MEDICAL PLAN COMPARISON - CALIFORNIA

Limits are based on a calendar year basis. See the Plan Summary for additional services.
This comparison is provided for informational purposes only. Should any discrepancy exist between this document and the official documents or contracts, the official plan documents or contracts will govern.

See the medical plan summaries and the Benefit Plan Documents posted on the benefits website, www.myfibenefits.com

Services	United Healthcare Choice Plus (PPO 500)		United Healthcare HSA Choice Plus (PPO 2250 HSA)		United Healthcare Choice (EPO)	Kaiser CA HMO	Kaiser CA HSA
	In-network	Out-of-network **	In-network	Out-of-network**	In-network only	In-network only	In-network only
Calendar year deductible	$500 Individual; $1,000 Family		$2,250 Employee Only; or $4,500 Family Level		No deductible	No deductible	$2,000 Employee Only; or $4,000 Family Level
Maximum out-of-pocket	$3,000 Ind $6,000 Family (Excludes deductible)	$10,000 Ind $20,000 Family (Excludes deductible)	$3,000 Employee Only; or $5,500 Family Level (Includes the deductible)		$3,500 Individual $7,000 Family	$1,500 Individual $3,000 Family	$3,200 Employee Only;$6,000 Family Level (Includes the deductible)
Preventive Care	$35 (ded waived)	Not covered	$35 (ded waived)	Not covered	$20	$0	$0 (ded waived)
Preventive lab work	$35 (ded waived)	Not covered	20% (ded waived)	Not covered	$10	$0	$0 (ded waived)
Virtual Visits	$10 (ded waived)	Not covered	20%*	Not covered	$10	$0	$0*
Office visits/Urgent Care	$35 (ded waived)	40%*	20%*	50%*	$20	$20	$30*
Naturopathy visits	$35 (ded waived)	40%*	20%*	50%*	$20	Not covered	Not covered
Diagnostic lab & x-rays	$35 (ded waived)	40%*	20%*	50%*	$10	$5	$10*
Well baby care (screenings, immunization & vaccinations)	$35 (ded waived)	Not covered	$35 (ded. waived)[2]	Not covered	$20	$0	$0 (ded waived)
Emergency Room	$100 facility fee*; 20% physician fee*		20% facility fee*; 20% physician fee*		$100	$100	$100*
Hospitalization Inpatient physician Semi-private room	20%* $250 + 20%*	40%* 40%[1]*	20%* 20%*	50%* 50%*	$500/day up to 3 days/adm	$100/day	$250/adm*
Outpatient surgery Ambulatory Service Ctr. Hospital/Facility Treatment & supplies	20%* $125 + 20%* 20%*	40%* 40%* 40%*	20%* 20%* 20%*	50%* 50%* 50%*	$200 $400 No charge	$20	$150*
Pregnancy & maternity	20%*	40%*	20%*	50%*	$20 ***	$0 ***	$10 (ded waived)
Rehabilitative therapy	$35*	40%*	20%*	50%*	$20	$20	$30*
Chiropractic	$25* up to 12 visits	40%* up to 12 visits	20%* up to 20 visits	50%* up to 20 visits	$20 up to 12 visits	$15 up to 20 visits	$15* for chiropractic & $30* for acupuncture Up to 20 visits, combined
Acupuncture	$25* up to 12 visits	40%* up to 12 visits	20%* up to 20 visits	50%* up to 20 visits	$20 up to 12 visits		
Prescriptions Mail order available under all plans (up to a 90 or 100-day supply)	$10 Tier 1 $20 Tier 2 $35 Tier 3	25% + $10 25% + $25 25% + $35	$10 Tier 1* $25 Tier 2* $40 Tier 3*	25% + $10* 25% + $25* 25% + $40*	$10 Tier 1 $20 Tier 2 $35 Tier 3	$10 Generic $20 Brand	$10 Generic* $30 Brand*

* Coinsurance/co-pay rate applies after the deductible has been met.
** Out-of-network benefits are based on usual, reasonable and customary (UCR) charges. If the provider charges more than the UCR, you are responsible for the excess charges plus the co-pay or co-insurance. Certain services require pre-authorization. See the Plan Documents for details.
*** For office visit & for inpatient stay refer to hospitalization benefit.

[1] The maximum allowed for hospital services received from a non-preferred hospital is $600 per day. Members are responsible for the co-insurance percentage of this $600 plus all charges in excess of $600.
[2] Preventive and well-baby care office visit are not subject to the deductible. Other covered non-preventive services received during or in connection with the office visit are subject to the deductible and applicable copayment percentage.

Effective 01/01/2024