		Current	SISC	
		Kaiser	Kaiser	
		Kaiser	Kaiser	
		January 1, 2022	January 1, 2022 (will renew again October 1, 2022)	
Lifetime Maximum		Unlimited	Unlimited	
Individual Deductible		None	None	
Family Deductible		None	None	
		· · · · · · · · · · · · · · · · · · ·	112112	
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 admit	ted)	\$50 copayment	\$100 copayment	
Urgent Care	·	\$10 copayment	\$10 copayment	
Ambulance Services		\$50 copayment	\$50 copayment	
0.00 0.00		440	A40	
PCP Office Visit		\$10 copayment	\$10 copayment	
Specialist Office Visit		\$10 copayment	\$10 copayment	
Periodic Health Evaluations		\$10 copayment	No Charge	
Well Baby/Well Child Exams		No Charge	No Charge	
Pregnancy & Maternity Care Visits		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 on the SISC plan summary	
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 Service	26	\$10 copayment	\$10 copayment	
Renabilitation Outpatient Therapy Service	25	\$10 сораушент	\$10 copayment	
Chiropractic		Not Covered	\$10 copayment (through ASHP) Medically necessary	
Acupuncture		\$10 copayment - physician referral	\$10 copayment (through ASHP) Medically necessary	
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	
	#enrolled	Current Rates	SISC Rates	
Employee	(0)	\$0.00	\$0.00	
	(0)	\$0.00	\$0.00	
			70.00	
Employee + 1			\$0.00	
	(0)	\$0.00	\$0.00	
Employee + 1 Employee +2 or more	(0)		\$0.00 \$0.00	
Employee + 1		\$0.00	\$0.00	
Employee + 1 Employee +2 or more Monthly Total	(0)	\$0.00	•	

	Current	SISC
	Kaiser	Kaiser
	Kaisci	Kaisei
	January 1, 2022	January 1, 2022 (will renew again October 1, 2022)
Lifetime Maximum	Unlimited	Unlimited
Individual Deductible	None	\$500
Family Deductible		\$1,000
Family Deductible	None	\$1,000
Individual Maximum Out-of-Pocket	\$3,000	\$3,000
Family Maximum Out-of-Pocket	\$6,000	\$5,000
ranniy Maximum Out-or-r ocket	,0,000	\$0,000
Hospitalization Services	 \$500 per day	10%
Outpatient Services	\$500 per day	10/0
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
Periodic Health Evaluations	No Charge	No Charge
Well Baby/Well Child Exams	No Charge	No Charge
Pregnancy & Maternity Care Visits	No Charge	No Charge
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
Mental and Nervous Disorders		
In-patient	\$500 per day	10%
Out-patient	\$25 copayment	\$20 copayment
Substance Abuse	\$25 copuyment	\$20 copayment
In-patient:	\$500 per day	10%
Outpatient visits	\$25 copayment	\$20 copayment
Rehabilitation Outpatient Therapy Services	\$25 copayment	\$20 copayment
Chiropractic	Not Covered	\$10 copayment (through ASHP) Medically necessary
Acupuncture	Not Covered	\$10 copayment (through ASHP) Medically necessary
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
#enrolle	d Current Rates	SISC Rates
Employee (0)	\$0.00	\$0.00
Employee + 1 (0)	\$0.00	\$0.00
Employee +2 or more (0)	\$0.00	\$0.00
	•	
Monthly Total (0)	\$0.00	\$0.00
Annual Total	\$0.00	\$0.00
Annual Premium Difference		\$0.00

		Current	SISC
		Kaiser Sr. Advantage	3133
		Raisei Si. Auvailtage	
		January 1, 2022	
Lifetime Maximum		Unlimited	
Individual Deductible		None	
Family Deductible		None	
Individual Maximum Out-of-Pocket		\$1,500	
Family Maximum Out-of-Pocket		\$3,000	
Haspitalization Convince		\$500 per Admission	
Hospitalization Services Outpatient Services		\$500 per Admission	
Surgery in Hospital		\$50 copayment	
Surgery in Outpatient Facility		\$50 copayment	
Emergency Room (co-pay waived if admitted	1)	\$50 copayment	
Urgent Care	'/	\$20 copayment	
Ambulance Services		\$100 copayment	
PCP Office Visit		\$20 copayment	
Specialist Office Visit		\$20 copayment	
Periodic Health Evaluations		No Charge	
Well Baby/Well Child Exams		No Charge	
Pregnancy & Maternity Care Visits		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		1 1 7	
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%	
		20/0	
Prescription Retail Drugs:			
Deductible Caparia		None ¢10 consument	
Generic		\$10 copayment \$25 copayment	
Brand Non Formulary		\$25 copayment Not Covered	
Non-Formulary		Not Covered Not Covered	
Specialty Drugs		Not Covered	
Mail Order		Above copayments include a 100-day supply	
T		Current Rates	SISC Rates
Employee (with A & B)	(0)	\$143.43	\$0.00
Employee (With A & B)	(0)	\$286.86	\$0.00
Employee +2 or more (with A & B)	(0)	\$909.72	\$0.00
1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 -	(3)	φ303.7 <i>L</i>	φο.σο
Monthly Total	(0)	\$0.00	\$0.00
Annual Total		\$0.00	\$0.00
Annual Premium Difference			\$0.00

Monthly Total	(0)	\$0.00	\$0.00
Annual Total		\$0.00	\$0.00
Annual Premium Difference			\$0.00

^{**}Note: Items marked in Blue signify an increase in benefit. Items marked in Red signify a decrease in benefit.

			212.2
		Current	SISC
		Blue Shield HMO	Anthem Blue Cross
		\$10 / 100%	\$10 / 100%
		January 1, 2022	January 1, 2022 (will renew again October 1, 2022)
Lifetime Maximum		Unlimited	Unlimited
Individual Deductible		None	None
Family Deductible		None	None
raining 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 admit	ted)	\$50 copayment	\$100 copayment
Urgent Care		\$10 copayment	\$10 copayment
Ambulance Services		\$50 copayment	\$100 copayment
PCP Office Visit / Teladoc		\$10 copayment / No Charge Teladoc	\$10 copayment
Specialist Office Visit		\$10 copayment	\$10 copayment
Periodic Health Evaluations		No Charge	No Charge
Well Baby/Well Child Exams		No Charge	No Charge
Pregnancy & Maternity Care Visits		No Charge	\$10 copayment for prenatal office visits
		<u> </u>	
Allergy Injections and Immunizations		\$10 copayment	\$10 copayment for testing (immunizations are not listed)
Lab & X-Ray		No Charge	No Charge
Complex Radiology (CT Scan, MRI)		No Charge	\$100 copayment
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 Service	S	\$10 copayment	\$10 copayment
Chiropractic		Not Covered	Rider included \$10 copayment
Acupuncture		Not Covered	Rider included \$10 copayment
Durable Medical Equipment		50%	No Charge
Prescription Retail Drugs			
Deductible		None	None
Additional Out of Pocket Ma	vimum		\$1,500 Individual / \$2,500 Family
	AIIIIIIII	None C10 compared	
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		\$20 Generic/\$40 Brand - 90 day supply	No Charge Generic (Costco) / \$50 Brand (Costco)
	#enrolled	Current Rates	SISC Rates
Employee	(0)	\$0.00	\$0.00
Employee + 1	(0)	\$0.00	\$0.00
Employee + 2 or more	(0)	\$0.00	\$0.00
Monthly Total	(0)	\$0.00	\$0.00
Annual Total		\$0.00	\$0.00
Annual Premium Difference			\$0.00
Annual Premium Difference			φο.σο

		Command	CICC
		Current	SISC
		Blue Shield HMO	Anthem Blue Cross
		Retire and Spouse over 65	\$10 / 100%
		January 1, 2022	January 1, 2022 (will renew again October 1, 2022)
Lifetime Maximum		Unlimited	
Individual Deductible		None	
Family Deductible		None	
rainily beductible		None	
Individual Maximum Out-of-Pocket		\$1,000	
Family Maximum Out-of-Pocket		\$2,000	
Talling Waximum Out-OI-1 Ocket		\$2,000	
Hospitalization Services		No Charge	
Outpatient Services		0	
Surgery in Hospital		\$50 copayment	
Surgery in Outpatient Facility		\$50 copayment	
Emergency Room (co-pay waived if admir	tted)	\$50 copayment	
Urgent Care	·	\$10 copayment	
Ambulance Services		\$50 copayment	
PCP Office Visit / Teladoc		\$10 copayment / No Charge Teladoc	
Specialist Office Visit		\$10 copayment	
Periodic Health Evaluations		No Charge	
Well Baby/Well Child Exams		No Charge	
Pregnancy & Maternity Care Visits		No Charge	
Allergy Injections and Immunizations		\$10 copayment	
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		+p-/	
In-patient:		No Charge	
Outpatient visits		\$10 copayment	
Rehabilitation Outpatient Therapy Service	es	\$10 copayment	
Chiropractic		Not Covered	
Acupuncture		Not Covered	
Durable Medical Equipment		50%	
Prescription Retail Drugs			+
Deductible Drugs		None	
Additional Out of Pocket Max	kimum	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	
- 1	#enrolled	Current Rates	SISC Rates
Employee	(0)	\$0.00	\$0.00
Employee + 1	(0)	\$0.00	\$0.00
Employee + 2 or more	(0)	\$0.00	\$0.00
Monthly Total	(0)	\$0.00	\$0.00
Annual Total	(0)	\$0.00	\$0.00
Annual Premium Difference		φο.ου	\$0.00
Tamada Fremani Difference			\$0.00

		Current	SISC
		Blue Shield HMO	Anthem Blue Cross
		Retiree over 65 - spouse under 65	\$10 / 100%
		January 1, 2022	January 1, 2022 (will renew again October 1, 2022)
Lifetime Maximum		Unlimited	
Individual Deductible		None	
Family Deductible		None	
Individual Maximum Out-of-Pocket		¢1,000	
Family Maximum Out-of-Pocket		\$1,000 \$2,000	
runniy Maximum out of Focket		<i>\$2,000</i>	
Hospitalization Services		No Charge	
Outpatient Services		<u> </u>	
Surgery in Hospital		\$50 copayment	
Surgery in Outpatient Facility		\$50 copayment	
Emergency Room (co-pay waived if a	dmitted)	\$50 copayment	
Urgent Care		\$10 copayment	
Ambulance Services		\$50 copayment	
DCD Off: Nov. 17. L		640	
PCP Office Visit / Teladoc		\$10 copayment / No Charge Teladoc	
Specialist Office Visit		\$10 copayment	
Periodic Health Evaluations		No Charge	
Well Baby/Well Child Exams		No Charge	
Pregnancy & Maternity Care Visits Allergy Injections and Immunizations		No Charge	
Lab & X-Ray		\$10 copayment No Charge	
Complex Radiology (CT Scan, MRI)		No Charge	
complex nadiology (cr scan, wini)		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 Ser	rvices	\$10 copayment	
Chiropractic		Not Covered	
Acupuncture		Not Covered	
Durable Medical Equipment		50%	
Prescription Retail Drugs			
Prescription Retail Drugs Deductible		None	
Additional Out of Pocket	Maximum	None None	+
Generic Additional Out of Pocket	MANITUITI	\$10 copayment	
Brand		\$10 copayment \$20 copayment	+
Non-Formulary		Not Covered	
Specialty Drugs		20% up to \$200 max.	
Mail Order		\$20 Generic/\$40 Brand - 90 day supply	
	#enrolled	Current Rates	SISC Rates
Employee	(0)	\$0.00	\$0.00
Employee + 1	(0)	\$0.00	\$0.00
Employee + 2 or more	(0)	\$0.00	\$0.00
Monthly Total	(0)	\$0.00	\$0.00
Annual Total		\$0.00	\$0.00
Annual Premium Difference			\$0.00

		Command	CICC
		Current	SISC
		Blue Shield HMO	Anthem Blue Cross
		\$40 - 40%	\$30/\$40/\$500 per day
		January 1, 2022	January 1, 2022 (will renew again October 1, 2022)
Lifetime Maximum		Unlimited	Unlimited
Individual Deductible		None	None
Family Deductible		None	None
Turniny Beddetible		None	Hone
Individual Maximum Out-of-Pocket		\$3,500	\$2,500
Family Maximum Out-of-Pocket		\$7,000	\$5,000
,		. ,	.,
Hospitalization Services		40%	\$500 copayment per day (3 days max)
Outpatient Services			
Surgery in Hospital		40%	\$250 copayment
Surgery in Outpatient Facility		40%	\$250 copayment
Emergency Room (co-pay waived if admitted	d)	\$100 copayment	\$150 copayment
Urgent Care		\$40 copayment	\$30 copayment
Ambulance Services	-	\$100 copayment	\$100 copayment
PCP Office Visit / Teladoc		\$40 copayment / No Charge Teladoc	\$30 copayment
Specialist Office Visit		\$40 copayment / No Charge Teladoc \$40 copayment	\$40 copayment
Periodic Health Evaluations		No Charge	No Charge
Well Baby/Well Child Exams		No Charge	No Charge
Pregnancy & Maternity Care Visits		No Charge	\$30 copayment for prenatal office visits
Allergy Injections and Immunizations		\$40 copayment	\$30 copayment for testing (immunizations are not listed)
Lab & X-Ray		No Charge	No Charge
Complex Radiology (CT Scan, MRI)		No Charge	\$100 copayment
Complex Radiology (C1 Scall, Wiki)		No charge	\$100 copayment
Mental and Nervous Disorders			
In-patient		40%	\$500 copayment per day (3 days max)
Out-patient		\$40 copayment	\$30 copayment
Substance Abuse			
In-patient:		40%	\$500 copayment per day (3 days max)
Outpatient visits		\$40 copayment	\$30 copayment
		A40	<u> </u>
Rehabilitation Outpatient Therapy Services		\$40 copayment	\$30 copayment-office / \$40 copayment-hospital
Chiropractic		Not Covered	Rider included \$10 copayment
Acupuncture Durable Medical Equipment		Not Covered 50%	Rider included \$10 copayment 50%
Durable Medical Equipment		3070	3070
Prescription Retail Drugs	1		
Deductible		None	\$200 Individual / \$500 Family
Additional Out of Pocket Maxir	num	None	\$2,500 Individual / \$3,500 Family
Generic		\$15 copayment	\$10 copayment
Brand		\$30 copayment	\$35 copayment
Non-Formulary		Not Covered	Not listed
Specialty Drugs		20% up to \$200 max.	Mail Order only - Navitus \$35 - 30 day supply
Mail Order		\$30 Generic/\$60 Brand - 90 day supply	No Charge Generic (Costco) / \$90 Brand (Costco)
	#enrolled	Current Rates	SISC Rates
	(0)	\$0.00	\$0.00
Employee		4	\$0.00
Employee Employee + 1	(0)	\$0.00	Ş0.00
		\$0.00 \$0.00	\$0.00
Employee + 1 Employee + 2 or more	(0)	\$0.00	\$0.00
Employee + 1 Employee + 2 or more Monthly Total	(0)	\$0.00	\$0.00
Employee + 1 Employee + 2 or more	(0)	\$0.00	\$0.00

		Current	SISC
		Blue Shield HMO	Anthem Blue Cross
		Retiree and spouse over 65	\$30/\$40/\$500 per day
		January 1, 2022	January 1, 2022 (will renew again October 1, 2022)
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 ad	mitted)	\$100 copayment	
Urgent Care		\$40 copayment	
Ambulance Services		\$100 copayment	
PCP Office Visit / Teladoc		\$40 copayment / No Charge Teladoc	
Specialist Office Visit		\$40 copayment	
Periodic Health Evaluations		No Charge	
Well Baby/Well Child Exams		No Charge	
Pregnancy & Maternity Care Visits		No Charge	
Allergy Injections and Immunizations		\$40 copayment	
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 Serv	vices	\$40 copayment	
Chiropractic		Not Covered	
Acupuncture		Not Covered	
Durable Medical Equipment		50%	
Prescription Retail Drugs			
Deductible Deductible		None	
Additional Out of Pocke	t Maximum	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	
	#enrolled	Current Rates	SISC Rates
Employee	(0)	\$0.00	\$0.00
Employee + 1	(0)	\$0.00	\$0.00
Employee + 2 or more	(0)	\$0.00	\$0.00
Monthly Total	(0)	\$0.00	\$0.00
Annual Total	,	\$0.00	\$0.00
Annual Premium Difference			\$0.00

		Current	SISC
		Blue Shield	Anthem Blue Cross
		Retiree over 65 - spouse under 65	\$30/\$40/\$500 per day
		January 1, 2022	January 1, 2022 (will renew again October 1, 2022)
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		1070	
Surgery in Hospital		40%	
Surgery in Outpatient Facility		40%	
Emergency Room (co-pay waived if admitte	d)	\$100 copayment	
Urgent Care		\$40 copayment	
Ambulance Services		\$100 copayment	
PCP Office Visit / Teladoc		\$40 copayment / No Charge Teladoc	
Specialist Office Visit		\$40 copayment	
Periodic Health Evaluations		No Charge	
Well Baby/Well Child Exams		No Charge	
Pregnancy & Maternity Care Visits		No Charge	
Allergy Injections and Immunizations		\$40 copayment	
Lab & X-Ray		No Charge	
Complex Radiology (CT Scan, MRI)		No Charge	
NA . I IN D. I			
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 consument	
Chiropractic		\$40 copayment Not Covered	
Acupuncture		Not Covered Not Covered	
Durable Medical Equipment		50%	
Prescription Retail Drugs ³ :			
Deductible Additional Out of Pocket Ma	vimum	None	
Additional Out of Pocket Ma Generic	ximum	None \$15 copayment	
Brand		\$15 copayment \$30 copayment	
Non-Formulary		Not Covered	
Specialty Drugs		20% up to \$200 max.	
Mail Order		\$30 Generic/\$60 Brand - 90 day supply	-
	#enrolled	Current Rates	SISC Rates
Employee	(0)	\$0.00	\$0.00
Employee + 1	(0)	\$0.00	\$0.00
Employee + 2 or more	(0)	\$0.00	\$0.00
Manthly Tatal	(0)		<u></u>
Monthly Total Annual Total	(0)	\$0.00 \$0.00	\$0.00 \$0.00
Annual Premium Difference		ŞU.0U	\$0.00
Percentage Difference	-		#DIV/0!

		Currer		SI	SC	
		Blue Shield-\$5	00 90/70	Anthem Blue Cross PPO January 1, 2022 (will renew again October 1, 2022)		
		January 1,	2022			
		In-Network	Out-of-Network	In-Network	Out-of-Network	
Lifetime Maximum		Unlimite	ed	Unlii	mited	
Individual Deductible		\$500		\$5	500	
Family Deductible		\$1,000)	\$1,	.000	
Individual Maximum Out-of-Pocket		\$1,500	\$3,500	\$1,000	No Limit	
Family Maximum Out-of-Pocket		\$3,000	\$7,000	\$3,000	No Limit	
Hospitalization Services		10%	30% (\$600 per day)	10%	SEE NOTE BELOW* (\$600 per day)	
Outpatient Services						
Surgery in Hospital		10%	30% (\$350 per day)	10%	SEE NOTE BELOW*	
Surgery in Outpatient Facility		10%	30% (\$350 per day)	10%	SEE NOTE BELOW*	
Emergency Room (co-pay waived if admi	itted)	\$75 copayment (if admitted			itted, coinsurance applies)	
Urgent Care		\$20 copayment	30%	\$20 copayment	SEE NOTE BELOW*	
Ambulance Services		10% after ded	auctible	\$100 + 10% a	fter deductible	
PCP Office Visit / Teladoc		\$20 copayment/No Charge Teladoc	30%	No Charge for visits 1-3/\$20 copayment for visits 4 +	SEE NOTE BELOW*	
Specialist Office Visit		\$20 copayment	30%	\$20 copayment	SEE NOTE BELOW*	
Periodic Health Evaluations		No Charge	30%	No Charge	Not Covered	
Well Baby/Well Child Exams		No Charge	30%	No Charge	Not Covered	
Pregnancy & Maternity Care Visits		No Charge	30%	No Charge for visits 1-3/ \$20 copayment for visits 4 +	SEE NOTE BELOW*	
Allergy Injections and Immunizations		10%	30%	10%	SEE NOTE BELOW*	
Lab & X-Ray		\$20 copayment after deductible	30%	10%	Not Covered	
		\$35 if performed in a hospital after deductible	30%			
Complex Radiology (CT Scan, MRI)		10%	30%	10%	SEE NOTE BELOW*	
Mental and Nervous Disorders						
In-patient		10%	30% (\$600 per day)	10%	SEE NOTE BELOW*	
Out-patient		\$20 copayment	30%	\$20 copayment	SEE NOTE BELOW*	
Substance Abuse		100/	200/ /6000	100/	CEE NOTE BELOW!	
In-patient: Outpatient visits		10% \$20 copayment	30% (\$600 per day) 30%	10% \$20 copayment	SEE NOTE BELOW* SEE NOTE BELOW*	
Outpatient visits		320 сораушент	30/0	320 сорауннени	SEE NOTE BELOW	
Rehabilitation Outpatient Therapy Servic	es	\$20 copayment after deductible	30%	10%	Not Covered	
Chiropractic (up to 20 visits per year)		10%	30%	10% (medically necessary)	Not Covered	
Acupuncture (up to 20 visits per year) Durable Medical Equipment		\$25 copayment 10%	30% 30%	10% (12 visits) 10%	50% Not Covered	
Prescription Retail Drugs:						
Deductible		None		None		
Additional Out of Pocket Max	xımum	None	¢10 + 250/		al / \$2,500 Family	
Generic Brand		\$10 copayment \$15 copayment	\$10 + 25% \$15 + 25%	\$3 copayment \$15 copayment	The Benefit Summary does not	
Non-Formulary	Brand Non-Formulary		\$15 + 25%	Benefit Summary does not show Non-Formulary Drugs	 show out of network coverage. Not sure if out of network coverage is available. 	
Specialty Drugs		30% up to \$200 max.	30% up to \$200 max. + 25%	Mail Order only Navi	tus \$15 - 30 day supply	
Mail Order		\$20 / \$30 / \$60 - 90 day supply	Not Covered		tco) / \$35 Brand (Costco)	
	#enrolled	Current R			Rates	
Employee	(0)	\$0.00			.00	
Employee + 1	(0)	\$0.00			.00	
Employee + 2 or more	(0)	\$0.00			.00	
. ,						
Monthly Total	(0)	\$0.00			0.00	
Annual Total		\$0.00		·	0.00	
Annual Premium Difference				ŞC	0.00	

[&]quot;*When using Out-of-Network Providers, members are responsible for any difference between the maximum allowed amount and the actual charges, as well as any deductible and percentage copayments"

		Common	+		SC
		Currer Blue Shield-\$5		SIS Anthem Blue	
		Retiree and Spot		January 1, 2022 (will renew again October 1, 2022)	
		January 1, 2			
		In-Network	Out-of-Network	In-Network	Out-of-Network
Lifetime Maximum		Unlimite		III-NECWORK	Out of Network
ndividual Deductible		\$500			
Family Deductible		\$1,000)		
ndividual Maximum Out-of-Pocket		\$1,500	\$3,500		
Family Maximum Out-of-Pocket		\$3,000	\$7,000		
Lauritalia etian Camina		100/	200/ (6500		
Hospitalization Services		10%	30% (\$600 per day)		
Outpatient Services Surgery in Hospital		10%	200/ /6250 === d==/		
Surgery in Outpatient Facility		10%	30% (\$350 per day) 30% (\$350 per day)		
	mittad)	\$75 copayr			
mergency Room (co-pay waived if add Irgent Care	initeu)		30%		
Ambulance Services		\$20 copayment 10%	30%		
		10/0			
		\$20 copayment/No Charge			1
PCP Office Visit / Teladoc		Teladoc	30%		
Specialist Office Visit		\$20 copayment	30%		
Periodic Health Evaluations		No Charge	30%		
Well Baby/Well Child Exams		No Charge	30%		
Pregnancy & Maternity Care Visits		10%	30%		
Allergy Injections and Immunizations		10%	30%		
ab & X-Ray		\$20 copayment	30%		
and an may		. ,			
		\$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%		1
Rehabilitation Outpatient Therapy Serv	rices	\$20 copayment	30%		
Chiropractic (up to 20 visits per year)		10%	30%		
Acupuncture Durable Medical Equipment		\$25 copayment 10%	30% 30%		
Durable Medical Equipment		10%	30%		
Prescription Retail Drugs:					
Deductible		None			
Additional Out of Pocket N	/laximum	None			
Generic Brand		\$10 copayment	\$10 + 25%		
Brand Non-Formulary		\$15 copayment \$30 copayment	\$15 + 25% \$30 + 25%		
<u> </u>		, ,	30% up to \$200 max. +		
Specialty Drugs		30% up to \$200 max.	25%		
		\$20 / \$30 / \$60 - 90 day			
Mail Order		\$20 / \$50 / \$60 - 90 day supply	Not Covered		
	н		atas	CICC	Pates
	#enrolled	Current Rates		SISC F	
Employee	(0)	\$0.00		\$0.	
Employee + 1	(0)	\$0.00		\$0.	
	(0)	\$0.00		\$0.	00
Employee + 2 or more					
	(0)	\$0.00		<u> </u>	00
Monthly Total	(0)	\$0.00 \$0.00		\$0. \$0.	
Employee + 2 or more Monthly Total Annual Total Annual Premium Difference	(0)	\$0.00 \$0.00		\$0. \$0. \$0.	.00

		Curre	ent	SISC		
	Blue Shield-\$500 90/70			Anthem Blue Cross PPO		
		Retiree over 65 - spouse under 65				
		January 1, 2022		January 1, 2022 (will renew again October 1, 2022)		
		In-Network Out-of-Network		In-Network Out-of-Network		
Lifetime Maximum		Unlim	ted			
Individual Deductible		\$50	n		1	
Family Deductible		\$1,000				
		φ2)3.				
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 admitt	ed)	\$75 copayment				
Urgent Care		\$20 copayment 30%			T	
Ambulance Services		10%				
		\$20 copayment/No Charge				
PCP Office Visit / Teladoc		Teladoc	30%			
Specialist Office Visit		\$20 copayment	30%			
Periodic Health Evaluations		No Charge	30%			
Well Baby/Well Child Exams		No Charge	30%			
Pregnancy & Maternity Care Visits		10%	30%			
Allergy Injections and Immunizations		10%	30%			
Lab & X-Ray		\$20 copayment	30%			
		\$35 if performed in a	200/			
		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		100/	30% (\$600 === d==)			
In-patient: Outpatient visits		10% \$20 copayment	30% (\$600 per day) 30%			
Outpatient visits		\$20 copayment	3070			
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%		1	
Proceeding Potail Drugs						
Prescription Retail Drugs:		None				
Deductible Additional Out of Pocket Maximum		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			
	#enrolled	Current Rates		SISC Rates		
Employee	(0)	\$1,185.85		\$0.00		
Employee + 1	(0)	\$2,288.69		\$0.00		
Employee + 2 or more	(0)	\$2,525.86		\$0.00		
	(0)	ĆO C	\$0.00		\$0.00	
Monthly Total	(0)					
	(0)	\$0.0 \$0.0			\$0.00 \$0.00 \$0.00	

		Current & F	Renewal	SISC	
		Blue Shield-\$500 90/70 - Dual Spousal		Anthem Blue Cross	
				In-Network	Out-of-Network
Lifetime Maximum		Unlimit	ted		
Individual Deductible		\$500)		
Individual Deductible Family Deductible		\$300			
,		. ,			
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		1/0	30% (3000 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		There is not a quote for	
Urgent Care		\$20 copayment 30% 10%		Anthem benefits pr	oposal provided
Ambulance Services		10%			
PCP Office Visit / Teladoc		\$20 copayment/No Charge Teladoc	30%		
Specialist Office Visit		\$20 copayment	30%		
Periodic Health Evaluations		No Charge	30%		
Well Baby/Well Child Exams		No Charge	30%		
Pregnancy & Maternity Care Visits		1%	30%		
Allergy Injections and Immunizations Lab & X-Ray		1%	30% 30%		
Lab & A-Nay		\$20 copayment			
		\$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 Substance Abuse		\$20 copayment	30%		
In-patient:		1%	30% (\$600 per day)		
Outpatient visits		\$20 copayment	30%		
		A			
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:					1
Deductible		None			·
Additional Out of Pocket Maximum Generic		None \$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		
	#enrolled	Current Rates		SISC Rates	
Employee	(0)	\$0.00		\$0.00	
Employee + 1	(0)	\$0.00		\$0.00	
Employee + 2 or more	(0)	\$0.00)	\$0.0	0
Monthly Total	(0) \$0.00		0	\$0.00	
Annual Total		\$0.00		\$0.00	
Annual Premium Difference				\$0.0	0