SISC Anthem Medical Plan OPTIONS

PLAN FEATURES	ANTHEM PREMIER HMO $10	ANTHEM CLASSIC HMO $20	ANTHEM VALUE HMO $30	ANTHEM CLASSIC PPO 20	
				PPO Provider	Non-PPO Provider
Calendar Year Deductible					
Individual	None	None	None	$500	
Family				$1,000	
Calendar Year Co-Pay Max (excluding Prescription Drug)					
Individual	$1,000	$2,000	$2,500	$2,000	
Family	$2,000	$4,000	$5,000	$4,000	
Hospital					
Inpatient Copay (per admission)	No charge	$250 copay	$500 per day(3 day max copay)	20%	0% (up to $600/day)
Outpatient Facility / Surgery Services	No charge	$125 copay	$250 copay	20%	50% of max allowable
Emergency Services					
Emergency Room	$100 copay	$100 copay	$150 copay	$100 visit/+20%	
Ambulance	$100 per trip	$100 per trip	$100 per trip	20%	
Physician Services (Includes Mental Health and Substance Abuse)					
Office Visits - Primary	$10 copay	$20 copay	$30 copay	$20 copay	Billed for charges
Office Visits - Specialist	$10 copay	$40 copay	$40 copay	$20 copay	Billed for charges
Urgent Care Visits (Out of service area)	$10 copay	$20 copay	$30 copay	$20 copay	Billed for charges
Diagnostic X-Ray/Lab					
Lab and X-Ray	No charge	No charge	No charge	20%	Not covered
Advanced Imaging (CT, MRI, PET)	$100 copay	$100 copay	$100 copay	20%	Billed for charges
Prescription Drugs					
Retail Pharmacy					
Generic (up to 30-day supply)	$9 copay	$10 copay	$9 copay	$9 copay	
Brand - Formulary (up to 30-day supply)	$35 copay	$35 copay	$35 copay	$35 copay	
Mail Order Pharmacy					
Generic (up to 90-day supply)	$0 copay	$0 copay	$0 copay	$0 copay	
Brand - Formulary (up to 90-day supply)	$90 copay	$90 copay	$90 copay	$90 copay	
Durable Medical Equipment					
DME	20%	20%	50%	20%	Not Covered
Infertility Testing/Treatment					
Infertility Services	Not Covered	Not Covered	Not Covered	Not covered	
Chiropractic/Acupuncture					
Office Visit	$10 copay	$10 copay	$10 copay	20%	Not Covered
# of combined visits per year (max)	30 per year	30 per year	30 per year	12 Visits a Calendar Year	
Single	**$715.20**	**$676.80**	**$596.40**	**$766.80**	
Employee + Spouse	**$1,438.80**	**$1,359.60**	**$1,196.40**	**$1,542.00**	
Employee + Child(ren)	**$1,359.60**	**$1,280.40**	**$1,117.20**	**$1,462.80**	
Family	**$2,058.00**	**$1,941.60**	**$1,700.40**	**$2,210.40**	

SISC Kaiser Medical Plan OPTIONS

Plan Features	KAISER $15	KAISER $20
Calendar Year Deductible		
Individual	None	None
Calendar Year Co-Pay Max (excluding Prescription Drug)		
Individual	$1,500	$1,500
Family	$3,000	$3,000
Hospital		
Inpatient Copay (per admission)	No charge	No charge
Outpatient Facility / Surgery Services	$15 copay	$20 copay
Emergency Services		
Emergency Room	$100 copay	$100 copay
Ambulance	$50 per trip	$50 per trip
Physician Services (Includes Mental Health and Substance Abuse)		
Office Visits - Primary & Specialist	$15 copay	$20 copay
Urgent Care	$15 copay	$20 copay
Routine physical maintenance exams	No charge	No charge
Well-child preventive exams (to age 23 months)	No charge	No charge
Eye Exams	No charge	No charge
Diagnostic X-Ray/Lab		
Lab and X-Ray	No charge	No charge
Prescription Drugs Retail Pharmacy		
Generic	$5 copay up to 30 day	$10 copay up to 30 day
Brand - Formulary	$20 copay up to 30 day	$30 copay up to 30 day
Mail Order Pharmacy		
Generic	$10 up to 100 day supply	$20 up to 100 day supply
Brand - Formulary	$40 up to 100 day supply	$60 up to 100 day supply
Durable Medical Equipment		
DME	No Charge	No charge
Infertility Testing/Treatment		
Infertility Services	Limited Services	Limited Services
Chiropractic/Acupuncture		
Office Visit	$10 copay/30 visits per year	$10 copay/30 visits per year
Single	**$697.20**	**$687.60**
Employee + Spouse	**$1,470.00**	**$1,449.60**
Employee + Child(ren)	**$1,342.80**	**$1,323.60**
Family	**$1,886.40**	**$1,858.80**