Your summary of benefits

Georgia Dental Association

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	$2,500 member / $7,500 family	$7,500 member / $22,500 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 the individual deductible and individual 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 individual deductible and individual out-of-pocket maximum.		
Preventive Care / Screening / Immunization	No charge	50% coinsurance after deductible is met
Doctor Home and Office Services		
Primary Care Visit	$35 copay per visit deductible does not apply	50% coinsurance after deductible is met
Specialist Care Visit	$60 copay per visit deductible does not apply	50% coinsurance after deductible is met
Prenatal and Post-natal Care	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Other Practitioner Visits:		
Retail Health Clinic Visit	$35 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
On-line Medical 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
Prescription Drugs - *Dispensed in the office*	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

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
Advanced Diagnostic Imaging:		
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
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/Behavioral 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

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Outpatient Surgery		
Facility Fees:		
Hospital	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Freestanding Surgical Center	$150 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
Hospital (Including Maternity, Mental / Behavioral Health, Substance Abuse):		
Facility Fees	$500 copay per admission and then 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:		
Office *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.*	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Outpatient Hospital *Limits are combined with Rehabilitation office visits.*	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
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) *Coverage for Inpatient rehabilitation and skilled nursing services is limited to 60 days combined per benefit period.*	30% coinsurance after deductible is met	50% coinsurance after deductible is met
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 Provider	Cost if you use a Non-Network Provider
Pharmacy Deductible	$250 person / $450 family	$250 person / $450 family
Pharmacy Out of Pocket	Combined with medical	Combined with medical
Prescription Drug Coverage *National Network with R90 and Optional Home Delivery* *Essential Drug List Formulary - No coverage for non-formulary drugs* *R90 - Up to a 90 day supply for maintenance drugs is available at most retail pharmacies if you opt out of Home Delivery*		
Tier 1 - Typically Generic *90 day supply (retail pharmacy). 90 day supply (home delivery).*	$15 copay per prescription, Pharmacy deductible does not apply (retail and home delivery)	$15 copay per prescription, Pharmacy deductible does not apply (retail only)
Tier 2 – Typically Preferred Brand *90 day supply (retail pharmacy). 90 day supply (home delivery).*	$50 copay per prescription after Pharmacy deductible is	$50 copay per prescription after

Covered Prescription Drug Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
	met (retail) and $100 copay per prescription after Pharmacy deductible is met (home delivery)	Pharmacy deductible is met (retail only)
Tier 3 - Typically Non-Preferred Brand *90 day supply (retail pharmacy). 90 day supply (home delivery).*	$90 copay per prescription after Pharmacy deductible is met (retail) and $270 copay per prescription after Pharmacy deductible is met (home delivery)	$90 copay per prescription after Pharmacy deductible is met (retail only)
Tier 4 - Typically Specialty (brand and generic) *30 day supply (retail pharmacy). 30 day supply (home delivery).*	25% coinsurance up to $350 per prescription after Pharmacy deductible is met (retail and home delivery)	25% coinsurance up to $350 per prescription after Pharmacy deductible is met (retail only)

Notes:

- Your copays, coinsurance and deductible count toward your out of pocket amount.
- If you have a visit with your Primary Care Physician, Specialist or Urgent Care at an Outpatient Facility (e.g., Hospital or Ambulatory Surgical Facility), benefits for Covered Services will be paid under "Outpatient Facility Services" which is generally coinsurance or coinsurance after your deductible is met.
  Costs may also vary by the site of service. Other cost shares may apply depending on services provided. Check your Certificate of Coverage for details.
- Opt-out Home Delivery for Maintenance Drugs (previously known as Home Delivery Choice) – For medications on your benefit plan's maintenance drug list, you may get your first 30-day supply and up to one more 30-day refill of the same Maintenance Medication at an in-network retail pharmacy. Prior to your 3rd fill, you must contact us at 1-833-203-1739 or at www.anthem.com and tell us if you would like to keep getting your Maintenance Medications from the retail pharmacy or if you would like to use Home Delivery. If you do not contact us, you will pay the full retail cost of any Maintenance Medication until you inform us of your decision.

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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Your Network: Blue Open Access POS

This summary of benefits is intended to be a brief outline of coverage. The entire provisions of benefits and exclusions are contained in the Group Contract, Certificate, and Schedule of Benefits. In the event of a conflict between the Group Contract and this description, the terms of the Group Contract will prevail.

By signing this Summary of Benefits, I agree to the benefits for the product selected as of the effective date indicated.

Authorized group signature (if applicable)	Date
Underwriting signature (if applicable)	Date

Language Access Services:

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 (855) 397-9267

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 (855) 397-9267 .

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Language Access Services:

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