



Medical Plans Benefits Summary

This chart provides a summary of benefits only. In any instance where information in this chart or Guide conflicts with the plan's Evidence of Coverage (EOC), the plan's EOC shall prevail. For a detailed description of benefits and exclusions, please review your plan's EOC. EOCs are available for download at sfhss.org.

	KAISER PERMANENTE	BLUE SHIELD OF CALIFORNIA			HEALTH NET*
	TRADITIONAL HMO	TRIO HMO	ACCESS+ HMO	PPO	CANOPYCARE HMO
Choice of Physician	PCP assignment required.	PCP assignment required.	PCP assignment required.	You may use any licensed provider. You receive a higher level of benefit and pay lower out-of-pocket costs when choosing in-network providers.	
Deductible	No deductible	No deductible	IN-NETWORK AND OUT-OF-AREA		OUT-OF-NETWORK
			\$250 employee only \$500 +1 dependent \$750 +2 or more deps	\$500 employee only \$1,000 +1 dependent \$1,500 +2 or more deps	
Out-of-Pocket Maximum does not include premium contributions	\$1,500 per individual \$3,000 per family	\$2,000 per individual \$4,000 per family	\$3,750 per individual \$7,500 per family	\$7,500 per individual	\$2,000 per individual \$4,000 per family
General Care and Urgent Care					
Annual Physical; Well Woman Exam	No charge	No charge		100% covered no deductible	50% covered after deductible
Doctor Office Visit	\$20 co-pay	\$25 co-pay		85% covered after deductible	50% covered after deductible
Urgent Care Visit	\$20 co-pay	\$25 co-pay		85% covered after deductible	50% covered after deductible
Family Planning	No charge	No charge		100% covered no deductible	50% covered after deductible
Immunizations	No charge	No charge		100% covered no deductible	100% covered no deductible
Lab and X-ray	No charge	No charge		85% covered after deductible & prior notification	50% covered after deductible & prior notification
Doctor's Hospital Visit	No charge	No charge		85% covered after deductible	50% covered after deductible
Prescription Drugs					
Pharmacy: Generic	\$5 co-pay 30-day supply	\$10 co-pay 30-day supply		\$10 co-pay 30-day supply	\$10 co-pay plus 50% Coinsurance; 30-day supply
Pharmacy: Brand-Name	\$15 co-pay 30-day supply	\$25 co-pay 30-day supply		\$25 co-pay 30-day supply	\$25 co-pay plus 50% Coinsurance; 30-day supply
Pharmacy: Non-Formulary	Only if authorized by a Kaiser Physician	\$50 co-pay 30-day supply		\$50 co-pay 30-day supply	\$50 co-pay, plus 50% Coinsurance; 30-day supply
Mail Order: Generic	\$10 co-pay 100-day supply	\$20 co-pay 90-day supply		\$20 co-pay 90-day supply	Not covered
Mail Order: Brand-Name	\$30 co-pay 100-day supply	\$50 co-pay 90-day supply		\$50 co-pay 90-day supply	Not covered
Mail Order: Non-Formulary	Only if authorized by a Kaiser Physician	\$100 co-pay 90-day supply		\$100 co-pay 90-day supply	Not covered
Specialty	20% up to \$100 co-pay; 30-day supply	20% up to \$100 co-pay; 30-day supply		\$50 co-pay 30-day supply	\$50 co-pay, plus 50% Coinsurance; 30-day supply

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	TRADITIONAL HMO	TRIO HMO	ACCESS+ HMO	IN-NETWORK AND OUT-OF-AREA	OUT-OF-NETWORK	CANOPYCARE HMO
Hospital Outpatient and Inpatient						
Hospital Outpatient	\$35 co-pay	\$100 co-pay per surgery		85% covered after deductible	50% covered after deductible	\$100 co-pay per surgery
Hospital Inpatient	\$100 co-pay per admission	\$200 co-pay per admission		85% covered after deductible; may require prior notification	50% covered after deductible; may require prior notification	\$200 co-pay per admission
Hospital Emergency Room	\$100 co-pay waived if hospitalized	\$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	\$100 co-pay waived if hospitalized
Skilled Nursing Facility	No charge 100 days per benefit period	No charge 100 days per plan year		85% covered after deductible; 120 days per plan year; limits apply	50% covered after deductible; 120 days per plan year; limits apply	No charge 100 days per plan year
Hospice	No charge when medically necessary	No charge authorization required		85% covered after deductible; prior notification	50% covered after deductible; prior notification	No charge authorization req.
Maternity and Fertility						
Hospital or Birthing Center	\$100 co-pay per admission	\$200 co-pay per admission		85% covered after deductible; may require prior notification	50% covered after deductible; may require prior notification	\$200 co-pay per admission
Pre-/Post-Partum Care	No charge	No charge		85% covered after deductible	50% covered after deductible	No charge
Well Child Care	No charge must enroll newborn within 30 days of birth; see EOC	No charge must enroll newborn within 30 days of birth; see EOC		100% covered no deductible	100% covered no deductible	No charge must enroll newborn within 30 days of birth; see EOC
Fertility Services	Co-pays apply; authorization required	Co-pays apply; authorization required		85% covered after deductible; limitations apply; prior notification	50% covered after deductible; limitations apply; prior notification	Co-pays apply; authorization required
Mental Health and Substance Abuse Services						
Outpatient Treatment	\$10 co-pay group \$20 co-pay individual	\$25 co-pay non-severe and severe		85% covered after deductible; prior notification	50% covered after deductible; prior notification	\$25 co-pay non-severe and severe
Inpatient Facility	\$100 co-pay per admission	\$200 co-pay per admission		85% covered after deductible; prior notification	50% covered after deductible; prior notification	\$200 co-pay per admission
Other						
Hearing Aids	Up to \$2,500 per ear, every 36 months; no evaluation charge	Up to \$2,500 per ear, every 36 months; no charge for evaluation		85% covered after deductible; up to \$2,500 per ear, every 36 months	50% covered after deductible; up to \$2,500 per ear, every 36 months	Up to \$5,000, combined for both ears, every 36 months; no charge for evaluation
Medical Equipment, Prosthetics and Orthotics	No charge as authorized by PCP	No charge as authorized by PCP		85% covered after deductible; prior notification	50% covered after deductible; prior notification	No charge as authorized by PCP
Physical and Occupational Therapy	\$20 co-pay authorization required	\$25 co-pay		85% covered after deductible; limitations may apply, see EOC	50% covered after deductible; limitations may apply, see EOC	\$25 co-pay
Acupuncture/Chiropractic	\$15 co-pay up to a combined total of 30 chiropractic and acupuncture visits/year; ASH network	\$15 co-pay 30 visits max for each per plan year; ASH network		50% covered after deductible; \$1,000 max per plan year	50% covered after deductible; \$1,000 max per plan year	\$15 co-pay 30 visits max for each per plan year; ASH network
Gender Dysphoria	Co-pays apply; authorization required	Co-pays apply; authorization required		85% covered after deductible; prior notification	50% covered after deductible; prior notification	Co-pays apply; authorization required