Certificated Benefit Information Sheet

Anthem Blue Cross Options for 2022-23 Benefit Plan Year (Oct. 2022 - Sept. 2023)

Brief Summary of Benefits	GROUP # 40450A	GROUP # 40450E	GROUP # 40450B	GROUP # 40450C	GROUP # 40450D
Professional Services:					
Office Visits / Urgent Care Co-pay	\$0 co-pay	\$20 co-pay	\$20 co-pay	\$20 co-pay	90%
Scans: CT, CAT, MRI, PET, etc.	100%	100%	90%	80%	90%
Diagnostic X-ray & Laboratory Procedures	100%	100%	90%	80%	90%
Infertility (diagnosis/treatment of infertility)	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Preventive Care Services	Deductible Waived	Deductible Waived	Deductible Waived	Deductible Waived	Deductible Waived
(includes physical exams & screenings)	100%	100%	100%	100%	100%
Hospital and Skilled Nursing Facility Services:					
Emergency Room (\$100 co-pay waived if admitted)	100%	100%	90%	80%	90%
Inpatient Hospital (preauthorization required)	100%	100%	90%	80%	90%
Outpatient Hospital (preauthorization required)	100%	100%	90%	80%	90%
Surgery, Outpatient (performed in an ambulatory surgery center)	100%	100%	90%	80%	90%
Surgery, Outpatient (performed in a hospital)	100%	100%	90%	80%	90%
Mental Health Services & Substance Abuse Treatmer	nt:	•			
Inpatient Care: Facility Based (preauthorization required)	100%	100%	90%	80%	90%
Outpatient Care: Facility Based	Deductible Waived	Deductible Waived	Deductible Waived	Deductible Waived	
(preauthorization required)	office visit co-pay applies	office visit co-pay applies	office visit co-pay applies	office visit co-pay applies	90%
Other Services:					
Acupuncture (limits apply)	100%	100%	90%	80%	90%
Ambulance (ground or air) (\$100 co-pay)	100%	100%	90%	80%	90%
Chiropractic (limits apply)	100%	100%	90%	80%	90%
Durable Medical Equipment (DME)	100%	100%	90%	80%	90%
Hearing Aids	Member pays cost in	Member pays cost in	Member pays cost in	Member pays cost in	Member pays for cost in
(\$700 benefit allowance per 24-month period)	excess of allowance	excess of allowance	excess of allowance	excess of allowance	excess of allowance
Physical Therapy and Occupational Therapy (limits apply)	100%	100%	90%	80%	90%
Individual / Family Deductible(s) - A portion of the covered					
expenses that an individual must pay before benefits are paid		\$100 per individual	\$100 per individual	\$300 per individual	\$3000 per individual
by the insurance plan. Deductibles are per calendar year.	\$300 family	\$300 family	\$300 family	\$600 family	\$5200 family
				-	_
Individual / Family Out of Pocket Max (OOP Max) The					
OOP Max is the most you have to pay in deductibles, co-					
insurance and co-pays for covered health services during a	\$1000 per individual	\$1000 per individual	\$1000 per individual	\$1000 per individual	\$5000 per individual
calendar year. All deductibles, co-insurance and co-pays	\$3000 family	\$3000 family	\$3000 family	\$3000 family	\$10,000 family
apply to the calendar year OOP maximum.					
	Outn	Latient Prescription Drugs			
	Network Costco	Network Costco	Network Costco	Network Costco	Network Costco
	Walk-in Walk-in Mail	Walk-in Walk-in Mail	Walk-in Walk-in Mail	Walk-in Walk-in Mail	Walk-in Walk-in Mail
Days supply		30 30 90 90	30 30 90 90	30 30 90 90	30 30 90 90
Generic Cost		\$9 Free Free Free			
Brand Name Cost	\$35 \$35 \$90 \$90	\$35 \$35 \$90 \$90	\$35 \$35 \$90 \$90	\$35 \$35 \$90 \$90	\$35 \$35 \$90 \$90
Out-of-Pocket Maximum	\$2500 individual	\$2500 individual	\$2500 individual	\$2500 individual	Medical and RX are combined in
Out-of-1 Ocket Maximum	\$3500 family	\$3500 family	\$3500 family	\$3500 family	the OOP Max. Rx subject to
This sheet is only a brief summary of benefits that reflects	deductible (The deductible mus be met prior to the plan paying				
plan booklets for details, limitations and exclusions. Benefits may be subject to change due to mid-year legislative changes.					indicated and prior to receiving

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indicated and prior to receiving the Costco RX Benefit).

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	GROUP # 40450A	GROUP # 40450E	GROUP # 40450B	GROUP # 40450C	GROUP # 40450D			
Medical / RX / Behavioral Monthly Cost	\$1,604.00	\$1,513.00	\$1,464.00	\$1,333.00	\$984.00			
TOTAL COST w/ Delta Dental Premier (Incentive) Plan	\$1,747.95	\$1,656.95	\$1,607.95	\$1,476.95	\$1,127.95			
TOTAL COST w/ Delta Dental PPO Plan	\$1,735.95	\$1,644.95	\$1,595.95	\$1,464.95	\$1,115.95			
Employer Contribution/Monthly	\$1,312.50	\$1,312.50	\$1,312.50	\$1,312.50	\$1,312.50			
10 MONTH EMPLOYEE COST								
Employee's Cost/Monthly with Delta Dental PPO Premier (Incentive) Plan	\$522.54	\$413.34	\$354.54	\$197.34	-\$221.46			
Employee's Cost/Monthly with Delta Dental PPO	\$508.14	\$398.94	\$340.14	\$182.94	-\$235.86			
11 MONTH EMPLOYEE COST								
Employee's Cost/Monthly with Delta Dental PPO Premier (Incentive) Plan	\$475.04	\$375.76	\$322.31	\$179.40	-\$201.33			
Employee's Cost/Monthly with Delta Dental PPO	\$461.95	\$362.67	\$309.22	\$166.31	-\$214.42			
12 MONTH EMPLOYEE COST								
Employee's Cost/Monthly with Delta Dental PPO Premier (Incentive) Plan	\$435.45	\$344.45	\$295.45	\$164.45	-\$184.55			
Employee's Cost/Monthly with Delta Dental PPO	\$423.45	\$332.45	\$283.45	\$152.45	-\$196.55			

Note: Monthly costs include: Medical, Dental, Vision, Life Insurance & Administrative Fee