Your summary of benefits

Anthem® Blue Cross and Blue Shield

Your Plan: City of Republic: Anthem Link Blue Preferred EPO

Your Network: Blue Preferred EPO

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Overall Deductible	$3,000 person / $6,000 family	Not covered
Overall Out-of-Pocket Limit	$7,500 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 toward the out-of-pocket limit(s) (excluding Non-Network Human Organ and Tissue Transplant (HOTT) Services).		
Doctor Visits (virtual and office) *Your plan requires the selection of a Primary Care Physician (PCP).*		
Medical Chats and Virtual Visits for Primary Care *from our Online Provider K Health, through its affiliated Provider groups are covered at $0 copay per visit deductible does not apply.*		
Virtual Visits from online provider LiveHealth Online *for urgent/acute medical and mental health and substance abuse care via www.livehealthonline.com are covered at No charge.*		
Primary Care (PCP) and Mental Health and Substance Abuse Care *virtual and office* *Coverage for Mental Health and Substance Abuse Care from a Non-Network provider is limited to 0 visits per benefit period, subject to In-Network cost shares.*	**virtual-**No charge **office-**$50 copay per visit deductible does not apply	Not covered
Specialist Care *virtual and office*	$75 copay per visit deductible does not apply	Not covered
Other Practitioner Visits		
Routine Maternity Care (Prenatal and Postnatal)	$500 copay per pregnancy deductible does not apply	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.*	$50 copay per visit deductible does not apply	Not covered
Chiropractic Services *Coverage is limited to 26 visits per benefit period.*	50% coinsurance deductible does not apply	Not covered
Other Services in an Office		
Allergy Testing	$75 copay per visit deductible does not apply‡	Not covered
Prescription Drugs *Dispensed in the office*	$400 copay per visit deductible does not apply	Not covered
Surgery	$75 copay per visit deductible does not apply‡	Not covered
Preventive care / screenings / immunizations	No charge	Not covered
Preventive Care for Chronic Conditions *per IRS guidelines*	No charge	Not covered
Diagnostic Services **Lab**		
Office	$75 copay per visit deductible does not apply‡	Not covered
Outpatient Hospital	$75 copay per visit after deductible is met	Not covered
X-Ray		
Office	$75 copay per visit deductible does not apply‡	Not covered
Outpatient Hospital	$75 copay per visit after deductible is met	Not covered
Advanced Diagnostic Imaging *for example: MRI, PET and CAT scans*		
Office	$200 copay per visit deductible does not apply	Not covered

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Freestanding Radiology Center	$500 copay per visit after deductible is met	Not covered
Outpatient Hospital	$500 copay per visit after deductible is met	Not covered
Emergency and Urgent Care		
Urgent Care *includes doctor services. Additional charges may apply depending on the care provided.*	$75 copay per visit deductible does not apply	Covered as In-Network
Emergency Room Facility Services *Copay waived if admitted.*	$500 copay per visit after deductible is met	Covered as In-Network
Emergency Room Doctor and Other Services	No charge after deductible is met	Covered as In-Network
Ambulance	$500 copay per trip after deductible is met	Covered as In-Network
Outpatient Mental Health and Substance Abuse Care at a Facility		
Facility Fees	$500 copay per visit deductible does not apply	Not covered
Doctor Services	No charge	Not covered
Outpatient Surgery		
Facility Fees		
Hospital	$500 copay per visit after deductible is met	Not covered
Ambulatory Surgical Center	$500 copay per visit after deductible is met	Not covered
Doctor and Other Services		
Hospital	No charge after deductible is met	Not covered
Ambulatory Surgical Center	No charge after deductible is met	Not covered
Hospital (Including Maternity, Mental Health and Substance Abuse)		
Facility Fees	$750 copay per admission 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
Human Organ and Tissue Transplants *Cornea transplants are treated the same as any other illness and subject to the medical benefits.*	$750 copay per admission after deductible is met	Not covered
Physician and other services *including surgeon fees*	No charge after deductible is met	Not covered
Home Health Care *Coverage is limited to 100 visits per benefit period. Limits are combined for all home health services.*	$75 copay per visit deductible does not apply	Not covered
Rehabilitation and Habilitation services *including physical, occupational and speech therapies.* *Coverage for physical and occupational therapies 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.*		
Office	$50 copay per visit deductible does not apply	Not covered
Outpatient Hospital	$100 copay per visit after deductible is met	Not covered
Pulmonary rehabilitation		
Office	$75 copay per visit deductible does not apply	Not covered
Outpatient Hospital	$150 copay per visit after deductible is met	Not covered
Cardiac rehabilitation *Coverage is limited to 36 visits per benefit period.*		
Office	$75 copay per visit deductible does not apply	Not covered
Outpatient Hospital	$150 copay per visit after deductible is met	Not covered
Dialysis/Hemodialysis		

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Office	$75 copay per visit deductible does not apply	Not covered
Outpatient Hospital	$500 copay per visit after deductible is met	Not covered
Chemo/Radiation Therapy		
Office	$75 copay per visit deductible does not apply	Not covered
Outpatient Hospital	$500 copay per visit after deductible is met	Not covered
Skilled Nursing Care (facility) *Coverage for Skilled Nursing, Outpatient Rehabilitation and Inpatient Rehabilitation facility settings is limited to 150 days combined per benefit period.*	$750 copay per admission after deductible is met	Not covered
Inpatient Hospice	$750 copay per admission after deductible is met	Not covered
Durable Medical Equipment	25% coinsurance after deductible is met	Not covered
Prosthetic Devices *Coverage for wigs is limited to 1 item after cancer treatment per benefit period.*	25% coinsurance after deductible is met	Not covered
Hearing Aids *Coverage for hearing aids is limited to children 1 through 17 years of age, with one hearing aid per ear every 36 months. Newborn hearing aids no limit.*	25% 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	Combined with In-Network medical deductible (does not apply to Tier 1a, Tier 1b, Tier 2 drugs)	Not covered

Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use a Non-Network Pharmacy
Pharmacy Out-of-Pocket Limit	Combined with In-Network medical out-of-pocket limit	Not covered
Prescription Drug Coverage **Network:** ***Base Network*** **Drug List:** ***National*** *If you select a brand name drug when a generic drug is available, additional cost sharing amounts may apply.*		
Day Supply Limits: **Retail Pharmacy** *30 day supply (cost shares noted below)* **Retail 90 Pharmacy** *90 day supply (3 times the 30 day supply cost share(s) charged at In-Network Retail Pharmacies noted below applies).* **Home Delivery Pharmacy** *90 day supply (maximum cost shares noted below) Maintenance medications are available through CarelonRx Mail (IngenioRx will become CarelonRx on January 1, 2023). You will need to call us on the number on your ID card to sign up when you first use the service.* **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 1a - Typically Lower Cost Generic	No charge (retail and home delivery)	Not covered (retail and home delivery)
Tier 1b - Typically Generic	$10 copay per prescription, deductible does not apply (retail) and $25 copay per prescription, deductible does not apply (home delivery)	Not covered (retail and home delivery)
Tier 2 – Typically Preferred Brand	$60 copay per prescription, deductible does not apply (retail) and $180 copay per prescription, deductible does not apply (home delivery)	Not covered (retail and home delivery)
Tier 3 - Typically Non-Preferred Brand	$125 copay per prescription after deductible is met (retail) and $375 copay per prescription after deductible is met (home delivery)	Not covered (retail and home delivery)
Tier 4 - Typically Specialty (brand and generic)	$400 copay per prescription after	Not covered (retail and home delivery)

Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use a Non-Network Pharmacy
	deductible is met (retail and home delivery)	

Covered Vision Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
This is a brief outline of your vision coverage. To receive the In-Network benefit, you must use a Blue View Vision Provider. Only children's vision services count towards your out of pocket limit.		
Children's Vision exam (up to age 19) *Limited to 1 exam per benefit period.*	No charge	Not covered
Adult Vision exam (age 19 and older) *Limited to 1 exam per benefit period.*	No charge	Not covered

Notes:

- Dependent age: to end of the month in which the child attains age 26.
- No charge means no deductible/copayment/coinsurance up to the maximum allowable amount. 0% means no coinsurance up to the maximum allowable 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 will be reduced when services are provided in a PCP's office.
- The representations of benefits in this document are subject to Missouri Department of Insurance, Financial Institutions and Professional Registration (DIFP) approval and are subject to change.

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.

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 (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)

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Language Access Services:

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