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

Anthem Blue Cros								-						
Brief Summary of Benefits	GROU	P # 40675A	GRC	GROUP # 40682A		GROUP # 40675B		GROUP # 40675C		GROUP # 40675E				
Professional Services:														
Office Visits / Urgent Care Co-pay	\$0	co-pay	0,	S20 co-pay	0,	\$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%			
nfertility (diagnosis/treatment of infertility)	Not	Covered	Not Covered		N	Not Covered		Not Covered		Not Covered				
Preventive Care Services	Deduct	ible Waived	Deductible Waived		Dedu	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%				
npatient Hospital (preauthorization required)	100%		100%			90%			80%			90%		
Dutpatient 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 Treatme	nt:		-		-			-			-			
npatient Care: Facility Based (preauthorization required)	100%		100%			90%		80%			90%			
Dutpatient Care: Facility Based	Deductible Waived office visit co-pay applies		Ded	uctible Waived	Ded	Deductible Waived			Deductible Waived					
preauthorization required)					office visit co-pay applies		office visit co-pay applies			90%				
		1 7 11				1 7 1	•		1.7					
Other Services:	-	1000/	<u>г</u>	1000/	T	000/			0.00/		r	000/		
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% 80%		90% 90%				
Durable Medical Equipment (DME)	100%		100%			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		exces	excess of allowance		excess of allowance		excess of allowance				
Physical Therapy and Occupational Therapy (limits apply)		100%		100%	-	90%			80%			90%		
ndividual / 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.	\$30	0 family	ily \$300 family		\$	\$300 family		\$600 family			\$5200 family			
ndividual / Family Out of Pocket Max (OOP Max) The														
DOP Max is the most you have to pay in deductibles, co	\$1000 per individual		\$1000 per individual		\$1000	\$1000 per individual		\$1000 per individual			\$5000 per individual			
nsurance and co-pays for covered health services during a				•		-			\$1000 per individual \$3000 family			-		
alendar year. All deductibles, co-insurance and co-pays	\$ \$30	\$3000 family \$3000		3000 family \$3000 family			φο	ooo ranniy		\$10,000 family				
apply to the calendar year OOP maximum.														
		Outp	atient Pre	escription Drugs										
	Network	Costco	Network		Network	Costc	0	Network	Cost	0	Network	Cost	co	
	Walk-in	Walk-in Mai	Walk-in	Walk-in Ma	Walk-in	Walk-in	Mail	Walk-in	Walk-in	Mail	Walk-in	Walk-in	Ма	
Days supply		30 90 90	30	30 90 90	30	30 90	90	30	30 90	90	30	30 90	90	
Generic Cost		Free Free Free	e \$9	Free Free Fre	\$9	Free Free		\$9	Free Free	Free	\$9	Free Free	Fre	
Brand Name Cost		\$35 \$90 \$90	\$35	\$35 \$90 \$90		\$35 \$90		\$35	\$35 \$90		\$35	\$35 \$90		
Out-of-Pocket Maximum		\$2500 individual		\$2500 individual		\$2500 individual		\$2500 individual		Medical and RX are combined i				
	\$35	00 family	\$3500 family		\$	\$3500 family		\$3500 family		the OOP Max. Rx subject to deductible (The deductible mus				
			-						-	-				
This sheet is only a brief summary of benefits that reflects	s In-Netwo	rk benefits. Vi	sit our w	ebsite at hr.fco	e.ora/ben	efits to revi	ew the	e benefit	summarie	s or	be met pri	or to the nlan	navin	
This sheet is only a brief summary of benefits that reflects blan booklets for details, limitations and exclusions. Bene	-				-		ew the	e benefit	summarie	s or		or to the plan and prior to		
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	GROUP # 40675A	GROUP # 40682A	GROUP # 40675B	GROUP # 40675C	GROUP # 40675E
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	\$1,752.05	\$1,661.05	\$1,612.05	\$1,481.05	\$1,132.05
TOTAL COST w/ Delta Dental PPO Plan	\$1,740.05	\$1,649.05	\$1,600.05	\$1,469.05	\$1,120.05
Employer Contribution/Monthly	\$1,229.17	\$1,229.17	\$1,229.17	\$1,229.17	\$1,229.17
	11 MONTH	I EMPLOYEE COST			
Employee's Cost/Monthly with Delta Dental PPO Premier (Incentive) Plan	\$570.41	\$471.14	\$417.69	\$274.78	-\$105.95
Employee's Cost/Monthly with Delta Dental PPO	\$557.32	\$458.05	\$404.60	\$261.69	-\$119.04
	12 MONTH	EMPLOYEE COST			
Employee's Cost/Monthly with Delta Dental PPO Premier (Incentive) Plan	\$522.88	\$431.88	\$382.88	\$251.88	-\$97.12
Employee's Cost/Monthly with Delta Dental PPO	\$510.88	\$419.88	\$370.88	\$239.88	-\$109.12

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