Benefits	Blue Shield GMAPD PPO	Aetna GMAPD PPO
	In-Network	**In-Network**
Calendar Year Deductible Single / Single in Family / Family	$0	$0
Annual Out-of-Pocket Maximum Single / Single in Family / Family	$1,500	$1,500
Physician Office Visit	$10 Co-payment	$10 Co-payment
Specialist Copay	$20 Co-payment	$20 Co-payment
Preventive Care	$0 Co-payment	$0 Co-payment
Physical, Occupational, & Speech Therapy	$10 Co-payment	$10 Co-payment
Lab and X-Ray	$0 Co-payment	$0 Co-payment
Chiropractic (up to 20 visits per CY)	$15 Co-payment (up to 20 visits per CY)	$15 Co-payment
Acupuncture (up to 20 visits per CY)	$15 Co-payment (up to 20 visits per CY)	$15 Co-payment
Hospitalization		
Inpatient Hospitalization	$0 Co-payment	$0 Copayment
Outpatient Surgery	$10 Co-payment	$10 Co-payment
Other Benefits		
Ambulance	$50 Co-payment	$50 Co-payment
Emergency Room	$20 Co-payment	$20 Co-payment
Durable Medical Equipment	20%	**$0 Co-payment**
Skilled Nursing Facility	Days 1-100: $0 Co-payment	Days 1-100: $0 Co-payment
Hospice	Covered by Original Medicare	Covered by Original Medicare
Mental Health		
Inpatient	$0 Co-payment	$0 Co-payment
Outpatient	20%	**$20 Co-payment**
Substance Abuse		
Inpatient	$0 Co-payment	$0 Co-payment
Outpatient	20%	**$20 Co-payment**
Foot Care Services		
Medicare-covered	$20 Co-payment	$20 Co-payment
Non-Medicare covered	Not Covered	Not covered
Hearing Services		
Medicare-covered Hearing Exam	$20 Co-payment	$20 Co-payment
Non-Medicare covered	$0 for Routine Hearing tests	$0 for Routine Hearing tests
Hearing Aids	Hearing Aids - Not covered	Hearing Aids - Not covered
Vision Services		
Medicare-covered Eye Exam	$20 Co-payment	$20 Co-payment
Medicare-covered Eyewear	Eyeglasses / Contacts covered after Cataract Surgery	Eyeglasses / Contacts covered after Cataract Surgery
Non-Medicare covered Eye Exam	$10 Co-payment	$10 Co-payment
Non-Medicare covered Eyewear	$150 once every 24 months	$150 once every 24 months
Prescription Drugs	**Generic / Brand / Non-Preferred**	**Generic / Brand / Brand Non-formulary**
Retail (Generic, Preferred, Non-Preferred, Specialty)	$10 / $20 / $35 / 30% up to a $150 (Preferred) $10 / $20 / $35 / 30% up to a $150 (Standard)	**$9 / $20 / $35 / 30% up to $150 (Preferred)** **$10 / $20 / $35 / 30% up to $150 (Standard)**
Mail Order	$20 / $40 / $60 / Not covered (Preferred) $30 / $60 / $105 / Not covered (Standard)	**$18 / $40 / $60 / Limits apply (Preferred)** **$30 / $60 / $105 / Limits apply (Standard)**

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