

RETIREE HEALTH PLANS FOR PARTICIPANTS OVER 65 OR MEDICARE ELIGIBLE

Participants under age 65 with Medicare Part A and B are also eligible.

Enrollment requires Medicare eligibility (both A & B are required)

PLAN YEAR 2026	KAISER SR. ADVANTAGE (HMO)	BLUE SHIELD 65 PLUS (HMO)	HEALTH NET SENIORITY PLUS (HMO)	HEALTH NET COB POINT OF SERVICE (POS)	NEW ANTHEM BC MEDICARE PREFERRED (PPO)	ANTHEM BLUE CROSS GOLD	ANTHEM BLUE CROSS SILVER
Monthly Premium** (Single coverage)*	\$ 274.32	\$ 263.10	\$ 345.28	\$1,037.76	\$ 682.38	\$ 1,166.11	\$ 273.10
Call for Info	(800) 464-4000	(800) 776-4466	(800) 275-4737	(800) 676-6976	(833) 848-8729	(800) 288-2539	(800)288-2539
Medical Group No.	114416/605629	W0054321	50874S	44293A	CAEGR017	26520W/CA012GRX	26520G
Local Network	Kaiser Permanente	BFMC, QualCare IPA, & Delano Medical Group	BFMC, Dignity Health & Independence	BFMC, Dignity Health, & Independence	Anthem Medicare Preferred (Nationwide)	Anthem Blue Cross	Anthem Blue Cross
Medicare Assignment Required	Yes - Medical Yes - Prescription	Yes - Medical Yes - Prescription	Yes - Medical Yes - Prescription	No - Medical Yes - Prescription	Yes - Medical Yes - Prescription	No - Medical Yes - Prescription	No - Medical
Office visits	\$ 10	\$ 0 PCP \$ 10 Specialists \$ 0 Teledoc Health	\$ 10	\$ 10 HMO \$ 20 PPO 30% OON (Out of Network)	\$ 0	Covers up to 20% of Allowable Charges (Medicare pays 80%)	Covers up to 20% of Allowable Charges (Medicare pays 80%)
ER visits	\$ 50 waived if admitted	\$ 50 waived if admitted	\$ 50 waived if admitted	\$ 35 HMO \$ 50 PPO 30% OON	\$ 50 waived if admitted	Covers up to 20% Allowable Charges (Medicare pays 80%)	Covers up to 20% Allowable Charges (Medicare pays 80%)
Hospital Admission	No Charge	\$150 per admission	\$200 per admission	\$ 0 HMO 10% PPO 30% OON	No charge	Covers Medicare Part A Deductible	Covers Medicare Part A Deductible
RX Retail	Up to 100-day supply: \$ 10 Generic \$ 20 Name Brand	\$ 10 Generic \$ 20 Brand \$ 20 Non-Preferred Brand 25% Injectables & Specialty Drugs (30 day)	\$ 5 Preferred Generic \$ 10 Generic \$ 20 Name Brand \$ 40 Non-Formulary \$ 0-25% Self Injectables & 25% Specialty Drugs (30 day)	\$ 10 Generic \$ 15 Name Brand \$ 35 Non-Formulary 25% Self Injectables & Specialty Drugs (30 day)	30-day supply: \$ 5 Generic \$ 10 Preferred	\$ 8 Generic \$ 12 Name Brand	NO PRESCRIPTION BENEFIT
RX Mail Order	up to 100-day supply: \$ 10 Generic \$ 20 Name Brand	\$ 20 Generic \$ 40 Brand \$ 40 Non-Preferred Brand 25% Injectables (100 day) & Specialty Drugs (30 day)	\$ 0 Generic \$ 40 Name Brand \$ 80 Non-Formulary \$ 0-25% Self Injectables & 25% Specialty Drugs (90 day)	\$ 20 Generic \$ 30 Name Brand \$ 70 Non-Formulary 25% Self Injectables & Specialty Drugs (90 day)	90-day supply: \$ 5 Generic \$ 10 Preferred	90-day supply \$ 0 Generic \$ 6 Name Brand	
Deductibles	None	None	Paid by plan	HMO: None PPO: None OON: \$200/Ind \$600/Fam	None	Member pays Medicare Part B Deductible	Member pays Medicare Part B Deductible
Lifetime Max	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	\$ 1 Million	\$ 1 Million
Vision	\$150 allowance every 24 months	Std Lenses: No charge Frames: \$100 / 2 yrs	Lenses: 12 months Frames: \$100 / 12 months	HMO: Eye exam \$ 10 Lenses / Frames: No benefit	Lenses: \$0 per year Frames: \$100 / 2 yrs	No Benefit	No Benefit
Self-Refer	Optometry, OB/GYN, Behavioral Health	OB/GYN	OB/GYN: 1 visit / yr	HMO/PPO: OB/GYN OON: Preventative covered with 30%	Yes – No limit	Yes - No Limit	Yes - No Limit
Dental	No Benefit	No Benefit	Limited Dental services / supplies	Limited Dental services / supplies	No Benefit	No Benefit	No Benefit

Your actual premium cost could be less if you are eligible for the County Stipend contribution of \$39.75 (single); \$53.69 (two); or \$61.50 (family). * Premiums are per person enrolled.

**** Rates are all subject to final approval by CMS and the California Dept. of Managed Care. This is a summary of the most frequently asked-about benefits.**