City of Atlanta
2022 Summary of Benefits

Custom PPO 15P Ded

The benefits and description of covered services within this summary are pending CMS approval and subject to change.

Covered Medical Benefits	In-Network Member Pays	Out-of-Network Member Pays
Annual Medical Deductible	$100 combined in-network and out-of-network	Same benefit as In-Network
Maximum Out-of-Pocket responsibility (does not include prescription drugs)	$3,350, combined in-network and out-of-network	Same benefit as In-Network
BENEFITS		
Inpatient Hospital Care	$250 copay, OOP $750 per year combined in-network and out-of-network. No limit to the number of days covered by the plan. $0 copay, after deductible for Medicare-covered physician services	Same benefit as In-Network
Outpatient Hospital Care Facility or ambulatory surgical center visit for surgery	$100 copay, after deductible	Same benefit as In-Network
Observation Room	$100 copay, after deductible	Same benefit as In-Network
Primary care office visit	$15 copay, after deductible	Same benefit as In-Network
Specialty care office visit	$25 copay	Same benefit as In-Network
Video Doctor Visits LiveHealth Online	$0 copay Speak to network telehealth providers using your computer or mobile device	
Preventive care	$0 copay	Same benefit as In-Network

Covered Medical Benefits	In-Network Member Pays	Out-of-Network Member Pays
Emergency room visit	$50 copay	
Urgently needed services	$15 copay	
Diagnostic Services, labs and imaging Diagnostic Lab Services	$0 copay, after deductible	Same benefit as In-Network
Diagnostic radiology services (such as MRIs, CT scans)	$0 copay, after deductible	Same benefit as In-Network
Outpatient x-rays	$0 copay, after deductible	Same benefit as In-Network
Hearing services Routine Hearing Exams	$0 copay 1 every 12 months, exam up to benefit maximum of $70 every 12 months, combined in-network and out-of-network.	Same benefit as In-Network
Hearing Aids	$0 copay, Hearing aids are limited to a $500 maximum benefit every 12 months combined in-network and out-of-network.	Same benefit as In-Network
Hearing aid fitting evaluations	$0 copay	Same benefit as In-Network
Routine Dental Services Non-Medicare covered	Not covered	Same benefit as In-Network
Vision Services Medicare-covered exams to diagnose and treat eye diseases and conditions - Specialist	$15 copay, after deductible	Same benefit as In-Network
Medicare-covered eyewear following Cataract Surgery	$0 copay, after deductible	Same benefit as In-Network
Non-Medicare covered eye exam	$0 copay, exam every year up to a benefit maximum of $70, combined in-network and out-of-network.	Same benefit as In-Network
Non-Medicare covered eyewear	$0 copay, eyewear is limited to a $100 maximum benefit every 24 months combined in-network and out-of-network.	Same benefit as In-Network
Mental Health Services Inpatient visit	$0 copay, No limit to the number of days covered by the plan.	Same benefit as In-Network
Outpatient group therapy professional visit	$0 copay	Same benefit as In-Network
Outpatient individual therapy professional visit	$0 copay	Same benefit as In-Network
Professional partial hospitalization	$0 copay	Same benefit as In-Network
Skilled Nursing Facility (SNF)	$0 copay for days 1-100 per benefit period, after deductible	Same benefit as In-Network
Outpatient Rehabilitation Services Physical, Occupational & Speech Therapy Visits	$0 copay, after deductible	Same benefit as In-Network
Ambulance service	$100 copay	

Covered Medical Benefits	In-Network Member Pays	Out-of-Network Member Pays
Routine Transportation (Non-Emergency)	Not covered	
Part B Drugs (Medicare-covered)	$0 copay	Same benefit as In-Network
Chiropractic care Medicare-covered	$20 copay, after deductible	Same benefit as In-Network
Non-Medicare covered	Not Covered	Same benefit as In-Network
Acupuncture care Medicare-covered	$15 copay, after deductible	Same benefit as In-Network
Non-Medicare covered	Not Covered	Same benefit as In-Network
Diabetes Management Supplies: Blood Glucose Test Strips, Lancet Devices, Lancets & Glucose Control Solutions	Through Pharmacy: Preferred Brand $0 copay Non-Preferred Brand $10 copay Through DME Provider: $0 copay	Same benefit as In-Network
Blood Glucose Monitor	Through Pharmacy: Preferred Brand $0 copay Non-Preferred Brand $10 copay Through DME Provider: $0 copay	Same benefit as In-Network
Therapeutic Shoes	$0 copay,	Same benefit as In-Network
Self-Management Training	$0 copay	Same benefit as In-Network
Continuous Glucose Monitors (CGMs)	$0 copay,	Same benefit as In-Network
Durable medical equipment (DME)	$0 copay, after deductible	Same benefit as In-Network
Foot Care (podiatry services) Medicare-covered	$25 copay, after deductible	Same benefit as In-Network
Routine foot care (Non-Medicare covered)	$0 copay, after deductible, 12 visits per year	Same benefit as In-Network
Home health care	$0 copay, after deductible	Same benefit as In-Network
ADDITIONAL BENEFITS AND SERVICES		
Foreign travel emergency (outside U.S. territories) Emergency care	$50 copay	
Urgently needed services	$15 copay	
Inpatient emergency care	$250 copay per admission (60 days per lifetime)	

Covered Medical Benefits	Member Pays
ADDITIONAL BENEFITS AND SERVICES CONTINUED	
SilverSneakers®	$0 copay
Medicare Community Resource Support	$0 copay
Healthy Meals (Post Inpatient Discharge or Chronic Condition)	$0 copay 56 meals
Adult Day Center	Not covered
Assistive Devices	Not covered
Flex Card	Not covered
Healthy Groceries	Not covered
Healthy Pantry (Supplemental Benefits for the Chronically Ill)	$0 copay
Wigs (Coverage for patients with chemotherapy-induced alopecia)	Not covered
Health & Fitness Tracker	Not covered
Over-the-Counter (OTC) Items	Not covered
In-Home Support	Not covered
Personal Emergency Response System (PERS)	Not covered
Personal Home Helper	Not covered

Covered Prescription Drug Benefits	2021 Member Pays	2022 Member Pays
Part D Drugs – Custom 15/25/50 (10R) ECDHLP		
Formulary	Premier	Premier
Network	Standard	Standard
Deductible	None	None
Standard True Out of Pocket (TrOOP) (Defines the end of the Part D Gap phase.)	$6,550	$7,050
Gap Coverage	Full	Full
Standard Retail Pharmacy 30 Day supply		
Tier 1	Select Generics $0 copay Generics $15 copay	Select Generics $0 copay Generics $15 copay
Tier 2	$25 copay	$25 copay
Tier 3	$50 copay	$50 copay
Mail Order Pharmacy 90 Day supply		
Tier 1	Select Generics $0 copay Generics $30 copay	Select Generics $0 copay Generics $30 copay
Tier 2	$50 copay	$50 copay
Tier 3	$100 copay	$100 copay
Medicare Catastrophic Minimum Copays Each year Medicare evaluates the minimum copays charged during the Catastrophic phase.		
Generic drugs	$3.70	$3.95
Brand drugs	$9.20	$9.85

For Use by Benefits Administrators Only

This document reflects cost shares only.

This information is not a complete description of benefits. Contact the plan for more information. Limitations, copayments, coinsurance and restrictions may apply.

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

The formulary, pharmacy network, and/or provider network may change at any time. You will receive notice when necessary.

Out-of-network/non-contracted providers are under no obligation to treat members, except in emergency situations. 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. Please call our customer service number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services.