# Your summary of benefits

Anthem®

Milton Park Partners, Inc.

Anthem® Blue Cross and Blue Shield

Your Plan: Anthem Blue Open Access POS OAP5 5000/0%/8150 KE

Your Network: Blue Open Access POS-**Draft**

| Covered Medical Benefits | Cost if you use an In-Network Provider | Cost if you use a Non-Network Provider |
|---|---|---|
| **Overall Deductible** | $5,000 member / $10,000 family | $10,000 member / $20,000 family |
| **Out-of-Pocket Limit** | $8,150 member / $16,300 family | $15,000 member / $30,000 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 | 30% coinsurance after deductible is met |
| **Doctor Home and Office Services** | | |
| **Primary Care Visit** | $25 copay per visit deductible does not apply | 30% coinsurance after deductible is met |
| **Specialist Care Visit** | $50 copay per visit deductible does not apply | 30% coinsurance after deductible is met |
| **Prenatal and Post-natal Care** | 0% coinsurance after deductible is met | 30% coinsurance after deductible is met |
| **Other Practitioner Visits:** | | |
| Medical Chats - *within our mobile app* | No charge | Not Applicable |
| Retail Health Clinic Visit | $25 copay per visit deductible does not apply | 30% coinsurance after deductible is met |

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| Covered Medical Benefits | Cost if you use an In-Network Provider | Cost if you use a Non-Network Provider |
|---|---|---|
| Preferred On-line Visit<br>*Includes Mental Health and Substance Abuse* | No charge for the first 12 visits and then $10 copay per visit deductible does not apply | 30% coinsurance after deductible is met |
| Other Participating Provider On-line Visit<br>*Includes Mental Health and Substance Abuse* | $25 copay per visit deductible does not apply | 30% coinsurance after deductible is met |
| Manipulation Therapy<br>*Coverage is limited to 20 visits per year.* | $25 copay per visit deductible does not apply | 30% 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‡ | 30% coinsurance after deductible is met |
| Chemo/Radiation Therapy | 0% coinsurance after deductible is met | 30% coinsurance after deductible is met |
| Dialysis/Hemodialysis | 0% coinsurance after deductible is met | 30% coinsurance after deductible is met |
| Prescription Drugs - *Dispensed in the office* | 0% coinsurance after deductible is met | 30% coinsurance after deductible is met |
| **Diagnostic Services**<br>**Lab:** | | |
| Office | **PCP**<br>$25 copay per visit deductible does not apply<br>**Specialist**<br>$50 copay per visit deductible does not apply | 30% coinsurance after deductible is met |
| Freestanding Lab/Reference Lab | No charge | 30% coinsurance after deductible is met |
| Outpatient Hospital | 0% coinsurance after deductible is met | 30% 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 | **PCP**<br>$25 copay per visit deductible does not apply<br>**Specialist**<br>$50 copay per visit deductible does not apply | 30% coinsurance after deductible is met |
| Freestanding Radiology Center | 0% coinsurance deductible does not apply | 30% coinsurance after deductible is met |
| Outpatient Hospital | 0% coinsurance after deductible is met | 30% coinsurance after deductible is met |
| **Advanced Diagnostic Imaging:** | | |
| Office | 0% coinsurance after deductible is met | 30% coinsurance after deductible is met |
| Freestanding Radiology Center | 0% coinsurance deductible does not apply | 30% coinsurance after deductible is met |
| Outpatient Hospital | 0% coinsurance after deductible is met | 30% coinsurance after deductible is met |
| **Emergency and Urgent Care** | | |
| **Urgent Care** | $50 copay per visit deductible does not apply | 30% coinsurance after deductible is met |
| **Emergency Room Facility Services**<br>*Cost share waived if admitted.* | $500 copay per visit deductible does not apply | Covered as In-Network |
| **Emergency Room Doctor and Other Services** | 0% coinsurance deductible does not apply | Covered as In-Network |
| **Ambulance** | 0% coinsurance after deductible is met | Covered as In-Network |

| Covered Medical Benefits | Cost if you use an In-Network Provider | Cost if you use a Non-Network Provider |
|---|---|---|
| **Outpatient Mental/Behavioral Health and Substance Abuse** | | |
| **Doctor Office Visit** | $25 copay per visit deductible does not apply | 30% coinsurance after deductible is met |
| **Facility Visit:** | | |
| Facility Fees | 0% coinsurance after deductible is met | 30% coinsurance after deductible is met |
| Doctor Services | 0% coinsurance after deductible is met | 30% coinsurance after deductible is met |
| **Outpatient Surgery** | | |
| **Facility Fees:** | | |
| Hospital | 0% coinsurance after deductible is met | 30% coinsurance after deductible is met |
| Freestanding Surgical Center | $500 copay per visit deductible does not apply | 30% coinsurance after deductible is met |
| **Doctor and Other Services:** | | |
| Hospital | 0% coinsurance after deductible is met | 30% coinsurance after deductible is met |
| Freestanding Surgical Center | 0% coinsurance deductible does not apply | 30% coinsurance after deductible is met |
| **Hospital (Including Maternity, Mental / Behavioral Health, Substance Abuse):** | | |
| **Facility Fees** | $2,500 copay per day to a maximum of $7,500 per admission | 30% coinsurance after deductible is met |
| **Doctor and other services** | 0% coinsurance after deductible is met | 30% coinsurance after deductible is met |
| **Recovery & Rehabilitation** | | |
| **Home Health Care**<br>*Coverage is limited to 100 visits per benefit period. Limits are combined for all home health services.* | 0% coinsurance after deductible is met | 30% coinsurance after deductible is met |

| Covered Medical Benefits | Cost if you use an In-Network Provider | Cost if you use a Non-Network Provider |
|---|---|---|
| **Rehabilitation services:** | | |
| Office<br>*Coverage for rehabilitative and habilitative physical therapy and occupational therapy combined is limited to 60 visits per year. Coverage for rehabilitative and habilitative speech therapy is limited to 40 visits per year.* | $25 copay per visit deductible does not apply | 30% coinsurance after deductible is met |
| Outpatient Hospital<br>*Limits are combined with Rehabilitation office visits*. | 0% coinsurance after deductible is met | 30% coinsurance after deductible is met |
| **Cardiac rehabilitation** | | |
| Office | 0% coinsurance after deductible is met | 30% coinsurance after deductible is met |
| Outpatient Hospital | 0% coinsurance after deductible is met | 30% coinsurance after deductible is met |
| **Skilled Nursing Care (facility)**<br>*Coverage for Inpatient rehabilitation and skilled nursing services is limited to 60 days combined per benefit period.* | 0% coinsurance after deductible is met | 30% coinsurance after deductible is met |
| **Hospice** | 0% coinsurance after deductible is met | 30% coinsurance after deductible is met |
| **Durable Medical Equipment** | 0% coinsurance after deductible is met | 30% coinsurance after deductible is met |
| **Prosthetic Devices** | 0% coinsurance after deductible is met | 30% 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** | $200 person / $400 family | $200 person / $400 family |
| **Pharmacy Out of Pocket** | Combined with medical | Combined with medical |
| **Prescription Drug Coverage**<br>*National Network with R90 and Optional home delivery Up to a 90-day supply is available at participating retail pharmacies.*<br>*Essential Drug List*<br>*No coverage for non-formulary drugs.* | | |
| **Tier 1 - Typically Generic**<br>*Per 30 day supply (retail pharmacy). Per 90 day supply (home delivery).* | $10 copay per prescription, Pharmacy deductible does not apply (retail and home delivery) | $10 copay per prescription, Pharmacy deductible does not apply (retail only) |
| **Tier 2 – Typically Preferred Brand**<br>*Per 30 day supply (retail pharmacy). Per 90 day supply (home delivery).* | $45 copay per prescription after Pharmacy deductible is met (retail) and $90 copay per prescription after Pharmacy deductible is met (home delivery) | $45 copay per prescription after Pharmacy deductible is met (retail only) |
| **Tier 3 - Typically Non-Preferred Brand**<br>*Per 30 day supply (retail pharmacy). Per 90 day supply (home delivery).* | $85 copay per prescription after Pharmacy deductible is met (retail) and $255 copay per prescription after Pharmacy deductible is met (home delivery) | $85 copay per prescription after Pharmacy deductible is met (retail only) |
| **Tier 4 - Typically Specialty (brand and generic)**<br>*Per 30 day supply (retail pharmacy). Per 30 day supply (home delivery).* | $125 copay per prescription after Pharmacy deductible is met (retail and home delivery) | $125 copay per prescription after Pharmacy deductible is met (retail only) |

**Notes:**

- Your copays, coinsurance and deductible count toward your out of pocket amount.
- 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.
- ‡ Your cost share may be reduced when services are provided in a PCP's 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.

*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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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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