Retiree – CA 2021	**United Healthcare**		**Kaiser**		**Health Net**	
Plan Feature	**Not Eligible for Medicare**	***"Medicare Advantage"*** **Enrolled in Medicare**	**Not Eligible for Medicare**	***"Senior Advantage"*** **Enrolled in Medicare**	**Not Eligible for Medicare**	***"Seniority Plus"*** **Enrolled in Medicare**
Annual Deductible	$500 per person, $1,000 family maximum; **Deductible applies unless otherwise noted**	None	$500 per person, $1,000 family maximum; **Deductible applies unless otherwise noted**	None	None	None
Annual Out of Pocket Maximum on Allowable Charges	Plan pays 100% after eligible out-of-pocket costs reach $3,000 in a year *($6,000 for a family)*	Plan pays 100% after co-payments reach $6,700 in a year	Plan pays 100% after eligible out-of-pocket costs reach $3,000 in a year *($6,000 for a family)*	Plan pays 100% after co-payments reach $1,500 in a year	Plan pays 100% after eligible out-of-pocket costs reach $3,000 in a year *($6,000 for a family)*	Plan pays 100% after co-payments reach $3,400 in a year
Inpatient Hospital Care	Plan pays 80% after deductible	Plan pays 100%	Plan pays 80% after deductible	Plan pays 100%	Plan pays 80%	Plan pays 100%
Outpatient Procedure	Plan pays 80% after deductible	Plan pays 100%	Plan pays 80% after deductible	You pay $10 per visit	Plan pays 80%	Plan pays 100%
Extended Care Facility ***(Skilled Nursing)***	Plan pays 80% after deductible; 100 days maximum per calendar year	Plan pays 100%; 100 days maximum per calendar year	Plan pays 80% after deductible; 100 days maximum per calendar year	Plan pays 100%; 100 days maximum per calendar year	Plan pays 100% for days 1-10, You pay $25 per day for days 11-100;100 days maximum per calendar year	Plan pays 100%; 100 days maximum per benefit period
Office Visits	***Not subject to deductible***		***Not subject to deductible***			
Primary Care Visit	You pay $30 per visit	You pay $5 per visit	You pay $30 per visit	You pay $10 per visit	You pay $30 per visit	You pay $5 per visit
Specialist	You pay $50 per visit	You pay $5 per visit	You pay $45 per visit	You pay $10 per visit	You pay $50 per visit	You pay $5 per visit
Preventative Care Services *(as required by the Affordable Care Act)*	Plan pays 100%; deductible does not apply	Plan pays 100%	Plan pays 100%; deductible does not apply	Plan pays 100%	Plan pays 100%	Plan pays 100%
Diagnostic X-ray & Lab	Plan pays 100%; deductible does not apply	Plan pays 100%	Plan pays 100% after deductible	Plan pays 100%	Plan pays 100%	Plan pays 100%
CAT Scans & MRI's	You pay $100 per test after deductible	Plan pays 100%	You pay 20% up to a maximum of $100 per test after deductible	Plan pays 100%	You pay $100 per test	Plan pays 100%
Durable Medical Equipment	Plan pays 80% after deductible	Plan pays 100%	Plan pays 80%; deductible does not apply	Plan pays 100%	Plan pays 100%	Plan pays 100%
Home Health Care	You pay $30 per visit, up to 100 visits per calendar year; deductible does not apply	Plan pays 100%	Plan pays 100%, up to 100 visits per calendar year; deductible does not apply	Plan pays 100%	You pay $30/visit starting the 31st day, up to 100 visits/ calendar year; requires prior authorization	Plan pays 100%
Physical Therapy	You pay $30 per visit; deductible does not apply	You pay $5 per visit	You pay $30 per visit after deductible	You pay $10 per visit	You pay $50 per visit	Plan pays 100%
Speech Therapy	You pay $30 per visit; deductible does not apply	You pay $5 per visit	You pay $30 per visit after deductible	You pay $10 per visit	You pay $50 per visit	Plan pays 100%

Chiropractic Care	**Not Covered**	You pay $5 per visit, maximum of 12 visits per calendar year	**Not Covered**	**Not Covered**	**Not Covered**	You pay $5 per visit, maximum of 20 visits per calendar year
Hearing Aids	Plan pays 80%; maximum benefit of $5,000 every 3 years; deductible does not apply	$500 allowance every 3 years	**Not Covered**	**Not Covered**	**Not Covered**	**Not Covered**
Mental Health and Substance Abuse Care						
Inpatient	Plan pays 80% after deductible	Plan pays 100%, maximum of 190 days per lifetime	Plan pays 80% after deductible	Plan pays 100%	Plan pays 80%	Plan pays 100%
Outpatient	You pay $40 per visit; deductible does not apply	You pay $5 per visit	You pay $15 per group session ($5 for substance abuse group session), or $30 per individual session; deductible does not apply	You pay $5 per group visit or $10 per individual visit	You pay $15 per group session, or $30 per individual session	You pay $5 per visit
Prescription Drugs	***Must be obtained at a participating HMO pharmacy***					
Included in Medical Out-of-pocket limit	***Not subject to deductible***		***Not subject to deductible***			
Short-term ***(outpatient)***	You pay $20 per generic, $40 per brand name, and $60 per non-preferred prescription, up to a 30-day supply	You pay $7 per generic and $14 per brand name prescription, up to a 30-day supply	You pay $15 per generic and $35 per brand name prescription, up to a 30-day supply	You pay $10 per prescription, up to a 100-day supply	You pay $20 per generic, $40 per brand name, and $60 per non-preferred prescription, up to a 30-day supply	You pay $5 per generic, $15 per brand name, and $35 per non-formulary prescription, up to a 30-day supply
Maintenance ***(30-day supply or more)***	**Mail order**- You pay $50 per generic, $100 per brand name, and $150 per non-preferred prescription, up to a 90-day supply	**Mail order**- You pay 2 co-pays per prescription, up to a 90-day supply	**Mail order**- You pay 2 co-pays per prescription, up to a 100-day supply	**Mail order-** You pay $10 per prescription, up to a 100-day supply	**Mail order**- You pay $40 per generic, $100 per brand name, and $150 per non-preferred prescription, up to a 90-day supply	**Mail order-** You pay 2 co-pays per prescription, up to a 90-day supply
Vision Care	You pay $30 for exam, **lenses & frames not covered;** deductible does not apply	You pay $5 for exam, limit of 1 exam every 12 months; $130 frame allowance every 24 months	No charge for routine exam, **lenses & frames not covered;** deductible does not apply	You pay $10 for exam; $150 frame allowance every 24 months	You pay $30 for exam; **lenses & frames not covered**	You pay $5 for exam, limit of 1 exam every 12 months; $100 frame allowance every 24 months
Dental Care	**Not Covered**	**Not Covered**	**Not Covered**	**Not Covered**	**Not Covered**	Refer to Dental Brochure
Ambulance	You pay $100 per transport; deductible does not apply	Plan pays 100%	Plan pays 100% after deductible	Plan pays 100%	You pay $100 per transport	Plan pays 100%
Emergency Room Care	You pay $250 co-pay after deductible *(co-payment waived if admitted to hospital)*	You pay $50 *(co-payment waived if admitted to hospital)*	You pay $125 co-pay after deductible *(co-payment waived if admitted to hospital)*	You pay $20 *(co-payment waived if admitted to hospital)*	You pay $250 co-pay *(co-payment waived if admitted to hospital)*	You pay $20 *(co-payment waived if admitted to hospital)*

THIS IS ONLY A SUMMARY: The above Plan benefits show only a partial summary of benefits. Please refer to the applicable Evidence of Coverage (EOC) booklet or Summary Plan Description booklet for prior-authorization requirements and specific restrictions, exclusions, and limitations.