Certificated Enrollment Form
Anthem Blue Cross Options for 2023-24 Benefit Plan Year (Oct. 2023 - Sept. 2024)

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 (includes physical exams & screenings)	Deductible Waived 100%	Deductible Waived 100%	Deductible Waived 100%	Deductible Waived 100%	Deductible Waived 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 Treatment:					
Inpatient Care: Facility Based (preauthorization required)	100%	100%	90%	80%	90%
Outpatient Care: Facility Based (preauthorization required)	Deductible Waived office visit co-pay applies	Deductible Waived office visit co-pay applies	Deductible Waived office visit co-pay applies	Deductible Waived 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 ($700 benefit allowance per 24-month period)	Member pays cost in excess of allowance	Member pays cost in excess of allowance	Member pays cost in excess of allowance	Member pays cost in excess of allowance	Member pays for cost in 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 by the insurance plan. Deductibles are per calendar year.	**$100 per individual $300 family**	**$100 per individual $300 family**	**$100 per individual $300 family**	**$300 per individual $600 family**	**$3000 per individual $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 calendar year. All deductibles, co-insurance and co-pays apply to the calendar year OOP maximum.	**$1000 per individual $3000 family**	**$1000 per individual $3000 family**	**$1000 per individual $3000 family**	**$1000 per individual $3000 family**	**$5000 per individual $10,000 family**

Outpatient 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	30	30 90	90
Generic Cost	$9	Free Free	Free	$9	Free Free	Free	$9	Free Free	Free	$9	Free Free	Free	$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 $3500 family			$2500 individual $3500 family			$2500 individual $3500 family			$2500 individual $3500 family			Medical and RX are combined in the OOP Max. Rx subject to deductible (The deductible must be met prior to the plan paying as indicated and prior to receiving the Costco RX Benefit).		

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

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	GROUP # 40450A	GROUP # 40450E	GROUP # 40450B	GROUP # 40450C	GROUP # 40450D
Medical / RX / Behavioral Monthly Cost	$1,712.00	$1,615.00	$1,563.00	$1,424.00	$1,034.00
TOTAL COST w/ Delta Dental Premier (Incentive) Plan	$1,847.85	$1,750.85	$1,698.85	$1,559.85	$1,169.85
TOTAL COST w/ Delta Dental PPO Plan	$1,835.85	$1,738.85	$1,686.85	$1,547.85	$1,157.85
Employer Contribution/Monthly	$1,495.83	$1,495.83	$1,495.83	$1,495.83	$1,495.83
10 MONTH EMPLOYEE COST					
Employee's Cost/Monthly with Delta Dental PPO Premier (Incentive) Plan	**$422.42**	**$306.02**	**$243.62**	**$76.82**	**-$391.18**
Employee's Cost/Monthly with Delta Dental PPO	**$408.02**	**$291.62**	**$229.22**	**$62.42**	**-$405.58**
11 MONTH EMPLOYEE COST					
Employee's Cost/Monthly with Delta Dental PPO Premier (Incentive) Plan	**$384.02**	**$278.20**	**$221.48**	**$69.84**	**-$355.61**
Employee's Cost/Monthly with Delta Dental PPO	**$370.93**	**$265.11**	**$208.39**	**$56.75**	**-$368.71**
12 MONTH EMPLOYEE COST					
Employee's Cost/Monthly with Delta Dental PPO Premier (Incentive) Plan	**$352.02**	**$255.02**	**$203.02**	**$64.02**	**-$325.98**
Employee's Cost/Monthly with Delta Dental PPO	**$340.02**	**$243.02**	**$191.02**	**$52.02**	**-$337.98**

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

Group # 40450A _____

Group # 40450E _____

Group # 40450B _____

Group # 40450C _____

Group # 40450D _____

Delta Dental Premier (Incentive) Plan _____

Delta Dental PPO Plan _____

Name (Please Print)

Social Security Number (LAST 4 DIGITS)

Employee Signature

Date