2027
HDHP Medical Plans

January 1 – December 1, 2027



Benefit Features	UnitedHealthcare (UHC) Harmony HDHP with Health Savings Account (HSA) Option **UHC Harmony HDHP Network** PCP Referred (within the UHC Harmony HDHP network)	Kaiser Permanente HDHP with Health Savings Account (HSA) Option **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 a specialist within the same medical group. PCP must be a member of the UHC Harmony HDHP Network: Sharp	Your choice of Kaiser Permanente physicians and providers. Must receive services from your Primary Care Physician (PCP) or be referred by your PCP to a specialist within the same medical group.
Annual* Deductible		
Employee Only Coverage (Annual Deductible includes Medical Care and copay Drug Benefits)	$2,700	$1,750
Employee + Family Coverage (Annual Deductible includes Medical Care and copay Drug Benefits)	$3,500 per individual $3,500 per family**	$3,500 per individual $3,500 per family**
Annual Out-of-Pocket Maximum (Includes Deductible)		
Individual	$3,500	$3,500
Family	$6,000	$7,000
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
Preventive 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 & Lab Tests	You pay 10% after 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
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
Outpatient CT, PET, MRI, MRA, and Nuclear Medicine	You pay 10% after deductible	You pay 10% after deductible

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Other Services (continued)		
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/Acupuncture	You pay 10% after deductible for chiropractic care; you pay 20% after deductible for acupuncture	Not covered. Discounts available through https://healthy.kaiserpermanente.org/health-wellness/fitness-offerings
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)	You pay $10 copay	You pay $10 copay after deductible
Brand (Tier 2)	You pay $20 copay	You pay $30 copay after deductible
Non-Formulary (Tier 3)	You pay $35 copay	If prescribed by KP physician, covered at the brand copay
Specialty Rx (Tier 4)	Above applicable copays apply	You pay $30 copay after deductible
Mail-Order		
Generic (Tier 1)	You pay $20 copay for up to 90-day supply	You pay $20 copay for a 31- to 100-day supply
Brand (Tier 2)	You pay $40 copay for up to 90-day supply	You pay $60 copay for a 31- to 100-day supply
Non-Formulary (Tier 3)	You pay $60 copay for up to 90-day supply	Not covered
Specialty Rx (Tier 4)	Above applicable copays apply	Availability for mail order varies by item. Talk to your local pharmacy.
Cost For Coverage Per Pay Period***		
Employee Only	$314.65	$350.40
Employee + 1 Dependent	$625.69	$700.80
Employee + 2 or more Dependents	$882.36	$991.63
Health Savings Account Option		
Individual Contribution Maximum for 2027	$4,500	$4,500
Family Contribution Maximum for 2027 (Family includes employee plus one or more dependents)	$9,000	$9,000

* *All references to "annual" and "per year" on this chart refer to policy year of January 1 through December 31, 2027.*

** *The individual deductible included in family coverage will not exceed $3,500 for 2027. If one member of the family reaches $3,500, co-insurance goes into effect for all family members.*

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

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, then 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.