	Current	SISC
	Kaiser	Kaiser
	GRANDFATHERED	Benefit Summary says effective 10/1/2020
	January 1, 2021	
Lifetime Maximum	Unlimited	Unlimited
Individual Deductible	None	None
Family Deductible	None	None
Individual Maximum Out-of-Pocket	\$1,500	\$1,500
Family Maximum Out-of-Pocket	\$1,300	\$1,500
anny waximum out-or-rocket	\$3,000	\$3,000
Hospitalization Services	No Charge	No Charge
Outpatient Services		
Surgery in Hospital	\$10 copayment	\$10 copayment
Surgery in Outpatient Facility	\$10 copayment	\$10 copayment
Emergency Room (co-pay waived if admitted)	\$50 copayment	\$100 copayment
Urgent Care	\$10 copayment	\$10 copayment
Ambulance Services	\$50 copayment	\$50 copayment
PCP Office Visit	¢10 sanayım ant	Ć10 sa navyma ant
	\$10 copayment	\$10 copayment
Specialist Office Visit	\$10 copayment	\$10 copayment
Routine Physical Exams/Well Woman	\$10 copayment	No Charge
Well Baby/Well Child Exams	No Charge	No Charge
Pregnancy & Maternity Care	No Charge	No Charge
Allergy Injections and Immunizations	\$5 copayment	No Charge
Lab & X-Ray	No Charge	No Charge
Complex Radiology (CT Scan, MRI)	No Charge	Not listed
Mental and Nervous Disorders		
In-patient	No Charge	No Charge
Out-patient	\$10 copayment	\$10 copayment
Substance Abuse		
In-patient:	No Charge	No Charge
Outpatient visits	\$10 copayment	\$10 copayment
Rehabilitation Outpatient Therapy Services	\$10 copayment	\$10 copayment
		Medically Necessary - If ASH Rider is
Chiropractic	Not Covered	included -\$10 copayment for
	The covered	chiropractic and acupuncture - 30
A suprime at time	¢10 consument abusision referrel	visits per year
Acupuncture Durable Medical Equipment	\$10 copayment - physician referral 20% per item	No Charge
Darable Medical Equipment	20/0 μει πεπι	ino Cilaige
Prescription Retail Drugs:		
Deductible	None	None
Generic	\$10 copayment	\$10 copayment
Brand	\$20 copayment	\$10 copayment
Non-Formulary	Not Covered Not Covered	
Specialty Drugs	\$20 copayment	\$10 copayment
Mail Order	\$20 Generic/\$40 Brand - 100 day	Above includes 100 day supply
	supply	1111 100 day sappiy

	Current	SISC		
	Kaiser	Kaiser		
	Adjunct	Benefit Summary says effective 10/1/2020		
	January 1, 2021			
Lifetime Maximum	Unlimited	Unlimited		
Individual Deductible	None	\$500		
Family Deductible	None	\$1,000		
I amily beductible	None	\$1,000		
Individual Maximum Out-of-Pocket	\$3,000	\$3,000		
Family Maximum Out-of-Pocket	\$6,000	\$6,000		
Hospitalization Services	\$500 per day	10%		
Outpatient Services				
Surgery in Hospital	\$500 per day	10%		
Surgery in Outpatient Facility	\$250 copayment	10%		
Emergency Room (co-pay waived if admitted)	\$150 copayment	10%		
Urgent Care Ambulance Services	\$25 copayment \$150 copayment	\$20 copayment \$150 copayment		
Annoulance Services	\$150 copayment	\$150 copayment		
PCP Office Visit	\$25 copayment	\$20 copayment		
Specialist Office Visit	\$50 copayment	\$20 copayment		
Routine Physical Exams/Well Woman	No Charge	No Charge		
Well Baby/Well Child Exams	No Charge	No Charge		
Pregnancy & Maternity Care	No Charge - prenatal visits	No Charge - prenatal visits		
Allergy Injections and Immunizations	\$5 copayment	No Charge		
Lab & X-Ray	\$10 copayment	\$10 copayment		
Complex Radiology (CT Scan, MRI)	\$50 copayment	10% up to a max of \$50 (deductible waived)		
Mental and Nervous Disorders				
In-patient	\$500 per day	10%		
Out-patient	\$25 copayment	\$20 copayment		
Substance Abuse				
In-patient:	\$500 per day	10%		
Outpatient visits	\$25 copayment	\$20 copayment		
Rehabilitation Outpatient Therapy Services	\$25 copayment	\$20 copayment		
Chiropractic	Not Covered	Medically Necessary - If ASH Rider is		
Acupuncture	Not Covered	included -\$10 copayment for chiropractic and acupuncture - 30		
Durable Medical Equipment	50%	visits per year 20%		
	55/5	25,0		
Prescription Retail Drugs:	N.	N.		
Deductible Generic	None \$10 copayment	None \$10 consyment		
Brand	\$10 copayment \$30 copayment	\$10 copayment \$30 copayment		
Non-Formulary	Not Covered	Not Covered		
Specialty Drugs	\$30 copayment	\$30 copayment		
Mail Order	\$20 Generic/\$60 Brand - 100 day supply	\$20 Generic/\$60 Brand - 100 day		

	Current	CICC
	Current	SISC
	Kaiser Sr. Advantage	
	January 1, 2021	
Lifetime Maximum	Unlimited	
Individual Deductible	None	
Family Deductible	None	
Individual Maximum Out-of-Pocket	\$1,500	
Family Maximum Out-of-Pocket	\$3,000	
Hospitalization Services	\$500 per Admission	
Outpatient Services		
Surgery in Hospital	\$50 copayment	
Surgery in Outpatient Facility	\$50 copayment	
Emergency Room (co-pay waived if admitted)	\$50 copayment	
Urgent Care	\$20 copayment	
Ambulance Services	\$100 copayment	
PCP Office Visit	\$20 copayment	
Specialist Office Visit	\$20 copayment	
Routine Physical Exams/Well Woman	No Charge	
Well Baby/Well Child Exams	No Charge	
Pregnancy & Maternity Care	No Charge	
Allergy Injections and Immunizations	\$3 copayment	
Lab & X-Ray	No Charge	
Complex Radiology (CT Scan, MRI)	No Charge	
Mental and Nervous Disorders		
In-patient	\$500 per Admission	
Out-patient	\$20 copayment	
Substance Abuse	4500	
In-patient: Outpatient visits	\$500 per Admission \$20 copayment	
Outpatient visits	<u> </u>	
Rehabilitation Outpatient Therapy Services	\$20 copayment	
Chiropractic	\$20 copayment	
Acupuncture	Not Covered	
Durable Medical Equipment	20%	
Prescription Retail Drugs:		
Deductible	None	
Generic	\$10 copayment	
Brand	\$25 copayment	
Non-Formulary	Not Covered	
Specialty Drugs	Not Covered	
Mail Order	Above copayments include a 100-	
Man order	day supply	

	Current Blue Shield HMO	SISC Blue Shield HMO Benefit Summary says effective 10/1/2020
	January 1, 2021	
Lifetime Maximum	Unlimited	Unlimited
Individual Deductible	None	None
Family Deductible	None	None
Individual Maximum Out-of-Pocket	\$1,000	\$1,000
Family Maximum Out-of-Pocket	\$2,000	\$2,000
Hospitalization Services	No Charge	No Charge
Outpatient Services		
Surgery in Hospital	\$50 copayment	No Charge
Surgery in Outpatient Facility	\$50 copayment	No Charge
Emergency Room (co-pay waived if admitted)	\$50 copayment	\$100 copayment
Urgent Care	\$10 copayment	\$10 copayment
Ambulance Services	\$50 copayment	\$100 copayment
PCP Office Visit / Teledoc	\$10 copayment / No Charge Teledoc	\$10 copayment
C : I' + Off - Vr 'i	copayment (was \$5 copayment)	Ć10
Specialist Office Visit	\$10 copayment	\$10 copayment
Routine Physical Exams/Well Woman	No Charge	No Charge
Well Baby/Well Child Exams	No Charge	No Charge
Pregnancy & Maternity Care Allergy Injections and Immunizations	No Charge \$10 copayment + 50% for serum	No Charge \$10 copayment + 50% for serum
Lab & X-Ray	No Charge	No Charge
Complex Radiology (CT Scan, MRI)	No Charge	No Charge
Mental and Nervous Disorders		
In-patient	No Charge	No Charge
Out-patient	\$10 copayment	\$10 copayment
Substance Abuse In-patient: Outpatient visits	No Charge \$10 copayment	No Charge \$10 copayment
Rehabilitation Outpatient Therapy Services	\$10 copayment	\$10 copayment
Chiropractic	Not Covered	Medically Necessary - If ASH Rider is included -\$10 copayment for
Acupuncture	Not Covered	chiropractic and acupuncture - 30 visits per year
Durable Medical Equipment	50%	No Charge
Prescription Retail Drugs:		
Separate out of pocket maximum for prescriptions	None	\$1,500 Individual / \$3,000 Family
Deductible	None	None
Generic	\$10 copayment	\$5 copayment
Brand	\$20 copayment	\$20 copayment
Non-Formulary	Not Covered	Not listed
Specialty Drugs	20% up to \$200 max.	Mail order only Navitus \$20 - 30 day supply
Mail Order (90 Day Supply)	\$20 Generic/\$40 Brand - 90 day supply	No Charge Generic (Costco) / \$50 Brand (Costco)

	Current	SISC
	Blue Shield HMO	3130
	Retire and Spouse over 65	
	January 1, 2021	
Lifetime Maximum	Unlimited	
Individual Deductible	None	
Family Deductible	None	
Individual Maximum Out-of-Pocket	\$1,000	
Family Maximum Out-of-Pocket	\$2,000	
Hospitalization Services	No Charge	
Outpatient Services		
Surgery in Hospital	\$50 copayment	
Surgery in Outpatient Facility	\$50 copayment	
Emergency Room (co-pay waived if admitted)	\$50 copayment	
Urgent Care	\$10 copayment	
Ambulance Services	\$50 copayment	
	+ = = = p = p	
	\$10 copayment / No Charge Teledoc	
PCP Office Visit / Teledoc	copayment (was \$5 copayment)	
Specialist Office Visit		
_ '	\$10 copayment	
Routine Physical Exams/Well Woman	No Charge	
Well Baby/Well Child Exams	No Charge	
Pregnancy & Maternity Care	No Charge	
Allergy Injections and Immunizations	\$10 copayment + 50% for serum	
Lab & X-Ray	No Charge	
Complex Radiology (CT Scan, MRI)	No Charge	
Mental and Nervous Disorders		
In-patient	No Charge	
Out-patient	\$10 copayment	
Substance Abuse		
In-patient:	No Charge	
Outpatient visits	\$10 copayment	+
Debabilitation Outpationt Thomas Commisses	¢10 as as as as t	
Rehabilitation Outpatient Therapy Services	\$10 copayment Not Covered	
Chiropractic		
Acupuncture Durable Medical Equipment	Not Covered 50%	
Durable Medical Equipment	50%	
Procerintian Potail Druge:		
Prescription Retail Drugs:	N	
Separate out of pocket maximum for prescriptions Deductible	None None	
Generic		+
Brand	\$10 copayment \$20 copayment	
	\$20 copayment Not Covered	
Non-Formulary		
Specialty Drugs Mail Order	20% up to \$200 max. \$20 Generic/\$40 Brand - 90 day supply	+ -
IVIAII UTUET	220 Generic/240 brailu - 30 day Suppry	

	Current	SISC
	Current Blue Shield HMO	SISC
	Retiree over 65 - spouse under 65	
	January 1, 2021	
Lifetime Maximum	Unlimited	
Individual Deductible	None	
Family Deductible	None	
Turriny Deddecible	None	
Individual Maximum Out-of-Pocket	\$1,000	
Family Maximum Out-of-Pocket	\$2,000	
Hospitalization Services	No Charge	
Outpatient Services		
Surgery in Hospital	\$50 copayment	
Surgery in Outpatient Facility	\$50 copayment	
Emergency Room (co-pay waived if admitted)	\$50 copayment	
Urgent Care	\$10 copayment	
Ambulance Services	\$50 copayment	
PCP Office Visit / Teledoc	\$10 copayment / No Charge Teledoc	
Tel office visity release	copayment (was \$5 copayment)	
Specialist Office Visit	\$10 copayment	
Routine Physical Exams/Well Woman	No Charge	
Well Baby/Well Child Exams	No Charge	
Pregnancy & Maternity Care	No Charge	
Allergy Injections and Immunizations	\$10 copayment + 50% for serum	
Lab & X-Ray	No Charge	
Complex Radiology (CT Scan, MRI)	No Charge	
Mental and Nervous Disorders		
In-patient	No Charge	
Out-patient	\$10 copayment	
Substance Abuse	N. O.	
In-patient:	No Charge	
Outpatient visits	\$10 copayment	
Rehabilitation Outpatient Therapy Services	\$10 copayment	
Chiropractic	Not Covered	_
Acupuncture	Not Covered	
Durable Medical Equipment	50%	
December 1 Detail D		
Prescription Retail Drugs:	<u> </u>	
Separate out of pocket maximum for prescriptions	None	
Deductible	None	
Generic	\$10 copayment	
Brand	\$20 copayment	
Non-Formulary	Not Covered	
Specialty Drugs	20% up to \$200 max.	
Mail Order	\$20 Generic/\$40 Brand - 90 day supply	

	Current Blue Shield HMO	SISC Blue Shield HMO Benefit Summary says effective 10/1/2020
	January 1, 2021	
Lifetime Maximum	Unlimited	Unlimited
Individual Deductible	None	None
Family Deductible	None	None
	1,10119	
Individual Maximum Out-of-Pocket	\$3,500	\$3,500
Family Maximum Out-of-Pocket	\$7,000	\$7,000
Talling the annual of the second	ψ./,σσσ	ψ.,,σσσ
Hospitalization Services	40%	40%
Outpatient Services	1070	1979
Surgery in Hospital	40%	40%
Surgery in Outpatient Facility	40%	40%
Emergency Room (co-pay waived if admitted)	\$100 copayment	\$200 copayment
Urgent Care	\$40 copayment	\$40 copayment
Ambulance Services	\$100 copayment	\$100 copayment
7 Hindulative Sel Vices	\$100 copuyment	\$100 copayment
	\$40 copayment / No Charge Teledoc	
PCP Office Visit / Teledoc	copayment (was \$5 copayment)	\$40 copayment
Specialist Office Visit	\$40 copayment	\$40 copayment
Routine Physical Exams/Well Woman	No Charge	No Charge
Well Baby/Well Child Exams	No Charge	No Charge
Pregnancy & Maternity Care	No Charge	No Charge
Allergy Injections and Immunizations	\$40 copayment + 50% for serum	\$40 copayment + 50% for serum
Lab & X-Ray		1 1
·	No Charge	No Charge
Complex Radiology (CT Scan, MRI)	No Charge	No Charge
Mental and Nervous Disorders		
In-patient	40%	40%
Out-patient	\$40 copayment	\$40 copayment
Substance Abuse	у то сорауттете	ф то сорауттетт
In-patient:	40%	40%
Outpatient visits	\$40 copayment	\$40 copayment
Rehabilitation Outpatient Therapy Services	\$40 copayment	\$40 copayment
Chiropractic	Not Covered	
Acupuncture	Not Covered	
Durable Medical Equipment	50%	40%
Prescription Retail Drugs ³ :		
Separate out of pocket maximum for prescriptions	None	\$1,500 Individual / \$3,000 Family
Deductible	None	None
Generic	\$15 copayment	\$7 copayment
Brand	\$30 copayment	\$25 copayment
Non-Formulary	Not Covered	Not listed
Specialty Drugs	20% up to \$200 max.	Mail order only Navitus \$25 - 30 day supply
Mail Order	\$30 Generic/\$60 Brand - 90 day supply	No Charge Generic (Costco) / \$60 Brand (Costco)

	Current Blue Shield HMO Retiree and spouse over 65 January 1, 2021	SISC Blue Shield HMO
Lifetime Maximum	Unlimited	
Individual Deductible Family Deductible	None None	
ranniy beddetible	None	
Individual Maximum Out-of-Pocket	\$3,500	
Family Maximum Out-of-Pocket	\$7,000	
Hospitalization Services	40%	
Outpatient Services	1070	
Surgery in Hospital	40%	
Surgery in Outpatient Facility	40%	
Emergency Room (co-pay waived if admitted)	\$100 copayment	
Urgent Care	\$40 copayment	
Ambulance Services	\$100 copayment	
PCP Office Visit / Teledoc	\$40 copayment / No Charge Teledoc	
	copayment (was \$5 copayment)	
Specialist Office Visit	\$40 copayment	
Routine Physical Exams/Well Woman	No Charge	
Well Baby/Well Child Exams	No Charge	
Pregnancy & Maternity Care	No Charge	
Allergy Injections and Immunizations	\$40 copayment + 50% for serum	
Lab & X-Ray	No Charge	
Complex Radiology (CT Scan, MRI)	No Charge	
Mental and Nervous Disorders		
In-patient	40%	
Out-patient	\$40 copayment	
Substance Abuse		
In-patient:	40%	
Outpatient visits	\$40 copayment	
Rehabilitation Outpatient Therapy Services	\$40 copayment	
Chiropractic	Not Covered	
Acupuncture	Not Covered	
Durable Medical Equipment	50%	
Prescription Retail Drugs ³ :		
Separate out of pocket maximum for prescriptions	None	
Deductible	None	
Generic	\$15 copayment	
Brand	\$30 copayment	
Non-Formulary	Not Covered	
Specialty Drugs Mail Order	20% up to \$200 max.	
ividii Ufuel	\$30 Generic/\$60 Brand - 90 day supply	

	Current	SISC
	Blue Shield	Blue Shield HMO
	Retiree over 65 - spouse under 65	
	January 1, 2021	
Lifetime Maximum	Unlimited	
Individual Deductible	None	
Family Deductible	None	
Individual Maximum Out-of-Pocket	\$3,500	
Family Maximum Out-of-Pocket	\$7,000	
Hospitalization Services	40%	
Outpatient Services		
Surgery in Hospital	40%	
Surgery in Outpatient Facility	40%	
Emergency Room (co-pay waived if admitted)	\$100 copayment	
Urgent Care	\$40 copayment	
Ambulance Services	\$100 copayment	
DCD Off Ar it / T. L. L.	\$40 copayment / No Charge Teledoc	
PCP Office Visit / Teledoc	copayment (was \$5 copayment)	
Specialist Office Visit	\$40 copayment	
Routine Physical Exams/Well Woman	No Charge	
Well Baby/Well Child Exams	No Charge	
Pregnancy & Maternity Care	No Charge	
Allergy Injections and Immunizations	\$40 copayment + 50% for serum	
Lab & X-Ray	No Charge	
Complex Radiology (CT Scan, MRI)		
Complex Radiology (C1 Scall, MRI)	No Charge	
Mental and Nervous Disorders		
In-patient	40%	
Out-patient	\$40 copayment	
Substance Abuse		
In-patient:	40%	
Outpatient visits	\$40 copayment	
Rehabilitation Outpatient Therapy Services	\$40 copayment	
Chiropractic	Not Covered	
Acupuncture	Not Covered	
Durable Medical Equipment	50%	
Prescription Retail Drugs ³ :		
Separate out of pocket maximum for prescriptions	None	
Deductible	None	
Generic	\$15 copayment	
Brand	\$30 copayment	
Non-Formulary	Not Covered	
Specialty Drugs	20% up to \$200 max.	
Mail Order	\$30 Generic/\$60 Brand - 90 day supply	

	Current Blue Shield-\$50 January 1, 20	0 90/70	SISC Blue Shield PPO Benefit Summary says effective 10/1/2020		SISC Blue Shield PPO Benefit Summary says effective 10/1/2020	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Lifetime Maximum	Unlimited		Unli	mited	Uni	imited
			,			
Individual Deductible	\$500		<u>'</u>	500		3,000
Family Deductible	\$1,000		\$1	,000	Şe	5,000
Individual Maximum Out-of-Pocket	\$1,500	\$3,500	¢1	,000	¢	1,000
Family Maximum Out-of-Pocket	\$3,000	\$3,500	· ·	,000		3,000
rainily Maximum Out-of-Focket	\$3,000	\$7,000	γυ	,000	Ç	3,000
Hospitalization Services	10%	30% (\$600 per day)	10%	All charges above \$600	20%	All charges above \$600
Outpatient Services	1070	3070 (3000 pci day)	1070	7 til charges above 5000	2070	7 III CHAIGES ABOVE \$000
Surgery in Hospital	10%	30% (\$350 per day)	10%	All charges above \$350	20%	All charges above \$350
Surgery in Outpatient Facility	10%	30% (\$350 per day)	10%	All charges above \$350	20%	All charges above \$350
Emergency Room (co-pay waived if admitted)	\$75 copayment (if admitted,			itted, coinsurance applies)		nitted, coinsurance applies)
Urgent Care	\$20 copayment	30%	\$20 copayment	50%	\$40 copayment	50%
Ambulance Services	10% after dedu			fter deductible		after deductible
PCP Office Visit / Teledoc	\$20 copayment/No Charge Teledoc copayment (was \$5 copayment)	30%	\$20 copayment	50%	\$40 copayment	50%
Specialist Office Visit	\$20 copayment	30%	\$20 copayment	50%	\$40 copayment	50%
Routine Physical Exams/Well Woman	No Charge	30%	No Charge	Not Covered	No Charge	Not Covered
Well Baby/Well Child Exams	No Charge	30%	No Charge	Not Covered	No Charge	Not Covered
Pregnancy & Maternity Care	10%	30%	10%	50%	20%	50%
Allergy Injections and Immunizations	10%	30%	10%	50%	20%	50%
Lab & X-Ray	\$20 copayment after deductible	30%	10%	Not Covered	20%	Not Covered
	\$35 if performed in a hospital- after deductible	30%				
Complex Radiology (CT Scan, MRI)	10%	30%	10%	Not Covered	20%	Not Covered
Mental and Nervous Disorders						
In-patient	10%	30% (\$600 per day)	10%	All charges above \$600	20%	All charges above \$600
Out-patient	\$20 copayment	30%	\$20 copayment	50%	\$40 copayment	50%
Substance Abuse						
In-patient:	10% \$20 copayment	30% (\$600 per day) 30%	10% \$20 copayment	All charges above \$600	20% \$40 copayment	All charges above \$600 50%
Outpatient visits	\$20 copayment	30%	\$20 copayment	50%	\$40 copayment	50%
Rehabilitation Outpatient Therapy Services	\$20 copayment after deductible	30%	10%	Not Covered	20%	Not Covered
Chiropractic (20 visits per year)	10%	30%	10%	Not Covered	20%	Not Covered
Acupuncture (20 visits per year)	\$25 copayment after deductible	30%	10% (12 visits)	50%	20% (12 visits)	50%
Durable Medical Equipment	10%	30%	10%	Not Covered	20%	Not Covered
Prescription Retail Drugs:						
Separate out of pocket maximum for prescriptions	None		\$1,500 Individu	al / \$3,000 Family	\$1,500 Individu	ual / \$3,000 Family
Deductible	None	¢10 250/		one Out of National and Pate 1		lone
Generic Brand	\$10 copayment \$15 copayment	\$10 + 25% \$15 + 25%	\$3 copayment \$15 copayment	Out of Network not listed Out of Network not listed	\$7 copayment \$25 copayment	Out of Network not listed Out of Network not listed
Non-Formulary	\$30 copayment	\$30 + 25%	Not listed	Out of Network not listed	Not listed	Out of Network not listed
·		30% up to \$200 max. +		Navitus mail order - 30 day		Navitus mail order - 30 day
Specialty Drugs	30% up to \$200 max.	25%	supply		· •	
Mail Order	\$20 / \$30 / \$60 - 90 day supply	Not Covered	No Charge Generic (Costco) / \$35 Brand		No Charge Generic (Costco) / \$60 Brand	
			(Costco)		(Costco)	

	Curr Blue Shield-S Retiree and Sp January	\$500 90/70 ouse over 65	S	ISC
	In-Network	Out-of-Network	In-Network	Out-of-Network
Lifetime Maximum	Unlim	nited		
Individual Deductible	\$50	20		
Family Deductible	\$1,0			
Tanniy Deductible	Ψ1,0			
Individual Maximum Out-of-Pocket	\$1,500	\$3,500		
Family Maximum Out-of-Pocket	\$3,000	\$7,000		
Tarring Maximum out of Focket	\$3,000	\$1,000		
Hospitalization Services	10%	30% (\$600 per day)		
Outpatient Services				
Surgery in Hospital	10%	30% (\$350 per day)		
Surgery in Outpatient Facility	10%	30% (\$350 per day)		
Emergency Room (co-pay waived if admitted)	\$75 copa			<u> </u>
Urgent Care	\$20 copayment	30%		
Ambulance Services	100			
PCP Office Visit / Teledoc	\$20 copayment/No Charge Teledoc copayment (was \$5 copayment)	30%		
Specialist Office Visit	\$20 copayment	30%		
Routine Physical Exams/Well Woman	No Charge	30%		
Well Baby/Well Child Exams	No Charge	30%		
Pregnancy & Maternity Care	10%	30%		
Allergy Injections and Immunizations	10%	30%		
Lab & X-Ray	\$20 copayment	30%		
	\$35 if performed in a hospital	30%		
Complex Radiology (CT Scan, MRI)	10%	30%		
Mental and Nervous Disorders				
In-patient	10%	30% (\$600 per day)		
Out-patient	\$20 copayment	30%		
Substance Abuse				
In-patient:	10%	30% (\$600 per day)		
Outpatient visits	\$20 copayment	30%		
Dehabilitation Outpatient Theorem Commisses	¢20 aa	200/		
Rehabilitation Outpatient Therapy Services	\$20 copayment	30%		
Chiropractic (up to 20 visits per year) Acupuncture	10% \$25 copayment	30% 30%		
Durable Medical Equipment	325 copayment 10%	30%		
1 1 222	20,0	/ 0		
Prescription Retail Drugs:				
Separate out of pocket maximum for prescriptions	None			•
Deductible	None			
Generic	\$10 copayment	\$10 + 25%		
Brand Non-Formulary	\$15 copayment	\$15 + 25% \$20 + 25%		
Specialty Drugs	\$30 copayment 30% up to \$200 max.	\$30 + 25% 30% up to \$200 max. +		
Mail Order	\$20 / \$30 / \$60 - 90 day supply	25% Not Covered		

		rent -\$500 90/70	SISC	
	Retiree over 65 -	spouse under 65		
	January			
	In-Network	Out-of-Network	In-Network	Out-of-Network
Lifetime Maximum	Unlir	nited		
Individual Deductible		600		
Family Deductible	\$1,	000		1
Individual Maximum Out-of-Pocket	\$1,500	\$3,500		
Family Maximum Out-of-Pocket	\$3,000	\$7,000		
Hospitalization Services	10%	30% (\$600 per day)		
Outpatient Services	1070	30% (3000 pci day)		
Surgery in Hospital	10%	30% (\$350 per day)		
Surgery in Outpatient Facility	10%	30% (\$350 per day)		
Emergency Room (co-pay waived if admitted)		payment		
Urgent Care	\$20 copayment	30%		
Ambulance Services		0%		
PCP Office Visit / Teledoc	\$20 copayment/No Charge Teledoc copayment (was \$5 copayment)	30%		
Specialist Office Visit	\$20 copayment	30%		
Routine Physical Exams/Well Woman	No Charge	30%		
Well Baby/Well Child Exams	No Charge	30%		
Pregnancy & Maternity Care	10%	30%		
Allergy Injections and Immunizations	10%	30%		
Lab & X-Ray	\$20 copayment	30%		
,	\$35 if performed in a	/		
	hospital	30%		
Complex Radiology (CT Scan, MRI)	10%	30%		
Mental and Nervous Disorders				
In-patient	10%	30% (\$600 per day)		
Out-patient	\$20 copayment	30%		
Substance Abuse				
In-patient:	10%	30% (\$600 per day)		
Outpatient visits	\$20 copayment	30%		
Debublitation Octobrilla The Control	420	2221		
Rehabilitation Outpatient Therapy Services	\$20 copayment	30%		
Chiropractic (up to 20 visits per year)	10%	30%		
Acupuncture Durable Medical Equipment	\$25 copayment 10%	30% 30%		
5 a. a.a. medical Equipment	10/0	3370		
Prescription Retail Drugs:				
Separate out of pocket maximum for prescriptions	None			
Deductible		one		
Generic Brand	\$10 copayment	\$10 + 25%		
Non-Formulary	\$15 copayment \$30 copayment	\$15 + 25% \$30 + 25%		
Specialty Drugs	30% up to \$200 max.	30% up to \$200 max. + 25%		
Mail Order	\$20 / \$30 / \$60 - 90 day supply			

	Current &	Current & Renewal		SISC	
	Blue Shield-\$500 90/70 - Dual Spousal January 1, 2021				
	In-Network	Out-of-Network	In-Network	Out-of-Network	
Lifetime Maximum			III-Network	Out-oi-Network	
Lifetime Maximum	Unlimited				
Individual Deductible	\$5,	\$500			
Family Deductible	-	\$1,000			
Tarrilly Deductible	71,0	000			
Individual Maximum Out-of-Pocket	\$1,500	\$3,500			
Family Maximum Out-of-Pocket	\$3,000	\$7,000			
Turring Maximum Out of Focket	\$3,000	\$7,000			
Hospitalization Services	1%	30% (\$600 per day)			
Outpatient Services	170	3070 (\$000 per day)			
Surgery in Hospital	1%	30% (\$350 per day)			
Surgery in Outpatient Facility	1%	30% (\$350 per day)			
Emergency Room (co-pay waived if admitted)		\$75 copayment			
Urgent Care	\$20 copayment	30%			
Ambulance Services	10				
		1570			
PCP Office Visit / Teledoc	\$20 copayment/No	30%		- II	
	Charge Teledoc				
	copayment (was \$5				
	copayment)				
Specialist Office Visit	\$20 copayment	30%			
Routine Physical Exams/Well Woman	No Charge	30%			
Well Baby/Well Child Exams	No Charge	30%			
Pregnancy & Maternity Care	1%	30%			
Allergy Injections and Immunizations	1%	30%			
Lab & X-Ray	\$20 copayment	30%			
	\$35 if performed in a	30/0			
	hospital	30%			
Complex Radiology (CT Scan, MRI)	1%	30%			
Mental and Nervous Disorders	170	30/0			
In-patient	1%	30% (\$600 per day)			
Out-patient	\$20 copayment	30%			
Substance Abuse	уго сорауттетт	3070			
In-patient:	1%	30% (\$600 per day)			
Outpatient visits	\$20 copayment	30%			
Outputient visits	720 copuyment	3070			
Rehabilitation Outpatient Therapy Services	\$20 copayment	30%			
Chiropractic (up to 20 visits per year)	1%	30%			
		'			
Acupuncture	\$25 copayment (20 visits in or out of network)				
Durable Medical Equipment	1%	30%			
Prescription Retail Drugs:	N				
Deductible Generic	No \$10 copayment	ne \$10 + 25%			
Brand	\$15 copayment	\$10 + 25%			
Non-Formulary	\$30 copayment	\$30 + 25%			
Specialty Drugs	30% up to \$200 max.	Not Covered			
Mail Order	\$20 / \$30 / \$60 - 90				
	day supply	Not Covered			