Benefits	Blue Shield HDHP		Aetna OAMC PPO HDHP	
	In-Network	Out-Of-Network	In-Network	Out-Of-Network
Calendar Year Deductible				
Single / Single in Family / Family	$1,500 / $2,800 / $3,000		$1,500 / $1,500 / $3,000	**$3,000 / $3,000 / $6,000**
Annual Out-of-Pocket Maximum				
Single / Single in Family / Family	$3,000 / $3,000 / $6,000	$6,000 / $6,000 / $12,000	$3,000 / $3,000 / $6,000	$6,000 / $6,000 / $12,000
Physician Office Visit	10% after deductible	40% after deductible	10% after deductible	40% after deductible
Specialist Copay	10% after deductible	40% after deductible	10% after deductible	40% after deductible
Preventive Care	No Charge (ded waived)	Not Covered	No Charge (ded waived)	Not Covered
Lab and X-Ray	10% after deductible	40% after deductible	10% after deductible	40% after deductible
Chiropractic (20 visits/calendar year)	10% after deductible	50% after deductible	10% after deductible	50% after deductible
Acupuncture	Not Covered	Not Covered	**10% after deductible**	**40% after deductible**
Hospitalization				
Inpatient Hospitalization	$100 per admit + 10% after deductible	40% after deductible	**10% after deductible**	40% after deductible
Outpatient Surgery	10% after deductible	40% after deductible	10% after deductible	40% after deductible
Mental Health				
Inpatient	$100 per admit + 10% after deductible	40% after deductible	**10% after deductible**	40% after deductible
Outpatient	10% after deductible	40% after deductible	10% after deductible	40% after deductible
Substance Abuse				
Inpatient	$100 per admit + 10% after deductible	40% after deductible	**10% after deductible**	40% after deductible
Outpatient	10% after deductible	40% after deductible	10% after deductible	40% after deductible
Other Benefits				
Ambulance	10% after deductible	10% after deductible	10% after deductible	10% after deductible
Emergency Room	$100 + 10% after deductible	$100 + 10%	**10% after deductible**	**10% after deductible**
Durable Medical Equipment	10% after deductible	40% after deductible	10% after deductible	40% after deductible
Prescription Drugs	**Generic / Brand / Brand Non-formulary / Specialty**		**Generic / Brand / Brand Non-formulary / Specialty**	
Pharmacy				
Plan Deductible Applies?	Yes	Yes	Yes	Yes
$0 Chronic Drug List	Plan pays 100%	25% to $250 max. copay per prescription	Plan pays 100%	25% to $250 max. copay per prescription
Preferred Generic	$10 per prescription	25% + $10 to $250 max. copay per prescription	$10 per prescription	25% + $10 to $250 max. copay per prescription
Preferred Brand	$25 per prescription	25% + $25 to $250 max. copay per prescription	$25 per prescription	25% + $25 to $250 max. copay per prescription
Non-Preferred Generic and Brand	$40 per prescription	25% + $40 to $250 max. copay per prescription	$40 per prescription	25% + $40 to $250 max. copay per prescription
Specialty Drugs	30% (up to $200 copay max/drug)	Not Covered	30% up to $200 max. copay per prescription	Not Covered
Supply Limit	30 days	30 days	30 days	30 days
Mail Order				
Plan Deductible Applies?	Yes	Yes	Yes	Yes
$0 Chronic Drug List	Plan pays 100%	Not Covered	Plan pays 100%	Not Covered
Preferred Generic	$20 per prescription	Not covered	$20 per prescription	Not covered
Preferred Brand	$50 per prescription	Not covered	$50 per prescription	Not covered
Non-Preferred Generic and Brand	$80 per prescription	Not covered	$80 per prescription	Not covered
Specialty Drugs	20% to $100 max. copay/prescription	Not covered	20% to $100 max. copay/prescription	Not covered
Supply Limit	90 days	Not applicable	90 days	Not applicable

This summary is intended as a quick reference, not a comprehensive description. For more plan information, please go to Benefits Employee's website at https://www.smcgov.org/hr/health-benefits