# 2024 Traditional Medical Plans

January 1 – December 31, 2024

| 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<br>No charge for SA | You pay $25 per visit<br>No charge for SA | $25 copay per individual visit<br>$12 copay per group visit for MH<br>$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** | $ 693.32 | | $ 388.55 | $ 372.79 | $ 373.72 | $133.86 |
| • **Employee +1 Dependent** | $1,386.65 | | $ 776.81 | $ 745.27 | $ 747.44 | $235.13 |
| • **Employee +2 or more Dependents** | $1,962.15 | | $1,099.02 | $1,054.40 | $1,057.63 | $345.62 |

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

** *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.