

Anthem Blue Cross Options for 2026-27 Benefit Plan Year (Oct. 2026 - Sept. 2027)

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			\$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					
				Walk-in		Walk-in		Mail	Walk-in		Walk-in		Mail	Walk-in		Walk-in		Mail	Walk-in		Walk-in		Mail
				30		30 90		90	30		30 90		90	30		30 90		90	30		30 90		90
				\$9		Free Free		Free	\$9		Free Free		Free	\$9		Free Free		Free	\$9		Free Free		Free
				\$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.																							

Certificated Benefit Information Sheet
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	GROUP # 40450A	GROUP # 40450E	GROUP # 40450B	GROUP # 40450C	GROUP # 40450D
Medical / RX / Behavioral Monthly Cost	\$2,093.00	\$1,976.00	\$1,912.00	\$1,742.00	\$1,247.00
TOTAL COST w/ Delta Dental Premier (Incentive) Plan	\$2,228.85	\$2,111.85	\$2,047.85	\$1,877.85	\$1,382.85
TOTAL COST w/ Delta Dental PPO Plan	\$2,216.85	\$2,099.85	\$2,035.85	\$1,865.85	\$1,370.85
Employer Contribution/Monthly	\$1,908.33	\$1,908.33	\$1,908.33	\$1,908.33	\$1,908.33
11 MONTH EMPLOYEE COST					
Employee's Cost/Monthly with Delta Dental PPO Premier (Incentive) Plan	\$349.66	\$222.02	\$152.20	-\$33.25	-\$573.25
Employee's Cost/Monthly with Delta Dental PPO	\$336.57	\$208.93	\$139.11	-\$46.34	-\$586.34
12 MONTH EMPLOYEE COST					
Employee's Cost/Monthly with Delta Dental PPO Premier (Incentive) Plan	\$320.52	\$203.52	\$139.52	-\$30.48	-\$525.48
Employee's Cost/Monthly with Delta Dental PPO	\$308.52	\$191.52	\$127.52	-\$42.48	-\$537.48

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