Online Plan Comparison Tool

Feature	Kaiser $10-100 day	UHC Signature Value Full-Network HMO 20	Choice Plus PPO OSD1 In-Network	Choice Plus PPO OSD1 Out-of-Network
	Download Plan Details	Download Plan Details	Download Plan Details	
GENERAL BENEFITS				
Deductible	None	None	$500/individual $1,000/family	$500/individual $1,000/family
Maximum Benefit While Covered				
Annual Copayment Maximum	$1500 (Individual) $3000 (Family)	$1,000/individual (3 individual maximum per family)	$2,000/individual $4,000/family	$4,000/individual $8,000/individual
HRA	None			
PCP Office Visits	$10 copay per visit	$20 copay per visit	$20 copay per visit. (Applicable copayment or deductible/coinsurance applies for additional services: CT, PET, MRI, Nuclear Medicine; Pharmaceutical Products; Scopic Procedures; Surgery; Therapeutic Treatments.)	50% coinsurance after deductible has been met. (Applicable copayment or deductible/coinsurance applies for additional services: CT, PET, MRI, Nuclear Medicine; Pharmaceutical Products; Scopic Procedures; Surgery; Therapeutic Treatments.)
Specialist Office Visits	$10 copay per visit	$20 copay per visit	$20 copay per visit. (Applicable copayment or deductible/coinsurance applies for additional services: CT, PET, MRI, Nuclear Medicine; Pharmaceutical Products; Scopic Procedures; Surgery; Therapeutic Treatments.)	50% coinsurance after deductible has been met. (Applicable copayment or deductible/coinsurance applies for additional services: CT, PET, MRI, Nuclear Medicine; Pharmaceutical Products; Scopic Procedures; Surgery; Therapeutic Treatments.)
Preventative Care	No charge	No charge	No charge	Preventive care services covered in-network only.
Outpatient Surgery	$10 copay per procedure	No charge - Outpatient surgery at a participating free-standing or outpatient surgery facility	20% coinsurance after deductible has been met	50% coinsurance after deductible has been met.
Inpatient Hospital Care	No charge	$250 copay	20% coinsurance after deductible has been met.	50% coinsurance after deductible has been met. Pre-service notification is required.
Outpatient Diagnostic Laboratory and Radiology	No charge	No charge	Standard: Plan Pays 100% Complex: 20% coinsurance after deductible has been met.	50% coinsurance after deductible has been met.
Urgent Care (Copay waived if admitted to hospital)	$10 per visit	$20 copay per visit (at your medical group's urgent care facility) $50 copay per visit (at any other urgent care facility)	$50 copay per visit (Applicable copayment or deductible/coinsurance applies for additional services: CT, PET, MRI, Nuclear Medicine; Pharmaceutical Products; Scopic Procedures; Surgery; Therapeutic Treatments.)	50% coinsurance per visit after deductible has been met. Applicable copayment or deductible/coinsurance applies for additional services: CT, PET, MRI, Nuclear Medicine; Pharmaceutical Products; Scopic Procedures; Surgery; Therapeutic Treatments.
Emergency Room (Copay waived if admitted)	$50 per visit	$100 copay per visit	$100 copay per visit	$100 copay per visit. Pre-service notification is required if results in an inpatient stay.
Retail Prescription Drugs	$10 copay (for up to a 100-day supply)	Generic: $5 Preferred brand: $20 Non-preferred brand: 50% ($30 minimum, $125 maximum). Notes: - Up to a 30-day supply through Express Scripts-participating retail pharmacies. - If a brand-name drug is purchased when a generic alternative is available, you will be charged the generic drug copay plus the difference in cost between the brand name and generic drug, even if your doctor writes 'dispense as written' on the prescription. - You may obtain the first three fills of your long-term prescriptions at the retail pharmacy copay. On the fourth and subsequent fills, you will pay a higher cost if you continue to purchase it at retail.	Generic: $5 Preferred brand: $20 Non-preferred brand: 50% ($30 minimum, $125 maximum). Notes: - Up to a 30-day supply through Express-Scripts participating retail pharmacies. - If a brand-name drug is purchased when a generic alternative is available, you will be charged the generic drug copay plus the difference in cost between the brand name and generic drug, even if your doctor writes 'dispense as written' on the prescription. - You may obtain the first three fills of your long-term prescriptions at the retail pharmacy copay. On the fourth and subsequent fills, you will pay a higher cost if you continue to purchase it at retail.	Retail: With submission of a paper claim, member will be reimbursed at the rate the Plan would have been charged had the member used an in-network pharmacy less the member's copay.

Mail Order Prescription Drugs	$10 copay (for up to a 100-day supply)	Generic: $10 Preferred Brand: $40 Non-Preferred Brand: 50% ($60 minimum, $250 maximum) Notes: - 90-day supply through Express Scripts Mail-Order Service.	Generic: $10 Preferred Brand: $40 Non-Preferred Brand: 50% ($60 minimum, $250 maximum) Note: 90-day supply through Express Scripts Mail Order Pharmacy	Covered in-network only.
MENTAL HEALTH				
Mental Health Services	Inpatient: No charge Outpatient: $10 copay per visit ($5 for group visits)	Inpatient: $250 copay per admit Outpatient: $20 copay per visit	Inpatient: Preauthorization required through UnitedHealthcare. Inpatient: 20% coinsurance after deductible has been met. Outpatient: $20 copay per visit.	Preauthorization required through UnitedHealthcare. Inpatient: Plan pays 50% after deductible has been met. Outpatient:Plan pays 50% after deductible has been met.
Substance Abuse Services	Inpatient: No charge Outpatient: $10 copay per visit ($5 for group visits)	Inpatient: No charge Outpatient: No charge	Inpatient: Preauthorization required through UnitedHealthcare Inpatient: 20% coinsurance after deductible has been met. Outpatient: $20 copay per visit.	Preauthorization required through UnitedHealthcare. Inpatient: Plan pays 50% after deductible has been met. Outpatient: Plan pays 50% after deductible has been met.
OTHER BENEFITS				
Chiropractor Services	$10 copay per visit, unlimited visits , covered through OptumHealth.	$20 copay per visit, unlimited visits/calendar year. Covered through OptumHealth. No referral required.	You pay a $20 copay per visit, unlimited visits/calendar year. Covered through OptumHealth. No referral required.	Covered in-network only.
Outpatient Physical/Rehabilitation Therapy	$10 copay per visit (Physical, occupational, and speech therapy)	$20 copay per visit Notes: - Outpatient Rehabilitation Therapy at a Participating Free-Standing or Outpatient Facility (including physical, occupational and speech therapy). - Covered services are based on medical necessity and may require prior authorization.	$20 copay per visit. Notes: - Covered services are based on medical necessity and may require prior authorization. Benefits are limited to combination of in- and out of network visits. - Benefits are limited as follows: 50 visits each of physical, occupational and speech therapy; 20 visits of pulmonary rehabilitation; 36 visits of cardiac rehabilitation; 30 visits of post-cochlear implant aural therapy.	50% coinsurance after deductible has been met. See in-network rehabilitation for type and and number of visits allowed. Benefits are limited to combination of in- and out of network visits.
Disclaimer	This summary is merely a brief description of the major benefits of the plan(s) and is not intended to alter or expand benefits rights or liabilities as set forth in the official plan documents and contracts. Limitations may apply. See the Certificate/Evidence of Coverage for details.	This summary is merely a brief description of the major benefits of the plan(s) and is not intended to alter or expand benefits rights or liabilities as set forth in the official plan documents/contracts. Limitations may apply. See the Certificate/Evidence of Coverage for details.	This summary is merely a brief description of the major benefits of the plan(s) and is not intended to alter or expand benefits rights or liabilities as set forth in the official plan documents/contracts. Limitations may apply. See the Certificate/Evidence of Coverage for details	This summary is merely a brief description of the major benefits of the plan(s) and is not intended to alter or expand benefits rights or liabilities as set forth in the official plan documents/contracts. Limitations may apply. See the EOC for details.