

Your summary of benefits



Anthem® Blue Cross and Blue Shield

Your Plan: Georgia Dental Association: Anthem Blue Open Access POS OAP5 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 | \$1,000 member / \$3,000 family | \$1,500 member / \$4,500 family |
| Out-of-Pocket Limit | \$7,900 member / \$15,800 family | \$23,700 member / \$47,400 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> <p>Primary Care (PCP)</p> <p>Mental Health and Substance Abuse care</p> | | |
| | \$30 copay per visit deductible does not apply | 50% coinsurance after deductible is met |
| | \$30 copay per visit deductible does not apply | 50% coinsurance after deductible is met |

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

GA/LG/Georgia Dental Association: Anthem Blue Open Access POS OAP5 AE/Q8RU/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 |
|---|---|---|
| Specialist | \$50 copay per visit deductible does not apply | 50% coinsurance after deductible is met |
| <p>Medical Chats and Virtual Visits for Primary Care from our Online Provider K Health, its affiliated Provider groups, via our mobile app, website or Anthem-enabled device</p> <p>Virtual Visits from Online Provider LiveHealth Online via www.livehealthonline.com; our mobile app, website or Anthem-enabled device</p> <p>Primary Care (PCP) and Mental Health and Substance Abuse</p> <p>Specialist Care</p> | <p>No charge</p> <p>\$30 copay per visit deductible does not apply</p> <p>\$50 copay per visit deductible does not apply</p> | |
| <p><u>Visits in an Office</u></p> <p>Primary Care (PCP)</p> <p>Specialist Care</p> | <p>\$30 copay per visit deductible does not apply</p> <p>\$50 copay per visit deductible does not apply</p> | <p>50% coinsurance after deductible is met</p> <p>50% coinsurance after deductible is met</p> |
| <p><u>Other Practitioner Visits</u></p> <p>Routine Maternity Care (Prenatal and Postnatal)</p> <p>Retail Health Clinic Visit</p> <p>Manipulation Therapy <i>Coverage is limited to 20 visits per year.</i></p> <p>Acupuncture</p> | <p>20% coinsurance after deductible is met</p> <p>\$30 copay per visit deductible does not apply</p> <p>\$50 copay per visit deductible does not apply</p> <p>Not covered</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>Not covered</p> |
| <p><u>Other Services in an Office</u></p> <p>Allergy Testing</p> <p>Chemo/Radiation Therapy</p> | <p>\$30 copay per visit deductible does not apply</p> <p>20% coinsurance after deductible is met</p> | <p>50% 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 |
|--|---|--|
| <p>Dialysis/Hemodialysis</p> <p>Prescription Drugs <i>Dispensed in the office</i></p> <p>Surgery</p> | <p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p> <p>20% 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>Diagnostic Services</u></p> <p>Lab</p> <p>Office</p> <p>Freestanding Lab/Reference Lab</p> <p>Outpatient Hospital</p> | <p>\$30 copay per service deductible does not apply</p> <p>No charge</p> <p>20% 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>\$30 copay per visit deductible does not apply</p> <p>20% coinsurance deductible does not apply</p> <p>20% 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>Freestanding Radiology Center</p> <p>Outpatient Hospital</p> | <p>20% coinsurance after deductible is met</p> <p>20% coinsurance deductible does not apply</p> <p>20% 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> |

| Covered Medical Benefits | Cost if you use an In-Network Provider | Cost if you use a Non-Network Provider |
|--|--|---|
| <p><u>Emergency and Urgent Care</u></p> <p>Urgent Care</p> <p>Emergency Room Facility Services <i>Cost share waived if admitted.</i></p> <p>Emergency Room Doctor and Other Services</p> <p>Ambulance</p> | <p>\$75 copay per visit deductible does not apply</p> <p>\$375 copay per visit and 20% coinsurance deductible does not apply</p> <p>20% coinsurance deductible does not apply</p> <p>20% coinsurance after deductible is met</p> | <p>50% coinsurance after deductible is met</p> <p>Covered as In-Network</p> <p>Covered as In-Network</p> <p>Covered as In-Network</p> |
| <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>\$30 copay per visit deductible does not apply</p> <p>20% coinsurance after deductible is met</p> <p>20% 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>20% coinsurance after deductible is met</p> <p>\$150 copay per visit and 20% coinsurance deductible does not apply</p> <p>20% coinsurance after deductible is met</p> <p>20% coinsurance deductible does not apply</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> |

| Covered Medical Benefits | Cost if you use an In-Network Provider | Cost if you use a Non-Network Provider |
|---|---|---|
| <p><u>Hospital (Including Maternity, Mental Health and Substance Abuse)</u></p> <p>Facility Fees</p> <p>Doctor and other services</p> | <p>\$500 copay per admission and 30% coinsurance after deductible is met</p> <p>20% 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 <i>Coverage is limited to 120 visits per benefit period. Limits are combined for all home health services.</i></p> | <p>20% coinsurance after deductible is met</p> | <p>50% coinsurance after deductible is met</p> |
| <p>Rehabilitation services <i>Coverage for rehabilitative and habilitative speech therapy is limited to 20 visits per year. Physical therapy is limited to 60 visits per year. And Occupational therapy is limited to 20 visits per year.</i></p> <p>Office</p> <p>Outpatient Hospital</p> | <p>\$50 copay per visit deductible does not apply</p> <p>20% coinsurance after deductible is met</p> | <p>50% coinsurance after deductible is met</p> <p>50% coinsurance after deductible is met</p> |
| <p>Cardiac rehabilitation</p> <p>Office</p> <p>Outpatient Hospital</p> | <p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p> | <p>50% coinsurance after deductible is met</p> <p>50% coinsurance after deductible is met</p> |
| <p>Skilled Nursing Care (facility) <i>Coverage for Inpatient rehabilitation and skilled nursing services is limited to 60 days combined per benefit period.</i></p> | <p>20% coinsurance after deductible is met</p> | <p>50% coinsurance after deductible is met</p> |
| <p>Inpatient Hospice</p> | <p>20% coinsurance after deductible is met</p> | <p>50% coinsurance after deductible is met</p> |
| <p>Durable Medical Equipment</p> | <p>20% coinsurance after deductible is met</p> | <p>50% coinsurance after deductible is met</p> |
| <p>Prosthetic Devices</p> | <p>20% coinsurance after deductible is met</p> | <p>50% coinsurance after deductible is met</p> |

| 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 |
| <p>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.</p> | | |
| <p>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.</p> | | |
| <p>Tier 1 - Typically Generic Per 30 day supply (retail pharmacy and Retail 90 pharmacy). Per 90 day supply (home delivery).</p> | \$15 copay per prescription, deductible does not apply (retail and home delivery) | \$15 copay per prescription, deductible does not apply (retail only) |
| <p>Tier 2 – Typically Preferred Brand Per 30 day supply (retail pharmacy and Retail 90 pharmacy). Per 90 day supply (home delivery).</p> | \$40 copay per prescription, deductible does not apply (retail) and \$80 copay per prescription, deductible does not apply (home delivery) | \$40 copay per prescription, deductible does not apply (retail only) |
| <p>Tier 3 - Typically Non-Preferred Brand Per 30 day supply (retail pharmacy and Retail 90 pharmacy). Per 90 day supply (home delivery).</p> | \$65 copay per prescription, deductible does not apply (retail) and \$195 copay per prescription, deductible does not apply (home delivery) | \$65 copay per prescription, deductible does not apply (retail only) |
| <p>Tier 4 - Typically Specialty (brand and generic) Per 30 day supply (specialty pharmacy).</p> | 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.
- 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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