	SISC Anthem PPO 90-G $20, Rx 5-20	
Benefit	**Network**	**NonNetwork**
Annual Deductible	$500 single/$1,000 family	
Coinsurance	Plan 90%, Member 10%	100% above plan allowable
Office Visit Exam	$0 visits 1-3, then $20 copay visits 4+	All billed amounts exceeding the max. allowed.
Annual Out-of-Pocket Limit (OOP)	$1,000 single/ $3,000 family	Unlimited
Deductible included in OOP Limit	YES	N/A
Lifetime Plan Maximum	Unlimited	Unlimited
Preventive Services		
Well-Child Care (through age 6)	No charge	Not covered
Routine Physical Exam/immunizations (age 7+)	No charge	Not covered
Immunizations through age 6	No charge	Not covered
Well Woman Exams	No charge	Not covered
Mammograms	No charge, if part of WWE	Not covered
Adult Periodic Exams w/ Preventive Tests	No charge	Not covered
Diagnostic X-Ray and Lab Tests	10% coinsurance	Not covered
Pregnancy and Maternity Pre-Natal Care	$0 visits 1-3, then $20 copay visits 4+	All billed amounts exceeding the max. allowed.
Inpatient Hospital		
Pre-Authorization of Services Required	10% coinsurance	All billed amounts exceeding the max. allowed. Not to exceed $600/day
Semi-Private Room and Board,Services and Supplies	10% coinsurance	All billed amounts exceeding the max. allowed. Not to exceed $600/day
Out-Patient Facility Charge (Ambulatory Surgical Centers)	10% coinsurance, some services have benefit limit	All billed amounts exceeding the max. allowed.
Emergency Room	$100 copay (Waived if admitted), then 10% coinsurance	Covered at in-network level of benefits
Non-Emergency	$100 copay (Waived if admitted), then 10% coinsurance	Covered at in-network level of benefits
Ambulance (Air and Ground)	$100 copay/trip, then 10% coinsurance	Covered at in-network level of benefits
Prescription Drugs		
At Retail:		
- Generic copay	$5 network; $0 Costco	Not covered
- Brand copay	$20	Not Covered
Number of days supply	30 days	Not Covered
From Mail Order	Costco Mail	N/A
- Generic copay	$0 copay	Not covered
- Brand copay	$20/30-day and $50/90-day	Not covered
Number of days supply	30 or 90 days	Not Covered
Other Services		
DME and Prosthetics (limits apply)	10% coinsurance	No covered
Home Health Care	10% coinsurance	All billed amounts exceeding the max. allowed.
Skilled Nursing or Extended Care Facility (100 days/year)	10% coinsurance	All billed amounts exceeding the max. allowed.
Hospice Care	No charge	All billed amounts exceeding the max. allowed.
Chiropractic Services (subject to review by ASH)	10% coinsurance	Not covered
Acupuncture (limit to 12 visits per year)	10% coinsurance	50% of max. allowed amount
Infertility Diagnosis	10% coinsurance	All billed amounts exceeding the max. allowed
Infertility Treatment	Not covered	Not covered
Rehabilitation Services - Physical, Occupational, Speech	Member pays 10%, after deductible	All billed amounts exceeding the max. allowed.
Inpatient Mental/Nervous & Substance Abuse	10% coinsurance	All billed amounts exceeding the max. allowed. Not to exceed $600/day
Outpatient Mental/Nervous & Substance Abuse	$20 copay per visit	All billed amounts exceeding the max. allowed.
	The EOC will supersede information in this summary if different	