Classified Benefits Information Sheet

Anthem Blue Cross Options for 2025-2026 Benefit Plan Year (Oct. 2025-Sept. 2026)

Brief Summary of Benefits			0675A			40682A			JP # 40				P # 4067	5C	GR	OUP # 4067	5F
Professional Services:	O.CO.	J. 11 4	00101	0.10	0. "	-10002/1		0,101	JI 11 40	0,00		0.100	1 11 4001		J Oil	001 11 4001	<u> </u>
Office Visits / Urgent Care Co-pay	\$	0 со-ра	av	\$	20 co	-pav	Ī	\$2	20 co-pa	v		\$20) со-рау			90%	
Scans: CT, CAT, MRI, PET, etc.	100%		100%				90%				80%			90%			
Diagnostic X-ray & Laboratory Procedures	100%		100%			i	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	Deduc	Deductible Waived		Deductible Waived				Deductible Waived				Deductible Waived					
(preauthorization required)	office visit co-pay applies		office visit co-pay applies			es	office visit co-pay applies			s of	office visit co-pay applies		90%				
Other Services:	1			<u> </u>											1		
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	excess of allowance		excess of allowance				excess of allowance				excess of allowance		exce	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				\$100 per individual				\$300 per individual			\$3400 per individual			
by the insurance plan. Deductibles are per calendar year.	\$300 family			\$300 family				\$300 family				\$600 family			\$6800 family		
							_										
Individual / Family Out of Pocket Max (OOP Max) The																	
OOP Max is the most you have to pay in deductibles, co-		\$1000 per individual			\$1000 per individual				\$1000 per individual			\$1000 per individual \$3000 family			\$6000 per individual \$12,000 family		
insurance and co-pays for covered health services during a	00000 5 11			\$3000 family				\$3000 family									
calendar year. All deductibles, co-insurance and co-pays					φοσοσ ranning			ψοσοσ ranning				40000 failing			\$12,000 family		
apply to the calendar year OOP maximum.																	
				atient Pr			gs										
	Network		ostco	Network		Costco		Network		stco	_	etwork	Costo		Network	Costo	
	Walk-in	Walk		Walk-in		lk-in M	_	Walk-in	Walk-i		_		Walk-in	Mail	Walk-in	Walk-in	Mail
Days supply			90 90	30	30		0	30	30 9				30 90	90	30	30 90	90
Generic Cost	¥ -		Free Free			Free Fr			Free Fr				ree Free		\$9	Free Free	
Brand Name Cost			\$90 \$90	\$35		\$90 \$	90		\$35 \$9		0 5		35 \$90		\$35	\$35 \$90	\$90
Out-of-Pocket Maximum	\$2500 individual			\$2500 individual			\$2500 individual				Ţ			Medical and RX are combined in			
2	\$3	\$3500 family			\$3500 family			\$3500 family							the OOP Max. Rx subject to deductible (The deductible must be		
This sheet is only a brief summary of benefits that reflects	In-Notwo	ork ha	nofite Vi	sit our w	aheite	at hr fo	ne (ora/henet	ite to r	waive	he be	enefit sı	ımmaries	or		o the plan payir	

This sheet is only a brief summary of benefits that reflects In-Network 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.

deductible (The deductible must be met prior to the plan paying as indicated and prior to receiving the Costco RX Benefit).

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	GROUP # 40675A	GROUP # 40682A	GROUP # 40675B	GROUP # 40675C	GROUP # 40675E	
Medical / RX / Behavioral Monthly Cost	\$1,889.00	\$1,783.00	\$1,726.00	\$1,573.00	\$1,124.00	
TOTAL COST w/ Delta Dental Premier (Incentive) Plan	\$2,028.95	\$1,922.95	\$1,865.95	\$1,712.95	\$1,263.95	
TOTAL COST w/ Delta Dental PPO Plan	\$2,016.95	\$1,910.95	\$1,853.95	\$1,700.95	\$1,251.95	
Employer Contribution/Monthly	\$1,412.50	\$1,412.50	\$1,412.50	\$1,412.50	\$1,412.50	
	11 MONTI	H EMPLOYEE COST				
Employee's Cost/Monthly with Delta Dental PPO Premier (Incentive) Plan	\$672.49	\$556.85	\$494.67	\$327.76	-\$162.05	
Employee's Cost/Monthly with Delta Dental PPO	\$659.40	\$543.76	\$481.58	\$314.67	-\$175.15	
	12 MONTI	H EMPLOYEE COST				
Employee's Cost/Monthly with Delta Dental PPO Premier (Incentive) Plan	\$616.45	\$510.45	\$453.45	\$300.45	-\$148.55	
Employee's Cost/Monthly with Delta Dental PPO	\$604.45	\$498.45	\$441.45	\$288.45	-\$160.55	
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Note: Monthly costs include: Medical, Dental, Vision, Life Insurance & Administrative Fee