	Current Kaiser GRANDFATHERED January 1, 2021	SISC Kaiser Benefit Summary says effective 10/1/2020
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	$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 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
Chiropractic	Not Covered	Medically Necessary - If ASH Rider is included -$10 copayment for chiropractic and acupuncture - 30 visits per year
Acupuncture	$10 copayment - physician referral	
Durable Medical Equipment	20% per item	No Charge
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 supply	Above includes 100 day supply

	Current Kaiser Adjunct January 1, 2021	SISC Kaiser Benefit Summary says effective 10/1/2020
Lifetime Maximum	Unlimited	Unlimited
Individual Deductible	None	$500
Family Deductible	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	$25 copayment	$20 copayment
Ambulance 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 included -$10 copayment for chiropractic and acupuncture - 30 visits per year
Acupuncture	Not Covered	
Durable Medical Equipment	50%	20%
Prescription Retail Drugs:		
Deductible	None	None
Generic	$10 copayment	$10 copayment
Brand	$30 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 supply

	Current Kaiser Sr. Advantage January 1, 2021	SISC
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 In-patient:	$500 per Admission	
Outpatient visits	$20 copayment	
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-day supply	

	Current Blue Shield HMO January 1, 2021	SISC Blue Shield HMO Benefit Summary says effective 10/1/2020
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 copayment (was $5 copayment)	$10 copayment
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	No Charge	No Charge
Allergy Injections and Immunizations	$10 copayment + 50% for serum	$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:	No Charge	No Charge
Outpatient visits	$10 copayment	$10 copayment
Rehabilitation Outpatient Therapy Services	$10 copayment	$10 copayment
Chiropractic	Not Covered	Medically Necessary - If ASH Rider is included -$10 copayment for chiropractic and acupuncture - 30 visits per year
Acupuncture	Not Covered	
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 Blue Shield HMO Retire and Spouse over 65 January 1, 2021	SISC
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	
PCP Office Visit / Teledoc	$10 copayment / No Charge 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	
Rehabilitation Outpatient Therapy Services	$10 copayment	
Chiropractic	Not Covered	
Acupuncture	Not Covered	
Durable Medical Equipment	50%	
Prescription Retail Drugs:		
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 Retiree over 65 - spouse under 65 January 1, 2021	SISC
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	
PCP Office Visit / Teledoc	$10 copayment / No Charge 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	
Rehabilitation Outpatient Therapy Services	$10 copayment	
Chiropractic	Not Covered	
Acupuncture	Not Covered	
Durable Medical Equipment	50%	
Prescription Retail Drugs:		
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 January 1, 2021	SISC Blue Shield HMO Benefit Summary says effective 10/1/2020
Lifetime Maximum	Unlimited	Unlimited
Individual Deductible	None	None
Family Deductible	None	None
Individual Maximum Out-of-Pocket	$3,500	$3,500
Family Maximum Out-of-Pocket	$7,000	$7,000
Hospitalization Services	40%	40%
Outpatient Services		
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
PCP Office Visit / Teledoc	$40 copayment / No Charge 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	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 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	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	
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	20% up to $200 max.	
Mail Order	$30 Generic/$60 Brand - 90 day supply	

	Current Blue Shield Retiree over 65 - spouse under 65 January 1, 2021	SISC Blue Shield HMO
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	
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	20% up to $200 max.	
Mail Order	$30 Generic/$60 Brand - 90 day supply	

	Current Blue Shield-$500 90/70 January 1, 2021		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		Unlimited		Unlimited	
Individual Deductible	$500		$500		$3,000	
Family Deductible	$1,000		$1,000		$6,000	
Individual Maximum Out-of-Pocket	$1,500	$3,500	$1,000		$4,000	
Family Maximum Out-of-Pocket	$3,000	$7,000	$3,000		$8,000	
Hospitalization Services	10%	30% ($600 per day)	10%	All charges above $600	20%	All charges above $600
Outpatient Services						
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, coinsurance applies)		$100 copayment (if admitted, coinsurance applies)		$100 copayment (if admitted, coinsurance applies)	
Urgent Care	$20 copayment	30%	$20 copayment	50%	$40 copayment	50%
Ambulance Services	10% after deductible		$100 + 10% after deductible		$100 + 20% 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%	30% ($600 per day)	10%	All charges above $600	20%	All charges above $600
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 Individual / $3,000 Family		$1,500 Individual / $3,000 Family	
Deductible	None		None		None	
Generic	$10 copayment	$10 + 25%	$3 copayment	Out of Network not listed	$7 copayment	Out of Network not listed
Brand	$15 copayment	$15 + 25%	$15 copayment	Out of Network not listed	$25 copayment	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
Specialty Drugs	30% up to $200 max.	30% up to $200 max. + 25%	$15 copayment through Navitus mail order - 30 day supply		$25 copayment through Navitus mail order - 30 day supply	
Mail Order	$20 / $30 / $60 - 90 day supply	Not Covered	No Charge Generic (Costco) / $35 Brand (Costco)		No Charge Generic (Costco) / $60 Brand (Costco)	

	Current Blue Shield-$500 90/70 Retiree and Spouse over 65 January 1, 2021		SISC	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Lifetime Maximum	Unlimited			
Individual Deductible	$500			
Family Deductible	$1,000			
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				
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 copayment			
Urgent Care	$20 copayment	30%		
Ambulance Services	10%			
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%		
Rehabilitation Outpatient Therapy Services	$20 copayment	30%		
Chiropractic (up to 20 visits per year)	10%	30%		
Acupuncture	$25 copayment	30%		
Durable Medical Equipment	10%	30%		
Prescription Retail Drugs:				
Separate out of pocket maximum for prescriptions	None			
Deductible	None			
Generic	$10 copayment	$10 + 25%		
Brand	$15 copayment	$15 + 25%		
Non-Formulary	$30 copayment	$30 + 25%		
Specialty Drugs	30% up to $200 max.	30% up to $200 max. + 25%		
Mail Order	$20 / $30 / $60 - 90 day supply	Not Covered		

	Current Blue Shield-$500 90/70 Retiree over 65 - spouse under 65 January 1, 2021		SISC	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Lifetime Maximum	Unlimited			
Individual Deductible	$500			
Family Deductible	$1,000			
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				
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 copayment			
Urgent Care	$20 copayment	30%		
Ambulance Services	10%			
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%		
Rehabilitation Outpatient Therapy Services	$20 copayment	30%		
Chiropractic (up to 20 visits per year)	10%	30%		
Acupuncture	$25 copayment	30%		
Durable Medical Equipment	10%	30%		
Prescription Retail Drugs:				
Separate out of pocket maximum for prescriptions	None			
Deductible	None			
Generic	$10 copayment	$10 + 25%		
Brand	$15 copayment	$15 + 25%		
Non-Formulary	$30 copayment	$30 + 25%		
Specialty Drugs	30% up to $200 max.	30% up to $200 max. + 25%		
Mail Order	$20 / $30 / $60 - 90 day supply	Not Covered		

	Current & Renewal Blue Shield-$500 90/70 - Dual Spousal January 1, 2021		SISC	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Lifetime Maximum	Unlimited			
Individual Deductible	$500			
Family Deductible	$1,000			
Individual Maximum Out-of-Pocket	$1,500	$3,500		
Family Maximum Out-of-Pocket	$3,000	$7,000		
Hospitalization Services	1%	30% ($600 per day)		
Outpatient Services				
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%			
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	1%	30%		
Allergy Injections and Immunizations	1%	30%		
Lab & X-Ray	$20 copayment	30%		
	$35 if performed in a hospital	30%		
Complex Radiology (CT Scan, MRI..)	1%	30%		
Mental and Nervous Disorders In-patient	1%	30% ($600 per day)		
Out-patient	$20 copayment	30%		
Substance Abuse In-patient:	1%	30% ($600 per day)		
Outpatient visits	$20 copayment	30%		
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:				
Deductible	None			
Generic	$10 copayment	$10 + 25%		
Brand	$15 copayment	$15 + 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		