Your summary of benefits

Anthem

Anthem® Blue Cross and Blue Shield

Your Contract Code: 79D7

Your Plan: The FedCap Group, Inc.: PPO

Your Network: PPO

Out-of-Network Reimbursement rate: 330% of National Medicare

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	$35 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 *Your plan applies a separate Pharmacy Deductible to prescription drugs obtained at a pharmacy. See the Covered Prescription Drug Benefits section.*	$1,000 person / $2,500 family	$3,000 person / $7,500 family
Overall Out-of-Pocket Limit	$3,250 person / $8,125 family	$5,000 person / $12,500 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 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. All medical and prescription drug deductibles, copayments and coinsurance apply to the out-of-pocket limit. In-Network and Non-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 *virtual and office*	$20 copay per visit deductible does not apply	40% coinsurance after deductible is met
Specialist Care *virtual and office*	$35 copay per visit deductible does not apply	40% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Other Practitioner Visits		
Routine Maternity Care (Prenatal and Postnatal)	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Retail Health Clinic *for routine care and treatment of common illnesses; usually found in major pharmacies or retail stores.*	$20 copay per visit deductible does not apply	40% coinsurance after deductible is met
Chiropractic Services	$35 copay per visit deductible does not apply	40% coinsurance after deductible is met
Acupuncture	10% coinsurance after deductible is met	30% coinsurance after deductible is met
Other Services in an Office		
Allergy Testing	$35 copay per visit deductible does not apply‡	40% coinsurance after deductible is met
Prescription Drugs *Dispensed in the office*	No charge	40% coinsurance after deductible is met
Surgery	$35 copay per visit deductible does not apply‡	40% coinsurance after deductible is met
Preventive care / screenings / immunizations	No charge	40% coinsurance after deductible is met
Diagnostic Services **Lab**		
Office	No charge	40% coinsurance after deductible is met
Freestanding Lab/Reference Lab	No charge	40% coinsurance after deductible is met
Outpatient Hospital	20% coinsurance after deductible is met	40% coinsurance after deductible is met
X-Ray		
Office	No charge	40% coinsurance after deductible is met
Outpatient Hospital	20% coinsurance after deductible is met	40% 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 *for example: MRI, PET and CAT scans*		
Office	$35 copay per visit deductible does not apply‡	40% coinsurance after deductible is met
Outpatient Hospital	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Emergency and Urgent Care		
Urgent Care *includes doctor services. Additional charges may apply depending on the care provided.*	$35 copay per visit deductible does not apply	$35 copay per visit deductible does not apply
Emergency Room Facility Services *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	40% coinsurance after deductible is met
Doctor Services	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Outpatient Surgery		
Facility Fees		
Hospital	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Ambulatory Surgical Center	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Physician and other services *including surgeon fees*		
Hospital	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Ambulatory Surgical Center	20% coinsurance after deductible is met	40% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Hospital (Including Maternity, Mental Health and Substance Use Disorder Services)		
Facility Fees *Coverage for Inpatient Rehabilitation is limited to 60 days per benefit period.*	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Physician and other services *including surgeon fees*	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Home Health Care *Coverage is limited to 200 visits per benefit period.*	20% coinsurance deductible does not apply	40% coinsurance deductible does not apply
Rehabilitation and Habilitation services *including physical, occupational and speech therapies.* *Coverage for physical therapy is limited to 90 visits per benefit period.* *Coverage for occupational and speech therapies is limited to 30 visits combined per benefit period.*		
Office	$35 copay per visit deductible does not apply	Not covered
Outpatient Hospital	20% coinsurance after deductible is met	Not covered
Pulmonary rehabilitation		
Office	$35 copay per visit deductible does not apply	40% coinsurance after deductible is met
Outpatient Hospital	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Cardiac rehabilitation		
Office	$35 copay per visit deductible does not apply	40% coinsurance after deductible is met
Outpatient Hospital	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Dialysis/Hemodialysis *office and outpatient hospital*	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Chemo/Radiation Therapy		

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Office	$35 copay per visit deductible does not apply‡	40% coinsurance after deductible is met
Outpatient Hospital	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Skilled Nursing Care (facility) *Coverage is limited to 60 days per benefit period.*	20% coinsurance after deductible is met	Not covered
Inpatient Hospice *Coverage is limited to 210 days per lifetime.*	20% coinsurance after deductible is met	Not covered
Durable Medical Equipment	20% coinsurance after deductible is met	Not covered
Prosthetic Devices *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 drug)	Not covered
Pharmacy Out-of-Pocket Limit	Combined with In-Network medical out-of-pocket limit	Not covered
Prescription Drug Coverage **Network:** ***Base Network*** **Drug List:** ***Essential*** *Drugs not included on the Essential drug list will not be covered.*		
Day Supply Limits: **Retail Pharmacy** *30 day supply (cost shares noted below)* **Home Delivery Pharmacy** *90 day supply (maximum cost shares noted below). Maintenance medications are available through CarelonRx Pharmacy. You may get two 30-day supply fills of the same maintenance medication at a retail pharmacy. Prior to your 3rd fill, you must call us on the number on your ID card and tell us if you would like to keep getting your maintenance medications from a 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.* **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.*		

Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use a Non-Network 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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(TTY/TDD: 711)

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