



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.

	HEALTH NET	KAISER PERMANENTE	BLUE SHIELD OF CALIFORNIA		
	CANOPYCARE HMO	TRADITIONAL HMO	TRIO HMO	ACCESS+ HMO	BLUE SHIELD OF CALIFORNIA PPO
Choice of Physician	PCP assignment required.	KP network only. 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	No deductible	IN-NETWORK AND OUT-OF-AREA	
				\$250 employee only \$500 +1 \$750 +2 or more	OUT-OF-NETWORK \$500 employee only \$1,000 +1 \$1,500 +2 or more
Out-of-Pocket Maximum does not include premium contributions	\$2,000 per individual \$4,000 per family	\$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
General Care and Urgent Care					
Annual Physical; Well Woman Exam	No charge	No charge	No charge	100% covered no deductible	50% covered after deductible
Doctor Office Visit	\$25 co-pay	\$20 co-pay	\$25 co-pay	85% covered after deductible	50% covered after deductible
Urgent Care Visit	\$25 co-pay in-network and out-of-network	\$20 co-pay	\$25 co-pay in-network	85% covered after deductible	50% covered after deductible
Family Planning	No charge	No charge	No charge	100% covered no deductible	50% covered after deductible
Immunizations	No charge	No charge	No charge	100% covered no deductible	100% covered no deductible
Lab and X-ray	No charge	No charge	No charge	85% covered after deductible & prior notification	50% covered after deductible & prior notification
Doctor's Hospital Visit	No charge	No charge	No charge	85% covered after deductible	50% covered after deductible
Prescription Drugs					
Pharmacy: Generic	\$10 co-pay 30-day supply	\$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	\$25 co-pay 30-day supply	\$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	\$50 co-pay 30-day supply	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	\$20 co-pay 90-day supply	\$10 co-pay 100-day supply	\$20 co-pay 90-day supply	\$20 co-pay 90-day supply	Not covered
Mail Order: Brand-Name	\$50 co-pay 90-day supply	\$30 co-pay 100-day supply	\$50 co-pay 90-day supply	\$50 co-pay 90-day supply	Not covered
Mail Order: Non-Formulary	\$100 co-pay 90-day supply	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	20% up to \$100 co-pay; 30-day supply	\$50 co-pay 30-day supply	\$50 co-pay, plus 50% Coinsurance; 30-day supply

	HEALTH NET	KAISER PERMANENTE	BLUE SHIELD OF CALIFORNIA			
	CANOPYCARE HMO	TRADITIONAL HMO	TRIO HMO	ACCESS+ HMO	IN-NETWORK AND OUT-OF-AREA	OUT-OF-NETWORK
Hospital Outpatient and Inpatient						
Hospital Outpatient	\$100 co-pay per surgery	\$35 co-pay	\$100 co-pay per surgery		85% covered after deductible	50% covered after deductible
Hospital Inpatient	\$200 co-pay per admission	\$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
Hospital Emergency Room	\$100 co-pay waived if hospitalized	\$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
Skilled Nursing Facility	No charge 100 days per plan year	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
Hospice	No charge authorization req.	No charge when medically necessary	No charge authorization required		85% covered after deductible; prior notification	50% covered after deductible; prior notification
Maternity and Fertility						
Hospital or Birthing Center	\$200 co-pay per admission	\$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
Pre-/Post-Partum Care	No charge	No charge	No charge		85% covered after deductible	50% covered after deductible
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	No charge must enroll newborn within 30 days of birth; see EOC		100% covered no deductible	100% covered no deductible
IVF, GIFT, ZIFT and Artificial Insemination	Co-pays apply; authorization required	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
Mental Health and Substance Abuse Services						
Outpatient Treatment	\$25 co-pay non-severe and severe	\$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
Inpatient Facility including detox and residential rehab	\$200 co-pay per admission	\$100 co-pay per admission	\$200 co-pay per admission		85% covered after deductible; prior notification	50% covered after deductible; prior notification
Other						
Hearing Aids 1 aid per ear every 36 months; no charge for evaluation	Up to \$5,000, combined for both ears, every 36 months; no charge for evaluation	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
Medical Equipment, Prosthetics and Orthotics	No charge as authorized by PCP	No charge as authorized by PCP	No charge as authorized by PCP		85% covered after deductible; prior notification	50% covered after deductible; prior notification
Physical and Occupational Therapy	\$25 co-pay	\$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
Acupuncture/Chiropractic	\$15 co-pay 30 visits max for each per plan year; ASH network	\$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
Gender Dysphoria office visits and outpatient surgery	Co-pays apply; authorization required	Co-pays apply; authorization required	Co-pays apply; authorization required		85% covered after deductible; prior notification	50% covered after deductible; prior notification