2021
High Deductible Medical Plans
January 1 – December 31, 2021

Benefit Features			
	UnitedHealthcare (UHC)		**Kaiser Permanente**
	High Deductible Plan with Health Savings Account Option		**High Deductible Plan with Health Savings Account Option**
	In-Network ***Self-Referred*** (within UHC network)	**Out-of-Network** ***Self-Referred*** (outside network)	**Kaiser Permanente Network** ***PCP Referred*** (within Kaiser Network)
Choice of Provider	May obtain care directly from any UHC Network Provider.	May obtain care from any other provider. However, you pay the highest costs when you use this level under the plan.	Your choice of Kaiser Permanente physicians and providers.
Annual Deductible*			
• Employee only coverage (Annual Deductible includes Medical Care and copay Drug Benefits)	$2,700	$3,000	$1,500
• Employee plus family coverage (Annual Deductible includes Medical Care and copay Drug Benefits)	$2,800 per individual $3,000 per family	$3,000 per individual $6,000 per family	$2,800 per individual $3,000 per family
Annual Out-of-Pocket Maximum (Includes Deductible)	$3,000 per individual $6,000 per family	$9,000 per individual $18,000 per family	$3,000 per individual $6,000 per family
	In-Network and Out-of-Network Maximums are separate and are exclusive of each other.		
Out-of-Hospital Services			
• Office Visits	You pay 10% after deductible	You pay 30% after deductible	You pay 10% after deductible
• Specialist Visits	You pay 10% after deductible	You pay 30% after deductible	You pay 10% after deductible
• Urgent Care Facility	You pay 10% after deductible	You pay 30% after deductible	You pay 10% after deductible
Preventative Care			
• Well-Baby/Well-Child	No copay or deductible	You pay 30% after deductible	No copay or deductible
• Adult Physical Exam	No copay or deductible	You pay 30% after deductible	No copay or deductible
• Well-Woman Care	No copay or deductible	You pay 30% after deductible	No copay or deductible
• Prostate Cancer Screening	No copay or deductible	You pay 30% after deductible	No copay or deductible
• Colorectal Cancer Screenings	No copay or deductible	You pay 30% after deductible	No copay or deductible
• Specialty X-rays, (CT, MRI, PET) **Precertification Required**	No copay or deductible	You pay 10% after deductible	You pay 10% after deductible
• Diagnostic X-Rays and Lab Tests	No copay or deductible	You pay 30% after deductible	You pay 10% after deductible
In-Hospital Services			

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• Semiprivate Room and Board (Precertification required)	You pay 10% after deductible	You pay 30% after deductible	You pay 10% after deductible
• Emergency Room	You pay 10% after deductible	You pay 10% after deductible	You pay 10% after deductible
Outpatient Surgery	You pay 10% after deductible	You pay 30% after deductible	You pay 10% after deductible
Durable Medical Equipment	You pay 50% after deductible	You pay 50% after deductible	You pay 10% after deductible; benefit limited to $2,500 per plan year
Prosthetic Devices	You pay 10% after deductible	You pay 30% after deductible	No charge after deductible
Skilled Nursing Facility (Maximum 100 days per year)	You pay 10% after deductible	You pay 30% after deductible	You pay 10% after deductible
Mental Health & Substance Abuse			
• Outpatient Physician Visits	You pay 10% after deductible	You pay 30% after deductible	You pay 10% after deductible
• Inpatient Physician Visits	You pay 10% after deductible	You pay 30% after deductible	You pay 10% after deductible
Physical/ Occupational/ Speech Therapy	You pay 10% after deductible, limit 20 visits per calendar year	You pay 30% after deductible, limit 20 visits per calendar year	You pay 10% after deductible
Chiropractic Care	You pay 10% after deductible, limit 24 visits per calendar year	You pay 30% after deductible, limit 24 visits per calendar year	Not covered. Discounts available through www.kp.org
Prescription Drug Benefits			
Retail	Up to 30-day supply		
• Generic (Tier 1)	$10 copay after deductible	$10 copay after deductible	**Generic** (after deductible) – $10 copay for a 30-day supply $20 copay for a 31 to 60 day supply $30 copay for 61 to 100 day supply
• Brand (Tier 2)	$30 copay after deductible	$30 copay after deductible	**Brand** (after deductible) – $30 copay for a 30-day supply $60 copay for a 31 to 60 day supply $90 copay for 61 to 100 day supply
• Non-Formulary (Tier 3)	$50 copay after deductible	$50 copay after deductible	**Brand Non-Formulary:** If prescribed by KP physician, covered at the brand copay for up to 30-day supply
• Non-Formulary (Tier 4)	$50 copay after deductible	$50 copay after deductible	
Mail-Order	31 to 90-day supply		
• Generic (Tier 1)	$25 copay after deductible	$25 copay after deductible	**Generic** (after deductible) – $10 copay 30-day supply $20 copay for a 31 to 100 day supply
• Brand (Tier 2)	$75 copay after deductible	$75 copay after deductible	**Brand** (after deductible) – $30 copay 30-day supply $60 copay for a 31 to 100 day supply
• Non-Formulary (Tier 3)	$125 copay after deductible	$125 copay after deductible	**Brand Non-Formulary:** Not covered
• Non-Formulary (Tier 4)	$125 copay after deductible	$125 copay after deductible	
Cost For Coverage Per Pay Period**			
• Employee Only	$514.56		$228.67

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• Employee +1 Dependent	$1,029.09		$457.34
• Employee +2 or more Dependents	$1,456.17		$647.13
Health Savings Account Option			
• Individual Contribution Maximum for 2020	$3,600		$3,600
• Family Contribution Maximum for 2020 (Family includes employee plus one or more dependents)	$7,200		$7,200

* *All references to "annual" and "per year" on this chart refer to policy year of January 1 through December 31, 2021.*

** *The individual deductible included in family coverage will not exceed $2,800 for 2021. If one member of the family reaches $2,800, co-insurance goes into effect for that person. The rest of the family only needs to meet an additional $200 deductible. At that point, the deductible is met and coinsurance goes into effect for all family members.*

*** *Excluding the third pay periods in the months of April and October.*

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.