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.		PCP assignment required.
				IN-NETWORK AND OUT-OF-AREA	OUT-OF-NETWORK	
Deductible	No deductible	No deductible		$250 employee only $500 +1 dependent $750 +2 or more deps	$500 employee only $1,000 +1 dependent $1,500 +2 or more deps	No deductible
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	No charge
Doctor Office Visit	$20 co-pay	$25 co-pay		85% covered after deductible	50% covered after deductible	$25 co-pay
Urgent Care Visit	$20 co-pay	$25 co-pay		85% covered after deductible	50% covered after deductible	$25 co-pay
Family Planning	No charge	No charge		100% covered no deductible	50% covered after deductible	No charge
Immunizations	No charge	No charge		100% covered no deductible	100% covered no deductible	No charge
Lab and X-ray	No charge	No charge		85% covered after deductible & prior notification	50% covered after deductible & prior notification	No charge
Doctor's Hospital Visit	No charge	No charge		85% covered after deductible	50% covered after deductible	No charge
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	$10 co-pay 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	$25 co-pay 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	$50 co-pay 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	$20 co-pay 90-day supply
Mail Order: Brand-Name	$30 co-pay 100-day supply	$50 co-pay 90-day supply		$50 co-pay 90-day supply	Not covered	$50 co-pay 90-day supply
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	$100 co-pay 90-day supply
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	20% up to $100 co-pay; 30-day supply

	KAISER PERMANENTE	BLUE SHIELD OF CALIFORNIA				HEALTH NET
	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 yea
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