Your summary of benefits

Anthem® Blue Cross and Blue Shield

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

Visits with Virtual Care-Only Providers	Cost through our mobile app and website
Primary Care, and medical services for urgent/acute care	No charge
Mental Health & Substance Use Disorder Services	No charge
Specialist care	$80 copay per visit deductible does not apply

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Overall Deductible *Your plan applies a separate Pharmacy Deductible to prescription drugs obtained at a pharmacy. See the Covered Prescription Drug Benefits section.*	$3,000 member / $9,000 family	$9,000 member / $27,000 family
Overall Out-of-Pocket Limit	$9,450 member / $18,900 family	$23,700 member / $47,400 family
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. All medical and prescription drug deductibles, copayments and coinsurance apply to the out-of-pocket limit (excluding Non-Network Human Organ and Tissue Transplant (HOTT) services). In-Network and Non-Network deductibles and out-of-pocket limit amounts are separate and do not accumulate toward each other.		
Doctor Visits (virtual and office) *You are encouraged to select a Primary Care Physician (PCP).*		
Primary Care (PCP) *virtual and office*	$50 copay per visit deductible does not apply	50% coinsurance after deductible is met
Mental Health and Substance Use Disorder Services *virtual and office*	No charge	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
Specialist Care *virtual and office*	$80 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 *for routine care and treatment of common illnesses; usually found in major pharmacies or retail stores.*	$50 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	$50 copay per visit deductible does not apply‡	50% coinsurance after deductible is met
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
Preventive care / screenings / immunizations	No charge	50% coinsurance after deductible is met
Preventive Care for Chronic Conditions *per IRS guidelines*	No charge	50% coinsurance after deductible is met
Diagnostic Services **Lab**		
Office	No charge	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

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
X-Ray Office Freestanding Radiology Center Outpatient Hospital	$50 copay per visit deductible does not apply‡ 30% coinsurance deductible does not apply 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 *for example: MRI, PET and CAT scans* Office Freestanding Radiology Center Outpatient Hospital	30% coinsurance after deductible is met 30% coinsurance deductible does not apply 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** *includes doctor services. Additional charges may apply depending on the care provided.* **Emergency Room Facility Services** *Your copay, coinsurance and deductible will be waived if admitted.* **Emergency Room Doctor and Other Services** **Ambulance** *Authorized Non-Network non-emergency ambulance services are limited to an Anthem maximum payment of $50,000 per trip.*	$100 copay per visit deductible does not apply $750 copay per visit and then 30% coinsurance deductible does not apply 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
Outpatient Mental Health and Substance Use Disorder Services at a Facility Facility Fees Doctor Services	30% coinsurance after deductible is met 30% 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
Outpatient Surgery		
Facility Fees		
Hospital	$500 copay per visit and 30% coinsurance after deductible is met	50% coinsurance after deductible is met
Ambulatory Surgical Center	$200 copay per visit and 30% coinsurance deductible does not apply	50% coinsurance after deductible is met
Physician and other services *including surgeon fees*		
Hospital	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Ambulatory Surgical Center	30% coinsurance deductible does not apply	50% coinsurance after deductible is met
Hospital (Including Maternity, Mental Health and Substance Use Disorder Services) *If readmitted within 72 hours for the same condition, no additional facility copay is required. If transferred between facilities, only one copay will apply.*		
Facility Fees	$1,000 copay per admission and 30% coinsurance after deductible is met	50% coinsurance after deductible is met
Physician and other services *including surgeon fees*	30% coinsurance after deductible is met	50% coinsurance after deductible is met
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 and Habilitation services *including physical, occupational and speech therapies.* *Coverage for physical therapy is limited to 60 visits per year.* *Coverage for occupational therapy is limited to 20 visits per year.* *Coverage for speech 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
Pulmonary rehabilitation *office and outpatient hospital*	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 and outpatient hospital*	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Dialysis/Hemodialysis *office and outpatient hospital*	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Chemo/Radiation Therapy *office and 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.*	$500 copay per admission 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 *Coverage for wigs is limited to 1 item after cancer treatment per benefit period.*	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Hearing Aids *Hearing Aids for Members 18 years of age and under. Limited to $3,000 per hearing aid per hearing impaired ear every 48 months*	30% coinsurance after deductible is met	50% coinsurance after deductible is met

Covered Prescription Drug Benefits	Cost if you use a Preferred Network Pharmacy	Cost if you use an In-Network Pharmacy	Cost if you use a Non-Network Pharmacy
Pharmacy Deductible *combined for Preferred Network, In-Network and Non-Network Pharmacies*	$600 person / $1,200 family (does not apply to Tier 1a, Tier 1b drugs)	$600 person / $1,200 family (does not apply to Tier 1a, Tier 1b drugs)	$600 person / $1,200 family (does not apply to Tier 1a, Tier 1b drugs)
Pharmacy Out-of-Pocket Limit	Combined with In-Network medical 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:** ***Rx Choice Tiered Network*** **Drug List:** ***Essential*** *Drugs not included on the Essential drug list will not be covered.*			
Day Supply Limits: **Retail Pharmacy** *30 day supply (cost shares noted below)* **Retail 90 Pharmacy** *90 day supply (cost shares noted below)*			

Covered Prescription Drug Benefits	Cost if you use a Preferred Network Pharmacy	Cost if you use an In-Network Pharmacy	Cost if you use a Non-Network Pharmacy
Home Delivery Pharmacy *90 day supply (maximum cost shares noted below). Maintenance medications are available through CarelonRx Pharmacy. You will need to call us on the number on your ID card to sign up when you first use the service.* **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.*			
Tier 1a - Typically Lower Cost Generic *each 90 day supply script filled at Retail 90 pharmacies is subject to 30 day supply cost share charged at Preferred Network and In-Network Retail Pharmacies.*	$20 copay per prescription, Pharmacy deductible does not apply (retail) and $20 copay per prescription, Pharmacy deductible does not apply (home delivery)	$30 copay per prescription, Pharmacy deductible does not apply (retail)	$30 copay per prescription, Pharmacy deductible does not apply (retail only)
Tier 1b - Typically Generic *each 90 day supply script filled at Retail 90 pharmacies is subject to 30 day supply cost share charged at Preferred Network and In-Network Retail Pharmacies.*	$40 copay per prescription, Pharmacy deductible does not apply (retail) and $40 copay per prescription, Pharmacy deductible does not apply (home delivery)	$50 copay per prescription, Pharmacy deductible does not apply (retail)	$50 copay per prescription, Pharmacy deductible does not apply (retail only)
Tier 2 – Typically Preferred Brand *each 90 day supply script filled at Retail 90 pharmacies is subject to 1.2 times the 30 day supply cost share charged at Preferred Network and In-Network Retail Pharmacies.*	$75 copay per prescription after Pharmacy deductible is met (retail) and $150 copay per prescription after Pharmacy deductible is met (home delivery)	$85 copay per prescription after Pharmacy deductible is met (retail)	$85 copay per prescription after Pharmacy deductible is met (retail only)
Tier 3 - Typically Non-Preferred Brand *each 90 day supply script filled at Retail 90 pharmacies is subject to 2.7 times the 30 day supply cost share charged at Preferred Network and In-Network Retail Pharmacies.*	$100 copay per prescription after Pharmacy deductible is met (retail) and $300 copay per prescription after Pharmacy deductible is met (home delivery)	$110 copay per prescription after Pharmacy deductible is met (retail)	$110 copay per prescription after Pharmacy deductible is met (retail only)
Tier 4 - Typically Specialty (brand and generic)	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)	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.
- Screening and diagnostic imaging for the detection of breast cancer, including diagnostic mammograms, 3D mammography, breast ultrasounds and MRIs are covered in full as required by state mandate.
- The limits for physical, occupational, and speech therapy, if any apply to this plan, will not apply if you get care as part of the Mental Health and Substance Use Disorder benefit.
- ‡ You will pay the PCP's office visit copay when services are provided in their 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.
- The representations of benefits in this document are subject to Georgia Department of Insurance (GA DOI) approval and are subject to change.

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.

Anthem Blue Cross and Blue Shield is the trade name of Blue Cross Blue Shield Healthcare Plan of Georgia, Inc. Independent licensee of the Blue Cross and Blue Shield Association. ® ANTHEM is a registered trademark of Anthem Insurance Companies, Inc.

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

Intentionally Left Blank

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 .

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:

Chinese(中文)：如果您對本文件有任何疑問，您有權使用您的語言免費獲得協助和資訊。如需與譯員通話，請致電(855) 397-9267。

Farsi (فارسي)**:** در صورتی که سؤالی پیرامون این سند دارید، این حق را دارید که اطلاعات و کمک را بدون هیچ هزینه ای به زبان مادریتان دریافت کنید. برای گفتگو با یک مترجم شفاهی، با شماره (855) 397-9267 تماس بگیرید.

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.

Japanese (日本語):この文書についてなにかご不明な点があれば、あなたにはあなたの言語で無料で支援を受け情報を得る権利があります。通訳と話すには、(855) 397-9267 にお電話ください。

Korean (한국어): 본 문서에 대해 어떠한 문의사항이라도 있을 경우, 귀하에게는 귀하가 사용하는 언어로 무료 도움 및 정보를 얻을 권리가 있습니다. 통역사와 이야기하려면(855) 397-9267로 문의

Navajo (Diné): Díí naaltsoos biká'ígíí łahgo bína'ídíłkidgo ná bohónéedzą dóó bee ahóót'i' t'áá ni nizaad k'ehjį bee níł hodoonih t'áadoo bááh ílínígóó.

Language Access Services:

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: (855) 99267.

Punjabi (ਪੰਜਾਬੀ): ਜੇ ਤੁਹਾਡੇ ਇਸ ਦਸਤਾਵੇਜ਼ ਬਾਰੇ ਕੋਈ ਸਵਾਲ ਹੁੰਦੇ ਹਨ ਤਾਂ ਤੁਹਾਡੇ ਕੋਲ ਮੁਫ਼ਤ ਵਿੱਚ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮਦਦ ਅਤੇ ਜਾਣਕਾਰੀ [illegible] (855) 397-9267 [illegible]

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.

Spanish (Español): Si tiene preguntas acerca de este documento, tiene derecho a recibir ayuda e información en su idioma, sin costos. Para hablar con un intérprete, llame al (855) 397-9267.

Tagalog (Tagalog): Kung mayroon kang anumang katanungan tungkol sa dokumentong ito, may karapatan kang humingi ng tulong at impormasyon sa iyong wika nang walang bayad. Makipag-usap sa isang tagapagpaliwanag, tawagan ang (855) 397-9267.

Vietnamese (Tiếng Việt): Nếu quý vị có bất kỳ thắc mắc nào về tài liệu này, quý vị có quyền nhận sự trợ giúp và thông tin bằng ngôn ngữ của quý vị hoàn toàn miễn phí. Để trao đổi với một thông dịch viên, hãy gọi (855) 397-9267.

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.