Your summary of benefits

Meriwether County BOC

Anthem® Blue Cross and Blue Shield

Your Plan: Anthem Blue Open Access POS OAP5 6000/0%/8150 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	$6,000 member / $12,000 family	$12,000 member / $24,000 family
Out-of-Pocket Limit	$8,150 member / $16,300 family	$15,000 member / $30,000 family
The family deductible and out-of-pocket maximum are embedded, meaning the cost shares of one family member will be applied to both per member deductible and per member 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 per member deductible or per member out-of-pocket maximum. Your copays, coinsurance and deductible count toward your out of pocket amount(s). In-network and out-of-network deductibles and out-of-pocket maximum amounts are separate and do not accumulate toward each other.		
Preventive Care / Screening / Immunization	No charge	30% coinsurance after deductible is met
Preventive Care for Chronic Conditions *per IRS guidelines*	No charge	30% coinsurance after deductible is met
Virtual Care (Telemedicine / Telehealth Visits) **Virtual Visits - Online visits with Doctors who also provide services in person**		
Primary Care (PCP)	$30 copay per visit deductible does not apply	30% coinsurance after deductible is met
Mental Health and Substance Abuse care	$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
Specialist	$60 copy per visit deductible does not apply	30% coinsurance after deductible is met
Medical Chats and Virtual (Video) Visits for Primary Care from our Online Provider K Health, through its affiliated Provider groups	No charge	
Virtual Visits from Online Provider LiveHealth Online *via www.livehealthonline.com; our mobile app, website or Anthem-enabled device*		
Primary Care (PCP) and Mental Health and Substance Abuse	$5 copy per visit deductible does not apply	
Specialist Care	$60 copy per visit deductible does not apply	
Visits in an Office		
Primary Care (PCP)	$30 copy per visit deductible does not apply	30% coinsurance after deductible is met
Specialist Care	$60 copy per visit deductible does not apply	30% coinsurance after deductible is met
Other Practitioner Visits		
Routine Maternity Care (Prenatal and Postnatal)	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Retail Health Clinic Visit	$30 copy per visit deductible does not apply	30% coinsurance after deductible is met
Manipulation Therapy *Coverage is limited to 20 visits per year.*	$30 copy per visit deductible does not apply	30% coinsurance after deductible is met
Acupuncture	Not covered	Not covered
Other Services in an Office		
Allergy Testing	$60 copy per visit deductible does not apply‡	30% coinsurance after deductible is met
Chemo/Radiation Therapy	0% 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
Dialysis/Hemodialysis	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Prescription Drugs *Dispensed in the office*	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Surgery	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Diagnostic Services **Lab**		
Office	$60 copay per visit deductible does not apply‡	30% coinsurance after deductible is met
Freestanding Lab/Reference Lab	No charge	30% coinsurance after deductible is met
Outpatient Hospital	0% coinsurance after deductible is met	30% coinsurance after deductible is met
X-Ray		
Office	$60 copay per visit 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	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Advanced Diagnostic Imaging *for example: MRI, PET and CAT scans*		
Office	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Freestanding Radiology Center	0% coinsurance deductible does not apply	30% coinsurance after deductible is met
Outpatient Hospital	0% 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
Emergency and Urgent Care		
Urgent Care	$50 copay per visit deductible does not apply	30% coinsurance after deductible is met
Emergency Room Facility Services	$500 copay per visit and 0% coinsurance 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	0% coinsurance after deductible is met	Covered as In-Network
Outpatient Mental Health and Substance Abuse		
Doctor Office Visit	$30 copay per visit deductible does not apply	30% coinsurance after deductible is met
Facility Visit		
Facility Fees	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Doctor Services	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Outpatient Surgery		
Facility Fees		
Hospital	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Freestanding Surgical Center	$200 copay per visit deductible does not apply	30% coinsurance after deductible is met
Doctor and Other Services		
Hospital	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Freestanding Surgical Center	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
Hospital (Including Maternity, Mental Health and Substance Abuse)		
Facility Fees	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Doctor and other services	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Recovery & Rehabilitation		
Home Health Care *Coverage is limited to 100 visits per benefit period.*	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Rehabilitation services *Coverage for rehabilitative and habilitative physical therapy and occupational therapy combined is limited to 20 visits per year. Coverage for rehabilitative and habilitative speech therapy is limited to 20 visits per year.*		
Office	$30 copay per visit deductible does not apply	30% coinsurance after deductible is met
Outpatient Hospital	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Cardiac rehabilitation		
Office	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Outpatient Hospital	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Skilled Nursing Care (facility) *Coverage is limited to 60 days per benefit period.*	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Inpatient Hospice	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Durable Medical Equipment	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Prosthetic Devices *Coverage for wigs is limited to 1 item after cancer treatment per benefit period.*	0% coinsurance after deductible is met	30% coinsurance after deductible is met

Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use a Non-Network Pharmacy
Pharmacy Deductible	Not applicable	Not applicable
Pharmacy Out-of-Pocket Limit	Combined with In-Network medical out-of-pocket limit	Combined with Non-Network medical out-of-pocket limit
Prescription Drug Coverage *Cost shares for drugs included on the Essential drug list appear below. Drugs not included on the Essential drug list will not be covered. Your plan uses the Base Network. You may receive up to a 90 day supply of medication at Retail 90 pharmacies.*		
Home Delivery Pharmacy *Maintenance medication are available through IngenioRx 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.*		
Tier 1 - Typically Generic *Per 30 day supply (retail pharmacy and Retail 90 pharmacy). Per 90 day supply (home delivery).*	$15 copay per prescription, deductible does not apply (retail and home delivery)	$15 copay per prescription, deductible does not apply (retail only)
Tier 2 – Typically Preferred Brand *Per 30 day supply (retail pharmacy and Retail 90 pharmacy). Per 90 day supply (home delivery).*	$50 copay per prescription, deductible does not apply (retail) and $125 copay per prescription, deductible does not apply (home delivery)	$50 copay per prescription, deductible does not apply (retail only)
Tier 3 - Typically Non-Preferred Brand *Per 30 day supply (retail pharmacy and Retail 90 pharmacy). Per 90 day supply (home delivery).*	$75 copay per prescription, deductible does not apply (retail) and $190 copay per prescription, deductible does not apply (home delivery)	$75 copay per prescription, deductible does not apply (retail only)
Tier 4 - Typically Specialty (brand and generic) *Per 30 day supply (specialty pharmacy).*	25% coinsurance up to $350 per prescription, deductible does not apply (retail and home delivery)	25% coinsurance up to $350 per prescription, deductible does not apply (retail only)

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.
- ‡ Your cost share will be reduced when services are provided in a PCP's office.
- When using a non-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.

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(TTY/TDD: 711)

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