# Your summary of benefits

Anthem

Anthem® Blue Cross and Blue Shield

Your Contract Code: 79D4

Your Plan: The FedCap Group, Inc.: EPO

Your Network: Blue Access

| 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** | $40 copay per visit deductible does not apply |

| Covered Medical Benefits | Cost if you use an In-Network Provider | Cost if you use a Non-Network Provider |
|---|---|---|
| **Overall Deductible**<br>*Your plan applies a separate Pharmacy Deductible to prescription drugs obtained at a pharmacy. See the Covered Prescription Drug Benefits section.* | $500 person /<br>$1,000 family | Not covered |
| **Overall Out-of-Pocket Limit** | $7,150 person /<br>$14,300 family | Not covered |
| The family deductible and out-of-pocket limit are embedded, meaning the cost shares of one family member will be applied to the per person deductible and per person 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 person deductible or per person out-of-pocket limit.<br>All medical and prescription drug deductibles, copayments and coinsurance apply to the out-of-pocket limit. | | |
| **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** *virtual and office* | $25 copay per visit deductible does not apply | Not covered |
| **Specialist Care** *virtual and office* | $40 copay per visit deductible does not apply | Not covered |
| **Other Practitioner Visits** | | |
| **Routine Maternity Care** (Prenatal and Postnatal) | 20% coinsurance after deductible is met | Not covered |

| Covered Medical Benefits | Cost if you use an In-Network Provider | Cost if you use a Non-Network Provider |
|---|---|---|
| **Retail Health Clinic** *for routine care and treatment of common illnesses; usually found in major pharmacies or retail stores.* | $25 copay per visit deductible does not apply | Not covered |
| **Chiropractic Services** | $25 copay per visit deductible does not apply | Not covered |
| **Acupuncture** | $40 copay per visit deductible does not apply | Not covered |
| **Other Services in an Office** | | |
| **Allergy Testing** | $40 copay per visit deductible does not apply‡ | Not covered |
| **Prescription Drugs** *Dispensed in the office* | 20% coinsurance after deductible is met | Not covered |
| **Surgery** | $40 copay per visit deductible does not apply‡ | Not covered |
| **Preventive care / screenings / immunizations** | No charge | Not covered |
| **Diagnostic Services** | | |
| **Lab** | | |
| Office | No charge | Not covered |
| Freestanding Lab/Reference Lab | No charge | Not covered |
| Outpatient Hospital | 20% coinsurance after deductible is met | Not covered |
| **X-Ray** | | |
| Office | No charge | Not covered |
| Outpatient Hospital | 20% coinsurance after deductible is met | Not covered |
| **Advanced Diagnostic Imaging** *for example: MRI, PET and CAT scans* | | |
| Office | 20% coinsurance after deductible is met | Not covered |
| Outpatient Hospital | 20% coinsurance after deductible is met | Not covered |

| Covered Medical Benefits | Cost if you use an In-Network Provider | Cost if you use a Non-Network Provider |
|---|---|---|
| **Emergency and Urgent Care** | | |
| **Urgent Care** *includes doctor services. Additional charges may apply depending on the care provided.* | $40 copay per visit deductible does not apply | Covered as In-Network |
| **Emergency Room Facility Services**<br>*Your copay will be waived if admitted within 24 hours.* | $250 copay per occurrence for the first 1 visit deductible does not apply | Covered as In-Network |
| **Emergency Room Doctor and Other Services** | No charge | Covered as In-Network |
| **Ambulance** | 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 deductible does not apply | Not covered |
| Doctor Services | 20% coinsurance deductible does not apply | Not covered |
| **Outpatient Surgery** | | |
| **Facility Fees** | | |
| Hospital | 20% coinsurance after deductible is met | Not covered |
| Ambulatory Surgical Center | 20% coinsurance after deductible is met | Not covered |
| **Physician and other services** *including surgeon fees* | | |
| Hospital | 20% coinsurance after deductible is met | Not covered |
| Ambulatory Surgical Center | 20% coinsurance after deductible is met | Not covered |
| **Hospital (Including Maternity, Mental Health and Substance Use Disorder Services)** | | |
| **Facility Fees**<br>*Coverage for Inpatient Rehabilitation is limited to 60 days per benefit period.* | 20% coinsurance after deductible is met | Not covered |

| Covered Medical Benefits | Cost if you use an In-Network Provider | Cost if you use a Non-Network Provider |
|---|---|---|
| **Physician and other services** *including surgeon fees* | 20% coinsurance after deductible is met | Not covered |
| **Home Health Care**<br>*Coverage is limited to 100 visits per benefit period.* | 20% coinsurance deductible does not apply | Not covered |
| **Rehabilitation and Habilitation services** *including physical, occupational and speech therapies.*<br>*Coverage for physical therapy is limited to 90 visits per benefit period.*<br>*Coverage for occupational and speech therapies is limited to 30 visits combined per benefit period.* | | |
| Office | $25 copay per visit deductible does not apply | Not covered |
| Outpatient Hospital | 20% coinsurance after deductible is met | Not covered |
| **Pulmonary rehabilitation** *office and outpatient hospital* | 20% coinsurance after deductible is met | Not covered |
| **Cardiac rehabilitation** *office and outpatient hospital* | 20% coinsurance after deductible is met | Not covered |
| **Dialysis/Hemodialysis** *office and outpatient hospital*<br>*Coverage is limited to 10 visits per benefit period. Applies to Non Network.* | 20% coinsurance after deductible is met | 20% coinsurance after deductible is met |
| **Chemo/Radiation Therapy** *office and outpatient hospital* | 20% coinsurance after deductible is met | Not covered |
| **Skilled Nursing Care (facility)**<br>*Coverage is limited to 60 days per benefit period.* | 20% coinsurance after deductible is met | Not covered |
| **Inpatient Hospice** | 20% coinsurance after deductible is met | Not covered |
| **Durable Medical Equipment** | 20% coinsurance after deductible is met | Not covered |
| **Prosthetic Devices**<br>*Coverage for wigs is limited to 1 item after cancer treatment per benefit period.* | 20% coinsurance after deductible is met | Not covered |

| Covered Prescription Drug Benefits | Cost if you use an In-Network Pharmacy | Cost if you use a Non-Network Pharmacy |
|---|---|---|
| **Pharmacy Deductible** | $100 person / $200 family (does not apply to Tier 1 drugs) | Not covered |
| **Pharmacy Out-of-Pocket Limit** | Combined with In-Network medical out-of-pocket limit | Not covered |
| **Prescription Drug Coverage**<br>**Network:** ***Base Network***<br>**Drug List:** ***Essential*** *Drugs not included on the Essential drug list will not be covered.* | | |
| **Day Supply Limits:**<br>**Retail Pharmacy** *30 day supply (cost shares noted below)*<br>**Retail 90 Pharmacy** *90 day supply (3 times the 30 day supply cost share(s) charged at In-Network Retail Pharmacies noted below applies).*<br>**Home Delivery Pharmacy** *90 day supply (maximum cost shares noted below). Maintenance medications are available through CarelonRx Pharmacy. You will need to call us on the number on your ID card to sign up when you first use the service.*<br>**Specialty Pharmacy** *30 day supply (cost shares noted below for retail and home delivery apply). We may require certain drugs with special handling, provider coordination or patient education be filled by our designated specialty pharmacy.* | | |
| **Tier 1 - Typically Generic** | $10 copay per prescription, Pharmacy deductible does not apply (retail) and $20 copay per prescription, Pharmacy deductible does not apply (home delivery) | Not covered |
| **Tier 2 – Typically Preferred Brand** | $35 copay per prescription after Pharmacy deductible is met (retail) and $70 copay per prescription after Pharmacy deductible is met (home delivery) | Not covered |
| **Tier 3 - Typically Non-Preferred Brand/Specialty Drugs** | Greater of $80 or 20% coinsurance up to $400 per prescription after Pharmacy deductible is met (retail and home delivery) | Not covered |

**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.
- 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.
- Covered Infertility services: lab and radiology tests, cryopreservation, fertility drugs, surgical treatments such as: Artificial Insemination, In-vitro fertilization (IVF), GIFT, ZIFT. Cost share will be applied based on service and setting.

*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 Evidence of Coverage (EOC). If there is a difference between this summary and the Evidence of Coverage (EOC), the Evidence of Coverage (EOC), will prevail.*



Questions: Visit us at www.anthem.com

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## Language Access Services:

# 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 (844) 241-7085

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)**

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## Language Access Services:

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