City of Republic Employee Benefits Effective 1/1/2022

Health Care Plan—Anthem Blue Cross Blue Shield

The chart below is a simple summary of the plan. Please review the complete summary of benefits for the new plans carefully so you understand the benefits covered under the Health Plan.

	*Anthem Blue Preferred Cox Only**	*Anthem Blue Access Mercy/Cox*	*Anthem Blue Access Mercy/Cox*
*Premium Per Pay Period** *Employee Only* *Emp + Spouse* *Emp + Child(ren)* *Family*	$0.00 $156.10 $170.55 $453.35	$0.00 $180.07 $195.46 $496.31	$9.89 $198.06 $214.13 $528.53
Annual Deductible *In-Network* *Out of Network*	**Individual/Family** $3,000/$6,000 $10,000/$20,000	**Individual/Family** $3,000/$6,000 $10,000/$20,000	**Individual/Family** $2,000/$4,000 $6,000/$12,000
Out of Pocket Max *In-Network* *Out of Network*	**Individual/Family** $6,500/$13,000 $20,000/$40,000	**Individual/Family** $6,500/$13,000 $20,000/$40,000	**Individual/Family** $4,000/$6,000 $12,000/$24,000
Co-Insurance Max *In-Network* *Out of Network*	**Individual/Family** $3,500/$7,000 $10,000/$20,000	**Individual/Family** $3,500/$7,000 $10,000/$20,000	**Individual/Family** $2,000/$4,000 $6,000/$12,000
Office Visit *In-Network* *Out of Network*	**Primary/Specialist** $30/$70 copay 50% after deductible **Lab/xray towards ded/coins**	**Primary/Specialist** $30/$70 copay 50% after deductible **Lab/xray towards ded/coins**	**Primary/Specialist** $30/$70 copay 50% after deductible **Lab/xray towards ded/coins**
Preventive Care *In-Network* *Out of Network*	Covered at 100% 50% after deductible	Covered at 100% 50% after deductible	Covered at 100% 50% after deductible
Urgent Care *In-Network* *Out of Network*	$50 copay 50% after deductible	$50 copay 50% after deductible	$50 copay 50% after deductible
Emergency Room	Deductible then $250	Deductible then $250	Deductible then $250
Prescription Drug Benefit Retail (Tier 1/2/3/4)	$15/$40/$75/25% w/ $250 max	$15/$40/$75/25% w/ $250 max	$15/$40/$75/25% w/ $250 max

*Will not cover Barnes Jewish Hospital

Dental Plan—Delta Dental

Reliance has a network of dentists that offer contracted rates to Reliance members. You can go to www.deltadentalmo.com.

A summary of the costs and benefits are listed below.

	Monthly Premium	***Employer Cost***	***Employee Cost***	***Employee Cost Per Pay Period****
Employee Only	$25.64	$25.64	$0.00	$0.00
Employee & Spouse	$52.45	$25.64	$26.81	$13.41
Employee & Child(ren)	$58.40	$25.64	$32.76	$16.38
Family	$91.60	$25.64	$65.96	$32.98

This is intended to be a summary of benefits. For detailed benefit coverage and frequency refer to the dental certificate (to be provided)	***In-Network Dentist (Negotiated Fee Schedule)***	***Out-of-Network Dentist (90% of Reasonable and Customary Charges)***
Deductible	$50 per person; max $150 per family	$50 per person, max $150 per family
Preventive Dental Services: *Examples: Cleanings, Exams, Fluoride, Bitewing X-rays*	Plan Pays 100% up to calendar year maximum; deductible waived	Plan Pays 100% up to calendar year maximum; deductible waived
Basic Dental Services: *Examples: Fillings, Root Canal, Periodontal, Oral Surgery*	Plan Pays 90% after deductible up to calendar year maximum	Plan Pays 80% after deductible up to calendar year maximum
Major Dental Services: *Examples: Bridges, Crowns, Dentures*	Plan Pays 60% after deductible to calendar year maximum	Plan Pays 50% after deductible to calendar year maximum
Calendar Year Maximum Benefit	$2,000 per person	$2,000 per person
Orthodontia ***Lifetime Maximum Benefit***	Plan Pays 50% up to lifetime maximum for children up to age 19 $1,000 per person	Plan Pays 50% up to lifetime maximum for children up to age 19 $1,000 per person

Voluntary Vision Plan—Superior Vision

Go to www.superiorvision.com, choose "Locate a Provider" (at the bottom of the page).

	Monthly Premium	***Employee Cost Per Pay Period****
Employee Only	$5.94	$2.97
Employee & Spouse	$11.89	$5.95
Employee & Child(ren)	$10.08	$5.04
Family	$16.61	$8.31

This is intended to be a summary of benefits. For detailed benefit coverage and frequency refer to the dental certificate (to be provided)	***In-Network Provider Benefits***
Comprehensive Eye Exam	$10 copay
Materials/Eyewear	$25 copay
Standard Corrective Lenses - *Single Vision* - *Lined Bifocal* - *Lined Trifocal* - *Lenticular*	Covered after eyewear copay (Lenses allowed once every 12 months)
Additional Lens Upgrades: *Progressive lenses, Anti-reflective coating, etc.*	Costs for these upgrades will be listed in the employee enrollment guide
Frame Allowance	Covered up to $130 after eyewear copay (Frame allowed once every 24 months)
Contact Lenses	Covered up to $130
Contact Lens Fitting Fee	Covered in full after $30 co-pay