

Your summary of benefits



Anthem® Blue Cross and Blue Shield

Your Plan: One Diversified, LLC: Anthem Blue Open Access POS OAP5

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	\$50 copay per visit deductible does not apply

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Overall Deductible	\$1,000 member / \$2,000 family	\$2,000 member / \$4,000 family
Overall Out-of-Pocket Limit	\$5,000 member / \$9,500 family	\$8,000 member / \$16,000 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) *You are encouraged to select a Primary Care Physician (PCP).*

Primary Care (PCP) and Mental Health and Substance Use Disorder Services <i>virtual and office</i>	\$30 copay per visit deductible does not apply	50% coinsurance after deductible is met
Specialist Care <i>virtual and office</i>	\$50 copay per visit deductible does not apply	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	\$30 copay per visit deductible does not apply \$30 copay per visit deductible does not apply 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	\$30/\$50 copay per visit deductible does not apply [†] 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	No charge No charge 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	No charge No charge 20% coinsurance after deductible is met	 50% 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 an Out-of-Network Provider
Advanced Diagnostic Imaging <i>for example: MRI, PET and CAT scans</i> Office Freestanding Radiology Center Outpatient Hospital	20% coinsurance after deductible is met 20% coinsurance deductible does not apply \$500 copay per occurrence and 20% 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 <i>includes doctor services. Additional charges may apply depending on the care provided.</i> Emergency Room Facility Services <i>Your copay will be waived if admitted.</i> Emergency Room Doctor and Other Services Ambulance <i>Authorized Out-of-Network non-emergency ambulance services are limited to an Anthem maximum payment of \$50,000 per trip. The \$50,000 limit does not apply to air ambulance services.</i>	\$75 copay per visit deductible does not apply \$200 copay per visit deductible does not apply 20% coinsurance deductible does not apply 20% coinsurance after deductible is met	50% coinsurance after deductible is met Covered as In-Network Covered as In-Network Covered as In-Network
<u>Outpatient Mental Health and Substance Use Disorder Services at a Facility</u> Facility Fees Doctor Services	20% coinsurance after deductible is met 20% coinsurance after deductible is met	50% coinsurance after deductible is met 50% coinsurance after deductible is met
<u>Outpatient Surgery</u> Facility Fees Hospital Ambulatory Surgical Center	\$500 copay per occurrence and 20% coinsurance after deductible is met 20% 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 an Out-of-Network Provider
Physician and other services <i>including surgeon fees</i> Hospital Ambulatory Surgical Center	20% coinsurance after deductible is met 20% coinsurance after deductible is met	50% 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 Physician and other services <i>including surgeon fees</i>	20% coinsurance after deductible is met 20% coinsurance after deductible is met	50% 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 Outpatient Hospital	\$30 copay per visit deductible does not apply 20% coinsurance after deductible is met	50% 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 Office Outpatient Hospital	\$30 copay per visit deductible does not apply 20% coinsurance after deductible is met	50% 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

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
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 an Out-of-Network Pharmacy
Pharmacy Deductible	Not Applicable	Not Applicable
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	\$10 copay per prescription (retail) and \$20 copay per prescription (home delivery)	\$10 copay per prescription (retail)

Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use an Out-of-Network Pharmacy
Tier 2 – Typically Preferred Brand	\$35 copay per prescription (retail) and \$70 copay per prescription (home delivery)	\$35 copay per prescription (retail)
Tier 3 - Typically Non-Preferred Brand	\$60 copay per prescription (retail) and \$120 copay per prescription (home delivery)	\$60 copay per prescription (retail)

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.

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

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Get help in your language

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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

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(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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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 la' bich'í' hadeesdzih nínízingo koj' hodiłnih (855) 397-9267.

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