



2025 Traditional Medical Plans

January 1 – December 31, 2025



Benefit Features						
	UHC/UMR Select Plus Plan PPO		UHC SignatureValue Performance HMO – Network 1	UHC SignatureValue CS VEBA Alliance HMO	Kaiser Permanente (HMO)	SIMNSA Mexico HMO
	PPO Network Self-referred (within UHC PPO network)	Out-of-Network Self-referred (outside PPO network)	HMO Network 1 PCP Referred (within HMO medical group)	UHC Network PCP Referred (within HMO medical group)	HMO Network PCP Referred (within Kaiser network)	SIMNSA Network PCP Referred (within SIMNSA network)
Provider Networks			Sharp, Rady	Scripps, Rady, UCSD	Kaiser	Mexico Only
Annual Deductible*						
• Individual	\$300	\$600	None	None	None	None
• Maximum Per Family	\$600	\$1,200	None	None	None	None
Annual Out-of-Pocket Maximum (Excludes Deductible)						
• Individual	\$2,300	\$4,600	\$2,000	\$2,000	\$1,500	\$6,350
• Family	\$4,600	\$9,200	\$6,000	\$6,000	\$3,000	\$12,700
Out-of-Hospital Services						
• Office Visits	You pay \$20 per visit (deductible waived)	You pay 40% after deductible	You pay \$25 copay	You pay \$25 copay	You pay \$25 copay	You pay \$7 copay
• Specialist Visits	You pay \$40 per visit (deductible waived)	You pay 40% after deductible	You pay \$25 copay	You pay \$40 copay	You pay \$25 copay	You pay \$7 copay
• Urgent Care Facility	\$75 copay (deductible waived)	You pay 40% after deductible	You pay \$25 copay	You pay \$25 copay	You pay \$25 copay	If care received in Mexico: \$25 copay; If care received in U.S.: \$50 copay
Preventative Care						
• Well-Baby/Well-Child	No Copay	You pay 40% after deductible	No Copay	No Copay	No Copay	No Copay
• Adult Physical Exam	No Copay		No Copay	No Copay	No Copay	No Copay
• Well-Woman Care	No Copay		No Copay	No Copay	No Copay	No Copay
• Prostate Cancer Screening	No Copay		No Copay	No Copay	No Copay	No Copay
• Colorectal Cancer Screenings	No Copay		No Copay	No Copay	No Copay	No Copay

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Lab/X-Rays/ Diagnostics						
• Preventive Diagnostic X-Ray/ Lab	100% covered	You pay 40% after deductible	100% covered	100% covered	No copay	No Copay
• Outpatient CT, PET, MRI, MRA, and Nuclear Medicine	You pay 20% after deductible	You pay 40% after deductible	No copay	No copay	No copay	No Copay
In-Hospital Services						
• Semiprivate Room and Board (Precertification required)	You pay \$150 copay per admission; then you pay 20% after deductible	You pay \$300 copay per admission; then you pay 40% after deductible	You pay \$200 per admission	You pay \$200 per admission	You pay \$100 per admission	No Copay
• Emergency Room	You pay \$125 (waived if admitted); then 20% after deductible	You pay \$125 (waived if admitted); then 20% after deductible	You pay \$125 (waived if admitted)	You pay \$125 (waived if admitted)	You pay \$125 (waived if admitted)	You pay \$250 copay (waived if admitted)
Other Services						
• Outpatient Surgery	You pay 20% after deductible	You pay 40% after deductible	No copay	You pay \$100 copay	You pay \$25 per procedure	No Copay
• Durable Medical Equipment	You pay 20% after deductible	You pay 40% after deductible	No copay	No copay	No copay	No Copay
• Skilled Nursing Facility	You pay 20% after deductible; precertification required; maximum 100 days a year	You pay 50% after deductible; precertification required; maximum 100 days a year	No copay; maximum 100 days a year	No copay; maximum 100 days a year	No copay; maximum 100 days a year	You pay \$10 copay; available on the SIMNSA campus only; no maximum days limit
• Physical/ Occupational/ Speech Therapy	You pay \$20 copay	You pay 40% after deductible	You pay \$25 copay	You pay \$25 copay	You pay \$25 copay	You pay \$10 copay
• Chiropractic Care/ Acupuncture	You pay \$20 copay for chiropractic care; you pay 20% after the deductible for acupuncture	You pay 40% after deductible	You pay \$20 copay; unlimited visits	You pay \$20; unlimited visits	Not covered; discounts available through www.kp.org	Chiropractic care not covered; Acupuncture: You pay \$10 copay; unlimited visits
Mental Health & Substance Abuse						
• Outpatient Physician Visits	You pay \$20 per visit	You pay 40% after deductible	You pay \$25 copay for physician No charge for SA	You pay \$25 per visit No charge for SA	\$25 copay per individual visit \$12 copay per group visit for MH \$5 copay per group visit for SA	You pay \$7 copay for physician
• Inpatient Physician Visits	You pay 20% after deductible	You pay 40% after deductible	You pay \$200 per admission	You pay \$200 per admission	You pay \$100 per admission	No Copay

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Prescription Drug Benefits						
Retail (up to 30-day supply)						
• Tier 1/Generics	You pay \$10 copay				You pay \$10 copay	You pay \$10 copay
• Tier 2/Brand	You pay \$20 copay				You pay \$25 copay	You pay \$10 copay
• Tier 3/Brand Non-Formulary	You pay \$35 copay				If prescribed by KP physician, covered at the brand copay	You pay \$10 copay
• Tier 4/Specialty	Above applicable copays apply				You pay \$25 copay	You pay \$10 copay
Mail-Order						
• Tier 1/Generics	You pay \$20 copay for up to 90-day supply				\$20 copay for up to 100-day supply	Not covered
• Tier 2/Brand	You pay \$40 copay for up to 90-day supply				\$50 copay for up to 100 day supply	
• Tier 3/Brand Non-Formulary	You pay \$60 copay for up to 90-day supply				You pay if prescribed by KP physician, covered at the brand copay for up to a 30-day supply	
• Tier 4/Specialty	Above applicable copays apply				\$25 copay for up to 30 days	
Cost For Coverage (Per Pay Period)**						
• Employee Only	\$739.10		\$416.85	\$399.94	\$372.56	\$139.22
• Employee +1 Dependent	\$1,478.21		\$833.38	\$799.55	\$745.12	\$244.54
• Employee +2 or more Dependents	\$2,091.71		\$1,179.06	\$1,131.19	\$1,054.35	\$359.45

* All references to “annual” and “per year” on this chart refer to policy year of January 1 through December 31, 2025.

** Based on 24 pay periods in the year/twice a month deductions.

THIS COMPARISON CHART IS NOT A CONTRACT

The Comparison Chart is a summary of general benefits available to County of San Diego eligible employees. Wherever conflicts occur between the contents of this Comparison Chart and the Plan terms, than the Evidence of Coverage (EOC) plan document shall prevail. Space does not permit listing all limitations and exclusions that apply to each plan. Before using your benefits, call the insurance carrier for more information.