

# Your summary of benefits



Anthem® Blue Cross and Blue Shield

Your Plan: City of Republic-Anthem Blue Access PPO

Your Network: Blue Access

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<b>Overall Deductible</b>	\$3,000 person / \$6,000 family	\$10,000 person / \$20,000 family
<b>Out-of-Pocket Limit</b>	\$6,500 person / \$13,000 family	\$20,000 person / \$40,000 family
<p>The family deductible and out-of-pocket maximum are embedded, meaning the cost shares of one family member will be applied to both per person deductible and per person 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 per person deductible or per person out-of-pocket maximum.</p> <p>All medical and prescription drug deductibles, copayments and coinsurance apply toward the out-of-pocket maximum (excluding Non-Network Human Organ and Tissue Transplant (HOTT) Services).</p> <p>In-network and out-of-network deductibles and out-of-pocket maximum amounts are separate and do not accumulate toward each other.</p>		
<b>Preventive Care / Screening / Immunization</b>	No charge	50% coinsurance after medical deductible is met
<b>Preventive Care for Chronic Conditions</b> <i>per IRS guidelines</i>	No charge	50% coinsurance after medical deductible is met
<p><b><u>Virtual Care (Telemedicine / Telehealth Visits)</u></b></p> <p><b>Virtual Visits - Online visits with Doctors who also provide services in person</b></p>		
Primary Care (PCP)	\$30 copay per visit medical deductible does not apply	50% coinsurance after medical deductible is met
Mental Health and Substance Abuse care	\$30 copay per visit medical deductible does not apply	50% coinsurance after medical deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Specialist	\$70 copay per visit medical deductible does not apply	50% coinsurance after medical deductible is met
<b>Medical Chats and Virtual Visits for Primary Care</b> from our Online Provider K Health, its affiliated Provider groups, via our mobile app, website or Anthem-enabled device	No charge	
<b>Virtual Visits from Online Provider LiveHealth Online</b> via <a href="http://www.livehealthonline.com">www.livehealthonline.com</a> ; our mobile app, website or Anthem-enabled device  Primary Care (PCP) and Mental Health and Substance Abuse  Specialist Care	\$10 copay per visit medical deductible does not apply	\$70 copay per visit medical deductible does not apply
<u><b>Visits in an Office</b></u>  <b>Primary Care (PCP)</b>  <b>Specialist Care</b>	\$30 copay per visit medical deductible does not apply  \$70 copay per visit medical deductible does not apply	50% coinsurance after medical deductible is met  50% coinsurance after medical deductible is met
<u><b>Other Practitioner Visits</b></u>  <b>Routine Maternity Care</b> (Prenatal and Postnatal)  <b>Retail Health Clinic</b>  <b>Chiropractic Services</b> <i>Coverage is limited to 26 visits per benefit period.</i>	20% coinsurance after medical deductible is met  \$30 copay per visit medical deductible does not apply  50% coinsurance medical deductible does not apply	50% coinsurance after medical deductible is met  50% coinsurance after medical deductible is met  Not covered
<u><b>Other Services in an Office</b></u>  <b>Allergy Testing</b> <i>When Allergy injections are billed separately by network providers, the member is responsible for a \$10 copay. When billed as part of an office visit, there is no additional cost to the member for the injection.</i>	20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<b>Chemo/Radiation Therapy</b>	\$70 copay per visit medical deductible does not apply <sup>†</sup>	50% coinsurance after medical deductible is met
<b>Dialysis/Hemodialysis</b>	\$70 copay per visit medical deductible does not apply	50% coinsurance after medical deductible is met
<b>Prescription Drugs</b> <i>Dispensed in the office</i>	20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
<b>Surgery</b>	\$70 copay per visit medical deductible does not apply <sup>†</sup>	50% coinsurance after medical deductible is met
<b><u>Diagnostic Services</u></b> <b>Lab</b> Office  Outpatient Hospital	No charge  20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met  50% coinsurance after medical deductible is met
<b>X-Ray</b> Office  Outpatient Hospital	No charge  20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met  50% coinsurance after medical deductible is met
<b>Advanced Diagnostic Imaging</b> <i>for example: MRI, PET and CAT scans</i>  Office  Freestanding Radiology Center	20% coinsurance after medical deductible is met  20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met  50% coinsurance after medical deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Outpatient Hospital	20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
<p><b><u>Emergency and Urgent Care</u></b></p> <p><b>Urgent Care</b></p> <p><b>Emergency Room Facility Services</b> <i>Copay waived if admitted.</i></p> <p><b>Emergency Room Doctor and Other Services</b></p> <p><b>Ambulance</b></p>	<p>\$50 copay per visit medical deductible does not apply</p> <p>\$250 copay per visit after medical deductible is met</p> <p>20% coinsurance after medical deductible is met</p> <p>20% coinsurance after medical deductible is met</p>	<p>50% coinsurance after medical deductible is met</p> <p>Covered as In-Network</p> <p>Covered as In-Network</p> <p>Covered as In-Network</p>
<p><b><u>Outpatient Mental Health and Substance Abuse</u></b></p> <p><b>Doctor Office Visit</b></p> <p><b>Facility Visit</b></p> <p>Facility Fees</p> <p>Doctor Services</p>	<p>\$30 copay per visit medical deductible does not apply</p> <p>20% coinsurance after medical deductible is met</p> <p>20% coinsurance after medical deductible is met</p>	<p>50% coinsurance after medical deductible is met</p> <p>50% coinsurance after medical deductible is met</p> <p>50% coinsurance after medical deductible is met</p>
<p><b><u>Outpatient Surgery</u></b></p> <p><b>Facility Fees</b></p> <p>Hospital</p> <p>Freestanding Surgical Center</p>	<p>20% coinsurance after medical deductible is met</p> <p>20% coinsurance after medical deductible is met</p>	<p>50% coinsurance after medical deductible is met</p> <p>50% coinsurance after medical deductible is met</p>

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<p><b>Doctor and Other Services</b></p> <p>Hospital</p> <p>Freestanding Surgical Center</p>	<p>20% coinsurance after medical deductible is met</p> <p>20% coinsurance after medical deductible is met</p>	<p>50% coinsurance after medical deductible is met</p> <p>50% coinsurance after medical deductible is met</p>
<p><b><u>Hospital (Including Maternity, Mental Health and Substance Abuse)</u></b></p> <p><b>Facility Fees</b></p> <p><b>Human Organ and Tissue Transplants</b> <i>Kidney and Cornea are treated the same as any other illness and subject to the medical benefits.</i></p> <p><b>Doctor and other services</b></p>	<p>20% coinsurance after medical deductible is met</p> <p>20% coinsurance after medical deductible is met</p> <p>20% coinsurance after medical deductible is met</p>	<p>50% coinsurance after medical deductible is met</p> <p>50% coinsurance after medical deductible is met</p> <p>50% coinsurance after medical deductible is met</p>
<p><b><u>Recovery &amp; Rehabilitation</u></b></p> <p><b>Home Health Care</b> <i>Coverage is limited to 100 visits per benefit period. Limits are combined for all home health services.</i></p>	<p>20% coinsurance after medical deductible is met</p>	<p>50% coinsurance after medical deductible is met</p>
<p><b>Rehabilitation services</b> <i>Coverage for Physical and Occupational Rehabilitation and Habilitation therapy is limited to 40 visits combined per benefit period. Limit includes manipulative treatment when performed by someone other than a chiropractor. Speech Therapy has no visit limit. Benefit limit does not apply to Applied Behavioral Analysis. Benefit limit does not apply when performed as part of Early Intervention.</i></p> <p>Office</p> <p>Outpatient Hospital</p>	<p>\$30 copay per visit medical deductible does not apply</p> <p>20% coinsurance after medical deductible is met</p>	<p>50% coinsurance after medical deductible is met</p> <p>50% coinsurance after medical deductible is met</p>

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<p><b>Cardiac rehabilitation</b>  <i>Coverage is limited to 36 visits per benefit period.</i></p> <p>Office</p> <p>Outpatient Hospital</p>	<p>\$70 copay per visit  medical deductible does not apply</p> <p>20% coinsurance after  medical deductible is met</p>	<p>50% coinsurance after  medical deductible is met</p> <p>50% coinsurance after  medical deductible is met</p>
<p><b>Pulmonary rehabilitation</b>  <i>Coverage is limited to 20 visits per benefit period.</i></p> <p>Office</p> <p>Outpatient Hospital</p>	<p>\$70 copay per visit  medical deductible does not apply</p> <p>20% coinsurance after  medical deductible is met</p>	<p>50% coinsurance after  medical deductible is met</p> <p>50% coinsurance after  medical deductible is met</p>
<p><b>Skilled Nursing Care (facility)</b>  <i>Coverage for Skilled Nursing, Outpatient Rehabilitation and Inpatient Rehabilitation facility settings is limited to 150 days combined per benefit period.</i></p>	<p>20% coinsurance after  medical deductible is met</p>	<p>50% coinsurance after  medical deductible is met</p>
<p><b>Inpatient Hospice</b></p>	<p>20% coinsurance after  medical deductible is met</p>	<p>50% coinsurance after  medical deductible is met</p>
<p><b>Durable Medical Equipment</b></p>	<p>20% coinsurance after  medical deductible is met</p>	<p>50% coinsurance after  medical deductible is met</p>
<p><b>Prosthetic Devices</b>  <i>Coverage for wigs is limited to 1 item after cancer treatment per benefit period.</i></p>	<p>20% coinsurance after  medical deductible is met</p>	<p>50% coinsurance after  medical deductible is met</p>
Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use a Non-Network Pharmacy
<p><b>Pharmacy Deductible</b></p>	<p>Not applicable</p>	<p>Not applicable</p>

Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use a Non-Network Pharmacy
<b>Pharmacy Out-of-Pocket Limit</b>	Combined with In-Network medical out-of-pocket limit	Combined with Non-Network medical out-of-pocket limit
<p><b>Prescription Drug Coverage</b> Cost shares for drugs included on the National drug list appear below. Your plan uses the Base Network. You may receive up to a 90 day supply of medication at Retail 90 pharmacies.</p>		
<p><b>Home Delivery Pharmacy</b> Maintenance medication are available through IngenioRx 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.</p>		
<p><b>Tier 1 - Typically Generic</b> Per 30 day supply (retail pharmacy and Retail 90 pharmacy). Per 90 day supply (home delivery).</p>	<p>\$15 copay per prescription, deductible does not apply (retail) and \$38 copay per prescription, deductible does not apply (home delivery)</p>	<p>50% coinsurance, deductible does not apply (retail) and Not covered (home delivery)</p>
<p><b>Tier 2 – Typically Preferred Brand</b> Per 30 day supply (retail pharmacy and Retail 90 pharmacy). Per 90 day supply (home delivery).</p>	<p>\$40 copay per prescription, deductible does not apply (retail) and \$120 copay per prescription, deductible does not apply (home delivery)</p>	<p>50% coinsurance, deductible does not apply (retail) and Not covered (home delivery)</p>
<p><b>Tier 3 - Typically Non-Preferred Brand</b> Per 30 day supply (retail pharmacy and Retail 90 pharmacy). Per 90 day supply (home delivery).</p>	<p>\$75 copay per prescription, deductible does not apply (retail) and \$225 copay per prescription, deductible does not apply (home delivery)</p>	<p>50% coinsurance, deductible does not apply (retail) and Not covered (home delivery)</p>
<p><b>Tier 4 - Typically Specialty (brand and generic)</b> Per 30 day supply (specialty pharmacy).</p>	<p>25% coinsurance up to \$250 per prescription, deductible does not apply (retail and home delivery)</p>	<p>50% coinsurance, deductible does not apply (retail) and Not covered (home delivery)</p>

Covered Vision Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<i>This is a brief outline of your vision coverage. Only children's vision services count towards your out of pocket limit.</i>		
<b><u>Children's Vision (up to age 19)</u></b> <b>Child Vision Deductible</b>	\$0 person	\$0 person
<b>Vision exam</b> <i>Limited to 1 exam per benefit period.</i>	No charge	\$0 copayment up to plan's Maximum Allowed Amount
<b><u>Adult Vision (age 19 and older)</u></b> <b>Adult Vision Deductible</b>	\$0 person	\$0 person
<b>Vision exam</b> <i>Limited to 1 exam per benefit period.</i>	No charge	Reimbursed Up to \$42

**Notes:**

- Dependent age: to end of the month in which the child attains age 26.
- Members are encouraged to always obtain prior approval when using non-network providers. Precertification will help the member know if the services are considered not medically necessary.
- No charge means no deductible/copayment/coinsurance up to the maximum allowable amount. 0% means no coinsurance up to the maximum allowable amount. However, when choosing a Non-network provider, the member is responsible for any balance due after the plan payment.
- The representations of benefits in this document are subject to Division of Insurance approval and are subject to change.
- 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 will be reduced when services are provided in a PCP's office.

*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.*



## 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 (833) 578-4436

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)

**Arabic (العربية):** إذا كان لديك أي استفسارات بشأن هذا المستند، فيحق لك الحصول على المساعدة والمعلومات بلغتك دون مقابل. للتحدث إلى مترجم، اتصل على (833) 578-4436.

**Armenian (հայերեն).** Եթե այս փաստաթղթի հետ կապված հարցեր ունեք, դուք իրավունք ունեք անվճար ստանալ օգնություն և տեղեկատվություն ձեր լեզվով: Թարգմանչի հետ խոսելու համար զանգահարեք հետևյալ հեռախոսահամարով՝ (833) 578-4436:

**Chinese(中文):** 如果您對本文件有任何疑問，您有權使用您的語言免費獲得協助和資訊。如需與譯員通話，請致電(833) 578-4436。

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**French (Français):** Si vous avez des questions sur ce document, vous avez la possibilité d'accéder gratuitement à ces informations et à une aide dans votre langue. Pour parler à un interprète, appelez le (833) 578-4436.

**Haitian Creole (Kreyòl Ayisyen):** Si ou gen nenpòt kesyon sou dokiman sa a, ou gen dwa pou jwenn èd ak enfòmasyon nan lang ou gratis. Pou pale ak yon entèprèt, rele (833) 578-4436.

**Italian (Italiano):** In caso di eventuali domande sul presente documento, ha il diritto di ricevere assistenza e informazioni nella sua lingua senza alcun costo aggiuntivo. Per parlare con un interprete, chiami il numero (833) 578-4436.

**Japanese (日本語):** この文書についてなにかご不明な点があれば、あなたにはあなたの言語で無料で支援を受け情報を得る権利があります。通訳と話すには、(833) 578-4436 にお電話ください。

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## Language Access Services:

**Navajo (Diné):** Dii naaltsoos biká'ígíí lahgo bina'idiikidgo ná bohónéedzǎ dóó bee ahóót'i' t'áá ni nizaad k'ehǫ́ bee nił hodoonih t'áadoo bááh ilínígóó. Ata' halne'ígíí la' bich'í' hadeesdzih ninizingo kojí' hodíílnih (833) 578-4436.

**Polish (polski):** W przypadku jakichkolwiek pytań związanych z niniejszym dokumentem masz prawo do bezpłatnego uzyskania pomocy oraz informacji w swoim języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer: (833) 578-4436.

**Punjabi (ਪੰਜਾਬੀ):** ਜੇ ਤੁਹਾਡੇ ਇਸ ਦਸਤਾਵੇਜ਼ ਬਾਰੇ ਕੋਈ ਸਵਾਲ ਹੁੰਦੇ ਹਨ ਤਾਂ ਤੁਹਾਡੇ ਕੋਲ ਮੁਫਤ ਵਿੱਚ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮਦਦ ਅਤੇ ਜਾਣਕਾਰੀ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੁੰਦਾ ਹੈ। ਇੱਕ ਦੁਭਾਸ਼ੀਏ ਨਾਲ ਗੱਲ ਕਰਨ ਲਈ, (833) 578-4436 ਤੇ ਕਾਲ ਕਰੋ।

**Russian (Русский):** Если у вас есть какие-либо вопросы в отношении данного документа, вы имеете право на бесплатное получение помощи и информации на вашем языке. Чтобы связаться с устным переводчиком, позвоните по тел. (833) 578-4436.

**Spanish (Español):** Si tiene preguntas acerca de este documento, tiene derecho a recibir ayuda e información en su idioma, sin costos. Para hablar con un intérprete, llame al (833) 578-4436.

**Tagalog (Tagalog):** Kung mayroon kang anumang katanungan tungkol sa dokumentong ito, may karapatan kang humingi ng tulong at impormasyon sa iyong wika nang walang bayad. Makipag-usap sa isang tagapagpaliwanag, tawagan ang (833) 578-4436.

**Vietnamese (Tiếng Việt):** Nếu quý vị có bất kỳ thắc mắc nào về tài liệu này, quý vị có quyền nhận sự trợ giúp và thông tin bằng ngôn ngữ của quý vị hoàn toàn miễn phí. Để trao đổi với một thông dịch viên, hãy gọi (833) 578-4436.

### It's important we treat you fairly

That's why we follow federal civil rights laws in our health programs and activities. We don't discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, we offer free aids and services. For people whose primary language isn't English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711). If you think we failed to offer these services or discriminated based on race, color, national origin, age, disability, or sex, you can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator in writing to Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279. Or you can file a complaint with 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 or by calling 1-800-368-1019 (TDD: 1-800-537-7697) or online at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>. Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.