Benefit	Kaiser 90 HMO 0/15	Blue Shield Plat Trio 0/25 OffEx	2021 CalPERS Select
			In-Network
Individual Ded	0	0	$1000*/$500
Family Ded	0	0	$2000*/$1000
Individual OOP Max	$4,500	$2,350	$3,000
Family OOP Max	$9,000	$4,700	$6,000
Lifetime Max	Unlimited	Unlimited	
PC/Specialist	$20/$30	$25/$50	$10/$35 per visit - deductible does not apply; enrolled with PCP vs. not-enroll
Adult Preventative Care	No Charge	No charge	No Charge
Child Preventative Care	No Charge	No charge	No Charge
Pre/Postnatal Care	No Charge	No charge	No Charge
Physical Therapy	$20	$25	20% coinsurance
Chiropratic Care	Not Covered	$15/20 visits a calendar year	Chirocraptic care rider 20 visits/benefits period combined with acupuncture
Inpatient Hospital	$250/day up to 5 days	$250/day up to 3 days	20% coinsurance
Inpatient Surgery	N/A	No charge	20% coinsurance
Maternity Delivery/IP	$250/day up to 5 days	$250/day up to 3 days	20% coinsurance
Mental Health IP	$250/day up to 5 days	$250/day up to 3 days	20% coinsurance
Substance Abuse IP	$250/day up to 5 days	$250/day up to 3 days	20% coinsurance
Outpatient Facility	$125	$100/$150 (ASC/Hospital)	20% coinsurance
Outpatient Surgery	N/A	No charge	20% coinsurance
Lab/X Ray	$20/$30	$20/$50	20% coinsurance
Advanced Radiology	$100	$50/$200 (FS/Hospital)	20% coinsurance
Mental Healh OP	$20	$25	$10/visit if PCP enrolled; Deductible does not apply; other outpatient 20%
Susbtance Abuse OP	$20	$25	$10/visit if PCP enrolled; Deductible does not apply; other outpatient 20%
Emergency Room	$150 (waived if admitted)	$250 (waived if admitted)	20% coinsurance; $50 deductible waived if admitted
Ambulance	$150	$150	20% coinsurance
Urgent Care	$20	$25	$35/visit; Deductible does not apply
Rx Generic	$5	$5/$10	$5/$10
Rx Preferred	$20	$15/$30	$20/$40
Rx Non Preffered	$20	$25/$45	$50/$100
Rx Speciality	10%; $250 max/script	20%; $250 max/script	Follows tier structure above
Home Health Care	$20/100 visits per year	$25/100 visits per calendar year	20% coinsurance
Skilled Nursing	$150/day/up to 5 days; 100 days/yr	$100/day; 100 days/benefit period	20% coinsurance first 10 days; 30% following 90 days
Infertility Treatment	Not Covered	Not covered	Covered (see plan document- limitations may apply)
DME	10% base and supplemental	50%	20% coinsurance
Hospice Services	No charge	No charge	20% coinsurance
Pediatric Vision	No charge; 1 pair per year	Covered: see brochure	Not covered; City has separate dental and vision plans
Pediatric Dental	Bundled w/copay plan	Covered: see brochure	Not covered; City has separate dental and vision plans

** 5 credits available to lower deductible: biometric screening, condition care, flu shot, second opinion, smoking cessation