

Retiree Health Plan Summaries

PARTICIPANTS OVER AGE 65

PLAN YEAR 2026

NOTE:

- **TO BE ELIGIBLE TO ENROLL IN THESE PLANS, YOU MUST HAVE BOTH MEDICARE PART A & B**
- **FOR CURRENT PARTICIPATING PHYSICIAN INFORMATION, PLEASE CONTACT EACH PLAN DIRECTLY.**

This summary is for informational purposes only. Members should review complete plan document prior to enrolling in a health plan. If any item differs between these summaries and any plan documents, the plan document will govern.

This page intentionally left blank

KAISER PERMANENTE SENIOR ADVANTAGE GROUP # 114416

- Chiropractic Visit: \$10 copay, up to 30 visits per calendar year
- Hearing Aid Allowance: \$500 per aid, every 36 months
- \$10 copayment for medical primary care and specialty care office visit
- No charge for routine physical exams
- \$10 copayment for routine eye exam with a Plan Optometrist
- \$10 copayment for outpatient surgery and certain other outpatient procedures
- No charge for most X-Rays and laboratory tests.
- No copayment for inpatient hospital services
- \$50 copayments for in area emergency services, specified coverage for out of area emergency services, waived if admitted. Worldwide coverage.
- \$50 ambulance copayment per trip
- 20% coinsurance for durable medical equipment, or prosthesis, limited to items covered by Medicare.
- No charge for Home Health Care (part-time, intermittent)
- No charge for skilled nursing facility care, up to 100 days per benefit period
- \$150 allowance toward eyeglasses or contact lenses, fitting and dispensing every 24 months at Kaiser optical departments.
- One Pass will be available to Senior Advantage members beginning 1/1/2025. One Pass can help you stay active and thrive with competitive pricing starting at \$10 a month. Register at youronepass.com.
- Healthy meals delivered to your home immediately following an inpatient stay at a hospital or skilled nursing facility. Up to 84 meals covered, all at no cost.
- Get a ride to and from your appointments at no cost. Your plan covers up to 24 one-way trips (50 miles per trip) per calendar year. To schedule a ride, call 1-877-930-1477 or 1-833-226-6760 for wheel or gurney services.
- For services subject to the maximum, you will not pay anymore Cost Share for the rest of the calendar year if the Copayments and Coinsurance you pay for those Services add up to the following amount: For any one Member \$1,000 per calendar year.
- **Prescription Drug Benefit**
 - \$10 generic copayment for prescriptions from plan pharmacy (up to 100-day supply)
 - \$20 Name Brand copayment for prescriptions from plan pharmacy (up to 100-day supply)

For additional plan information, please contact Kaiser Member Services at (800) 464-4000
FOR ENROLLMENT FORMS, PLEASE CONTACT KERN COUNTY HEALTH & WELLNESS AT (661) 868-3182



BLUE SHIELD 65 PLUS

GROUP # W0054321

Large 18 county service area which we offer Blue Shield 65 Plus:

Alameda, Contra Costa*, Kern, Los Angeles, Merced, Nevada*, Orange, Riverside, San Bernardino, San Diego, San Francisco, San Joaquin, San Luis Obispo, San Mateo, Santa Barbara, Santa Clara, Santa Cruz, and Stanislaus. *Partial County

- \$ 0 Co-payment for Primary Care Physicians office visits
- \$ 0 Co-payment for Annual Physical Exam
- \$ 0 Co-payment for Teledoc Health visits
- \$ 10 Co-payment for Specialists office visits
- \$ 0 Co-payment for X-Ray and Lab services
- \$ 0 Co-payment for Durable Medical Equipment
- \$150 Co-payment for each Inpatient hospital admission
- \$ 50 Co-payment for Emergency Care, waived if admitted
- \$ 30 Co-payment for Urgent Care Services
- \$ 0 Co-payment for Ambulance Services
- \$ 0 Co-payment for Outpatient Surgery in an Ambulatory Surgery Center
- \$ 10 Co-payment for routine Vision and routine Hearing exams (1 per year)
- Eyewear: Lenses covered (in full or subject to an eyewear allowance).
 - \$100 Frame Allowance every 2 years.
- Silver Sneakers Fitness program offered at NO additional cost.
 - Unlimited access to all 13,000 locations nationwide.

- **Prescription Drug Benefit**

(No deductible and Full coverage – NO coverage gap/doughnut hole)

	Retail Pharmacy (30- day supply)	Home Delivery (100-day supply)
Tier 1 – Generics	\$ 10 copay	\$ 20 copay
Tier 2 – Preferred Brand	\$ 20 copay	\$ 40 copay
Tier 3 – Non-Preferred Brand	\$ 20 copay	\$ 40 copay
Tier 4 – Injectables	25%	25%
Tier 5 – Specialty*	25%	25%*

* Limited up to maximum of 30-day supply per fill.

Local Kern County Providers:

Bakersfield Family Medical Center (BFMC), Delano Medical Group, or QualCare IPA

For additional plan information, please contact Blue Shield at 1-800-776-4466 (TTY: 711)

FOR ENROLLMENT FORMS, PLEASE CONTACT KERN COUNTY HEALTH & WELLNESS AT (661) 868-3182



HEALTH NET SENIORITY PLUS

GROUP # 50874S

- \$ 10 copayment for office visits (at participating provider group)
- \$ 10 copayment for specialist services (when determined medically necessary)
- No charge for x-ray, laboratory procedures and mammography
- No charge for durable medical equipment
- \$200 for hospital stays (semi-private or intensive care) per admission
- \$ 50 copayment for emergency room, waived if admitted.
- \$ 50 copayment for urgent care facility
- \$ 10 copayment for vision and hearing exams
- \$100 frame allowance (once every 12 months). Lenses every 12 months.
- \$ 10 copayment for routine chiropractic care (20 visits per calendar year)
- \$ 10 copayment for chiropractic care, limited to the Medicare-allowed chiropractic benefit. Authorized by your participating provider group.
- Prescription (30-day supply)
 - \$ 5 copay Preferred Generic
 - \$ 10 copay Generic
 - \$ 20 copay Brand Name
 - \$ 40 copay Non-formulary: Brand or Generic
 - \$ 0 - 25% copay for Self-Injectables
 - 25% copay for Specialty Drugs
- Limited dental services ~ Plan 8R (contact Health Net for specifics)

Local Kern County providers:

Dignity Health Medical Network, Bakersfield Family Medical Center, Independence Medical Group.

For additional plan information, please call Health Net at (800) 275-4737

FOR ENROLLMENT FORMS, PLEASE CONTACT **KERN COUNTY HEALTH & WELLNESS** AT (661) 868-3182



HEALTH NET MEDICARE COB POS

GROUP #44293A

This plan allows you freedom and flexibility. You decide what your benefit will be each time you need services. You have three levels to choose from:

- **Level 1:** For the highest benefit, use the HMO Level, which utilizes Dignity Health Medical Group, Bakersfield Family Medical Center or Independence Medical Group doctors.
- **Level 2:** You may also use the PPO Level, which are other doctors contracted with Health Net.
- **Level 3:** If you prefer to use a doctor that is not associated with Health Net at all, the plan will pay up to 70% of usual charges, after deductible, for covered services.

HMO – Level 1	PPO – Level 2	OUT OF NETWORK – Level 3 **
• No deductible • \$10 copy Office Visits • \$10 copay for routine Vision/Hearing exam • Prescription (30-day supply) ➢ \$10 copay Generic ➢ \$15 copay Brand Name ➢ \$35 copay Non-Formulary ➢ 25% copay Self Injectables ➢ 25% copay Specialty Drugs ① • No charge for X-Rays, Labs • No charge for Durable Medical Equipment (DME) • No charge for Hospitalizations • \$35 copay for Emergency Room or Urgent Care • Unlimited Benefit Maximum	• No deductible • \$20 copay for Office Visits • Vision/Hearing Exam not covered • Prescription (30-day supply) ➢ \$10 copay Generic ➢ \$15 copay Brand Name ➢ \$35 copay Non-Formulary ➢ 25% copay Self Injectables ➢ 25% copay Specialty Drugs① • 90% of contract rates for X-Rays & Labs • 50% for Durable Medical Equipment (DME) • 90% of contract rates for Hospitalizations ② • \$50 facility copay for Emergency/Urgent Care, plus 10% for Professional Services • Unlimited Benefit Maximum	• Deductible: \$200 Individual/ \$600 family per calendar year • 70% of MMA coverage for Office Visits • Vision/Hearing Exam not covered • Prescription (30-day supply) ➢ \$10 copay Generic ➢ \$15 copay Brand Name ➢ \$35 copay Non-Formulary ➢ 25% copay Self Injectables ➢ 25% copay Specialty Drugs ① • 70% of MMA for X-Rays & Labs • Durable Medical Equipment (DME) not covered • 70% of MMA for Hospitalizations ② • 70% of MMA for Emergency Room or Urgent Care facility • Unlimited Benefit Maximum
① All prescriptions must be filled at a participating pharmacy ② Pre-Certification is required on certain services, including scheduled hospitalizations. ** Members are responsible for any amount exceeding Maximum Amount Allowed (MAA)		

For additional plan information, please call Health Net at (800) 676-6976

FOR ENROLLMENT FORMS, PLEASE CONTACT KERN COUNTY HEALTH & WELLNESS AT (661) 868-3182

Only for participants over age 65 or Medicare eligible



ANTHEM BLUE CROSS MEDICARE PREFERRED (PPO)

GROUP # CAEGR017

THIS PLAN IS A NEW OFFERING FOR 2026 PLAN YEAR

Plan Features:	In-Network members pay:	Out-of-Network members pay:
Annual medical deductible	\$0 combined in-network and out-of-network	
Maximum out-of-pocket responsibility (Does not include Part D prescription drugs)	\$3,400 combined in-network and out-of-network	
Covered Benefits:	In-Network members pay:	Out-of-Network members pay:
Inpatient hospital care		
No limit to the number of days covered by the plan	\$0 copay per admission	\$0 copay per admission
Outpatient hospital facility	\$0 copay per visit	\$0 copay per visit
Outpatient hospital services observation room	\$0 copay per visit	\$0 copay per visit
Primary care office visit	\$0 copay per visit	\$0 copay per visit
Specialty care office visit	\$0 copay per visit	\$0 copay per visit
Preventive care, screenings and tests	\$0 copay per visit	\$0 copay per visit
Emergency care	\$50 copay per visit \$50 copay is waived if the member is admitted to the hospital within 72 hours for the same condition.	
Urgently needed services	\$0 copay per visit	\$0 copay per visit
X-Ray visit and/or simple diagnostic test	\$0 copay per visit	\$0 copay per visit
Complex diagnostic test	\$0 copay per visit	\$0 copay per visit
Skilled Nursing Facility	\$0 copay of days 1-100 per benefit period (100-day limit per benefits period)	\$0 copay of days 1-100 per benefit period (100-day limit per benefits period)
Prescription Drugs:	Network Pharmacy per 30-day supply	Mail-Order pharmacy per 90-day supply
Tier 1: Select Generics	\$0	\$0
Tier 1: Generics	\$5	\$5
Tier 2: Preferred Drugs	\$10	\$10
Tier 3: Non-Preferred Drugs, including Specialty Drugs	\$10	\$30

For additional plan information, please contact Anthem Blue Cross at (833) 848-8729.

FOR ENROLLMENT FORMS, PLEASE CONTACT KERN COUNTY HEALTH & WELLNESS AT (661) 868-3182

Only for participants over age 65 or Medicare eligible



ANTHEM BLUE CROSS GOLD

ASSURANCE 90 WITH PRESCRIPTION

MEDICAL GROUP# 26520W

PRESCRIPTION GROUP # CA012GRX

- Hospitalization benefit includes payment of portions of the Medicare Part A deductible for in-patient care and certain out-patient benefits.
- Coinsurance payment for Skilled Nursing Facility care for the 21st through 100th day during each benefit period
- Certain hospital inpatient benefits for mental or nervous disorders up to 190 days during each member’s lifetime
- Physical Therapy and occupational therapy, limited to our combined maximum payment of \$100.00 for each member during any year.
- After the Medicare Part B deductible is met by the member each year, payment of the physician 20% of Medicare's allowable charges for certain services.
- Certain out of country emergency services up to 90 days per lifetime.
- Lifetime maximum of \$1,000,000.00
- Prescription Benefits:

	Retail Pharmacy (30-day supply)	Mail Order Pharmacy (90-day supply)*
Generics	\$ 8 copay	\$ 0 copay
Preferred Brand	\$12 copay	\$ 6 copay

For additional plan information, please contact Anthem Blue Cross at (800) 288-2539
FOR ENROLLMENT FORMS, PLEASE CONTACT KERN COUNTY HEALTH & WELLNESS AT (661) 868-3182

Only for participants over age 65 or Medicare eligible



ANTHEM BLUE CROSS SILVER

ASSURANCE 90

WITHOUT PRESCRIPTION COVERAGE

GROUP # 26520G

Summary information about Anthem Blue Cross Silver Plan is as follows:

- Hospitalization benefit includes payment of portions of the Medicare Part A deductible for in-patient care and certain out-patient benefits
- Coinsurance payment for Skilled Nursing Facility care for the 21st through 100th day during each benefit period
- Certain hospital inpatient benefits for mental or nervous disorders up to 190 days during each members lifetime
- Physical Therapy and occupational therapy, limited to our combined maximum payment of \$100.00 for each member during any year.
- After the Medicare Part B deductible is met by the member each year, payment of the physician 20% of Medicare's allowable charges for certain services.
- Certain out of country emergency services up to 90 days per lifetime.
- Lifetime maximum of \$1,000,000.00
- **NO PRESCRIPTION DRUG COVERAGE** – Even if you don't take prescription drugs currently, you should consider purchasing an individual Medicare drug plan (Part D) to avoid a Medicare penalty for no prescription drug coverage.

For additional plan information, please contact Anthem Blue Cross at (800) 288-2539
FOR ENROLLMENT FORMS, PLEASE CONTACT **KERN COUNTY HEALTH & WELLNESS** AT (661) 868-3182

This page intentionally left blank