

# Your summary of benefits



Anthem® Blue Cross and Blue Shield

FDM GROUP INC

Anthem Blue Access EPO Copay Deductible and Coinsurance

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 deductible does not apply
Mental Health & Substance Use Disorder Services	No charge deductible does not apply
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 an Out-of-Network Provider
Overall Deductible	\$750 person / \$1,875 family	Not covered
Overall Out-of-Pocket Limit	\$6,000 person / \$15,000 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.

All medical and prescription drug deductibles, copayments and coinsurance apply to the out-of-pocket limit.

<b>Doctor Visits (virtual and office)</b> You are encouraged to select a Primary Care Physician (PCP).		
<b>Primary Care (PCP) and Mental Health and Substance Use Disorder Services</b> <i>virtual and office</i>	\$25 copay per visit deductible does not apply	Not covered
<b>Specialist Provider</b> <i>virtual and office</i>	\$40 copay per visit deductible does not apply	Not covered
<b>Other Practitioner Visits</b>		
<b>Maternity Doctor services</b> (prenatal/postpartum care and delivery)	10% coinsurance after deductible is met	Not covered
<b>Retail Health Clinic</b> 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
<b>Chiropractic Services</b>	\$25 copay per visit deductible does not apply	Not covered

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
<b>Acupuncture</b> <i>Coverage is limited to 20 visits per benefit period.</i>	\$40 copay per visit deductible does not apply	Not covered
<b>Other Services in an Office</b>  <b>Allergy Testing</b>  <b>Allergy Injections</b>  <b>Prescription Drugs</b> <i>Dispensed in the office</i>  <b>Surgery</b>	\$40 copay per visit deductible does not apply <sup>‡</sup>  10% coinsurance after deductible is met  10% coinsurance after deductible is met  \$40 copay per visit deductible does not apply <sup>‡</sup>	Not covered  Not covered  Not covered  Not covered  Not covered
<b>Preventive care / screenings / immunizations</b>	No charge	Not covered
<b>Preventive Care for Chronic Conditions</b> <i>per IRS guidelines</i>	No charge	Not covered
<b>Diagnostic Services Lab</b>  Office  Freestanding Lab/Reference Lab  Outpatient Hospital	No charge  No charge  10% coinsurance after deductible is met	Not covered  Not covered  Not covered
<b>Diagnostic Services X-Ray</b>  Office  Outpatient Hospital	No charge  10% coinsurance after deductible is met	Not covered  Not covered
<b>Diagnostic Services Advanced Diagnostic Imaging</b> <i>for example: MRI, PET and CAT scans</i>  Office  Outpatient Hospital	No charge  10% coinsurance after deductible is met	Not covered  Not covered
<b>Emergency and Urgent Care</b>  <b>Urgent Care</b> <i>includes doctor services. Additional charges may apply depending on the care provided.</i>  <b>Emergency Room Facility Services</b> <i>Your copay will be waived if admitted.</i>  <b>Emergency Room Doctor and Other Services</b>	\$50 copay per visit deductible does not apply  \$200 copay per visit deductible does not apply  No charge	Covered as In-Network  Covered as In-Network  Covered as In-Network

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
<b>Ambulance</b>	10% coinsurance after deductible is met	Covered as In-Network
<b><u>Outpatient Mental Health and Substance Use Disorder Services at a Facility</u></b>		
<b>Facility Fees</b>	No charge	Not covered
<b>Doctor Services</b>	No charge	Not covered
<b><u>Outpatient Surgery</u></b>		
<b>Facility Fees</b>		
Hospital	10% coinsurance after deductible is met	Not covered
Ambulatory Surgical Center	10% coinsurance after deductible is met	Not covered
<b>Physician and other services including surgeon fees</b>		
Hospital	10% coinsurance after deductible is met	Not covered
Ambulatory Surgical Center	10% coinsurance after deductible is met	Not covered
<b><u>Hospital (Including Maternity, Mental Health and Substance Use Disorder Services)</u></b>		
<b>Facility Fees</b>		
Coverage for Inpatient Rehabilitation is limited to 30 days per benefit period.	10% coinsurance after deductible is met	Not covered
<b>Physician and other services including surgeon fees</b>		
<b><u>Home Health Care</u></b>		
Coverage is limited to 100 visits per benefit period.	\$40 copay per visit deductible does not apply	Not covered
<b><u>Therapy Services</u></b>		
<b>Rehabilitation and Habilitation services including physical, occupational and speech therapies.</b>		
Coverage for physical and occupational therapies is limited to 30 visits combined per benefit period. Coverage for speech therapy is limited to 30 visits per benefit period.		
Office	\$25 copay per visit deductible does not apply	Not covered
Outpatient Hospital	10% coinsurance after deductible is met	Not covered
<b>Pulmonary rehabilitation</b>		

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Office	\$40 copay per visit deductible does not apply	Not covered
Outpatient Hospital	10% coinsurance after deductible is met	Not covered
<b>Cardiac rehabilitation</b> <i>Coverage is limited to 36 visits per benefit period.</i> Office  Outpatient Hospital	\$40 copay per visit deductible does not apply  10% coinsurance after deductible is met	Not covered  Not covered
<b>Dialysis/Hemodialysis office and outpatient hospital</b> <i>Coverage is limited to 10 visits per benefit period. Applies to Out-of-Network.</i>	10% coinsurance after deductible is met	Covered as In-Network
<b>Chemo/Radiation Therapy office and outpatient hospital</b>	10% coinsurance after deductible is met	Not covered
<b>Skilled Nursing Care (facility)</b> <i>Coverage is limited to 60 days per benefit period.</i>	10% coinsurance after deductible is met	Not covered
<b>Inpatient Hospice</b>	10% coinsurance after deductible is met	Not covered
<b><u>Additional Services, Equipment and Devices</u></b> <b>Durable Medical Equipment</b>	10% coinsurance after deductible is met	Not covered
<b>Diabetic Equipment and Supplies</b>	No charge	Not covered
<b>Prosthetic Devices</b>	10% coinsurance after deductible is met	Not covered
<b>Wigs</b> <i>Coverage for wigs is limited to 1 item per benefit period for severe hair loss resulting from injury, disease, or as a side effect of disease treatment.</i>	10% coinsurance after deductible is met	Not covered
Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use an Out-of-Network Pharmacy
<b>Pharmacy Deductible</b> combined for In-Network and Out-of-Network Pharmacies	Not applicable	Not covered
<b>Pharmacy Out-of-Pocket Limit</b>	Combined with In-Network medical out-of-pocket limit	Not covered
<b>Prescription Drug Coverage</b>		

Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use an Out-of-Network Pharmacy
<b>Network: Base Network</b> <b>Drug List: National</b>		
<b>Day Supply Limits:</b> <b>Retail Pharmacy</b> 30 day supply (cost shares noted below) <b>Retail 90 Pharmacy</b> 90 day supply (3 times the 30 day supply cost share(s) charged at In-Network Retail Pharmacies noted below applies). <b>Home Delivery Pharmacy</b> 90 day supply (maximum cost shares noted below). Maintenance medications are available through our home delivery pharmacy. You will need to call us on the number on your ID card to sign up when you first use the service. <b>Specialty Pharmacy</b> 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.		
<b>Tier 1 - Typically Generic</b>	\$10 copay per prescription (retail) and \$20 copay per prescription (home delivery)	Not covered
<b>Tier 2 - Typically Preferred Brand</b>	\$35 copay per prescription (retail) and \$70 copay per prescription (home delivery)	Not covered
<b>Tier 3 - Typically Non-Preferred Brand/Specialty Drugs</b>	\$50 copay per prescription (retail) and \$100 copay per prescription (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.
- Screening and diagnostic imaging for the detection of breast cancer, including diagnostic mammograms, 3D mammography, breast ultrasounds and MRIs are covered in full as required by state mandate.
- 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.
- <sup>†</sup>You will pay your PCP or Specialist office visit copay for certain services 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. Lifetime Maximum: IVF limited to 3 cycles.

*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.*

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Questions: Visit us at [www.anthem.com](http://www.anthem.com)

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## We're here for you – in many languages

The law requires us to include a message in all of these different languages. Curious what they say? Here's the English version: "You have the right to get help in your language for free. Just call the Member Services number on your ID card." Visually impaired? You can also ask for other formats of this document

### Spanish

Usted tiene derecho a obtener asistencia en su idioma sin cargo. Llame al número de Servicios para Miembros que figura en su tarjeta de identificación. ¿Tiene alguna deficiencia visual? También puede solicitar este documento en otros formatos.

### Chinese

您有權免費獲得使用您的語言提供的協助。只需撥打印於您的ID卡上的會員服務部電話號碼即可。視力障礙？您也可以索取本文件的其他格式。

### Vietnamese

Quý vị có quyền nhận trợ giúp bằng ngôn ngữ của mình, miễn phí. Quý vị chỉ cần gọi đến số điện thoại của Ban Dịch vụ Thành viên trên thẻ ID của quý vị. Quý vị bị khiếm thị? Quý vị cũng có thẻ yêu cầu các định dạng khác của tài liệu này.

### Korean

귀하는 귀하의 언어로 된 도움을 무료로 받을 권리가 있습니다. 귀하의 ID 카드에 있는 가입자 서비스 번호로 전화하십시오. 시각 장애인이신가요? 다른 형식으로 된 이 문서를 요청하실 수 있습니다.

### Tagalog

May karapatan kang makakuha ng tulong na nasa iyong wika nang libre. Tawagan lang ang numero ng Member Services na nasa iyong ID card. May kapansanan sa paningin? Maaari ka ring humingi ng iba pang mga format ng dokumentong ito.

### Russian

У вас есть право на бесплатное получение помощи на вашем родном языке. Просто позвоните в отдел обслуживания участников по номеру, указанному на вашей идентификационной карте. У вас проблемы со зрением? Вы также можете запросить этот документ в других форматах.

### French Creole

Ou gen dwa jwenn èd nan lang ou gratis. Jis rele nimewo Sèvis Manm ki sou Kat ID ou a gratis Gen pwoblèm vizyèl? Ou ka mande tou pou lòt fòma nan dokiman sa a.

### Arabic

الحق في الحصول على هذه المعلومات والحصول على المساعدة بلغتك مجاناً.  
فقط اتصل برقم خدمات الأعضاء الموجود على بطاقة هويتك. هل تعاني من ضعف البصر؟ يمكنك أيضاً طلب تنسيرات أخرى لهذه الوثيقة.

### French

Vous avez le droit d'obtenir de l'aide dans votre langue gratuitement. Appelez simplement le numéro du Services membres figurant sur votre carte d'identité. Vous êtes une personne malvoyante ? Vous pouvez également demander à accéder à ce document dans d'autres formats.

### Persian

شما حق دارید به زبان خود به صورت رایگان کمک بگیرید. فقط با شماره خدمات اعضاء مدرج در کارت عضویت خود تماس بگیرید. آیا دچار اختلال بینایی هستید؟ همچنین میتوانید فرمتهای دیگر این سند را درخواست کنید.

### Armenian

Դուք իրավունք ունեք անվճար օգնություն ստանալու ձեր լեզվով: Պարզապես զանգահարեք ձեր ID քարտի վրա գտնվող Անդամների սպասարկման համարին: Տեսողության խանգարում ունեցն եք: Կարող եք նաև խնդրել այս փաստաթղթի այլ ձևաչափեր:

### Japanese

あなたにはあなたの言語で無料で支援を受ける権利があります。IDカードに記載されている会員サービス番号にお電話ください」視覚障害をお持ちですか？他の形式でこの文書を要求することもできます。

### Italian

Hai il diritto di ricevere assistenza gratuita nella tua lingua. Basta chiamare il numero del Servizio Membri presente sulla tua tessera identificativa. Hai problemi di vista? È possibile richiedere anche altri formati di questo documento.

### German

Sie haben das Recht, kostenlose Hilfe in Ihrer Sprache zu erhalten. Rufen Sie einfach die Nummer des Mitgliederservices auf Ihrer ID-Karte an. Sehbehindert? Sie können dieses Dokument auch in anderen Formaten anfordern.

### Polish

Masz prawo do bezpłatnej pomocy w swoim języku. Wystarczy zadzwonić pod numer Biura Obsługi Klienta podany na karcie identyfikacyjnej. Masz wadę wzroku? Możesz również poprosić o inne formaty tego dokumentu.

### Pennsylvania Dutch

Du hoscht's Recht fer Hilf griege in dei Schprooch fer nix. Duh yuscht die Member Services Number uffrufe uff dei ID Card. Hoscht Druwwel fer sehne? Du kannscht des do Schreiwas in en differnter Weg griege so as du's besser sehne kannscht.

### TTY/TDD:711

### It's important we treat you fairly

We follow federal civil rights laws in our health programs and activities. Members can get reasonable modifications as well as free auxiliary aids and services if you have a disability. We don't discriminate, on the basis of race, color, national origin, sex, age or disability. For people whose primary language isn't English (or have limited proficiency), we offer free language assistance services like interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711) or visit our website. If you think we failed in any areas or to learn more about grievance procedures, you can mail a complaint to: Compliance Coordinator, P.O. Box 27401, Richmond, VA 23279, or directly to the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201. You can also call 1-800- 368-1019 (TDD: 1-800-537-7697) or visit <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>