

Your summary of benefits



Anthem® Blue Cross and Blue Shield

Your Plan: Ram Partners: Anthem Blue Open Access POS HSAOAP8 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	\$5,000 member / \$10,000 family	\$15,000 member / \$30,000 family
Overall Out-of-Pocket Limit	\$6,900 member / \$13,800 family	\$20,700 member / \$41,400 family
<p>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.</p> <p>Your copays, coinsurance and deductible count toward your out of pocket limit(s).</p> <p>In-Network and Non-Network deductibles and out-of-pocket limit amounts are separate and do not accumulate toward each other.</p>		
<p>Doctor Visits (virtual and office) <i>You are encouraged to select a Primary Care Physician (PCP).</i></p>		
<p>Medical Chats and Virtual Visits for Primary Care <i>from our Online Provider K Health, through its affiliated Provider groups are covered at 0% coinsurance after deductible is met.</i></p>		
<p>Virtual Visits from online provider LiveHealth Online <i>for urgent/acute medical and mental health and substance abuse care via www.livehealthonline.com are covered at \$5 copay per visit after deductible is met.</i></p>		
<p>Primary Care (PCP) and Mental Health and Substance Abuse Care <i>virtual and office</i></p>	0% coinsurance after deductible is met	50% coinsurance after deductible is met
<p>Specialist Care <i>virtual and office</i></p>	0% coinsurance after deductible is met	50% coinsurance after deductible is met
<p>Other Practitioner Visits</p>		
<p>Routine Maternity Care (Prenatal and Postnatal)</p>	0% coinsurance after deductible is met	50% coinsurance after deductible is met
<p>Retail Health Clinic Visit <i>for routine care and treatment of common illnesses; usually found in major pharmacies or retail stores.</i></p>	0% coinsurance after deductible is met	50% coinsurance after deductible is met

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Questions: (855) 397-9267 or visit us at www.anthem.com

GA/LG/Ram Partners: Anthem Blue Open Access POS HSAOAP8 AE/6HK3/01-01-2023

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<p>Manipulation Therapy <i>Coverage is limited to 20 visits per year.</i></p> <p>Acupuncture</p>	<p>0% coinsurance after deductible is met</p> <p>Not covered</p>	<p>50% coinsurance after deductible is met</p> <p>Not covered</p>
<p><u>Other Services in an Office</u></p> <p>Allergy Testing</p> <p>Prescription Drugs <i>Dispensed in the office</i></p> <p>Surgery</p>	<p>0% coinsurance after deductible is met</p> <p>0% coinsurance after deductible is met</p> <p>0% coinsurance after deductible is met</p>	<p>50% coinsurance after deductible is met</p> <p>50% coinsurance after deductible is met</p> <p>50% coinsurance after deductible is met</p>
<p>Preventive care / screenings / immunizations</p>	<p>No charge</p>	<p>50% coinsurance after deductible is met</p>
<p>Preventive Care for Chronic Conditions <i>per IRS guidelines</i></p>	<p>No charge</p>	<p>50% coinsurance after deductible is met</p>
<p><u>Diagnostic Services</u></p> <p>Lab</p> <p>Office</p> <p>Freestanding Lab/Reference Lab</p> <p>Outpatient Hospital</p>	<p>0% coinsurance after deductible is met</p> <p>0% coinsurance after deductible is met</p> <p>0% coinsurance after deductible is met</p>	<p>50% coinsurance after deductible is met</p> <p>50% coinsurance after deductible is met</p> <p>50% coinsurance after deductible is met</p>
<p>X-Ray</p> <p>Office</p> <p>Freestanding Radiology Center</p> <p>Outpatient Hospital</p>	<p>0% coinsurance after deductible is met</p> <p>0% coinsurance after deductible is met</p> <p>0% coinsurance after deductible is met</p>	<p>50% coinsurance after deductible is met</p> <p>50% coinsurance after deductible is met</p> <p>50% coinsurance after deductible is met</p>
<p>Advanced Diagnostic Imaging <i>for example: MRI, PET and CAT scans</i></p> <p>Office</p>	<p>0% coinsurance after deductible is met</p>	<p>50% coinsurance after deductible is met</p>

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Freestanding Radiology Center Outpatient Hospital	0% coinsurance after deductible is met 0% coinsurance after deductible is met	50% coinsurance after deductible is met 50% coinsurance after deductible is met
<u>Emergency and Urgent Care</u> Urgent Care Emergency Room Facility Services Emergency Room Doctor and Other Services Ambulance	0% coinsurance after deductible is met 0% coinsurance after deductible is met 0% coinsurance after deductible is met 0% coinsurance after deductible is met	50% coinsurance after deductible is met Covered as In-Network Covered as In-Network Covered as In-Network
<u>Outpatient Mental Health and Substance Abuse Care at a Facility</u> Facility Fees Doctor Services	0% coinsurance after deductible is met 0% coinsurance after deductible is met	50% coinsurance after deductible is met 50% coinsurance after deductible is met
<u>Outpatient Surgery</u> Facility Fees Hospital Ambulatory Surgical Center Doctor and Other Services Hospital Ambulatory Surgical Center	0% coinsurance after deductible is met 0% coinsurance after deductible is met 0% coinsurance after deductible is met 0% coinsurance after deductible is met	50% coinsurance after deductible is met 50% coinsurance after deductible is met 50% coinsurance after deductible is met 50% coinsurance after deductible is met
<u>Hospital (Including Maternity, Mental Health and Substance Abuse)</u> Facility Fees Physician and other services <i>including surgeon fees</i>	0% coinsurance after deductible is met 0% coinsurance after deductible is met	50% coinsurance after deductible is met 50% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Home Health Care <i>Coverage is limited to 100 visits per benefit period. Limits are combined for all home health services.</i>	0% coinsurance after deductible is met	50% coinsurance after deductible is met
Rehabilitation and Habilitation services <i>including physical, occupational and speech therapies.</i> <i>Coverage for physical and occupational therapies is limited to 20 visits combined per year. Coverage for speech therapy is limited to 20 visits per year.</i> Office Outpatient Hospital	0% coinsurance after deductible is met	50% coinsurance after deductible is met
Pulmonary rehabilitation <i>office and outpatient hospital</i>	0% coinsurance after deductible is met	50% coinsurance after deductible is met
Cardiac rehabilitation <i>office and outpatient hospital</i>	0% coinsurance after deductible is met	50% coinsurance after deductible is met
Dialysis/Hemodialysis <i>office and outpatient hospital</i>	0% coinsurance after deductible is met	50% coinsurance after deductible is met
Chemo/Radiation Therapy <i>office and outpatient hospital</i>	0% coinsurance after deductible is met	50% coinsurance after deductible is met
Skilled Nursing Care (facility) <i>Coverage for Inpatient rehabilitation and skilled nursing services is limited to 60 days combined per benefit period.</i>	0% coinsurance after deductible is met	50% coinsurance after deductible is met
Inpatient Hospice	0% coinsurance after deductible is met	50% coinsurance after deductible is met
Durable Medical Equipment	0% coinsurance after deductible is met	50% coinsurance after deductible is met
Prosthetic Devices	0% coinsurance after deductible is met	50% coinsurance after deductible is met
Hearing Aids <i>Coverage is limited to 1 item per hearing-impaired ear up to \$3,000 per ear, every 48 months for members through age 18.</i>	0% coinsurance after deductible is met	50% 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	Combined with In-Network medical deductible	Combined with Non-Network medical deductible
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 Network: <i>Base Network</i> Drug List: <i>Essential Drugs not included on the Essential drug list will not be covered.</i>		
Day Supply Limits: Retail Pharmacy 30 day supply (cost shares noted below) Retail 90 Pharmacy 90 day supply (cost shares noted below) Home Delivery Pharmacy 90 day supply (maximum cost shares noted below) Maintenance medications are available through CarelonRx Mail (IngenioRx will become CarelonRx on January 1, 2023). You will need to call us on the number on your ID card to sign up when you first use the service. 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. Drug cost share assistance programs may be available for certain specialty drugs.		
Tier 1 - Typically Generic <i>each 90 day supply script filled at Retail 90 pharmacies is subject to one 30 day supply cost share charged at In-Network Retail Pharmacies.</i>	\$15 copay per prescription after deductible is met (retail and home delivery)	\$15 copay per prescription after deductible is met (retail only)
Tier 2 – Typically Preferred Brand <i>each 90 day supply script filled at Retail 90 pharmacies is subject to two times the 30 day supply cost share charged at In-Network Retail Pharmacies.</i>	\$35 copay per prescription after deductible is met (retail) and \$70 copay per prescription after deductible is met (home delivery)	\$35 copay per prescription after deductible is met (retail only)
Tier 3 - Typically Non-Preferred Brand <i>each 90 day supply script filled at Retail 90 pharmacies is subject to 3 times the 30 day supply cost share charged at In-Network Retail Pharmacies.</i>	\$60 copay per prescription after deductible is met (retail) and \$180 copay per prescription after deductible is met (home delivery)	\$60 copay per prescription after deductible is met (retail only)
Tier 4 - Typically Specialty (brand and generic)	25% coinsurance up to \$350 per prescription after deductible is met	25% coinsurance up to \$350 per prescription after deductible is met (retail only)

Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use a Non-Network Pharmacy
	(retail and home delivery)	

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.
- 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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Get help in your language

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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

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(TTY/TDD: 711)

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Language Access Services:

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