

Your summary of benefits



Anthem® Blue Cross and Blue Shield

Your Plan: Georgia Dental Association: Anthem Blue Open Access POS HSAOAP3B

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
Out-of-Pocket Limit	\$7,050 member / \$14,100 family	\$21,150 member / \$42,300 family
<p>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.</p> <p>Your copays, coinsurance and deductible count toward your out of pocket amount(s).</p> <p>In-network and out-of-network deductibles and out-of-pocket maximum amounts are separate and do not accumulate toward each other.</p>		
Preventive Care / Screening / Immunization	No charge	50% coinsurance after deductible is met
Preventive Care for Chronic Conditions <i>per IRS guidelines</i>	No charge	50% coinsurance after deductible is met
<p><u>Virtual Care (Telemedicine / Telehealth Visits)</u></p> <p>Virtual Visits - Online visits with Doctors who also provide services in person</p>		
Primary Care (PCP)	\$35 copay per visit after deductible is met	50% coinsurance after deductible is met
Mental Health and Substance Abuse care	0% coinsurance after deductible is met	50% coinsurance after deductible is met
Specialist	\$60 copay per visit after deductible is met	50% coinsurance after deductible is met

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Questions: (877) 812-9777 or visit us at www.anthem.com

GA/LG/Georgia Dental Association: Anthem Blue Open Access POS HSAOAP3B/Q83W/01-01-2022

Modified 10/08/2021 (NGF) C. Bowen III

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Medical Chats and Virtual Visits for Primary Care <i>from our Online Provider K Health, its affiliated Provider groups, via our mobile app, website or Anthem-enabled device</i>	\$0 copay per visit after deductible is met	\$0 copay per visit after deductible is met
Virtual Visits from Online Provider LiveHealth Online <i>via www.livehealthonline.com; our mobile app, website or Anthem-enabled device</i> Primary Care (PCP) and Mental Health Substance Abuse Specialist Care	\$35 copay per visit after deductible is met \$60 copay per visit after deductible is met	50% coinsurance after deductible is met 50% coinsurance after deductible is met
<u>Visits in an Office</u> Primary Care (PCP) Specialist Care	\$35 copay per visit after deductible is met \$60 copay per visit after deductible is met	50% coinsurance after deductible is met 50% coinsurance after deductible is met
<u>Other Practitioner Visits</u> Routine Maternity Care (Prenatal and Postnatal) Retail Health Clinic Visit Manipulation Therapy <i>Coverage is limited to 20 visits per year.</i> Acupuncture	30% coinsurance after deductible is met \$35 copay per visit after deductible is met 30% coinsurance after deductible is met Not covered	50% coinsurance after deductible is met 50% coinsurance after deductible is met 50% coinsurance after deductible is met Not covered
<u>Other Services in an Office</u> Allergy Testing Chemo/Radiation Therapy Dialysis/Hemodialysis Prescription Drugs <i>Dispensed in the office</i>	30% coinsurance after deductible is met 30% coinsurance after deductible is met 30% coinsurance after deductible is met 30% 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

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Surgery	\$60 copay per surgery after deductible is met	50% coinsurance after deductible is met
<u>Diagnostic Services</u> Lab Office Freestanding Lab/Reference Lab Outpatient Hospital	30% coinsurance after deductible is met 30% coinsurance after deductible is met 30% coinsurance after deductible is met	50% coinsurance after deductible is met 50% coinsurance after deductible is met 50% coinsurance after deductible is met
X-Ray Office Freestanding Radiology Center Outpatient Hospital	30% coinsurance after deductible is met 30% coinsurance after deductible is met 30% coinsurance after deductible is met	50% coinsurance after deductible is met 50% coinsurance after deductible is met 50% coinsurance after deductible is met
Advanced Diagnostic Imaging <i>for example: MRI, PET and CAT scans</i> Office Freestanding Radiology Center Outpatient Hospital	30% coinsurance after deductible is met 30% coinsurance after deductible is met 30% coinsurance after deductible is met	50% 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	\$75 copay per visit after deductible is met 30% coinsurance after deductible is met 30% coinsurance after deductible is met 30% coinsurance after deductible is met	50% coinsurance after deductible is met Covered as In-Network Covered as In-Network Covered as In-Network

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<p><u>Outpatient Mental Health and Substance Abuse</u></p> <p>Doctor Office Visit</p> <p>Facility Visit</p> <p>Facility Fees</p> <p>Doctor Services</p>	<p>0% coinsurance after deductible is met</p> <p>30% coinsurance after deductible is met</p> <p>30% 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><u>Outpatient Surgery</u></p> <p>Facility Fees</p> <p>Hospital</p> <p>Freestanding Surgical Center</p> <p>Doctor and Other Services</p> <p>Hospital</p> <p>Freestanding Surgical Center</p>	<p>30% coinsurance after deductible is met</p> <p>30% coinsurance after deductible is met</p> <p>30% coinsurance after deductible is met</p> <p>30% coinsurance after deductible is met</p> <p>30% 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>50% coinsurance after deductible is met</p> <p>50% coinsurance after deductible is met</p>
<p><u>Hospital (Including Maternity, Mental Health and Substance Abuse)</u></p> <p>Facility Fees</p> <p>Doctor and other services</p>	<p>30% coinsurance after deductible is met</p> <p>30% coinsurance after deductible is met</p>	<p>50% coinsurance after deductible is met</p> <p>50% coinsurance after deductible is met</p>
<p><u>Recovery & Rehabilitation</u></p> <p>Home Health Care</p> <p><i>Coverage is limited to 120 visits per benefit period. Limits are combined for all home health services.</i></p>	<p>30% coinsurance after deductible is met</p>	<p>50% coinsurance after deductible is met</p>
<p>Rehabilitation services</p> <p><i>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.</i></p> <p>Office</p>	<p>30% 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
Outpatient Hospital	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Cardiac rehabilitation Office Outpatient Hospital	30% coinsurance after deductible is met 30% coinsurance after deductible is met	50% 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>	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Inpatient Hospice	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Durable Medical Equipment	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Prosthetic Devices	30% 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 medical deductible	Combined with 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 <i>Cost shares for drugs included on the National drug list appear below. Drugs not included on the National 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.</i>		
Home Delivery Pharmacy <i>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.</i>		
Tier 1 - Typically Generic <i>Per 30 day supply (retail pharmacy and Retail 90 pharmacy). Per 90 day supply (home delivery).</i>	\$20 copay per prescription after deductible is met (retail) and \$43 copay	\$20 copay 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
	per prescription after deductible is met (home delivery)	
Tier 2 – Typically Preferred Brand <i>Per 30 day supply (retail pharmacy and Retail 90 pharmacy). Per 90 day supply (home delivery).</i>	\$45 copay per prescription after deductible is met (retail) and \$90 copay per prescription after deductible is met (home delivery)	\$45 copay per prescription after deductible is met (retail only)
Tier 3 - Typically Non-Preferred Brand <i>Per 30 day supply (retail pharmacy and Retail 90 pharmacy). Per 90 day supply (home delivery).</i>	\$85 copay per prescription after deductible is met (retail) and \$255 copay per prescription after deductible is met (home delivery)	\$85 copay per prescription after deductible is met (retail only)
Tier 4 - Typically Specialty (brand and generic) <i>Per 30 day supply (specialty pharmacy).</i>	25% coinsurance up to \$350 per prescription after deductible is met (retail and home delivery)	25% coinsurance up to \$350 per prescription after deductible is met (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.
- 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

Curious to know what all this says? We would be too. Here's the English version:

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 (877) 812-9777

Separate from our language assistance program, we make documents available in alternate formats for members with visual impairments. If you need a copy of this document in an alternate format, please call the customer service telephone number on the back of your ID card.

(TTY/TDD: 711)

Arabic (العربية): إذا كان لديك أي استفسارات بشأن هذا المستند، فيحق لك الحصول على المساعدة والمعلومات بلغتك دون مقابل. للتحدث إلى مترجم، اتصل على (877) 812-9777.

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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 (877) 812-9777.

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Language Access Services:

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Polish (polski): W przypadku jakichkolwiek pytań związanych z niniejszym dokumentem masz prawo do bezpłatnego uzyskania pomocy oraz informacji w swoim języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer: (877) 812-9777.

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