Classified Election Form
Anthem Blue Cross Two-Tiered Anchor Bronze PPO Plan
2023-2024 Benefit Plan Year (Oct. 2023-Sept. 2024)

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

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.

COSTS		
	Employee	**Employee + Child(ren)**
Monthly Cost	$595.25	$944.25
Employer Contribution Monthly	-$1,412.50	-$1,412.50
Total Costs/Monthly	-$817.25	-$468.25

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

11 MONTH EMPLOYEE COST	**Employee**	**Employee + Child(ren)**
	-$891.55	-$510.82

12 MONTH EMPLOYEE COST	**Employee**	**Employee + Child(ren)**
	-$817.25	-$468.25

When electing this plan, you certify you understand you are eligible to participate in the medical plan and the life insurance policy only and you are not eligible to enroll in dental or vision. You also acknowledge this plan has no enrollment option for spouse or domestic partner and is only available to employee and employee's dependent child(ren) to age 26 only.

Employee ☐

Employee + Child(ren) ☐

Print Name

Sign Name

Date

Social Security Number (last 4 digits)