# MSCCU Benefits Information Sheet

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

| Brief Summary of Benefits | GROUP #40453A | GROUP # 40453E | GROUP # 40453B | GROUP # 40453C | GROUP # 40453D |
|---|---|---|---|---|---|
| **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** | **$3400 per individual $6800 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** | **$6000 per individual $12,000 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 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.**

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

| | GROUP # 40453A | GROUP # 40453E | GROUP # 40453B | GROUP # 40453C | GROUP # 40453D |
|---|---|---|---|---|---|
| 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 | $2,024.85 | $1,918.85 | $1,861.85 | $1,708.85 | $1,259.85 |
| TOTAL COST w/ Delta Dental PPO Plan | $2,012.85 | $1,906.85 | $1,849.85 | $1,696.85 | $1,247.85 |
| Employer Contribution/Monthly | $1,637.50 | $1,637.50 | $1,637.50 | $1,637.50 | $1,637.50 |
| **11 MONTH EMPLOYEE COST** | | | | | |
| **Employee's Cost/Monthly with Delta Dental PPO Premier (Incentive) Plan** | **$422.56** | **$306.93** | **$244.75** | **$77.84** | **-$411.98** |
| **Employee's Cost/Monthly with Delta Dental PPO** | **$409.47** | **$293.84** | **$231.65** | **$64.75** | **-$425.07** |
| **12 MONTH EMPLOYEE COST** | | | | | |
| **Employee's Cost/Monthly with Delta Dental PPO Premier (Incentive) Plan** | **$387.35** | **$281.35** | **$224.35** | **$71.35** | **-$377.65** |
| **Employee's Cost/Monthly with Delta Dental PPO** | **$375.35** | **$269.35** | **$212.35** | **$59.35** | **-$389.65** |

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