

## 2025 Benefits Plan Comparison

### Medical | Dental | Vision

#### UnitedHealthcare Medical Plans

[Glossary of common terms](#)

		UHC Choice Plus (PPO)	UHC Choice (EPO)	UHC Choice Plus High Deductible (HDHP) (HSA compatible)
<b>Overview</b>	<b>Payment level</b>	After calendar-year deductible, Plan generally pays 90% for network, 70% for non-network.	Plan generally pays 100% of network services with applicable copay.	After calendar-year deductible, Plan generally pays 80% for network, 60% for non-network.
	<b>Calendar year deductible</b>	<sup>1</sup> Network: \$500 Individual/ \$1,000 Family Non-network: \$1,000 Individual/\$2,000 Family Does not apply to services with copay, retail pharmacy, or preventive care services. Unless noted otherwise, the deductible will apply to all other network and non-network services.	None	<sup>3</sup> Network: \$1,650 Individual/Employee/Single, \$3,300 Family Non-network: \$3,300 Individual/Employee/Single, \$6,600 Family Deductible applies to all network and non-network services other than preventive care services.
	<b>Coinsurance</b>	Network: 90%; Non-network: 70%	100%	Network: 80%; Non-network: 60%
	<b>Out-of-pocket maximum - the most you pay per calendar year</b>	<sup>2</sup> Network: \$2,000 Individual, \$4,000 Family Non-network: \$4,000 Individual, \$8,000 Family Includes copays, deductibles, and coinsurance	<sup>2</sup> \$2,000 Individual, \$4,000 Family Includes copays and prescription coinsurance	<sup>4</sup> Network: \$3,300 Individual/Employee/Single, \$6,600 Family Non-network: \$6,600 Individual/Employee/Single, \$13,200 Family Includes deductibles and coinsurance
	<b>Preauthorization</b>	Required for hospital, skilled nursing facilities, certain outpatient procedures, home health, hospice, private duty nursing, and some prescriptions.	Required for some prescriptions.	Required for hospital, skilled nursing facilities, certain outpatient procedures, home health, hospice, private duty nursing, and some prescriptions.
<b>At the doctor's office</b>	<b>Primary care</b>	Network: \$25 copay; non-network:70%	\$20 copay	Network: 80%; non-network: 60%
	<b>Specialist</b>	Network: \$35 copay; non-network:70%	\$30 copay	Network: 80%; non-network: 60%
	<b>Routine physicals (PCP)</b>	100% including associated x-ray and lab services	No charge	100% including associated X-ray and lab services
	<b>Well-baby/child care</b>	100% including associated x-ray and lab services	No charge	100% including associated X-ray and lab services
	<b>X-ray and lab services</b>	Network: 90%; non-network: 70%	No charge	Network: 80%; non-network: 60%
<b>Urgent care clinic</b>	<b>Physician fees may apply</b>	Network: 90%; non-network:70%	\$35 copay	Network: 80%; non-network: 60%
<b>Hospitalization</b>	<b>Semiprivate room/board</b>	Network: 90%; non-network:70%	\$150 copay	Network: 80%; non-network: 60%
	<b>X-Ray and lab services</b>	Network: 90%; non-network:70%	No charge	Network: 80%; non-network: 60%
	<b>Surgery</b>	Network: 90%; non-network: 70%	No charge	Network: 80%; non-network: 60%
	<b>Emergency room</b>	90% after meeting Network deductible	\$50 copay (waived if admitted)	80% after meeting Network deductible

<sup>1</sup> **Applies to PPO:** If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.

<sup>2</sup> **Applies to PPO & EPO :** If you have other family members on the plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.

<sup>3</sup> **Applies to HDHP:** If you have other family members on the plan, the overall family deductible must be met before the plan begins to pay – the Individual deductible doesn't apply if you cover two or more people (including yourself).

<sup>4</sup> **Applies to HDHP:** If you have other family members on the plan, the overall family out-of-pocket limits must be met – the individual out-of-pocket limit doesn't apply if you cover two or more people (including yourself).

## UnitedHealthcare Medical Plans (continued)

Glossary of common terms

		UHC Choice Plus (PPO)	UHC Choice (EPO)	UHC Choice Plus High Deductible (HDHP) (HSA compatible)
<b>Maternity</b>	<b>Including prenatal care, delivery, and routine nursery charges (non-specialists). Does not include hospitalization.</b>	Network: 90% - \$25 copay for initial PPO doctor's office visit (waived after initial visit); Non-network: 70%	100% - \$20 copay for initial PCP doctor's office visit (waived after initial visit)	Network: 80% Non-network: 60%
<b>Prescriptions</b>	<b>Network pharmacy</b>	90% - member pays 10%, up to the maximum listed below	90% - member pays 10%, up to the maximum listed below	80%
	- Tier 1 - Tier 2 - Tier 3 - Specialty	- \$20 - \$50 - \$80 - \$100	- \$20 - \$50 - \$80 - \$100	
	<b>Mail order</b>	90% - member pays 10%, up to the maximum listed below	90% - member pays 10%, up to the maximum listed below	80%
	- Tier 1 - Tier 2 - Tier 3 - Specialty	- \$40 - \$100 - \$160 - N/A	- \$40 - \$100 - \$160 - N/A	
<b>Mental health/ substance use</b>	<b>Outpatient office visit</b>	Network: \$25 copay; non-network: 70%	\$20 copay	Network: 80%; non-network: 60%
	<b>Outpatient-other services (including ABA therapy)</b>	Network: 90%; non-network: 70%	\$20 copay	Network: 80%; non-network: 60%
	<b>Inpatient</b>	Network: 90%; non-network: 70%	100% after \$150 inpatient copay	Network: 80%; non-network: 60%
<b>Other services</b>	<b>Fertility medical treatment</b>	Contact UnitedHealthcare for preauthorization requirements and network details.	Contact UnitedHealthcare for preauthorization requirements and network details.	Contact UnitedHealthcare for preauthorization requirements and network details.
	<b>Acupuncture</b>	Network: \$35 copay; non-network: 70%; 26 visits per calendar year maximum	\$30 copay; 26 visits per calendar year maximum	Network: 80%; non-network: 60%; 26 visits per calendar year maximum
	<b>Chiropractic care</b>	Network: \$35 copay; non-network: 70%; 26 visits per calendar year maximum	\$30 copay; 26 visits per calendar year maximum	Network: 80%; non-network: 60%; 26 visits per calendar year maximum

<sup>1</sup>Up to 31-day supply

<sup>2</sup>Up to 90-day supply

**A note about non-network payment levels**—applies to UHC Choice Plus (PPO) and UHC Choice Plus High Deductible (HDHP) plans: Non-network claims may be adjusted based upon a reference-based methodology that is geographically adjusted, and based on what providers generally charge for the same or similar service.

		Kaiser HMO (California)	Kaiser HMO (Oregon)
<b>Overview</b>	<b>Payment level</b>	Plan generally pays 100% after out-of-pocket maximum is met	Plan generally pays 100% after out-of-pocket maximum is met
	<b>Calendar year deductible</b>	None	None
	<b>Out-of-pocket maximum for the year</b>	\$1,500 Individual/\$3,000 Family; includes copays	\$600 Individual/\$1,200 Family
	<b>Preauthorization</b>	N/A	N/A
<b>At the doctor's office</b>	<b>Primary care</b>	\$25 copay	\$25 copay
	<b>Specialist</b>	\$35 copay	\$35 copay
	<b>Routine physicals (PCP)</b>	No charge	No charge
	<b>Well-baby/child care</b>	No charge	No charge
	<b>X-ray and lab services</b>	No charge	\$15 copay
<b>Urgent care clinic</b>	<b>Physician fees may apply</b>	\$25 copay/visit	\$35 copay
<b>Hospitalization</b>	<b>Semiprivate room/board</b>	\$150 copay per admission	\$50 copay per day to \$250 maximum per admission
	<b>X-ray and lab services</b>	Included in inpatient hospital copay	Included in inpatient hospital copay
<b>Emergency room (not covered for non-emergencies)</b>	<b>Surgery</b>	Included in inpatient hospital copay /\$30 copay for outpatient surgery	Included in inpatient hospital copay/\$20 copay for outpatient
	<b>Emergency room</b>	\$75 copay (waived if admitted)	Kaiser facility: \$75 copay (waived if admitted); Qualifying care non-Kaiser facility: \$75 copay (waived if admitted)
<b>Prescriptions</b>	<b>Network pharmacy</b>	\$10 copay (generic)/\$20 copay (brand) up to a 30-day supply (50% drugs for the treatment of sexual dysfunction)	\$10 (generic)/\$20 (formulary brand)/\$40 (non-formulary)/\$150 (specialty) (up to 30-day supply)
	<b>Non-network pharmacy</b>	Not covered	Not covered—unless qualifying emergency
	<b>Mail order</b>	\$20 copay (generic)/\$40 copay (brand) up to 100-day supply	\$20 (generic)/\$40 (formulary brand)/\$80 non-formulary for 90-day supply
<b>Maternity</b>	<b>Including prenatal care, delivery, and routine nursery charges (non-specialists). Does not include hospitalization.</b>	No charge for prenatal and postnatal visits	No charge for prenatal and postnatal visits
<b>Mental health/ Substance use</b>	<b>Outpatient</b>	Mental health: \$20 copay individual/\$10 copay group visit; Substance use disorder: \$20 copay individual/\$5 copay group visit	\$25 copay
	<b>Inpatient</b>	Mental health: \$150 hospital admission copay; Substance use disorder: \$150 hospital admission copay (detox only); \$100 copay Transitional residential recovery services	\$50 copay per day to a \$250 maximum per admission
<b>Other medical care</b>	<b>Fertility medical treatment</b>	Diagnosis and treatment of underlying conditions of infertility. IVF/GIFT/ ZIFT covered, up to 2 cycles per lifetime.	Diagnosis of underlying conditions of infertility. IVF/GIFT/ZIFT, covered, up to \$30K per lifetime.
	<b>Acupuncture</b>	Non-physician specialist visit: \$20 copay per visit Physician specialist visit: \$30 copay per visit	Acupuncture \$25 copay 12 visits/year
	<b>Chiropractic care</b>	\$15 copay per visit - 30 visits per calendar year maximum. Kaiser/American Specialty Health Plans (ASHP) network only.	Chiropractic \$25 copay 20 visits/year

## Aetna dental plans

[Glossary of common terms](#)

Overview	Preferred Provider Organization (PPO)	Dental Maintenance Organization (DMO)
<b>Summary</b>	<p>Enrollees may use any provider</p> <p>Participating PPO dentists provide dental services at a reduced fee schedule</p>	<p>All services (except for certain emergency care) must be provided or prescribed by your selected DMO network primary care dentist. DMO network is limited and differs from PPO network. You can switch DMO dentists by calling Aetna any time before the 15th of the month and the change will become effective the first day of the following month.</p>
<b>Benefit basis</b>	Reasonable and customary (maximum paid based on the most common costs for services or procedures in a specific geographic area)	Negotiated in advance between Aetna and network providers.
<b>Calendar year maximum benefit</b>	<p>\$2,500 per covered member</p> <p>Preventive services are not applied to the calendar year maximum benefit</p>	None
<b>Calendar year deductible</b> Per person Per family	<p>Individual deductible waived for preventive care and orthodontia</p> <p>\$50 \$150</p>	<p>None None</p>
<b>Preventive care</b>	<p>100%; exams, cleaning, fluoride for children, bitewing x-rays</p> <p>Prophylaxis limited to four (4) times per calendar year for adults and two (2) times per calendar year for children</p>	<p>100%; exams, cleaning, fluoride for children, x-rays</p> <p>Prophylaxis limited to four (4) times per calendar year</p>
<b>Basic care</b>	80%; extractions, fillings, periodontics, endodontics, minor restorations, space maintainers, other x-rays	100%; extractions, fillings, most periodontics and endodontics, minor restorations
<b>Major care</b>	60%; inlays, onlays, crowns, bridgework, dentures, implants	60%; inlays, onlays, crowns, bridgework, dentures, space maintainers
<b>Orthodontia, adults and children</b>	<p>50%</p> <p>\$2,500 lifetime maximum benefit per covered member</p>	<p>50%</p> <p>Limited to 24 months of active and 24 months of post treatment. If enrolling for the first time and you or dependent have already started an orthodontic treatment program, the DMO option will not cover your orthodontia expenses.</p>

## VSP vision plans

[Glossary of common terms](#)

	Basic Plan	Plus Plan
	<b>Frequency</b>	
<b>Exams</b>	Once every calendar year No copay for Exam	Once every calendar year No copay for Exam
<b>Lenses*</b>	Once every other calendar year (Every calendar year if prescription changes)	Once every calendar year
<b>Frames</b>	Once every other calendar year	Once every calendar year
<b>Contacts*</b>	Once every other calendar year	Once every calendar year
<b>Lens enhancements - covered in full</b>	Polycarbonate lenses for children Standard progressives	Anti-glare coating High index lenses Polycarbonate lenses Standard progressives Tints/light-reactive UV coating
	<b>Copays</b>	
<b>Lens &amp; Frame copay</b>	\$30	\$20
<b>Retinal screening copay</b>	\$15	\$15
<b>Computer VisionCare (Benefit available to employees only; not available to enrolled dependents)</b>	\$10 copay for services Exam every calendar year Lenses & frame every other calendar year \$80 Allowance for frame Anti-glare coating	\$10 copay for services Exam every 12 months Lenses & frame every calendar year \$90 Allowance for frame Anti-glare coating
<b>LightCare</b>	One pair of non-prescription sunglasses or non-prescription blue light filtering glasses, in lieu of prescription frame/lens benefit	One pair of non-prescription sunglasses or non-prescription blue light filtering glasses, in lieu of prescription frame/lens benefit

\*You can get either glasses or contacts (but not both) every calendar year or every other calendar year.

VSP vision plans (continued)

	Basic Plan and Plus Plan	
	In-network maximum	Out-of-network maximum
Exam	Covered	Covered up to: \$42
Retinal screening	Covered	Not Covered
Single vision lenses	Covered	Covered up to: \$40
Lined bifocal lenses	Covered	Covered up to: \$60
Lined trifocal lenses	Covered	Covered up to: \$80
Progressive lenses	Covered	Covered up to: \$80
Frames	Basic Plan: Covered up to \$180 Plus Plan: Covered up to \$250	Covered up to \$70
Contact lenses	Basic Plan: Covered up to \$105 Plus Plan: Covered up to \$250	Basic Plan: Covered up to \$105 Plus Plan: Covered up to \$250

In addition to the features covered in the chart, VSP members are eligible for discounts, including the Laser VisionCare<sup>SM</sup> program.