20% <u>coinsurance</u>	30% <u>coinsurance</u>	-----none-----
If you are pregnant	Office visits	20% <u>coinsurance</u>	30% <u>coinsurance</u>	Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	20% <u>coinsurance</u>	30% <u>coinsurance</u>	
	Childbirth/delivery facility services	20% <u>coinsurance</u>	30% <u>coinsurance</u>	
If you need help recovering or have other special health needs	<u>Home health care</u>	20% <u>coinsurance</u>	30% <u>coinsurance</u>	120 visits/benefit period for Home Health and Private Duty Nursing combined.
	<u>Rehabilitation services</u>	20% <u>coinsurance</u>	30% <u>coinsurance</u>	*See Therapy Services section.
	<u>Habilitation services</u>	20% <u>coinsurance</u>	30% <u>coinsurance</u>	
	<u>Skilled nursing care</u>	20% <u>coinsurance</u>	30% <u>coinsurance</u>	30 days/benefit period for Inpatient rehabilitation and skilled nursing services combined.
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	30% <u>coinsurance</u>	*See <u>Durable Medical Equipment</u> section.
	<u>Hospice services</u>	No charge	No charge	-----none-----
	Children's eye exam	Not covered	Not covered	-----none-----
	Children's glasses	Not covered	Not covered	

\* For more information about limitations and exceptions, see the plan or policy document at <https://eoc.anthem.com/eocdps/aso>.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If your child needs dental or eye care	Children's dental check-up	Not covered	Not covered	-----none-----

**Excluded Services & Other Covered Services:**

**Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)**

- |  |  |   |
|--|--|---|
| <ul style="list-style-type: none"> <li>• Acupuncture</li> <li>• Cosmetic surgery</li> <li>• Glasses for a child</li> <li>• Routine eye care (Adult)</li> </ul> | <ul style="list-style-type: none"> <li>• Bariatric surgery</li> <li>• Dental care (Adult)</li> <li>• Infertility treatment</li> <li>• Routine foot care unless <u>medically necessary</u></li> </ul> | <ul style="list-style-type: none"> <li>• Children's dental check-up</li> <li>• Eye exams for a child</li> <li>• Long-term care</li> <li>• Weight loss programs</li> </ul> |
|--|--|---|

**Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)**

- |   |  |  |
|---|--|--|
| <ul style="list-style-type: none"> <li>• Hearing aids 1 item(s)/hearing-impaired ear every 48 months for children 18 years of age or under. \$3,000 maximum/hearing aid.</li> <li>• Spinal Manipulation 30 visits/year</li> </ul> | <ul style="list-style-type: none"> <li>• Most coverage provided outside the United States. See <a href="http://www.bcbsglobalcore.com">www.bcbsglobalcore.com</a></li> </ul> | <ul style="list-style-type: none"> <li>• Private-duty nursing 120 visits/benefit period combined with Home Health</li> </ul> |
|---|--|--|

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Georgia Office of Insurance and Safety Fire Commissioner, Consumer Services Division, 2 Martin Luther King, Jr. Drive, West Tower, Suite 716, Atlanta, Georgia 30334, (800) 656-2298, [www.oci.ga.gov/ConsumerService/Home.aspx](http://www.oci.ga.gov/ConsumerService/Home.aspx), Department of Labor, Employee Benefits Security Administration, (866) 444-EBSA (3272), [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform), or contact Anthem at the number on the back of your ID card. Other coverage options may be available to you, too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit [www.HealthCare.gov](http://www.HealthCare.gov) or call 1-800-318-2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact:

ATTN: Grievances and Appeals, P.O. Box 105449, Atlanta, GA 30548-5449

Department of Labor, Employee Benefits Security Administration, (866) 444-EBSA (3272), [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform)

\* For more information about limitations and exceptions, see the plan or policy document at <https://eoc.anthem.com/eocdps/aso>.

Additionally, a consumer assistance program can help you file your appeal. Contact Georgia Office of Insurance and Safety Fire Commissioner Customer Services Division, 2 Martin Luther King, Jr. Drive West Tower, Suite 702 Atlanta, GA 30334, (800) 656-2298, <https://oci.georgia.gov/insurance-resources/health>

**Does this plan provide Minimum Essential Coverage? Yes/No.**

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

**Does this plan meet the Minimum Value Standards? Yes/No.**

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

*To see examples of how this plan might cover costs for a sample medical situation, see the next section.*

## About these Coverage Examples:



**This is not a cost estimator.** Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost-sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby (9 months of in-network pre-natal care and a hospital delivery)		Managing Joe's Type 2 Diabetes (a year of routine in-network care of a well-controlled condition)		Mia's Simple Fracture (in-network emergency room visit and follow up care)	
■ The <u>plan's</u> overall <u>deductible</u>	\$1,000	■ The <u>plan's</u> overall <u>deductible</u>	\$1,000	■ The <u>plan's</u> overall <u>deductible</u>	\$1,000
■ <u>Specialist copayment</u>	\$45	■ <u>Specialist copayment</u>	\$45	■ <u>Specialist copayment</u>	\$45
■ <u>Hospital (facility) coinsurance</u>	20%	■ <u>Hospital (facility) coinsurance</u>	20%	■ <u>Hospital (facility) coinsurance</u>	20%
■ <u>Other coinsurance</u>	0%	■ <u>Other coinsurance</u>	0%	■ <u>Other coinsurance</u>	0%
<p><b>This EXAMPLE event includes services like:</b>  <u>Specialist office visits (prenatal care)</u>  <u>Childbirth/Delivery Professional Services</u>  <u>Childbirth/Delivery Facility Services</u>  <u>Diagnostic tests (ultrasounds and blood work)</u>  <u>Specialist visit (anesthesia)</u></p>		<p><b>This EXAMPLE event includes services like:</b>  <u>Primary care physician office visits (including disease education)</u>  <u>Diagnostic tests (blood work)</u>  <u>Prescription drugs</u>  <u>Durable medical equipment (glucose meter)</u></p>		<p><b>This EXAMPLE event includes services like:</b>  <u>Emergency room care (including medical supplies)</u>  <u>Diagnostic test (x-ray)</u>  <u>Durable medical equipment (crutches)</u>  <u>Rehabilitation services (physical therapy)</u></p>	
<b>Total Example Cost</b>	<b>\$12,700</b>	<b>Total Example Cost</b>	<b>\$5,600</b>	<b>Total Example Cost</b>	<b>\$2,800</b>
<b>In this example, Peg would pay:</b>		<b>In this example, Joe would pay:</b>		<b>In this example, Mia would pay:</b>	
<u>Cost Sharing</u>		<u>Cost Sharing</u>		<u>Cost Sharing</u>	
<u>Deductibles</u>	\$1,000	<u>Deductibles</u>	\$0	<u>Deductibles</u>	\$1,000
<u>Copayments</u>	\$0	<u>Copayments</u>	\$400	<u>Copayments</u>	\$100
<u>Coinsurance</u>	\$2,000	<u>Coinsurance</u>	\$0	<u>Coinsurance</u>	\$300
<i>What isn't covered</i>		<i>What isn't covered</i>		<i>What isn't covered</i>	
Limits or exclusions	\$70	Limits or exclusions	\$4,300	Limits or exclusions	\$10
<b>The total Peg would pay is</b>	<b>\$3,070</b>	<b>The total Joe would pay is</b>	<b>\$4,700</b>	<b>The total Mia would pay is</b>	<b>\$1,410</b>

The plan would be responsible for the other costs of these EXAMPLE covered services.



## Language Access Services:

(TTY/TDD: 711)

**Albanian (Shqip):** Nëse keni pyetje në lidhje me këtë dokument, keni të drejtë të merrni falas ndihmë dhe informacion në gjuhën tuaj. Për të kontaktuar me një përkthyes, telefononi (855) 397-9267

**Amharic (አማርኛ):** ስለዚህ ሰነድ ማንኛውም ጥያቄ ካለዎት በራስዎ ቋንቋ እርዳታ እና ይህን መረጃ በገና የማግኘት መብት አለዎት። አስተርጓሚ ለማናገር (855) 397-9267 ይደውሉ።

**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:

**Bassa (Bàsɔ̀ Wùdù):** M̄ dyi dyi-diè-djè b̄é b̄édjé b̄á céè-djè nià ke dyí ní, ɔ̀ m̀ò nì dyí-b̄édjèin-djè b̄é m̀ ké gbo-kpá-kpá kè b̄ɔ̀ kpɔ̀ djé m̀ b̄ídjí-wùdùùn b̄ó pídyi. B̄é m̀ ké wuɖu-zìin-nyò d̀ò gbo wùdù ke, d̀á (855) 397-9267.

**Bengali (বাংলা):** যদি এই নথিপত্রের বিষয়ে আপনার কোনো প্রশ্ন থাকে, তাহলে আপনার ভাষায় বিনামূল্যে সাহায্য পাওয়ার ও তথ্য পাওয়ার অধিকার আপনার আছে। একজন দোভাষীর সাথে কথা বলার জন্য (855) 397-9267 -তে কল করুন।

**Burmese (မြန်မာ):** ဤစာရွက်စာတမ်းနှင့် ပတ်သက်၍ သင့်တွင် မေးမြန်းလိုသည်များရှိပါက အချက်အလက်များနှင့် အကူအညီကို အခကြေးငွေ ပေးစရာမလိုပဲ သင့်ဘာသာစကားဖြင့် ရယူနိုင်ခွင့် သင့်တွင် ရှိပါသည်။ စကားပြန် တစ်ဦးနှင့် စကားပြောနိုင်ရန် ဖု (855) 397-9267 သို့ ခေါ်ဆိုပါ။

**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。

**Dinka (Dinka):** Na nɔŋ thiëc në ke de yä thorë, ke yin nɔŋ loŋ bē yi kuony ku wër alëu bē gɛɛr yic yin ne thoŋ du ke cin wëu tääuë ke piny. Te kør yin ba jam wënë ran ye thok geryic, ke yin cəl (855) 397-9267.

**Dutch (Nederlands):** Bij vragen over dit document hebt u recht op hulp en informatie in uw taal zonder bijkomende kosten. Als u een tolk wilt spreken, belt u (855) 397-9267.

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

## Language Access Services:

**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.

**German (Deutsch):** Wenn Sie Fragen zu diesem Dokument haben, haben Sie Anspruch auf kostenfreie Hilfe und Information in Ihrer Sprache. Um mit einem Dolmetscher zu sprechen, bitte wählen Sie (855) 397-9267.

**Greek (Ελληνικά)** Αν έχετε τυχόν απορίες σχετικά με το παρόν έγγραφο, έχετε το δικαίωμα να λάβετε βοήθεια και πληροφορίες στη γλώσσα σας δωρεάν. Για να μιλήσετε με κάποιον διερμηνέα, τηλεφωνήστε στο (855) 397-9267.

**Gujarati (ગુજરાતી):** જો આ દસ્તાવેજ અંગે આપને કોઈપણ પ્રશ્નો હોય તો, કોઈપણ ખર્ચ વગર આપની ભાષામાં મદદ અને માહિતી મેળવવાનો તમને અધિકાર છે. દુભાષિયા સાથે વાત કરવા માટે, કોલ કરો (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 entèprèt, rele (855) 397-9267.

**Hindi (हिंदी):** अगर आपके पास इस दस्तावेज़ के बारे में कोई प्रश्न हैं, तो आपको निःशुल्क अपनी भाषा में मदद और जानकारी प्राप्त करने का अधिकार है। दुभाषिये से बात करने के लिए, कॉल करें (855) 397-9267 ।

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