Your summary of benefits

Anthem®

Anthem® Blue Cross and Blue Shield

Your Plan: Georgia Dental Association: Anthem Blue Open Access POS OAP9 KE

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	$3,000 member / $9,000 family	$9,000 member / $27,000 family
Out-of-Pocket Limit	$7,900 member / $15,800 family	$23,700 member / $47,400 family
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. Your copays, coinsurance and deductible count toward your out of pocket amount(s). In-network and out-of-network deductibles and out-of-pocket maximum amounts are separate and do not accumulate toward each other.		
Preventive Care / Screening / Immunization	No charge	50% coinsurance after deductible is met
Preventive Care for Chronic Conditions *per IRS guidelines*	No charge	50% coinsurance after deductible is met
Virtual Care (Telemedicine / Telehealth Visits) **Virtual Visits - Online visits with Doctors who also provide services in person**		
Primary Care (PCP)	$35 copay per visit deductible does not apply	50% coinsurance after deductible is met
Mental Health and Substance Abuse care	No charge	50% coinsurance after deductible is met
Specialist	$60 copay per visit deductible does not apply	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
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* **Virtual Visits from Online Provider LiveHealth Online** *via www.livehealthonline.com; our mobile app, website or Anthem-enabled device*	No charge	
Primary Care (PCP) and Mental Health and Substance Abuse	$35 copay per visit deductible does not apply	
Specialist Care	$60 copay per visit deductible does not apply	
Visits in an Office		
Primary Care (PCP)	$35 copay per visit deductible does not apply	50% coinsurance after deductible is met
Specialist Care	$60 copay per visit deductible does not apply	50% coinsurance after deductible is met
Other Practitioner Visits		
Routine Maternity Care (Prenatal and Postnatal)	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Retail Health Clinic Visit	$35 copay per visit deductible does not apply	50% coinsurance after deductible is met
Manipulation Therapy *Coverage is limited to 20 visits per year.*	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Acupuncture	Not covered	Not covered
Other Services in an Office		
Allergy Testing	$35 copay per visit deductible does not apply	50% coinsurance after deductible is met
Chemo/Radiation Therapy	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Dialysis/Hemodialysis	30% 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
Prescription Drugs *Dispensed in the office*	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Surgery	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Diagnostic Services **Lab**		
Office	$35 copay per service deductible does not apply	50% coinsurance after deductible is met
Freestanding Lab/Reference Lab	No charge	50% coinsurance after deductible is met
Outpatient Hospital	30% coinsurance after deductible is met	50% coinsurance after deductible is met
X-Ray		
Office	$35 copay per visit deductible does not apply	50% coinsurance after deductible is met
Freestanding Radiology Center	30% coinsurance deductible does not apply	50% coinsurance after deductible is met
Outpatient Hospital	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Advanced Diagnostic Imaging *for example: MRI, PET and CAT scans*		
Office	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Freestanding Radiology Center	30% coinsurance deductible does not apply	50% coinsurance after deductible is met
Outpatient Hospital	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Emergency and Urgent Care		
Urgent Care	$75 copay per visit and 0% coinsurance deductible does not apply	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
Emergency Room Facility Services *Cost share waived if admitted.*	$375 copay per visit and 30% coinsurance deductible does not apply	Covered as In-Network
Emergency Room Doctor and Other Services	30% coinsurance after deductible is met	Covered as In-Network
Ambulance	30% coinsurance after deductible is met	Covered as In-Network
Outpatient Mental Health and Substance Abuse		
Doctor Office Visit	No charge	50% coinsurance after deductible is met
Facility Visit		
Facility Fees	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Doctor Services	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Outpatient Surgery		
Facility Fees		
Hospital	$300 copay per admission and 30% coinsurance after deductible is met	50% coinsurance after deductible is met
Freestanding Surgical Center	$200 copay per visit and 30% coinsurance deductible does not apply	50% coinsurance after deductible is met
Doctor and Other Services		
Hospital	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Freestanding Surgical Center	30% coinsurance deductible does not apply	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
Hospital (Including Maternity, Mental Health and Substance Abuse)		
Facility Fees	$500 copay per admission and 30% coinsurance after deductible is met	50% coinsurance after deductible is met
Doctor and other services	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Recovery & Rehabilitation		
Home Health Care *Coverage is limited to 120 visits per benefit period. Limits are combined for all home health services.*	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Rehabilitation services *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.*		
Office	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Outpatient Hospital	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Cardiac rehabilitation		
Office	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Outpatient Hospital	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Skilled Nursing Care (facility) *Coverage for Inpatient rehabilitation and skilled nursing services is limited to 60 days combined per benefit period.*	$300 copay per visit and 30% coinsurance deductible does not apply	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 a Preferred Network Provider	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Pharmacy Deductible	$350 person / $700 family	$350 person / $700 family	$350 person / $700 family
Pharmacy Out of Pocket	Combined with In-Network medical out of pocket maximum	Combined with In-Network medical out of pocket maximum	Combined with Non-Network medical out of pocket maximum
Prescription Drug Coverage *Essential Drug List* *No coverage for non-formulary drugs. Up to a 90 day supply is available at most retail pharmacies.*			
Tier 1a - Typically Lower Cost Generic *Covers up to a 90 day supply (retail pharmacy).* *Covers up to a 90 day supply (home delivery program).*	$5 copay per prescription, Pharmacy deductible does not apply (retail and home delivery)	$15 copay per prescription, Pharmacy deductible does not apply (retail) and Not covered (home delivery)	$15 copay per prescription, Pharmacy deductible does not apply (retail only)
Tier 1b - Typically Generic *Covers up to a 90 day supply (retail pharmacy).* *Covers up to a 90 day supply (home delivery program).*	$20 copay per prescription, Pharmacy deductible does not apply (retail and home delivery)	$30 copay per prescription, Pharmacy deductible does not apply (retail) and Not covered (home delivery)	$30 copay per prescription, Pharmacy deductible does not apply (retail only)
Tier 2 – Typically Preferred Brand *Covers up to a 90 day supply (retail pharmacy).* *Covers up to a 90 day supply (home delivery program).*	$45 copay per prescription after Pharmacy deductible is met (retail) and $90 copay per prescription after Pharmacy deductible is met (home delivery)	$55 copay per prescription after Pharmacy deductible is met (retail) and Not covered (home delivery)	$55 copay per prescription after Pharmacy deductible is met (retail only)
Tier 3 - Typically Non-Preferred Brand *Covers up to a 90 day supply (retail pharmacy).* *Covers up to a 90 day supply (home delivery program).*	$90 copay per prescription after Pharmacy deductible is met	$100 copay per prescription after Pharmacy deductible is met	$100 copay per prescription after Pharmacy

Covered Prescription Drug Benefits	Cost if you use a Preferred Network Provider	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
	(retail) and $270 copay per prescription after Pharmacy deductible is met (home delivery)	(retail) and Not covered (home delivery)	deductible is met (retail only)
Tier 4 - Typically Specialty (brand and generic) *Covers up to a 30 day supply (retail pharmacy). Covers up to a 30 day supply (home delivery program). No coverage for non-formulary drugs.*	25% coinsurance up to $450 per prescription after Pharmacy deductible is met (retail and home delivery)	35% coinsurance up to $550 per prescription after Pharmacy deductible is met (retail) and Not covered (home delivery)	35% coinsurance up to $550 per prescription after Pharmacy 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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(TTY/TDD: 711)

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