

Classified Benefit Information Sheet
Anthem Blue Cross Two-Tiered Anchor Bronze PPO Plan
2022-2023 Benefit Plan Year (Oct. 2022-Sept. 2023)

BRIEF SUMMARY OF BENEFITS	MEMBER PAYS
Hospital and Skilled Nursing Facility Services:	
Inpatient Hospital (preauthorization required)	30%
Outpatient Hospital (preauthorization required)	30%
Emergency Room (co-pay is waived if admitted)	30% after \$100 co-pay
Surgery, Outpatient (performed in an ambulatory surgery center)	30%
Surgery, Outpatient (performed in a hospital)	30%
Other Services:	
Ambulance (ground or air)	30% after \$100 co-pay
Acupuncture - (limits apply)	30%
Chiropractic - (limits apply)	30%
Durable Medical Equipment (DME)	30%
Physical and Occupational Therapy (limits apply)	30%
Hearing Aids (\$700 benefit allowance per 24-month period)	30% plus any cost in excess of allowance
Mental Health Services & Substance Abuse Treatment:	
Inpatient Care: Facility based care (preauthorization required)	30%
Outpatient: Facility based care (preauthorization required)	30%
Professional Services:	
Office Visit / Urgent Care co-pay	30% after deductible
Specialists/Consultants co-pay	30% after deductible
Scans: CT, CAT, MRI, PET, etc.	30%
Prenatal, Postnatal Office Visit co-pay	30% after deductible
Diagnostic X-ray and Laboratory Procedures	30%
Infertility (diagnosis/treatment of causes of infertility)	Not Covered
Preventive Care Services (includes physical exams & screenings)	0%, Deductible Waived
Calendar Year Out-Of-Pocket Maximum:	
Individual / Family Deductible(s) - A portion of the covered expenses that an individual must pay before benefits are paid by the insurance plan. Deductibles are per calendar year.	\$5,000 per individual \$10,000 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 calendar year. All deductibles, co-insurance and co-pays apply to the calendar year OOP maximum.	\$6,350 per individual \$12,700 family
Prescription Drug Plan:	
Generic co-pay/Days supply	After deductible, \$9/30-day
Brand Name co-pay/Days supply	After deductible, \$35/30-day
Mail Order (generic-brand co-pay/days supply)	After deductible, \$18-\$90/90-day

COSTS		
	Employee	Employee + Child(ren)
Monthly Cost	\$568.25	\$885.25
Employer Contribution/Monthly	-\$1,229.17	-\$1,229.17
Total Costs/Monthly	-\$660.92	-\$343.92

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

11 MONTH EMPLOYEE COST	Employee	Employee + Child(ren)
	-\$721.00	-\$375.19

12 MONTH EMPLOYEE COST	Employee	Employee + Child(ren)
	-\$660.92	-\$343.92

This is only a brief summary of benefits that reflects In-Network benefits. Please review the benefit summaries or plan booklets located at hr.fcoe.org/plan-documents for details, limitations and exclusions. Benefits may be subject to change due to mid-year legislative changes.

