

# Your summary of benefits



Anthem® Blue Cross and Blue Shield

Your Plan: One Diversified, LLC HSA OA POS

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  |
|--|---|---|
| <b>Overall Deductible</b>  | \$4,000 member /<br>\$8,000 family      | \$6,000 member /<br>\$12,000 family     |
| <b>Out-of-Pocket Limit</b>   | \$6,000 member /<br>\$9,000 family      | \$10,000 member /<br>\$20,000 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. |   |   |
| <b>Preventive Care / Screening / Immunization</b>  | No charge                               | 50% coinsurance after deductible is met |
| <b><u>Doctor Home and Office Services</u></b>  |   |   |
| <b>Primary Care Visit</b>  | 20% coinsurance after deductible is met | 50% coinsurance after deductible is met |
| <b>Specialist Care Visit</b>   | 20% coinsurance after deductible is met | 50% coinsurance after deductible is met |
| <b>Prenatal and Post-natal Care</b>  | 20% coinsurance after deductible is met | 50% coinsurance after deductible is met |
| <b><u>Other Practitioner Visits:</u></b>   |   |   |
| Retail Health Clinic Visit   | 20% coinsurance after deductible is met | 50% coinsurance after deductible is met |
| On-line Medical Visit  | 0% coinsurance after deductible is met  | 50% coinsurance after deductible is met |
| Manipulation Therapy<br><i>Coverage is limited to 20 visits per year.</i>  | 20% coinsurance after deductible is met | 50% coinsurance after deductible is met |
| Acupuncture  | Not covered                             | Not covered                             |

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

GA/LG/One Diversified, LLC HSA OA POS/595F/01-01-2021

| Covered Medical Benefits   | Cost if you use an In-Network Provider   | Cost if you use a Non-Network Provider   |
|--|--|--|
|  |  |  |
| <b><u>Other Services in an Office:</u></b><br>Allergy Testing<br><br>Chemo/Radiation Therapy<br><br>Dialysis/Hemodialysis<br><br>Prescription Drugs - <i>Dispensed in the office</i> | 20% coinsurance after deductible is met<br><br>20% coinsurance after deductible is met<br><br>20% coinsurance after deductible is met<br><br>20% coinsurance after deductible is met | 50% coinsurance after deductible is met<br><br>50% coinsurance after deductible is met<br><br>50% coinsurance after deductible is met<br><br>50% coinsurance after deductible is met |
| <b><u>Diagnostic Services</u></b><br><b>Lab:</b><br>Office<br><br>Freestanding Lab/Reference Lab<br><br>Outpatient Hospital  | 20% coinsurance after deductible is met<br><br>20% coinsurance after deductible is met<br><br>20% coinsurance after deductible is met  | 50% coinsurance after deductible is met<br><br>50% coinsurance after deductible is met<br><br>50% coinsurance after deductible is met  |
| <b>X-Ray:</b><br>Office<br><br>Freestanding Radiology Center<br><br>Outpatient Hospital  | 20% coinsurance after deductible is met<br><br>30% coinsurance after deductible is met<br><br>30% coinsurance after deductible is met  | 50% coinsurance after deductible is met<br><br>50% coinsurance after deductible is met<br><br>50% coinsurance after deductible is met  |
| <b>Advanced Diagnostic Imaging:</b><br>Office<br><br>Freestanding Radiology Center   | 20% coinsurance after deductible is met<br><br>30% coinsurance after deductible is met   | 50% coinsurance after deductible is met<br><br>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  | \$500 copay per occurrence and 20% coinsurance after deductible is met | \$500 copay per occurrence and 50% coinsurance after deductible is met |
| <b><u>Emergency and Urgent Care</u></b><br>Urgent Care                                       | 20% coinsurance after deductible is met                                | 50% coinsurance after deductible is met                                |
| Emergency Room Facility Services   | 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  |
| <b><u>Ambulance</u></b>  | 20% coinsurance after deductible is met                                | Covered as In-Network  |
| <b><u>Outpatient Mental/Behavioral Health and Substance Abuse</u></b><br>Doctor Office Visit | 20% coinsurance after deductible is met                                | 50% coinsurance after deductible is met                                |
| Facility Visit:  |  |  |
| 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                                |
| <b><u>Outpatient Surgery</u></b><br>Facility Fees:   |  |  |
| Hospital   | \$500 copay per occurrence and 20% coinsurance after deductible is met | \$500 copay per occurrence and 50% coinsurance after deductible is met |
| Freestanding Surgical Center   | 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 a Non-Network Provider   |
|---|--|--|
| <b>Doctor and Other Services:</b><br><br>Hospital<br><br>Freestanding Surgical Center   | 20% coinsurance after deductible is met<br><br>20% coinsurance after deductible is met | 50% coinsurance after deductible is met<br><br>50% coinsurance after deductible is met |
| <b><u>Hospital (Including Maternity, Mental / Behavioral Health, Substance Abuse):</u></b><br><br><b>Facility Fees</b><br><br><b>Doctor and other services</b>  | 20% coinsurance after deductible is met<br><br>20% coinsurance after deductible is met | 50% coinsurance after deductible is met<br><br>50% coinsurance after deductible is met |
| <b><u>Recovery &amp; Rehabilitation</u></b><br><br><b>Home Health Care</b><br><i>Coverage is limited to 60 visits per benefit period.</i>   | 20% coinsurance after deductible is met  | 50% coinsurance after deductible is met  |
| <b>Rehabilitation services:</b><br><br>Office<br><i>Coverage for rehabilitative and habilitative physical therapy and occupational therapy combined is limited to 37 visits per year. Coverage for rehabilitative and habilitative speech therapy is limited to 37 visits per year.</i><br><br>Outpatient Hospital<br><i>Limits are combined with Rehabilitation office visits.</i> | 20% coinsurance after deductible is met<br><br>20% coinsurance after deductible is met | 50% coinsurance after deductible is met<br><br>50% coinsurance after deductible is met |
| <b>Cardiac rehabilitation</b><br><br>Office<br><i>Coverage is limited to 36 visits per year.</i><br><br>Outpatient Hospital<br><i>Coverage is limited to 36 visits per year.</i>  | 20% coinsurance after deductible is met<br><br>20% coinsurance after deductible is met | 50% coinsurance after deductible is met<br><br>50% coinsurance after deductible is met |
| <b>Skilled Nursing Care (facility)</b><br><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  |

| Covered Medical Benefits  | Cost if you use an In-Network Provider  | Cost if you use a Non-Network Provider  |
|---------------------------|---|---|
| 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        | 20% 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                | Combined with medical deductible       | Combined with medical deductible       |
| Pharmacy Out of Pocket             | Combined with medical                  | Combined with medical                  |

### Prescription Drug Coverage

*Essential Drug List Formulary - No coverage for non-formulary drugs*

*Opt-out Home Delivery for Maintenance Drugs - see notes below*

*R90 - Up to a 90 day supply for maintenance drugs is available at most retail pharmacies if you opt out of Home Delivery*

|   |  |   |
|---|--|---|
| <b>Tier 1 - Typically Generic</b><br><i>90 day supply (retail pharmacy). 90 day supply (home delivery).</i>             | \$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 only) |
| <b>Tier 2 – Typically Preferred Brand</b><br><i>90 day supply (retail pharmacy). 90 day supply (home delivery).</i>     | \$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 only) |
| <b>Tier 3 - Typically Non-Preferred Brand</b><br><i>90 day supply (retail pharmacy). 90 day supply (home delivery).</i> | \$70 copay per prescription after deductible is met (retail) and \$140 copay   | \$70 copay per prescription after deductible is met (retail only) |

| Covered Prescription Drug Benefits | Cost if you use an In-Network Provider                   | Cost if you use a Non-Network Provider |
|------------------------------------|--|--|
|                                    | per prescription after deductible is met (home delivery) |  |

**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](http://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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## 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

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(TTY/TDD: 711)

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