Retirees

2027 Medical Plans for Retirees or Dependents *without* Medicare

	HEALTH NET CanopyCare HMO	KAISER PERMANENTE Traditional HMO (California)
DEDUCTIBLES		
Deductible and Out-of-Pocket Maximum (Medical)	No Deductible Annual out-of-pocket maximum $2,000/individual; $4,000/family	No Deductible Annual out-of-pocket maximum $1,500/individual; $3,000/family
PREVENTIVE CARE		
Routine Physical	No charge	No charge
Most Immunizations and Inoculations	No charge	No charge
Well Woman Exam and Family Planning	No charge	No charge
Routine Pre/Post-Partum Care	No charge	No charge visits limited; see EOC
PHYSICIAN AND OTHER PROVIDER CARE		
Office and Home Visits	$25 co-pay	$20 co-pay
Inpatient Hospital Visits	No charge	No charge
PRESCRIPTION DRUGS		
Pharmacy: Generic Drugs	$10 co-pay 30-day supply	$5 co-pay 30-day supply
Pharmacy: Brand-Name Drugs	$25 co-pay 30-day supply	$15 co-pay 30-day supply
Pharmacy: Non-Formulary Drugs	$50 co-pay 30-day supply	Only if authorized by a Kaiser Physician
Mail Order: Generic Drugs	$20 co-pay 90-day supply	$10 co-pay 100-day supply
Mail Order: Brand-Name Drugs	$50 co-pay 90-day supply	$30 co-pay 100-day supply
Mail Order: Non-Formulary Drugs	$100 co-pay 90-day supply	Only if authorized by a Kaiser Physician
Specialty Drugs	20% coinsurance up to $100 per prescription, 30-day supply	20% coinsurance up to $100 per prescription, 30-day supply
OUTPATIENT SERVICES		
Diagnostic X-ray and Laboratory	No charge	No charge
EMERGENCY		
Hospital Emergency Room	$100 co-pay waived if hospitalized	$100 co-pay waived if hospitalized
Urgent Care Facility	$25 co-pay in-network and out-of-network	$20 co-pay
HOSPITAL/SURGERY		
Inpatient	$200 co-pay per admission	$100 co-pay per admission
Outpatient	$100 co-pay per surgery	$35 co-pay

Retirees

2027 Medical Plans for Retirees or Dependents *without* Medicare

	BLUE SHIELD OF CALIFORNIA Trio HMO and Access+ HMO	BLUE SHIELD OF CALIFORNIA PPO	
		In-Network or Out-of-Area	Out-of-Network
DEDUCTIBLES			
Deductible and Out-of-Pocket Maximum (Medical)	No Deductible Annual out-of-pocket max $2,000/individual; $4,000/family	$250 Deductible Retiree only $500 Deductible + 1 $750 Deductible + 2 or more Annual out-of-pocket max $3,750/person; $7,500/family	$500 Deductible Retiree only $1,000 Deductible + 1 $1,500 Deductible + 2 or more Annual out-of-pocket max $7,500/person
PREVENTIVE CARE			
Routine Physical	No charge	100% covered no deductible	50% covered after deductible
Most Immunizations and Inoculations	No charge	100% covered no deductible	100% covered no deductible
Well Woman Exam and Family Planning	No charge	100% covered no deductible	50% covered after deductible
Routine Pre/Post-Partum Care	No charge visits limited; see EOC	85% covered after deductible	50% covered after deductible
PHYSICIAN AND OTHER PROVIDER CARE			
Office and Home Visits	$25 co-pay	85% covered after deductible	50% covered after deductible
Inpatient Hospital Visits	No charge	85% covered after deductible	50% covered after deductible
PRESCRIPTION DRUGS			
Pharmacy: Generic Drugs	$10 co-pay 30-day supply	$10 co-pay 30-day supply	$10 co-pay plus 50% coinsurance; 30-day supply
Pharmacy: Brand-Name Drugs	$25 co-pay 30-day supply	$25 co-pay 30-day supply	$25 co-pay plus 50% coinsurance; 30-day supply
Pharmacy: Non-Formulary Drugs	$50 co-pay 90-day supply	$50 co-pay 30-day supply	$50 co-pay, plus 50% coinsurance; 30-day supply
Mail Order: Generic Drugs	$20 co-pay 90-day supply	$20 co-pay 90-day supply	Not covered
Mail Order: Brand-Name Drugs	$50 co-pay 90-day supply	$50 co-pay 90-day supply	Not covered
Mail Order: Non-Formulary Drugs	$100 co-pay 90-day supply	$100 co-pay 90-day supply	Not covered
Specialty Drugs	20% coinsurance up to $100 per prescription, 30-day supply	$50 co-pay 30-day supply	$50 co-pay, plus 50% coinsurance; 30-day supply
OUTPATIENT SERVICES			
Diagnostic X-ray and Laboratory	No charge	85% covered after deductible	50% covered after deductible; prior notification
EMERGENCY			
Hospital Emergency Room	$100 co-pay waived if hospitalized	85% covered after deductible; if non-emergency 50% after deductible	85% covered after deductible; if non-emergency 50% after deductible
Urgent Care Facility	$25 co-pay in-network	85% covered after deductible	50% covered after deductible
HOSPITAL/SURGERY			
Inpatient	$200 co-pay; per admission	85% covered after deductible; notification required	50% covered after deductible; notification required
Outpatient	$100 co-pay per surgery	85% covered after deductible	50% covered after deductible

Each plan's Evidence of Coverage (EOC) contains a complete list of benefits and exclusions. If any discrepancy exists between the information provided in this Guide and the EOC, the EOC shall prevail. Download EOCs at **sfhss.org**.

Retirees

2027 Medical Plans for Retirees or Dependents *without* Medicare

	HEALTH NET CanopyCare HMO	KAISER PERMANENTE Traditional HMO (California)
REHABILITATIVE		
Physical/Occupational Therapy	$25 co-pay per visit	$20 co-pay authorization required
Acupuncture/Chiropractic	$15 co-pay 30 visits, of each type, max per plan year; ASH network	$15 co-pay 30 visits combined acupuncture or chiro. max per plan year; ASH network
GENDER DYSPHORIA		
Office Visits and Outpatient Surgery	Co-pays apply authorization required	Co-pays apply authorization required
DURABLE MEDICAL EQUIPMENT		
Home Medical Equipment	No charge	No charge as authorized by PCP according to formulary
Diabetic Monitoring Supplies	No charge based upon allowed charges	No charge see EOC
Prosthetics/Orthotics	No charge when medically necessary	No charge when medically necessary
Hearing Aids	Evaluation no charge up to $5,000 combined for both ears, every 36 months	Evaluation no charge 1 aid per ear, every 36 months, up to $2,500 each
MENTAL HEALTH		
Inpatient Hospitalization	$200 co-pay per admission	$100 co-pay per admission
Outpatient Treatment	$25 co-pay non-severe and severe	$10 co-pay group $20 co-pay individual
Inpatient Detox	$200 co-pay per admission	$100 co-pay per admission
Residential Rehabilitation	$200 co-pay per admission	$100 co-pay per admission; physician approval required
EXTENDED & END-OF-LIFE CARE		
Skilled Nursing Facility	No charge up to 100 days/year	No charge up to 100 days/year
Hospice	No charge authorization required	No charge when medically necessary
OUTSIDE SERVICE AREA		
Care Access and Limitations	Urgent care $25 co-pay	Only emergency services before condition permits transfer to Kaiser facility; co-pays apply

Retirees

2027 Medical Plans for Retirees or Dependents *without* Medicare

	BLUE SHIELD OF CALIFORNIA Trio HMO and Access+ HMO	BLUE SHIELD OF CALIFORNIA PPO	
		In-Network or Out-of-Area	Out-of-Network
REHABILITATIVE			
Physical/Occupational Therapy	$25 co-pay per visit	85% covered after deductible; limitations may apply, see EOC	50% covered after deductible; limitations may apply, see EOC
Acupuncture/Chiropractic	$15 co-pay 30 visits, of each type, max per plan year; ASH network	50% covered after deductible; $1,000 max/year	50% covered after deductible; $1,000 max/year
GENDER DYSPHORIA			
Office Visits and Outpatient Surgery	Co-pays apply authorization required	85% covered after deductible; notification required	50% covered after deductible; notification required
DURABLE MEDICAL EQUIPMENT			
Home Medical Equipment	No Charge	85% covered after deductible; notification required	50% covered after deductible; notification required
Diabetic Monitoring Supplies	No Charge based upon allowed charges	Co-pays apply see pharmacy benefits	Co-pays apply see pharmacy benefits
Prosthetics/Orthotics	No Charge when medically necessary	85% covered after deductible; when medically necessary; notification required	50% covered after deductible; when medically necessary; notification required
Hearing Aids	Evaluation no charge 1 aid per ear, every 36 months, up to $2,500 each	85% covered after deductible; 1 aid per ear, every 36 months, up to $2,500 each	50% covered after deductible; 1 aid per ear, every 36 months, up to $2,500 each
MENTAL HEALTH			
Inpatient Hospitalization	$200 co-pay per admission	85% covered after deductible; notification required	50% covered after deductible; notification required
Outpatient Treatment	$25 co-pay non-severe and severe	85% covered after deductible; notification required	50% covered after deductible; notification required
Inpatient Detox	$200 co-pay per admission	85% covered after deductible; notification required	50% covered after deductible; notification required
Residential Rehabilitation	$200 co-pay per admission	85% covered after deductible; authorization required	50% covered after deductible; authorization required
EXTENDED & END-OF-LIFE CARE			
Skilled Nursing Facility	No charge up to 100 days/year	85% covered after deductible; up to 120 days/year; notification required; custodial care not covered	50% covered after deductible; up to 120 days/year; notification required; custodial care not covered
Hospice	No charge authorization required	85% covered after deductible; authorization required	50% covered after deductible; authorization required
OUTSIDE SERVICE AREA			
Care Access and Limitations	Urgent care $50 co-pay guest membership benefits for college students in some areas	Coverage worldwide. In-network and out-of-network percentages and co-pays apply	Coverage worldwide. In-network and out-of-network percentages and co-pays apply

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