

**Certificated Benefit Information Sheets**  
**Anthem Blue Cross Two-Tiered Anchor Bronze PPO Plan**  
**2024-2025 Benefit Plan Year (Oct. 2024 - Sept. 2025)**

| BRIEF SUMMARY OF BENEFITS                                                                                                                                                                                                                                                |  | MEMBER PAYS                               |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------|
| <b>Hospital and Skilled Nursing Facility Services:</b>                                                                                                                                                                                                                   |  |                                           |
| 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%                                       |
| <b>Other Services:</b>                                                                                                                                                                                                                                                   |  |                                           |
| 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  |
| <b>Mental Health Services &amp; Substance Abuse Treatment:</b>                                                                                                                                                                                                           |  |                                           |
| Inpatient Care: Facility based care (preauthorization required)                                                                                                                                                                                                          |  | 30%                                       |
| Outpatient: Facility based care (preauthorization required)                                                                                                                                                                                                              |  | 30%                                       |
| <b>Professional Services:</b>                                                                                                                                                                                                                                            |  |                                           |
| 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                     |
| <b>Calendar Year Out-Of-Pocket Maximum:</b>                                                                                                                                                                                                                              |  |                                           |
| 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<br>\$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<br>\$12,700 family |
| <b>Prescription Drug Plan:</b>                                                                                                                                                                                                                                           |  |                                           |
| 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](http://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                  | \$605.25         | \$960.25              |
| Employer Contribution/Monthly | -\$1,600.00      | -\$1,595.83           |
| <b>Total Costs/Monthly</b>    | <b>-\$994.75</b> | <b>-\$635.58</b>      |

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

| 11 MONTH EMPLOYEE COST | Employee    | Employee + Child(ren) |
|------------------------|-------------|-----------------------|
|                        | -\$1,085.18 | -\$693.36             |

| 12 MONTH EMPLOYEE COST | Employee  | Employee + Child(ren) |
|------------------------|-----------|-----------------------|
|                        | -\$994.75 | -\$635.58             |

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.