Medical Plans Comparison Chart

Benefit	Kaiser Permanente	United HealthCare	POS Standard	POS High
Allergy Testing	$5 copay	$5 copay PCP $10 copay Specialist	**In-Network**: Covered in full **Out-of-Network:** 80% covered after deductible.	**In-Network**: Covered in full **Out-of-Network:** 80% covered after deductible.
Deductible	None	None	**In-Network**: None **Out-of-Network:** $300 individual; $600 family.	**In-Network**: None **Out-of-Network:** $300 individual; $600 family.
Diagnostic/Lab/X-Ray	Covered in full.	Covered in full.	**In-Network**: Covered in full **Out-of-Network:** 80% covered after deductible.	**In-Network**: Covered in full **Out-of-Network:** 80% covered after deductible.
Dr. Office Visits	$5 copay	$5 copay PCP $10 copay Specialist	**In-Network**: $15 copay **Out-of-Network:** 80% covered after deductible.	**In-Network**: $10 copay **Out-of-Network:** 80% covered after deductible.
Emergency Room	$50 copay waived if admitted to hospital	$25 copay waived if admitted to hospital. $15 copay for urgent care.	**In-Network**: $35 copay waived if admitted to hospital; **Out-of-Network:** 80% covered after deductible	**In-Network**: $25 copay waived if admitted to hospital **Out-of-Network:** 80% covered after deductible
Hearing Aids	For minor children. One hearing aid for each hearing impaired ear once every 36 months	For minor children. One hearing aid for each hearing impaired ear once every 36 months	**In-Network/Out-of-Network:** For minor children, one hearing aid for each hearing impaired ear once every 36 months	**In-Network/Out-of-Network:** For minor children, one hearing aid for each hearing impaired ear once every 36 months
Hearing Screening	$5 copay for hearing exam (hearing aids are excluded)	$5 Copay PCP $10 Copay Specialist	**In-Network**: Childhood hearing screening covered in full **Out-of-Network**: Child hood hearing screening, 80% not subject to deductible.	**In-Network**: Childhood hearing screening covered in full **Out-of-Network**: Child hood hearing screening, 80% not subject to deductible.
Home Health Care Services	Covered in full if medically necessary.	Covered in full. No copayment. 60 visit maximum for skilled care services per calendar year.	**In-Network**: Covered in full (90 visits max/calendar year **Out-of-Network**: 80% covered after deductible (90 visits max/calendar year)	**In-Network**: Covered in full (90 visits max/calendar year **Out-of-Network**: 80% covered after deductible (90 visits max/calendar year)
Hospice	Covered in full.	Covered in full. (See coverage booklet for eligibility information).	**In-Network**: Covered in full **Out-of-Network**: 80% covered after deductible.	**In-Network**: Covered in full **Out-of-Network**: 80% covered after deductible.
Hospital	Covered in full.	Covered in full.	**In-Network**: Covered in full after $150 copay per admission; **Out-of-Network**: 80% covered after deductible	**In-Network**: Covered in full **Out-of-Network**: 80% covered after deductible
Immunizations	Included in well child care visits up to age 5 at no charge.	$5 copay PCP	**In-Network**: Covered in full **Out-of-Network:** 80% covered after deductible	**In-Network**: Covered in full **Out-of-Network:** 80% covered after deductible
In vitro Fertilization	Limited to 3 attempts per live birth. Lifetime	Limited to 3 attempts per live birth. Lifetime	**In-Network/Out-of-Network:** Limited to 3	**In-Network/Out-of-Network:** Limited to 3

Medical Plans Comparison Chart

Benefit	Kaiser Permanente	United HealthCare	POS Standard	POS High
	maximum of $100,000.	maximum of $100,000.	attempts per live birth. Lifetime maximum of $100,000.	attempts per live birth. Lifetime maximum of $100,000.
Mammography - Preventive Screening Schedule	Schedule consistent with the current recommendations of the American College of Physicians.	Covered in full. Age 35-39; one baseline mammogram; Age 40-49; one mammogram every two calendar years; Age 50+ one mammogram per calendar year.	**In-Network/Out-of-Network:** Covered in full. Age 35-39: one baseline mammogram; Age 40-49; One mammogram every two calendar years; Age 50+ One mammogram per calendar year.	**In-Network/Out-of-Network:** Covered in full. Age 35-39: one baseline mammogram; Age 40-49; One mammogram every two calendar years; Age 50+ One mammogram per calendar year.
Maternity	Covered in full once pregnancy is diagnosed.	No copayment applies after the first visit.	**In-Network**: first visit 100% after $30 copay; other visits 100% **Out-of-Network:** 80% covered after deductible	**In-Network**: First visit 100% after $10 copay; other visits 100% **Out-of-Network:** 80% covered after deductible
Maximum Lifetime Benefit	Unlimited maximum.	Unlimited maximum.	**In-Network/Out-of-Network:** Unlimited maximum	**In-Network/Out-of-Network:** Unlimited maximum
Out-of-Pocket Annual Maximum	None	$1,100 per individual up to cap of $3,600 for a family.	**In-Network**: Individual: $1,000 plus the annual deductible; Family: $2,000 plus the annual deductible; **Out-of-Network:** Individual: $2,000 plus the annual deductible; Family: $4,000 plus the annual deductible.	**In-Network**: Individual: $1,000 plus the annual deductible; Family: $2,000 plus the annual deductible; **Out-of-Network:** Individual: $2,000 plus the annual deductible; Family: $4,000 plus the annual deductible.
Physical	Covered in full.	$5 copay PCP	**In-Network:** $15 copay Primary Care Physician; $30 copay specialist **Out-of-Network:** 80% covered after deductible (limit 1/calendar year)	**In-Network:** $10 copay **Out-of-Network:** 80% covered after deductible (limit 1/calendar year)
Prescriptions	Kaiser Rx plan (included with Kaiser HMO medical plan): $50 at on-site pharmacies and for mail order; $15 at participating pharmacies.	No Rx Plan included; diabetic supplies covered under a pharmacy rider.	**In-Network/Out-of-Network:** No Rx Plan included; diabetic supplies covered under a pharmacy rider.	**In-Network/Out-of-Network:** No Rx Plan included; diabetic supplies covered under a pharmacy rider.
Rehabilitation Services	Inpatient: Covered in full (unlimited). Outpatient $5 copay; outpatient services for physical therapy are limited to up to 30 visits; occupational and speech therapy per injury, incident or condition are covered	$10 copay/visit. 60 combined visits per year (short-term non-chronic conditions only).	**In-Network:** 100% **Out-of-Network:** 80% covered after deductible	**In-Network:** 100% **Out-of-Network:** 80% covered after deductible

Medical Plans Comparison Chart

Benefit	Kaiser Permanente	United HealthCare	POS Standard	POS High
	for a period not to exceed 90 days.			
Skilled Nursing Facility	Covered in full; 100 days maximum	Covered in full; 60 days per calendar year maximum.	**In-Network:** Covered in full (100 days max/calendar year) **Out-of-Network:** 80% covered after deductible (100 days max/calendar year).	**In-Network:** Covered in full (100 days max/calendar year) **Out-of-Network:** 80% covered after deductible (100 days max/calendar year).
Specialists	$5 copay	$10 copay	**In-Network:** $30 copay; **Out-of-Network:** 80% covered after deductible	**In-Network:** $10 copay **Out-of-Network:** 80% covered after deductible
Substance Abuse/Mental Health	Inpatient: Covered in full; Outpatient: $5 copay	Inpatient: Covered in full; Outpatient: $5 copay	**In-Network:** Inpatient- $150 per admission copay; Outpatient- $15 copay **Out-of-Network:** Inpatient- 80% covered after deductible; Outpatient- 80% covered after deductible.	**In-Network:** Inpatient- covered in full; Outpatient- $10 copay; **Out-of-Network:** Inpatient- 80% covered after deductible; Outpatient- 80% covered after deductible.
Surgery	Covered in full.	Inpatient: covered in full; Outpatient: $25 copay	**In-Network**: Covered in full **Out-of-Network:** 80% covered after deductible	**In-Network**: Covered in full **Out-of-Network:** 80% covered after deductible
Vision (Routine)	$5 copay for exams; 25% discount on lenses/frames at Kaiser centers; 15% discount off the costs of contact lenses.	$25 copay for exam; 15-20% discount through participating optical centers.	**In-Network**: Refraction not covered; (pediatric visual screening - covered in full under well child care). **Out-of-Network:** Refraction not covered (pediatric visual screening - 80% not subject to deductible under well child care).	**In-Network**: Refraction not covered; (pediatric visual screening - covered in full under well child care). **Out-of-Network:** Refraction not covered (pediatric visual screening - 80% not subject to deductible under well child care).
Well Child Care	Well baby/well child covered in full up to age 5.	$5 copay PCP	**In-Network**: $15 copay **Out-of-Network:** 80% not subject to deductible (up to age 18).	**In-Network**: $10 copay **Out-of-Network:** 80% not subject to deductible (up to age 18).

The County expects to continue its group insurance plans, but it is the County's position that there is no implied contract to do so. The County reserves the right to change or discontinue any terms of the plans, subject to applicable laws and collective bargaining agreements. The County may amend the plans, either prospectively or retroactively, as required by Federal or State law. In the event of a conflict between this chart, the County Code, the Summary Description and/or the Plan documents, the County Code, then the Plan Document and then the Summary Description will govern.

5/31/2016