

Georgia Dental Association

Anthem® Blue Cross and Blue Shield

Your Plan: Anthem Blue Open Access POS OAP5 1000/20%/7900 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
Overall Out-of-Pocket Limit	\$7,900 member / \$15,800 family	\$23,700 member / \$47,400 family
<p>The family deductible and out-of-pocket limit are embedded, meaning the cost shares of one family member will be applied to the per member deductible and per member out-of-pocket limit; in addition, amounts for all covered family members apply to both the family deductible and family out-of-pocket limit. No one member will pay more than the per member deductible or per member out-of-pocket limit.</p> <p>Your copays, coinsurance and deductible count toward your out of pocket limit(s).</p> <p>In-Network and Non-Network deductibles and out-of-pocket limit amounts are separate and do not accumulate toward each other.</p>		
<p>Doctor Visits (virtual and office) <i>You are encouraged to select a Primary Care Physician (PCP).</i></p>		
<p>Medical Chats and Virtual Visits for Primary Care <i>from our Online Provider K Health, through its affiliated Provider groups are covered at \$0 copay per visit deductible does not apply.</i></p>		
<p>Virtual Visits from online provider LiveHealth Online <i>for urgent/acute medical and mental health and substance abuse care via www.livehealthonline.com are covered at \$0 copay per visit deductible does not apply.</i></p>		
<p>Primary Care (PCP) and Mental Health and Substance Abuse Care <i>virtual and office</i></p>	<p>\$40 copay per visit deductible does not apply</p>	<p>50% coinsurance after deductible is met</p>
<p>Specialist Care <i>virtual and office</i></p>	<p>\$60 copay per visit deductible does not apply</p>	<p>50% coinsurance after deductible is met</p>

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

GA/LG/Anthem Blue Open Access POS OAP5 500/20%/4400 AE//01-01-2023

Modified 10/25/2022 (NGF) S. McGrady

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<p><u>Other Practitioner Visits</u></p> <p>Routine Maternity Care (Prenatal and Postnatal)</p> <p>Retail Health Clinic Visit <i>for routine care and treatment of common illnesses; usually found in major pharmacies or retail stores.</i></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>\$40 copay per visit deductible does not apply</p> <p>\$60 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>Prescription Drugs <i>Dispensed in the office</i></p> <p>Surgery</p>	<p>\$40 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>Preventive care / screenings / immunizations</p>	<p>No charge</p>	<p>50% coinsurance after deductible is met</p>
<p>Preventive Care for Chronic Conditions <i>per IRS guidelines</i></p>	<p>No charge</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>\$40 copay per visit 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>\$40 copay per visit deductible does not apply</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>Freestanding Radiology Center</p> <p>Outpatient Hospital</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>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>
<p><u>Emergency and Urgent Care</u></p> <p>Urgent Care <i>includes doctor services. Additional charges may apply depending on the care provided.</i></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>\$500 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 Care at a Facility</u></p> <p>Facility Fees</p> <p>Doctor Services</p>	<p>\$350 copay per visit and 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>

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<p><u>Outpatient Surgery</u></p> <p>Facility Fees</p> <p>Hospital</p> <p>Ambulatory Surgical Center</p> <p>Doctor and Other Services</p> <p>Hospital</p> <p>Ambulatory Surgical Center</p>	<p>\$350 copay per visit and 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>
<p><u>Hospital (Including Maternity, Mental Health and Substance Abuse)</u></p> <p>Facility Fees</p> <p>Physician and other services <i>including surgeon fees</i></p>	<p>\$500 copay per admission and 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>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 and Habilitation services <i>including physical, occupational and speech therapies.</i> <i>Coverage for physical therapy is limited to 60 visits per year</i> <i>Coverage for occupational therapy is limited to 20 visits per year</i> <i>Coverage for speech therapy is limited to 20 visits per year.</i></p> <p>Office</p> <p>Outpatient Hospital</p>	<p>\$60 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>Pulmonary rehabilitation <i>office and outpatient hospital</i></p>	<p>20% 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
Cardiac rehabilitation <i>office and outpatient hospital</i>	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Dialysis/Hemodialysis <i>office and outpatient hospital</i>	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Chemo/Radiation Therapy <i>office and outpatient hospital</i>	20% 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>	\$500 copay per visit and 20% coinsurance deductible does not apply	50% coinsurance after deductible is met
Inpatient Hospice	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Durable Medical Equipment	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Prosthetic Devices <i>Coverage for wigs is limited to 1 item after cancer treatment per benefit period.</i>	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Hearing Aids <i>Hearing Aids for Members 18 years of age and under. Limited to \$3,000 per hearing aid per hearing impaired ear every 48 months</i>	20% 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	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
Prescription Drug Coverage Network: <i>Base Network</i> Drug List: <i>Essential</i> <i>Drugs not included on the Essential drug list will not be covered.</i>		
Day Supply Limits: Retail Pharmacy <i>30 day supply (cost shares noted below)</i> Retail 90 Pharmacy <i>90 day supply (cost shares noted below)</i>		

Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use a Non-Network Pharmacy
<p>Home Delivery Pharmacy 90 day supply (maximum cost shares noted below) Maintenance medications are available through CarelonRx Mail (IngenioRx will become CarelonRx on January 1, 2023). You will need to call us on the number on your ID card to sign up when you first use the service.</p> <p>Specialty Pharmacy 30 day supply (cost shares noted below for retail and home delivery apply). We may require certain drugs with special handling, provider coordination or patient education be filled by our designated specialty pharmacy or an In-Network Pharmacy that carries your specialty drug.</p>		
<p>Tier 1 - Typically Generic each 90 day supply script filled at Retail 90 pharmacies is subject to one 30 day supply cost share charged at In-Network Retail Pharmacies.</p>	<p>\$25 copay per prescription (retail) and \$25 copay per prescription (home delivery)</p>	<p>\$25 copay per prescription (retail only)</p>
<p>Tier 2 – Typically Preferred Brand each 90 day supply script filled at Retail 90 pharmacies is subject to two times the 30 day supply cost share charged at In-Network Retail Pharmacies.</p>	<p>\$50 copay per prescription (retail) and \$80 copay per prescription (home delivery)</p>	<p>\$50 copay per prescription (retail only)</p>
<p>Tier 3 - Typically Non-Preferred Brand each 90 day supply script filled at Retail 90 pharmacies is subject to 3 times the 30 day supply cost share charged at In-Network Retail Pharmacies.</p>	<p>\$75 copay per prescription (retail) and \$195 copay per prescription (home delivery)</p>	<p>\$75 copay per prescription (retail only)</p>
<p>Tier 4 - Typically Specialty (brand and generic)</p>	<p>25% coinsurance up to \$350 per prescription (retail and home delivery)</p>	<p>25% coinsurance up to \$350 per prescription (retail only)</p>

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.
- † Your cost share will be reduced when services are provided in a PCP's office.
- 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 (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.

Armenian (հայերեն). Եթե այս փաստաթղթի հետ կապված հարցեր ունեք, դուք իրավունք ունեք անվճար ստանալ օգնություն և տեղեկատվություն ձեր լեզվով: Թարգմանչի հետ խոսելու համար զանգահարեք հետևյալ հեռախոսահամարով՝ (855) 397-9267:

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French (Français): Si vous avez des questions sur ce document, vous avez la possibilité d'accéder gratuitement à ces informations et à une aide dans votre langue. Pour parler à un interprète, appelez le (855) 397-9267.

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 (855) 397-9267.

Italian (Italiano): In caso di eventuali domande sul presente documento, ha il diritto di ricevere assistenza e informazioni nella sua lingua senza alcun costo aggiuntivo. Per parlare con un interprete, chiami il numero (855) 397-9267.

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Language Access Services:

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Russian (Русский): Если у вас есть какие-либо вопросы в отношении данного документа, вы имеете право на бесплатное получение помощи и информации на вашем языке. Чтобы связаться с устным переводчиком, позвоните по тел. (855) 397-9267.

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It's important we treat you fairly

That's why we follow federal civil rights laws in our health programs and activities. We don't discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, we offer free aids and services. For people whose primary language isn't English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711). If you think we failed to offer these services or discriminated based on race, color, national origin, age, disability, or sex, you can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator in writing to Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279. Or you can file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201 or by calling 1-800-368-1019 (TDD: 1-800-537-7697) or online at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>. Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.