

CRSIG - HSA Benefit Summaries

	Kaiser HSA	United Healthcare HSA 7PD	
		In Network	Out of Network
Annual Deductible (individual/family)	\$2,500 / \$5,000 Individual deductible applies for self only or any one member in a family	\$2,500 / \$5,000	\$4,500 / \$9,000 Individual deductible applies for self only or any one member in a family
Annual Maximum Copayments (individual / family)	\$2,500 / \$5,000 includes deductible Individual OOP max applies for self only or any one member in a family	\$3,500 / \$7,000 includes deductible	\$5,500 / \$11,000 includes deductible Individual OOP max applies for self only or any one member in a family
Lifetime Maximum	Unlimited	\$5,000,000	
Physician Office Visits/ Specialist Office Visit	No charge	20%	40%
Well Child Preventive Care	No charge (deductible waived)	No charge (deductible waived)	Not covered
Adult Preventive Care	No charge (deductible waived)	No charge (deductible waived)	Not covered
Room & Board Hospital Inpatient (semi-private)	No charge	20%	40%
Outpatient Surgery	No charge	20%	40%
Diagnostic X-Ray and Lab Tests	No charge (deductible waived for preventive screenings only)	20%	40%
Emergency Room Services	No charge	20%	
Urgent Care Services	No charge	20%	40%
Ambulance Services	No charge	20%	
Skilled Nursing Facility	No charge up to 100 days per benefit period	20% up to 60 days per year	40%
Durable Medical Equipment	No charge up to \$2,500 per calendar year	20% up to \$2,500 per year	40%
Prescription Drugs - Retail	No charge up to a 100 day supply	\$10 T1 / \$30 T2 / \$50 T3 up to a 31 day supply	\$10 T1 / \$30 T2 / \$50 T3 up to a 31 day supply
Prescription Drugs - Mail Order	No charge up to a 100 day supply	\$25 T1 / \$75 T2 / \$125 T3 up to a 90 day supply	Not covered
Self-Administered Injectibles	No charge	Covered under Medical benefit	
Chiropractic Care	Not covered	20% up to 24 visits per year	40%
Vision Exams	No charge - Exam Only	20% - Exam Only (once every 2 years)	Not covered
Monthly Premium Rates			
Employee Only	\$403.48	\$492.00	
Employee + One Dependent	\$851.34	\$1,038.12	
Employee + Two or More Dependents	\$1,218.50	\$1,485.85	

The information presented in the chart is a summary only. The information does not include all of the detailed explanation of benefits, exclusions and limitations. Plan participants should refer to the Evidence of Coverage (EOC) document for coverage details. In the event information in this summary differs from the EOC, the EOC will prevail.

* All benefits including prescriptions are subject to the deductible unless otherwise noted.