Your summary of benefits

Anthem® Blue Cross and Blue Shield

Your Plan: One Diversified, LLC 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
Overall Deductible	$750 member / $1,500 family	$2,000 member / $4,000 family
Out-of-Pocket Limit	$4,500 member / $9,000 family	$8,000 member / $16,000 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.		
Preventive Care / Screening / Immunization	No charge	50% coinsurance after deductible is met
Doctor Home and Office Services		
Primary Care Visit	$30 copay per visit deductible does not apply	50% coinsurance after deductible is met
Specialist Care Visit	$50 copay per visit deductible does not apply	50% coinsurance after deductible is met
Prenatal and Post-natal Care	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Other Practitioner Visits:		
Retail Health Clinic Visit	$30 copay per visit deductible does not apply	50% coinsurance after deductible is met
On-line Medical Visit	No charge for the first 12 visits and then $10 copay per visit deductible does not apply	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
Manipulation Therapy *Coverage is limited to 20 visits per year.*	$30 copay per visit deductible does not apply	50% coinsurance after deductible is met
Acupuncture	Not covered	Not covered
Other Services in an Office:		
Allergy Testing	$30 copay per visit deductible does not apply	50% coinsurance after deductible is met
Chemo/Radiation Therapy	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Dialysis/Hemodialysis	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Prescription Drugs - *Dispensed in the office*	20% coinsurance after deductible is met	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	20% coinsurance deductible does not apply	50% coinsurance after deductible is met
X-Ray:		
Office	No charge	50% coinsurance after deductible is met
Freestanding Radiology Center	No charge	50% coinsurance after deductible is met
Outpatient Hospital	20% coinsurance deductible does not apply	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
Advanced Diagnostic Imaging:		
Office	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Freestanding Radiology Center	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Outpatient Hospital	$500 copay per occurrence and 20% coinsurance after deductible is met	50% coinsurance after deductible is met
Emergency and Urgent Care		
Urgent Care	$75 copay per visit deductible does not apply	50% coinsurance after deductible is met
Emergency Room Facility Services *Copay waived if admitted.*	$200 copay per visit deductible does not apply	Covered as In-Network
Emergency Room Doctor and Other Services	20% coinsurance deductible does not apply	Covered as In-Network
Ambulance	20% coinsurance after deductible is met	Covered as In-Network
Outpatient Mental/Behavioral Health and Substance Abuse		
Doctor Office Visit	$30 copay per visit deductible does not apply	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

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 occurrence and 20% coinsurance after deductible is met	50% coinsurance after deductible is met
Freestanding Surgical Center	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Doctor and Other Services:		
Hospital	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Freestanding Surgical Center	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Hospital (Including Maternity, Mental / Behavioral Health, Substance Abuse):		
Facility Fees	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Doctor and other services	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Recovery & Rehabilitation		
Home Health Care *Coverage is limited to 60 visits per benefit period.*	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Rehabilitation services:		
Office *Coverage for Occupational Therapy is limited to 37 visits per year, Physical Therapy is limited to 37 visits per year and Speech Therapy is limited to 37 visits per year. Limit is combined for rehabilitative and habilitative services.*	$30 copay per visit deductible does not apply	50% coinsurance after deductible is met
Outpatient Hospital *Limits are combined with Rehabilitation office visits.*	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
Cardiac rehabilitation Office *Coverage is limited to 36 visits per year.* Outpatient Hospital *Limits are combined with Rehabilitation office visits.*	 $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
Skilled Nursing Care (facility) *Coverage for Inpatient rehabilitation and skilled nursing services is limited to 60 days combined per benefit period.*	20% coinsurance after deductible is met	50% coinsurance after deductible is met
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	Not applicable	Not applicable
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*		
Tier 1 - Typically Generic *90 day supply (retail pharmacy). 90 day supply (home delivery).*	$10 copay per prescription, deductible does not apply (retail) and $20 copay per prescription, deductible does not apply (home delivery)	$10 copay per prescription, deductible does not apply (retail only)

Covered Prescription Drug Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Tier 2 – Typically Preferred Brand *90 day supply (retail pharmacy). 90 day supply (home delivery).*	$35 copay per prescription, deductible does not apply (retail) and $70 copay per prescription, deductible does not apply (home delivery)	$35 copay per prescription, deductible does not apply (retail only)
Tier 3 - Typically Non-Preferred Brand *90 day supply (retail pharmacy). 90 day supply (home delivery).*	$60 copay per prescription, deductible does not apply (retail) and $120 copay per prescription, deductible does not apply (home delivery)	$60 copay per prescription, deductible does not apply (retail only)

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 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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(TTY/TDD: 711)

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