G.P.O. HMO				
	PERS ABC Trad. HMO		SISC Anthem Premier 10/0, Rx 5-20	
Benefit	**Network**	**NonNetwork**	**Network**	**NonNetwork**
Annual Deductible- Ind.	$0	N/A	$0	N/A
Family	$0	N/A	$0	N/A
Coinsurance	100% except infertility at 50%	0%	100%	0%
Office Visit Exam	$15 copay, then 100%	Not Covered	$10 copay, then 100%	Not Covered
Annual Out-of-Pocket Limit (OOP)	$1,500 Member; $3,000 Family: Rx $6,650 Member, $13,300 Family	Unlimited	$1,000 Member; $2,000 Family: Rx $1,500 Member, $2,500 Family	Unlimited
Deductible included in OOP Limit	N/A	N/A	N/A	N/A
Lifetime Plan Maximum	Unlimited	Unlimited	Unlimited	Unlimited
Preventive Services				
Well-Child Care (through age 6)	100%	Not Covered	Covered 100%	Not Covered
Routine Physical Exam/immunizations (age 7+)	100%	Not Covered	Covered 100%	Not Covered
Immunizations through age 6	100%	Not Covered	Covered 100%	Not Covered
Well Woman Exams	100%	Not Covered	Covered 100%	Not Covered
Mammograms	100%	Not Covered	Covered 100%	Not Covered
Adult Periodic Exams w/ Preventive Tests	100%	Not Covered	Covered 100%	Not Covered
Diagnostic X-Ray and Lab Tests	100%	Not Covered	Covered 100% (advanced imaging $100/test)	Not Covered
Pregnancy and Maternity Pre-Natal Care	100%	Not Covered	Covered 100%	Not Covered
Inpatient Hospital	100%	Not Covered	Covered 100%	Not Covered
Pre-Authorization of Services Required	Yes	Not Covered	Yes	Not Covered
Semi-Private Room and Board, Services and Supplies	100%	Not Covered	Covered 100%	Not Covered
Out-Patient Facility Charge (Ambulatory Surgical Centers)	100%	Not Covered	Covered 100%	Not Covered
Emergency Room	$50 copay WifA	Covered as In-Network	$100 copay WifA	Covered as In-Networ
Ambulance (Air and Ground)	100%	Covered as In-Network	$100 copay per trip	Covered as In-Networ
Prescription Drugs				
Deductible	N/A	N/A	N/A	N/A
At Retail:			Navitus	
- Generic copay	$5/30; $10/90	Not covered	$5 network; $0 Costco	Not covered
- Brand copay (P=Preferred; F=Formulary)	F $20/30, $40/90; NonF $50/30, $100/90	Not Covered	$20 all network	Not Covered
Specialty Pharmacy 30 day supply	As Above	Not Covered	As Above	Not Covered
Number of days supply	30/90 days	N/A	30 days	N/A
From Mail Order	$1,000 copay ann. max		Costco Mail	
- Generic copay	$10 copay	Not covered	$0 copay	Not covered
- Brand copay (P=Preferred; F=Formulary)	F $40; NonF $100	Not Covered	$20/30-day or $50/90-day	Not Covered
Number of days supply	90 days	N/A	30 or 90 days	N/A

G.P.O. HMO				
	PERS ABC Trad. HMO		SISC Anthem Premier 10/0, Rx 5-20	
Benefit	**Network**	**NonNetwork**	**Network**	**NonNetwork**
Other Services				
DME and Prosthetics (limits apply)	100%	Not Covered	No Charge	Not Covered
Home Health Care (100 visits)	No Charge	Not Covered	No Charge	Not Covered
Skilled Nursing or Extended Care Facility (100 days/year)	No Charge	Not Covered	No Charge	Not Covered
Hospice Care	No Charge	Not Covered	No Charge	Not Covered
Chiropractic Services	$15 copay/visit	Not Covered	built in rider $10 copay/visit, 30 visits total combined with Acu	Not Covered
Acupuncture	$15 copay/visit	Not Covered	built in rider $10 copay/visit, 30 visits total combined with Chiro	Not Covered
Infertility Diagnosis	50% of Covered Charges	Not Covered	50% of Covered Charges	Not Covered
Infertility Treatment	50% of Covered Charges	Not Covered	50% of Covered Charges	Not Covered
Rehabilitation Services - Physical, Occupational, Speech	$15/visit	Not Covered	$10/visit	Not Covered
Inpatient Mental/Nervous & Substance Abuse	100%	Not Covered	No Charge	Not Covered
Outpatient Mental/Nervous & Substance Abuse	$15 copay	Not Covered	$10 copay	Not Covered

The EOC will supersede information provided in this summary if different.