Benefits	Blue Shield PPO		Aetna OAMC PPO	
	In-Network	**Out-Of-Network**	**In-Network**	**Out-Of-Network**
Calendar Year Deductible				
Single / Single in Family / Family	$200/ $200 / $600	$500/ $500 / $1,000	$200 / $200 / $600	$500/ $500 / $1,000
Annual Out-of-Pocket Maximum				
Single / Single in Family / Family	$2,000/ $2,000 / $4,000	$4,000/ $4,000 / $8,000	$2,000/ $2,000 / $4,000	$4,000/ $4,000 / $8,000
Physician Office Visit	20% (ded waived)	40% after deductible	20% (ded waived)	40% after deductible
Specialist Copay	20% (ded waived)	40% after deductible	20% (ded waived)	40% after deductible
Preventive Care	No Charge (ded waived)	40% after deductible	No Charge (ded waived)	40% after deductible
Lab and X-Ray	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Chiropractic (30 visits/calendar year combined with Acupuncture	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Acupuncture (30 visits/calendar year combined with Chiropractic)	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Hospitalization				
Inpatient Hospitalization	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Outpatient Surgery	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Mental Health				
Inpatient	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Outpatient	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Substance Abuse				
Inpatient	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Outpatient	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Other Benefits				
Ambulance	20% after deductible	20% after deductible	20% after deductible	20% after deductible
Emergency Room	$100 (ded waived)		$100 (ded waived)	
Skilled Nursing Facility	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Durable Medical Equipment	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Prescription Drugs	**Generic / Formulary Brand/Non-Formulary Brand / Specialty**		**Generic / Formulary Brand/Non-Formulary Brand / Specialty**	
Pharmacy				
Plan Deductible Applies?	No	No	No	No
$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	$15 per prescription	25% + $15 to $250 max. copay per prescription	$15 per prescription	25% + $15 to $250 max. copay per prescription
Preferred Brand	$30 per prescription	25% + $30 to $250 max. copay per prescription	$30 per prescription	25% + $30 to $250 max. copay per prescription
Non-Preferred Generic and Brand	$45 per prescription	25% + $45 to $250 max. copay per prescription	$45 per prescription	25% + $45 to $250 max. copay per prescription
Specialty Drugs	20% (up to $100 copay max/drug)	20% (up to $100 copay max/drug + 25%)	20% to $100 max. copay per prescription	**Not Covered**
Supply Limit	30 days	30 days	30 days	30 days
Mail Order				
Plan Deductible Applies?	No	No	No	No
$0 Chronic Drug List	Plan pays 100%	Not Covered	Plan pays 100%	Not Covered
Preferred Generic	$30 per prescription	Not Covered	$30 per prescription	Not Covered
Preferred Brand	$60 per prescription	Not Covered	$60 per prescription	Not Covered
Non-Preferred Generic and Brand	$90 per prescription	Not covered	$90 per prescription	Not covered
Specialty Drugs	20% to $200 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