2024
High Deductible Medical Plans

January 1 – December 31, 2024

Benefit Features		
	UnitedHealthcare (UHC) Harmony HDHP with Health Savings Account (HSA) Option	**Kaiser Permanente HDHP** with Health Savings Account (HSA) Option
	UHC Harmony HDHP Network PCP Referred (within the UHC Harmony HDHP network)	**Kaiser Permanente Network** PCP Referred (within the Kaiser network)
Choice of Provider	Must receive services from your Primary Care Physician (PCP) or be referred by your PCP to specialist within the same medical group. **PCP must be a member of the UHC Harmony HDHP Network: Sharp, UCSD**	Your choice of Kaiser Permanente physicians and providers. Must receive services from your Primary Care Physician (PCP) or be referred by your PCP to specialist within the same medical group.
Annual* Deductible		
• Employee only coverage (Annual Deductible includes Medical Care and copay Drug Benefits)	$2,700	$1,600
• Employee plus family coverage (Annual Deductible includes Medical Care and copay Drug Benefits)	$3,200 per individual $3,200 per family**	$3,200 per individual $3,200 per family**
Annual Out-of-Pocket Maximum (Includes Deductible)		
• Individual • Family	$3,200 $6,000	$3,200 $6,400
Out-of-Hospital Services		
• Office Visits	You pay 10% after deductible	You pay 10% after deductible
• Specialist Visits	You pay 10% after deductible	You pay 10% after deductible
• Urgent Care Facility	You pay 10% after deductible	You pay 10% after deductible
Preventative Care		
• Well-Baby/Well-Child	No copay or deductible	No copay or deductible
• Adult Physical Exam	No copay or deductible	No copay or deductible
• Well-Woman Care	No copay or deductible	No copay or deductible
• Prostate Cancer Screening	No copay or deductible	No copay or deductible
• Colorectal Cancer Screenings	No copay or deductible	No copay or deductible
• Diagnostic X-Rays and Lab Tests	No copay or deductible	No copay or deductible
In-Hospital Services		
• Semiprivate Room and Board (Precertification required)	You pay 10% after deductible	You pay 10% after deductible
• Emergency Room	You pay 10% after deductible	You pay 10% after deductible

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Other Services		
• Outpatient Surgery	You pay 10% after deductible	You pay 10% after deductible
• Durable Medical Equipment	You pay 10% after deductible	You pay 10% after deductible; benefit limited to $2,500 per plan year
• Prosthetic Devices	You pay 10% after deductible	No charge after deductible
• Skilled Nursing Facility (Maximum 100 days per year)	You pay 10% after deductible	You pay 10% after deductible
• Physical/ Occupational/ Speech Therapy	You pay 10% after deductible	You pay 10% after deductible
• Chiropractic Care	$30 copay	Not covered. Discounts available through www.kp.org
Mental Health & Substance Abuse		
• Outpatient Physician Visits	You pay 10% after deductible	You pay 10% after deductible
• Inpatient Physician Visits	You pay 10% after deductible	You pay 10% after deductible
Prescription Drug Benefits	**All prescription drug benefits are subject to the plan deductible**	
Retail (up to 30-day supply)		
• Generic (Tier 1)	$10 copay	$10 copay after deductible
• Brand (Tier 2)	$20 copay	$30 copay after deductible
• Non-Formulary (Tier 3)	$35 copay	If prescribed by KP physician, covered at the brand copay
• Specialty Rx (Tier 4)	Above applicable copays apply	$30 copay
Mail-Order		
• Generic (Tier 1)	$20 copay for up to 90-day supply	$20 copay for a 31 to 100 day supply
• Brand (Tier 2)	$40 copay for up to 90-day supply	$60 copay for a 31 to 100 day supply
• Non-Formulary (Tier 3)	$60 copay for up to 90-day supply	Not covered
• Specialty Rx (Tier 4)	Above applicable copays apply	Not covered
Cost For Coverage Per Pay Period***		
• Employee Only	$236.70	$291.72
• Employee +1 Dependent	$470.69	$583.44
• Employee +2 or more Dependents	$663.79	$825.57
Health Savings Account Option		
• Individual Contribution Maximum for 2024	$4,150	$4,150
• Family Contribution Maximum for 2024 (Family includes employee plus one or more dependents)	$8,300	$8,300

* *All references to "annual" and "per year" on this chart refer to policy year of January 1 through December 31, 2024.*

** *The individual deductible included in family coverage will not exceed $3,200 for 2024. If one member of the family reaches $3,200, co-insurance goes into effect for all family members.*

*** *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.