Benefits	United Healthcare HMO	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	$6,700	$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)	Medicare-covered: 50% Non-Medicare covered: Not covered	$15 Co-payment	
Acupuncture (up to 20 visits per CY)	Medicare-covered: 50% Non-Medicare covered: Not covered	$15 Co-payment	
Hospitalization			
Inpatient Hospitalization	$250 Co-payment per admission	**$0 Copayment**	
Outpatient Surgery	$125 Co-payment per surgery	**$10 Co-payment**	
Other Benefits			
Ambulance	$50 Co-payment	$50 Co-payment	
Emergency Room	~~$50 Co-payment~~ ~~(waived if admitted within 24 hours)~~	**$20 Co-payment**	
Urgent Care	~~In-Network: $10 Co-payment~~ ~~Non-Network: $10 Co-payment~~	$10 Co-payment	
Durable Medical Equipment	$0 Co-payment	$0 Co-payment	
Skilled Nursing Facility	**Days 1-20:** $0 Co-payment **Days 21-100:** $50 Co-payment per day (up to 100 days per benefit period)	**Days 1-100: $0 Co-payment**	
Hospice	Covered by Original Medicare	Covered by Original Medicare	
Mental Health			
Inpatient	$250 Co-payment per admission (190-day lifetime max)	**$0 Co-payment**	
Outpatient	$20 Co-payment per visit	$20 Co-payment	
Substance Abuse			
Inpatient	$250 Co-payment	**$0 Co-payment**	
Outpatient	$20 Co-payment per visit	$20 Co-payment	
Dental Services			
Medicare-covered	$20 Co-payment	$20 Co-payment	
Foot Care Services			
Medicare-covered	**Primary Care Physician:** $20 Co-payment per visit	$20 Co-payment	
Non-Medicare covered	Not Covered	Not covered	
Hearing Services			
Medicare-covered Hearing Exam	**Primary Care Physician:** $20 Co-payment per visit	$20 Co-payment	
Non-Medicare covered	$0 Co-payment per test (1 test per 12 months)	$0 for Routine Hearing tests	
Hearing Aids		Hearing Aids - Not covered	
Vision Services			
Medicare-covered Eye Exam	**Primary Care Physician:** $20 Co-payment per visit	$20 Co-payment	
Medicare-covered Eyewear	Eyeglasses / Contacts covered after Cataract Surgery	Eyeglasses / Contacts covered after Cataract Surgery	
Non-Medicare covered Eye Exam	$20 Co-payment per each refractive exam (1 exam per year)	$10 Co-payment	
Non-Medicare covered Eyewear	Not Covered	**$150 once every 24 months**	
Prescription Drugs	**Generic / Brand / Non-Preferred**	**Generic / Brand / Brand Non-formulary**	
Retail (Generic, Preferred, Non-Preferred, Specialty)	Retail (30 day supply): $10 / $20 / $20 / $20	$9 / $20 / $35 / 30% up to $150 (Preferred) $10 / $20 / $35 / 30% up to $150 (Standard)	Not Covered
Mail Order	Mail Order (90 day supply): $20 / $40 / $40 /$40	$18 / $40 / $60 / Limits apply (Preferred) $30 / $60 / $105 / Limits apply (Standard)	Not Covered

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