CRISWELL AUTOMOTIVE - HEALTH PLAN OPTIONS COMPARISON

2024 / 2025

BENEFIT ITEM	HIGH DEDUCTIBLE HSA SISCO / CIGNA Network	KAISER HMO (DHMO 11) KAISER PROVIDERS ONLY	KAISER Flexible Choice-Flex G Tier 1: Kaiser Providers ONLY	Tier 2: PHCS/ Muliplan National Network (Contracted Benefits)	Tier 3: Out of Network Benefits
Deductible (October-September)	$2000/S, $4000/F	$500/S, $1000/F	none	$300/S, $600/F	$600/S, $1200/F
Out of Pocket Maximum	$5000/S, $10,000/F	$3000/S, $6000/F	$2250/S, $4500/F	$3000/S, $6000/F	$6000/S, $12,000/F
Coinsurance	90% (unless otherwise indicated)	100% (unless otherwise indicated)	100% (unless otherwise indicated)	80% (unless otherwise indicated)	60% (unless otherwise indicated)
Primary Care Physician	90% after ded	$20 copay	$20 copay	$35 copay	60% after ded
Specialist Physician	90% after ded	$30 copay	$30 copay	$45 copay	60% after ded
Preventive Care Covered Per Affordable Care Act Guidelines.	100%. See listing of services at https://www.healthcare.gov/coverage/preventive-care-benefits/	100%. See listing of services at https://www.healthcare.gov/coverage/preventive-care-benefits/	100%. See listing of services at https://www.healthcare.gov/coverage/preventive-care-benefits/	100%. See listing of services at https://www.healthcare.gov/coverage/preventive-care-benefits/	80% after ded. See listing of services at https://www.healthcare.gov/coverage/preventive-care-benefits/
Emergency Room	90% after ded	$100 copay	$100 copay	Covered under Tier 1	Covered under Tier 1
Urgent Care Facility	90% after ded	$30 copay	$30 copay	$45 copay	60% after ded
Ambulance Service	90% after ded	$100 copay	$100 copay	Covered under Tier 1	Covered under Tier 1
Allergy Testing	90% after ded	$30 copay	$30 copay	80% after ded	60% after ded
Diagnostic Xray & Lab	90% after ded	100%, no deductible	100%	80% after ded	60% after ded
MRI, CAT, PET Scans	90% after ded	100% after deductible	$100 copay	80% after ded	60% after ded
Outpatient Surgery	90% after ded	100% after deductible	$75 copay	80% after ded	60% after ded
Chiropractic Treatment	90% after ded, max $500/plan year	$30 copay, 20 visits/contract yr	$30 copay, 20 visits/contract yr	not covered	not covered
Home Health Care	90% after ded, max 100 visits/plan year	100%	$30 copay	80% after ded	60% after ded
Hospice	90% after ded, Max 190 days/Lifetime	100%	$30 copay	80% after ded	60% after ded
Skilled Nursing Facility	90% after ded, Max 190 days/plan year	100% after deductible	$100 copay, max 60 days	80%, max 40 days/contract yr	60%, max 40 days/contract yr
Durable Medical Equipment	100% after ded	100% after deductible	100% (Basic)	50% after ded	50% after ded
Inpatient Hospital	90% after ded	100% after deductible	$100 copay per admission	80% after ded	60% after ded
Mental Hlth/Subst Abuse: Inpatient	90% after ded	100% after deductible	$100 copay per admission	80% after ded per admit	60% after ded per admit
Outpatient	90% after ded	$20 copay	$20 copay (Individual)	$35 copay	60% after ded
Therapies (occ., physical, speech)	90% after ded, 30 visits/yr	$30 copay, 30 visits/contract yr	$30 copay, 30 visits/episode	$45 copay, 90 combined visits/yr	60%, 90 combined visits/yr
Vision Exam	Not covered	Optometrist: $20 Opthamologist: $30	Optometrist:$20 Opthamologist:$30	$45 copay	60% after ded
Hardware	Not covered	25% Discount	25% Discount	not covered	Frames: 40% Discount, $100 max Lenses: 40% discount, $150 Max
Hearing Aids	Not covered	$0 copay. 1 Hearing Aid every 36 months, $1,000 Benefit Maximum	Not covered	Not covered	Not covered
Acupuncture	90% after ded, max $500/plan year	$30 copay, 20 visits/contract yr	Not covered	Not covered	Not covered

PRESCRIPTION DRUG		Kaiser Providers ONLY	Contracted Pharmacies	Tier 1: Kaiser Providers ONLY	Tier 2: PHCS/ Muliplan National Network (Contracted Pharmacies)	Tier 3: Out of Network Benefits
Retail (30 days)	90% after deductible	$0/$25/$50	$10/$50/$75	$10/$30/$55	$25/$50/$75	$30/$55/$75
Mail Order (90 days)	90% after deductible	$0/$50/$100	$20/$100/$150	$20/$60/$110	$50/$100/$150	$60/$110/$150

HSA Account Contributions *(You must establish an HSA Account)*	Single	Single +1 Dep	Family	Single	Single + 1 Dep	Family	Single	Single + 1 Dep	Family
	$100.00	$100.00	$100.00	N/A	N/A	N/A	N/A	N/A	N/A

Employee Cost Format:	Single	Single +1 Dep	Family	Single	Single + 1 Dep	Family	Single	Single + 1 Dep	Family
Employee Contributions:									
BiWeekly Cost	$166.17	$281.54	$419.08	$175.39	$275.56	$400.64	$260.78	$440.00	$725.59
Monthly Cost	$360.00	$610.00	$908.00	$380.00	$597.00	$868.00	$565.00	$952.00	$1,572.00

NOTE:	The Medical Plan options above do not include Dental, Life Insurance or Short Term Disability. Those coverages are offered separately, with separate cost contributions. Please see additional material regarding Dental, Life Insurance and Short Term Disability.
Plan Affordability Provision:	Pursuant to Federal Health Plan Affordability regulations, the Single monthly health plan contribution of the HSA plan (least costly plan) will not exceed 8.39% of pay. If you are electing Single coverage under the HSA plan and the contribution above exceeds 8.39% of your pay, contact Barb Menso in Human Resources, immediately to obtain your specific costs based on your income.

The above information is a brief summary. It does not include all medical plan provisions or limitations. See the expanded Summary of Benefits and Coverage for expanded details