

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 2027	KAISER Senior Advantage (HMO)	BLUE SHIELD 65 Plus (HMO)	HEALTH NET Seniority Plus (HMO)	HEALTH NET COB POS (3-Tiered Point of Service)	ANTHEM BC Medicare Preferred (PPO)	ANTHEM BC Gold (Supplemental w/Rx)	ANTHEM BC Silver (Supplemental w/No Rx)
Monthly Premium** (Single / Two-Party)	\$ 274.32 \$ 548.43	\$ 275.84 \$ 551.68	\$ 370.95 \$ 741.90	\$ 1,037.76 \$ 2,075.52	\$ 719.78 \$ 1,439.56	\$ 1,252.99 \$ 2,506.15	\$ 330.70 \$ 663.63
Call for more info:	(800) 443-0815	(800) 776-4466	(800) 275-4737	(800) 676-6976	(833) 848-8729	(800) 288-2539	(800) 288-2539
Plan Group No:	114416 605629	W0054321	50874S	44293A	CAEGR017	26520W/CA012GRX	26520G
Local Network:	Kaiser Permanente Service Area: California	BFMC, Delano Med Group Service Area: California	BFMC, Dignity Health, Independence Service Area: California	BFMC, Dignity Health, Independence Service Area: California	Anthem Blue Cross Service Area: Nationwide	Anthem Blue Cross Service Area: Nationwide	Anthem Blue Cross Service Area: Nationwide
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
Annual Deductible:	No Deductible	No Deductible	No Deductible	HMO PPO: No Deductible Out-of-Network (OON) \$200 Ind \$600 Fam	In/Out-of-Network: No Deductible	Member Pays Medicare Part B Deductible	Member Pays Medicare Part B Deductible
Office Visits:	\$10 PCP \$10 Specialist	\$0 PCP \$10 Specialist \$0 Teladoc Health	\$10 PCP \$10 Specialist	\$10 HMO \$20 PPO *30% OON	In or Out-of-Network Medicare Providers \$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 + 10% Professional-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:	\$0	\$150/admission	\$200/admission	\$0 HMO 10% PPO *30% OON	\$0	Plan Covers Medicare Part A Deductible	Plan Covers Medicare Part A Deductible
Prescription Coverage (Retail):	up to 100-day \$10 Generic \$20 Brand-name	Preferred Retail 30-day \$10 Generic \$20 Preferred Brand \$20 Non-Preferred 25% Injectables 25% Specialty	30-day \$5 Generic \$20 Preferred Brand \$40 Non-Preferred 25% Specialty \$0 Injectable Vaccines	30-day / 90-day \$10 / \$30 Generic \$15 / \$45 Preferred \$35 / \$105 Non-Preferred 25% Specialty (30-day)	30-day / 90-day \$0 Select Generic \$5 / \$15 Generic \$10 / \$30 Preferred \$10 / \$30 Non-Preferred \$10 / \$30 Specialty	Up to 90-day or 100 units \$0 Select Generics \$8 Generic \$12 Preferred \$12 Non-Preferred \$12 Specialty	NO PRESCRIPTION BENEFIT
Prescription Coverage (Mail Order):	up to 100-day \$10 Generic \$20 Brand-name	Preferred Retail 100-day \$20 Generic \$40 Preferred Brand \$40 Non-Preferred 25% Injectables	90-day \$0 Generic \$40 Preferred Brand \$80 Non-Preferred	30-day / 90-day \$10 / \$20 Generic \$15 / \$30 Preferred \$35 / \$70 Non-Preferred 25% Specialty (30-day)	90-day \$0 Select Generic \$5 Generic \$10 Preferred \$10 Non-Preferred	Up to 90-day or 100 units \$0 Select Generics \$6 Generic \$6 Preferred \$6 Non-Preferred \$6 Specialty	
Self-Referral:	Optometry, OB/GYN, Behavioral Health	OB/GYN	OB/GYN: 1 visit/yr	HMO PPO: OB/GYN *OON: Preventive Svcs	Yes – No limit	Yes - No Limit	Yes - No Limit
Lifetime Max:	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	\$1 Million	\$1 Million
Vision:	Eyeglasses Allowance: \$150/24 months	Annual Eye Exam \$10 Frame Allowance: \$100/2 yrs	Routine Eye Exam: \$10/calendar yr Frame Allowance: \$100/12 months	HMO Only: Vision Exam \$10	In-Network Vision Exam: \$0/calendar yr Eyewear Allowance: \$100/2 yrs	No Benefit	No Benefit
Dental:	No Benefit	Limited coverage for Medicare-covered svcs	Preventive dental svcs: \$0	No Benefit	Limited coverage for Medicare-covered svcs	No Benefit	No Benefit

This is a summary of the most frequently asked about benefits. *Coinsurance applies after the deductible is met. **Rates are subject to final approval by CMS and the California Department of Managed Health Care. Your premium cost could be less if you are eligible for the County Stipend contribution of \$39.75 (single), \$53.69 (two-party), or \$61.50 (family).

For questions or to request enrollment forms, call Kern County Health & Wellness at **(661) 868-3182** or visit **www.kerncountyhealthbenefits.com**. Enrollment forms require original signatures.