Benefits	Blue Shield OOS PPO		Aetna OOS PPO	
	PPO	OON	PPO	OON
Calendar Year Deductible Single / Single in Family / Family	$300/ $300 / $900		$300 / $300 / $900	
Annual Out-of-Pocket Maximum Single / Single in Family / Family	$2,000/ $2,000 / $4,000	$3,000/ $3,000 / $6,000	$2,000 / $4,000	$3,000 / $6,000
Physician Office Visit	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Specialist Copay	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Preventive Care	No Charge (ded waived)	40% after deductible	No Charge (ded waived)	40% after deductible
Physical, Occupational, & Speech Therapy	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Lab and X-Ray	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Chiropractic (up to 20 visits per CY)	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Acupuncture (up to 20 visits per CY)	20% after deductible	Not Covered	20% after deductible	Not Covered
Hospitalization				
Inpatient Hospitalization	No Charge	30%after deductible	No Charge	30% after deductible
Outpatient Surgery	No Charge	30%after deductible	No Charge	30% 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	No Charge	No Charge	No Charge	No Charge
Prescription Drugs	**Generic / Brand / Brand Non-formulary**		**Generic / Brand / Brand Non-formulary**	
Retail (30 day supply)	$10/$20/$35	$10/$20/$35 + $25%	$10/$20/$35	$10/$20/$35 + $25%
Mail Order (90 day supply)	$20/$40/$60	Not Covered	$20/$40/**$70**	Not Covered
$0 Chronic Drugs	Included	Not Covered	Included	Not Covered
Specialty Drugs (30 day supply)	30% (up to $150 copay max/drug)	Not Covered	30% (up to $150 copay max/drug)	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