

Benefits
Calendar Year Deductible Single / Family
Annual Out-of-Pocket Maximum Single / Family
Physician Office Visit
Specialist Copay
Preventive Care
Lab and X-Ray
Chiropractic (20 visits/calendar year)
Acupuncture
Hospitalization
Inpatient Hospitalization
Outpatient Surgery
Mental Health
Inpatient
Outpatient
Substance Abuse
Inpatient
Outpatient
Other Benefits
Ambulance
Emergency Room
Durable Medical Equipment
Prescription Drugs
Stage 1: Annual Prescription Deductible
Stage 2: Initial Coverage
Tier 1: Generic
Tier 2: Preferred Brand
Tier 3: Non-Preferred Brand
Tier 4: Specialty
Stage 3: Coverage Gap Stage
Stage 4: Catastrophic Coverage

Kaiser HMO Senior Advantage
In-Network
None
\$1,500/\$3,000
\$10 per visit
\$10 per visit
No Charge
No Charge
\$15 per visit (Max 20 visits combined with acu)
\$15 per visit (Max 20 visits combined with chiro)
No Charge
\$10 per procedure
No Charge
\$10 (individual); \$5 (group)
No Charge
\$10 (individual); \$5 (group)
No Charge
\$20 per visit
No Charge
Generic / Brand / Brand Non- formulary / Specialty
Most covered outpatient items in accord with our drug formulary guidelines: \$10 for up to a 100-day supply

Aetna PPO Medicare Advantage	
In-Network	Out-Of-Network
None	None
\$1,500/\$3,000	\$1,500/\$3,000
\$10 per visit	\$10 per visit
\$20 per visit	\$20 per visit
No Charge	No Charge
No Charge	No Charge
For Medicare covered: \$15 copay, 12 visits in 90 days Non-Medicare covered: \$15 copay up to 20 visits a year	
For Medicare covered: \$15 copay, 12 visits in 90 days Non-Medicare covered: \$15 copay up to 20 visits a year	
No Charge	No Charge
\$10 per procedure	\$10 per procedure
No Charge	No Charge
\$20 per visit	\$20 per visit
No Charge	No Charge
\$20 per visit	\$20 per visit
\$50 per trip	\$50 per trip
\$20 per visit	\$20 per visit
No Charge	No Charge
Retail (30 day supply)	Retail/Mail Order (90 day supply)
No deductible, this payment stage doesn't apply.	
You pay the following until your total out-of-pocket drug costs reach \$4,660.	
Preferred Pharmacy: \$9 Copay	Preferred Pharmacy: \$18 Copay
Standard Pharmacy: \$10 copay	Standard Pharmacy: \$20 copay
\$20 copay	\$40 copay
\$35 copay	\$60 copay
30% coinsurance (up to a \$150 copay max) per prescription	Not covered
Because there is no coverage gap for the plan, this payment stage does not apply to you.	
After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail service) reach \$7,400, your share of the cost for a covered drug will be \$0.	

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>