

## Atlanta Plumbers Local 72

### 2025 Summary of Benefits

#### PPO Plan 10PHD

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#### About this Plan:

Anthem Blue Cross and Blue Shield gives you the tools and resources to make the best decisions for your health, like this summary of benefits. It's a snapshot of your plan's covered benefits and services and what they cost. This Summary of Benefits doesn't list every service we cover or every limitation or exclusion. For more details about your benefits and services, please review your *Evidence of Coverage* (EOC). You can access your EOC online by logging into the member portal at [www.anthem.com](http://www.anthem.com), or you can call Member Services with any questions you may have.

**Doctor and hospital choice:** You may go to doctors, specialists, and hospitals in or out of the network. You do not need a referral.

This plan offers coverage in our Centers for Medicare & Medicaid Services (CMS) defined geographic service area of all 50 states, Washington, DC, and all United States territories.

**How much is the monthly premium?:**

Contact your group plan benefit administrator to determine your actual premium amount, if applicable.

#### Questions?

Call our **Member Services Team** for answers or plan details and provide them with this group specific code GA011GRS.

Prospective Members, please contact your benefit administrator. When you enroll in the plan you will receive information that tells you where to go online to view your *Evidence of Coverage*.

## Anthem Medicare Preferred (PPO) Benefits Effective: 01/01/2025 – 12/31/2025

Plan Features	In-network:	Out-of-network:
<b>Annual medical deductible:</b>	\$50 combined in-network and out-of-network	
<b>Maximum out-of-pocket responsibility: (Does not include Part D prescription drugs)</b>	\$3,400 combined in-network and out-of-network	

Covered benefits	In-network, members pay:	Out-of-network, members pay:
<b>Inpatient hospital care*</b> No limit to the number of days covered by the plan	\$0 copay per admission	\$0 copay per admission
<b>Outpatient hospital facility or ambulatory surgical center visit for surgery*</b>	\$0 copay per visit	\$0 copay per visit
<b>Outpatient hospital services observation room</b>	\$0 copay per visit	\$0 copay per visit
<b>Primary care office visit</b>	\$10 copay per visit	\$10 copay per visit
<b>Specialty care office visit</b>	\$20 copay per visit	\$20 copay per visit
<b>Preventive care, screenings, and tests</b>	\$0 copay per visit	\$0 copay per visit
<b>Emergency care</b>	\$75 copay per visit \$75 copay is waived if the member is admitted to the hospital within 72 hours for the same condition.	
<b>Urgently needed services</b>	\$20 copay per visit \$20 copay is waived if the member is admitted to the hospital within 72 hours for the same condition.	
<b>X-ray visit and/or simple diagnostic test*</b>	\$20 copay per visit	\$20 copay per visit
<b>Complex diagnostic test and/or radiology visit*</b>	\$50 copay per visit	\$50 copay per visit
<b>Radiation therapy treatment*</b>	\$20 copay per visit	\$20 copay per visit

Covered benefits	In-network, members pay:	Out-of-network, members pay:
<b>Clinical/diagnostic lab test*</b>	\$0 copay per visit	\$0 copay per visit
<b>Medicare-covered basic hearing and balance exams performed by your specialist*</b>	\$20 copay per visit	\$20 copay per visit
<p><b>Routine hearing services</b> We have partnered with Hearing Care Solutions to bring you these discounts and services.</p>	<p>Must use a Hearing Care Solutions participating provider.</p> <p><b>Hearing exams</b> \$0 copay for routine hearing exams 1 exam every calendar year combined in-network and out-of-network</p> <p><b>Hearing aids fitting evaluation</b> \$0 copay for hearing aid fitting evaluations 1 evaluation per covered hearing aid combined in-network and out-of-network</p> <p><b>Routine hearing exams and fitting evaluations limit</b> \$70 maximum benefit every calendar year combined in-network and out-of-network</p> <p><b>Hearing aids</b> \$0 copay for hearing aids \$500 benefit per ear with a \$1,000 maximum benefit every three calendar years</p>	<p>Out-of-network providers must order hearing aids through Hearing Care Solutions.</p> <p><b>Hearing exams</b> \$0 copay for routine hearing exams 1 exam every calendar year combined in-network and out-of-network</p> <p><b>Hearing aids fitting evaluation</b> \$0 copay for hearing aid fitting evaluations 1 evaluation per covered hearing aid combined in-network and out-of-network</p> <p><b>Routine hearing exams and fitting evaluations limit</b> \$70 maximum benefit every calendar year combined in-network and out-of-network</p> <p><b>Hearing aids</b> \$0 copay for hearing aids through Hearing Care Solutions \$500 benefit per ear with a \$1,000 maximum benefit every three calendar years</p>
<b>Medicare-covered dental is non-routine care performed by your specialist*</b>	\$20 copay per visit	\$20 copay per visit

Covered benefits	In-network, members pay:	Out-of-network, members pay:
<b>Routine dental services</b>	<p>Must use a LIBERTY Dental participating provider.</p> <p><b>Oral exams</b> \$0 copay for oral exams 2 oral exams every calendar year combined in-network and out-of-network</p> <p><b>Cleanings</b> \$0 copay for cleaning 2 cleanings every calendar year combined in-network and out-of-network</p> <p><b>X-rays</b> \$0 copay for X-rays 1 full mouth or panoramic X-ray every calendar year combined in-network and out-of-network</p>	<p><b>Oral exams</b> 30% coinsurance for oral exams 2 oral exams every calendar year combined in-network and out-of-network</p> <p><b>Cleanings</b> 30% coinsurance for cleaning 2 cleanings every calendar year combined in-network and out-of-network</p> <p><b>X-rays</b> 30% coinsurance for X-rays 1 full mouth or panoramic X-ray every calendar year combined in-network and out-of-network</p>
<b>Medicare-covered exams performed by your specialist to diagnose and treat eye diseases and conditions</b>	\$20 copay per visit	\$20 copay per visit
<b>Medicare-covered glaucoma screening</b>	\$0 copay per visit	\$0 copay per visit
<b>Medicare-covered eyewear following cataract surgery</b>	\$20 copay per surgery	\$20 copay per surgery

Covered benefits	In-network, members pay:	Out-of-network, members pay:
<b>Routine vision services</b>	<p>Must use a Blue View Vision provider.</p> <p><b>Exams</b> \$0 copay for routine vision exams 1 exam every calendar year combined in-network and out-of-network</p> <p><b>Eyewear</b> \$0 copay for eyewear \$100 maximum benefit every two calendar years combined in-network and out-of-network</p>	<p><b>Exams</b> \$70 reimbursement for routine vision exams 1 exam every calendar year combined in-network and out-of-network</p> <p><b>Eyewear</b> \$100 reimbursement for eyewear, maximum benefit every two calendar years combined in-network and out-of-network</p>
<p><b>Inpatient services in a psychiatric hospital*</b> No limit to the number of days covered by the plan</p>	\$0 copay per admission	\$0 copay per admission
<p><b>Mental health professional individual therapy visit</b></p>	\$20 copay per visit	\$20 copay per visit
<p><b>Substance use disorder professional individual therapy visit</b></p>	\$20 copay per visit	\$20 copay per visit
<p><b>Skilled nursing facility (SNF) care*</b></p>	<p>\$0 copay for days 1-100 per benefit period</p> <p>100-day limit per benefit period</p>	<p>\$0 copay for days 1-100 per benefit period</p> <p>100-day limit per benefit period</p>
<p><b>Outpatient rehabilitation services*</b></p>	\$20 copay per visit	\$20 copay per visit
<p><b>Ambulance services</b></p>	<p>Your provider must get an approval from the plan before you get ground, air, or water transportation that is not an emergency.</p> <p>\$50 copay per one-way trip for ambulance services</p>	

Covered benefits	In-network, members pay:	Out-of-network, members pay:
<b>Medicare Part B prescription drugs*</b>	20% coinsurance for Part B drugs	20% coinsurance for Part B drugs
<b>Chiropractic services*</b> Medicare-covered	\$20 copay per visit	\$20 copay per visit
<b>Acupuncture for chronic low back pain*</b> Medicare-covered	\$10 copay per visit	\$10 copay per visit
<b>Cardiac rehabilitation services*</b>	\$0 copay per visit	\$0 copay per visit
<b>Pulmonary rehabilitation services*</b>	\$20 copay per visit	\$20 copay per visit
<b>Blood glucose test strips, lancets, lancet devices, and glucose control solutions</b> For a 30 day supply	<b>If purchased through a pharmacy:</b>  \$0 copay per purchase of OneTouch® (made by LifeScan, Inc.) and ACCU-CHECK® (made by Roche Diagnostics) \$10 copay for all other brands when purchased through the pharmacy	<b>If purchased through a pharmacy:</b>  \$0 copay per purchase of OneTouch® (made by LifeScan, Inc.) and ACCU-CHECK® (made by Roche Diagnostics) \$10 copay for all other brands when purchased through the pharmacy
<b>Blood glucose monitors</b>	<b>If purchased through a pharmacy:</b>  \$0 copay per purchase of OneTouch® (made by LifeScan, Inc.) and ACCU-CHECK® (made by Roche Diagnostics) \$10 copay for all other brands when purchased through the pharmacy	<b>If purchased through a pharmacy:</b>  \$0 copay per purchase of OneTouch® (made by LifeScan, Inc.) and ACCU-CHECK® (made by Roche Diagnostics) \$10 copay for all other brands when purchased through the pharmacy
<b>Therapeutic shoes</b>	\$0 copay per purchase	\$0 copay per purchase
<b>Diabetes self-management training</b>	\$0 copay per visit	\$0 copay per visit

Covered benefits	In-network, members pay:	Out-of-network, members pay:
<b>Continuous glucose monitors (CGMs)*</b>	\$0 copay per purchase	\$0 copay per purchase
<b>Durable medical equipment (DME) and related supplies*</b>	5% coinsurance per purchase	5% coinsurance per purchase
<b>Opioid treatment program services*</b>	\$20 copay per visit	\$20 copay per visit
<b>Podiatry services*</b>	\$10 copay per visit	\$10 copay per visit
<b>Routine foot care</b>	\$10 copay per visit 12 visits per year combined in-network and out-of-network	\$10 copay per visit 12 visits per year combined in-network and out-of-network
<b>Home health agency care*</b>	\$0 copay per visit	\$0 copay per visit
<b>Hospice care</b> When you enroll in a Medicare-certified hospice program, your hospice services and your Part A and B services are paid for by Original Medicare, not this plan.	\$20 copay for the one time only consultation 1 visit per lifetime	\$20 copay for the one time only consultation 1 visit per lifetime

Additional covered benefits and services	Member pays unless specified:
<b>Video doctor visits LiveHealth Online†</b>	\$0 copay for video doctor visits using LiveHealth Online
<b>Health and wellness programs SilverSneakers® Membership†</b> Take fitness classes virtually or visit a participating location.	\$0 copay for the SilverSneakers fitness benefit
<b>24/7 NurseLine†</b>	\$0 copay for 24/7 NurseLine
<b>Foreign travel emergency (outside U.S. territories)</b> <b>Emergency care</b> Emergency or urgently needed care services while traveling outside the United States or its territories during a temporary absence of less than six months	<b>Emergency care</b> \$75 copay for emergency care \$75 copay is waived if the member is admitted to the hospital within 72 hours for the same condition.
<b>Foreign Travel - Urgently Needed Services</b> Emergency or urgently needed care services while traveling outside the United States or its territories during a temporary absence of less than six months	<b>Urgently needed services</b> \$20 copay for urgently needed services \$20 copay is waived if the member is admitted to the hospital within 72 hours for the same condition.
<b>Foreign Travel - Inpatient Care</b> Emergency or urgently needed care services while traveling outside the United States or its territories during a temporary absence of less than six months	<b>Inpatient care</b> \$0 copay per admission 60 days per lifetime
<b>Healthy Meals†§*</b> Meals delivered after being discharged from inpatient hospital visit or for members living with a chronic condition	\$0 copay for Healthy Meals 14 meals per qualifying event, allows up to four (4) events each year (56 meals in total).
<b>Medicare Community Resource Support</b>	\$0 copay for Medicare Community Resource Support

\* Some services that fall within this benefit category require prior authorization. Based on the service you are receiving, your provider will know if prior authorization is needed. This means an approval in advance is needed, by your plan, to get covered services. In the network portion of a PPO, some in-

network medical services are covered only if your doctor or other in-network provider gets prior authorization from our plan. In a PPO, you do not need prior authorization to obtain out-of-network services. However, we recommend you ask for a pre-visit coverage decision to confirm that the services you are getting are covered and medically necessary. Benefit categories that include services that require prior authorization are marked with an asterisk in the benefits chart.

## This document reflects cost shares only.

†Must use the plan approved provider

§ The benefits mentioned are Special Supplemental Benefits for the Chronically Ill (SSBCI). You may qualify for SSBCI if you have a high risk for hospitalization and require intensive care coordination to manage chronic conditions such as Chronic Kidney Diseases, Chronic Lung Disorders, Cardiovascular Disorders, Chronic Heart Failure, or Diabetes. For a full list of chronic conditions or to learn more about other eligibility requirements needed to qualify for SSBCI benefits, please refer to Chapter 4 in the plan's Evidence of Coverage.

Some of the benefits and limitations listed above are combined in-network and out-of-network.

This information is not a complete description of the benefits. Contact the plan for more information. Limitations, copayments, coinsurance, and restrictions may apply. If there is a difference between this document and the *Evidence of Coverage* (EOC), the EOC is considered correct.

Benefits, premiums and/or copayments/coinsurance may change upon renewal or on January 1 of each year.

Out-of-network/non-contracted providers are under no obligation to treat Plan members, except in emergency situations. Please call our member service number or see your *Evidence of Coverage* for more information, including the cost-sharing that applies to out-of-network services. For a decision about whether we will cover an out-of-network service, we encourage you or your provider to ask us for a pre-service organization determination before you receive the service.

**Medicare & You 2025 resource:** For more information, we encourage you to read Medicare & You 2025. This booklet is mailed to people with Medicare every year in the fall. It has a summary of Medicare benefits, rights, and protections. It also includes answers to the most frequently asked questions. If you don't have a copy of this booklet, request one at [www.medicare.gov](http://www.medicare.gov). Or call **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, seven days a week. TTY users should call **1-877-486-2048**.

LiveHealth Online is offered through an arrangement with Amwell, a separate company, providing telehealth services on behalf of your health plan.

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