2021 Traditional Medical Plans

January 1 – December 31, 2021

Benefit Features						
	UnitedHealthcare Select Plus Plan PPO		**SignatureValue Performance HMO – Network 1**	**SignatureValue Performance HMO – Network 2**	**SignatureValue Alliance HMO**	**Kaiser Permanente (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)	**HMO Network 2** PCP Referred (within HMO medical group)	**UHC Network** PCP Referred (within HMO medical group)	**HMO Network** PCP Referred (within HMO medical group)
Choice of Provider	May obtain care directly from any UHC PPO Network Provider.	May obtain care from any other provider. However, you pay the highest costs when you use this level under the PPO Plan.	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 HMO Network 1*****	Must receive services from your Primary Care Physician (PCP) or be referred by your PCP to specialist within the same medical group. *****PCP can be selected from the UHC Care HMO Network 2*****	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 HMO Network*****	Your choice of Kaiser Permanente physicians and providers.
Annual Deductible*						
• Individual	$300 per individual	$600 per individual	None	None	None	None
• Maximum Per Family	$600 per family	$1,200 per family	None	None	None	None
Annual Out-of-Pocket Maximum (Excludes Deductible)	$2,300 per individual	$4,600 per individual	$2,000 per individual	$5,000 per individual	$2,000 per individual	$1,500 per individual
	$4,600 per family	$9,200 per family	$6,000 per family	$10,000 per family	$6,000 per family	$3,000 per family
Out-of-Hospital Services						
• Office Visits	You pay $20 per visit (deductible waived)	You pay 40% after deductible	You pay $25 copay	You pay $30 copay	You pay $25 copay	You pay $25 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 $40 copay	You pay $25 copay
• Urgent Care Facility	$125 copay (deductible waived)	You pay 40% after deductible	You pay $25 copay within Medical Group; you pay $40 copay Outside Medical Group	You pay $30 copay within Medical Group; you pay $100 Outside Medical Group	You pay $25 within area served by medical group; you pay $40 outside area served by medical group	You pay $25 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
Lab/X-Rays/ Diagnostics						
• Preventive Diagnostic X-Ray/Lab	100% covered	You pay 40% after deductible	100% covered	100% covered	100% covered	No copay
• Outpatient CT, PET, MRI, MRA, and Nuclear Medicine	You pay 20% after deductible	You pay 40% after deductible	No copay	You pay $200 copay	No copay	No copay

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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 $500 per admission	You pay $200 per admission	You pay $100 per admission
• Emergency Room	You pay $75 (waived if admitted directly from the ER); then you pay 20% after deductible	You pay $75 (waived if admitted directly from the ER) admission; then you pay 20% after deductible	You pay $125 (waived if admitted)	You pay $200 (waived if admitted)	You pay $125 (waived if admitted)	You pay $125 (waived if admitted)
Outpatient Surgery	You pay 20% after deductible	You pay 40% after deductible	No copay	You pay $250 copay	You pay $100 copay	You pay $25 per procedure
Durable Medical Equipment	You pay 20% after deductible	You pay 40% after deductible	No copay	No copay	No copay	No copay
Skilled Nursing Facility (Maximum 100 days per year)	You pay 20% after deductible; precertification required	You pay 50% after deductible; precertification required	No copay; 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
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 $30 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
• Inpatient Physician Visits	You pay 20% after deductible	You pay 40% after deductible	You pay $200 per admission	You pay $500 per admission	You pay $200 per admission	You pay $100 per admission
Physical/ Occupational/ Speech Therapy	You pay $20 copay	You pay 40% after deductible	You pay $25 copay	You pay $30 copay	You pay $25 copay	You pay $25 copay
Chiropractic Care/ Acupuncture	You pay $20 copay up to 24 visits per year for chiropractic care; you pay 20% after the deductible up to 12 visits for acupuncture (combined In- and Out-of-Network)	You pay 40% after deductible; up to 24 chiropractic care visits and 12 acupuncture visits per year	You pay $20 copay; unlimited visits	You pay $30 copay; unlimited visits	You pay $20; unlimited visits	Not covered; discounts available through www.kp.org
Prescription Drug Benefits						
Retail	**Tier 1:** You pay $10 copay for up to 30-day supply **Tier 2:** You pay $20 copay for up to 30-day supply **Tiers 3 & 4:** You pay $35 copay for up to 30-day supply					**Generics:** $10 copay for up to 30 days $20 copay for a 31 to 60 day supply $30 copay for a 61 to 100 day supply ($20 for mail order) **Brand:** $25 copay for up to 30 days $50 copay for a 31 to 60 day supply $75 copay for a 61 to 100 day supply ($50 for mail-order) **Brand NonFormulary:** If prescribed by KP physician, covered at the brand copay for up to a 30-day supply
Mail-Order	**Tier 1:** You pay $20 copay for up to 90-day supply **Tier 2:** You pay $40 copay for up to 90-day supply **Tiers 3 & 4:** You pay $60 copay for up to 90-day supply					

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Cost For Coverage (Per Pay Period)**						
• Employee Only	$629.72		$359.78	$461.28	$345.21	$292.93
• Employee +1 Dependent	$1,259.42		$719.29	$922.26	$690.14	$585.86
• Employee +2 or more Dependents	$1,782.10		$1,017.59	$1,304.75	$976.36	$828.99

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

** *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.