

Anthem® Blue Cross and Blue Shield

Your Plan: One Diversified, LLC: Anthem Blue Open Access POS HSA OAP8

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 after deductible is met
Mental Health & Substance Use Disorder Services	No charge after deductible is met
Specialist care	20% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Overall Deductible	\$3,500 member / \$7,000 family	\$7,000 member / \$14,000 family
Overall Out-of-Pocket Limit	\$5,000 member / \$10,000 family	\$10,000 member / \$20,000 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 deductibles, copayments and coinsurance apply to the out-of-pocket limit (excluding Out-of-Network Human Organ and Tissue Transplant (HOTT), Cellular and Gene Therapy services). In-Network and Out-of-Network deductibles and out-of-pocket limit amounts are separate and do not accumulate toward each other.		
Doctor Visits (virtual and office) <i>You are encouraged to select a Primary Care Physician (PCP).</i>		
Primary Care (PCP) and Mental Health and Substance Use Disorder Services <i>virtual and office</i>	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Specialist Care <i>virtual and office</i>	20% coinsurance after deductible is met	50% coinsurance after deductible is met
<u>Other Practitioner Visits</u>		
Maternity Doctor services (prenatal/postnatal care and delivery)	20% 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 an Out-of-Network Provider
Retail Health Clinic Visit <i>for routine care and treatment of common illnesses; usually found in major pharmacies or retail stores.</i> Manipulation Therapy <i>Coverage is limited to 20 visits per year.</i> Acupuncture	20% coinsurance after deductible is met 20% coinsurance after deductible is met Not covered	50% coinsurance after deductible is met 50% coinsurance after deductible is met Not covered
<u>Other Services in an Office</u> Allergy Testing Prescription Drugs <i>Dispensed in the office</i> Surgery	20% coinsurance after deductible is met 20% coinsurance after deductible is met 20% coinsurance after deductible is met	50% coinsurance after deductible is met 50% 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 <i>per IRS guidelines</i>	No charge	50% coinsurance after deductible is met
<u>Diagnostic Services</u> Lab Office Freestanding Lab/Reference Lab Outpatient Hospital	20% coinsurance after deductible is met 20% coinsurance after deductible is met 20% coinsurance after deductible is met	50% coinsurance after deductible is met 50% coinsurance after deductible is met 50% coinsurance after deductible is met
X-Ray Office Freestanding Radiology Center Outpatient Hospital	20% coinsurance after deductible is met 20% coinsurance after deductible is met 20% 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 <i>for example: MRI, PET and CAT scans</i> Office	20% 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 an Out-of-Network Provider
Freestanding Radiology Center	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Outpatient Hospital	\$500 copay per visit and 20% coinsurance after deductible is met	50% coinsurance after deductible is met
<u>Emergency and Urgent Care</u>		
Urgent Care	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Emergency Room Facility Services <i>Your coinsurance and deductible will be waived if admitted.</i>	20% coinsurance after deductible is met	Covered as In-Network
Emergency Room Doctor and Other Services	20% coinsurance after deductible is met	Covered as In-Network
Ambulance <i>Authorized Out-of-Network non-emergency ambulance services are limited to an Anthem maximum payment of \$50,000 per trip.</i>	20% coinsurance after deductible is met	Covered as In-Network
Outpatient Mental Health and Substance Use Disorder Services at a Facility		
Facility Fees	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Doctor Services	20% coinsurance after deductible is met	50% coinsurance after deductible is met
<u>Outpatient Surgery</u>		
Facility Fees		
Hospital	\$500 copay per visit and 20% coinsurance after deductible is met	50% coinsurance after deductible is met
Ambulatory Surgical Center	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Physician and other services <i>including surgeon fees</i>		
Hospital	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Ambulatory Surgical Center	20% coinsurance after deductible is met	50% coinsurance after deductible is met
<u>Hospital (Including Maternity, Mental Health and Substance Use Disorder Services)</u>		
Facility Fees	20% 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 an Out-of-Network Provider
Physician and other services <i>including surgeon fees</i>	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Home Health Care <i>Coverage is limited to 60 visits per benefit period. Limits are combined for all home health services.</i>	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Rehabilitation and Habilitation services <i>including physical, occupational and speech therapies.</i> <i>Coverage for physical, occupational, and speech therapies is limited to 37 visits each per year.</i>		
Office	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Outpatient Hospital	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Pulmonary rehabilitation <i>office and outpatient hospital</i>	20% coinsurance after deductible is met	50% coinsurance after deductible is met
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>	20% coinsurance after deductible is met	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>Coverage is limited to 1 item per hearing-impaired ear up to \$3,000 per ear, every 36 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 Out-of-Network Pharmacy
Pharmacy Deductible	Combined with in network medical deductible	Combined with out of network medical deductible
Pharmacy Out-of-Pocket Limit	Combined with in network medical out of pocket	Combined with out of network medical out of pocket
Prescription Drug Coverage Network: WellDyne Drug List: Clinical Focus		
Day Supply Limits: Retail Pharmacy 30-day supply (cost shares noted below) Retail 90 Pharmacy 90-day supply (cost shares noted below) Home Delivery Pharmacy 90-day supply (maximum cost shares noted below). You will need to call WellDyne 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). WellDyne 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 1 - Typically Generic	\$15 copay per prescription after deductible is met (retail) and \$30 copay per prescription after deductible is met (home delivery)	\$15 copay per prescription after deductible is met (retail)
Tier 2 – Typically Preferred Brand	\$40 copay per prescription after deductible is met (retail) and \$80 copay per prescription after deductible is met (home delivery)	\$40 copay per prescription after deductible is met (retail)
Tier 3 - Typically Non-Preferred Brand	\$70 copay per prescription after deductible is met (retail) and \$140 copay per prescription after deductible is met	\$70 copay per prescription after deductible is met (retail)

Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use a Out-of-Network Pharmacy
	(home delivery)	

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 after deductible 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.

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

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 (فارسی): 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 문의하십시오.

Navajo (Diné): Díí naaltsoos biká'ígíí lahgo bina'ídiłkidgo ná bohónéedzá dóó bee ahóót'i' t'áá ni nizaad k'ehj bee níl hodoonih t'áadoo báąh ilínígóó. Ata' halne'ígíí ła' bich'í' hadeesdzih nínízingo koj' hodiłnih (855) 397-9267.

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) 397-9267.

Punjabi (ਪੰਜਾਬੀ): ਜੇ ਤੁਹਾਡੇ ਇਸ ਦਸਤਾਵੇਜ਼ ਬਾਰੇ ਕੋਈ ਸਵਾਲ ਹੁੰਦੇ ਹਨ ਤਾਂ ਤੁਹਾਡੇ ਕੋਲ ਮੁਫਤ ਵਿੱਚ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮਦਦ ਅਤੇ ਜਾਣਕਾਰੀ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੁੰਦਾ ਹੈ। ਇੱਕ ਦੁਭਾਸ਼ੀਏ ਨਾਲ ਗੱਲ ਕਰਨ ਲਈ, (855) 397-9267 ਤੇ ਕਾਲ ਕਰੋ।

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>.