HOMETOWN HEALTH AND BUILDERS ASSOCIATION OF NORTHERN NEVADA
BRIEF SUMMARY OF PPO PLAN KEY BENEFITS

PPO										
Medical Plan	PPO 10-8060 D0250X3 S 2009		PPO 15-8060 D0500X3 S 2009		PPO 20-7050 D1000X3 S 2009		PPO 15-8060 D0500X3 P 2009		PPO 20-8060 D1000X3 S 2009	
Pharmacy Plan	RX $10-$30 ($50)		RX $10-$30 ($50)		RX $10-$30 ($50)		RX $10-$30 ($50)		RX $10-$30 ($50)	
Vision Plan	VSP EXAM PLUS $0		VSP EXAM PLUS $0		VSP EXAM PLUS $0		VSP EXAM PLUS $0		VSP EXAM PLUS $0	
Key Benefits - Member Responsibilities										
Deductibles –	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Single	$ 250	$ 500	$ 500	$ 1,000	$ 1,000	$ 2,000	$ 500	$ 1,000	$ 1,000	$ 2,000
Family	$ 750	$ 1,500	$ 1,500	$ 3,000	$ 3,000	$ 6,000	$ 1,500	$ 3,000	$ 3,000	$ 6,000
Max Annual Out-of-Pocket coinsurance –	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Single	$ 4,000	$ 8,000	$ 4,000	$ 8,000	$ 6,000	$ 12,000	$ 4,000	$ 8,000	$ 4,000	$ 8,000
Family	$ 12,000	$ 24,000	$ 12,000	$ 24,000	$ 18,000	$ 36,000	$ 12,000	$ 24,000	$ 12,000	$ 24,000
Medical Benefits	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
PCP office visits (includes wellness and OBGYN)	$ 10 copay / visit	40% coinsurance	$ 15 copay / visit	40% coinsurance	$ 20 copay / visit	50% coinsurance	$ 15 copay / visit	40% coinsurance	$ 20 copay / visit	40% coinsurance
Specialty care physician office visits	$ 20 copay / visit	40% coinsurance	$ 30 copay / visit	40% coinsurance	$ 40 copay / visit	50% coinsurance	$ 30 copay / visit	40% coinsurance	$ 40 copay / visit	40% coinsurance
Acute care hospital inpatient admissions	20% coinsurance	40% coinsurance	20% coinsurance	40% coinsurance	30% coinsurance	50% coinsurance	20% coinsurance	40% coinsurance	20% coinsurance	40% coinsurance
Emergency room services	20% coinsurance	40% coinsurance	20% coinsurance	40% coinsurance	30% coinsurance	50% coinsurance	$100 copay / visit	40% coinsurance	20% coinsurance	40% coinsurance
Urgent care center services	$ 35 copay / visit	40% coinsurance	$ 35 copay / visit	40% coinsurance	$ 40 copay / visit	50% coinsurance	$ 35 copay / visit	40% coinsurance	$ 40 copay / visit	40% coinsurance
Imaging services (excluding CT, PET & MRI)	20% coinsurance	40% coinsurance	20% coinsurance	40% coinsurance	30% coinsurance	50% coinsurance	no charge	40% coinsurance	20% coinsurance	40% coinsurance
General laboratory services	20% coinsurance	40% coinsurance	20% coinsurance	40% coinsurance	30% coinsurance	50% coinsurance	no charge	40% coinsurance	20% coinsurance	40% coinsurance
Pharmacy Benefits										
Formulary generic drugs	$10 copay / 30 day supply		$10 copay / 30 day supply		$10 copay / 30 day supply		$10 copay / 30 day supply		$10 copay / 30 day supply	
Formulary brand name drugs	$30 copay / 30 day supply		$30 copay / 30 day supply		$30 copay / 30 day supply		$30 copay / 30 day supply		$30 copay / 30 day supply	
Non-formulary drugs	$50 copay / 30 day supply		$50 copay / 30 day supply		$50 copay / 30 day supply		$50 copay / 30 day supply		$50 copay / 30 day supply	
VSP Vision Benefits										
Benefit frequency (exam / lens / frame)	12mo. / na / na		12mo. / na / na		12mo. / na / na		12mo. / na / na		12mo. / na / na	
copay (exam)	$0 copay		$0 copay		$0 copay		$0 copay		$0 copay	
Frame allowance	20% Discount		20% Discount		20% Discount		20% Discount		20% Discount	

PPO								
Medical Plan	PPO 20-8060 D2000X3 P 2009		PPO 30-7050 D2000X3 S 2009		PPO 30-8060 D3000X3 S 2009		PPO 40-7050 D4000X3 P 2009	
Pharmacy Plan	RX $15-$40 ($60)		RX $15-$40 ($60)		RX $15-$40 ($60)		RX $15-$40 ($60)	
Vision Plan	VSP EXAM PLUS $0		VSP EXAM PLUS $0		VSP EXAM PLUS $0		VSP EXAM PLUS $0	
Key Benefits - Member Responsibilities								
Deductibles –	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Single	$ 2,000	$ 4,000	$ 2,000	$ 4,000	$ 3,000	$ 6,000	$ 4,000	$ 8,000
Family	$ 6,000	$ 12,000	$ 6,000	$ 12,000	$ 9,000	$ 18,000	$ 12,000	$ 24,000
Max Annual Out-of-Pocket coinsurance –	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Single	$ 4,000	$ 8,000	$ 6,000	$ 12,000	$ 4,000	$ 8,000	$ 6,000	$ 12,000
Family	$ 12,000	$ 24,000	$ 18,000	$ 36,000	$ 12,000	$ 24,000	$ 18,000	$ 36,000
Medical Benefits	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
PCP office visits (includes wellness and OBGYN)	$ 20 copay / visit	40% coinsurance	$ 30 copay / visit	50% coinsurance	$ 30 copay / visit	40% coinsurance	$ 40 copay / visit	50% coinsurance
Specialty care physician office visits	$ 40 copay / visit	40% coinsurance	$ 50 copay / visit	50% coinsurance	$ 50 copay / visit	40% coinsurance	$ 50 copay / visit	50% coinsurance
Acute care hospital inpatient admissions	20% coinsurance	40% coinsurance	30% coinsurance	50% coinsurance	20% coinsurance	40% coinsurance	30% coinsurance	50% coinsurance
Emergency room services	$100 copay / visit	40% coinsurance	30% coinsurance	50% coinsurance	20% coinsurance	40% coinsurance	$100 copay / visit	50% coinsurance
Urgent care center services	$ 40 copay / visit	40% coinsurance	$ 50 copay / visit	50% coinsurance	$ 50 copay / visit	40% coinsurance	$ 50 copay / visit	50% coinsurance
Imaging services (excluding CT, PET & MRI)	no charge	40% coinsurance	30% coinsurance	50% coinsurance	20% coinsurance	40% coinsurance	no charge	50% coinsurance
General laboratory services	no charge	40% coinsurance	30% coinsurance	50% coinsurance	20% coinsurance	40% coinsurance	no charge	50% coinsurance
Pharmacy Benefits								
Formulary generic drugs	$15 copay / 30 day supply		$15 copay / 30 day supply		$15 copay / 30 day supply		$15 copay / 30 day supply	
Formulary brand name drugs	$40 copay / 30 day supply		$40 copay / 30 day supply		$40 copay / 30 day supply		$40 copay / 30 day supply	
Non-formulary drugs	$60 copay / 30 day supply		$60 copay / 30 day supply		$60 copay / 30 day supply		$60 copay / 30 day supply	
VSP Vision Benefits								
Benefit frequency (exam / lens / frame)	12mo. / na / na		12mo. / na / na		12mo. / na / na		12mo. / na / na	
copay (exam)	$0 copay		$0 copay		$0 copay		$0 copay	
Frame allowance	20% Discount		20% Discount		20% Discount		20% Discount	

D= Deductible
S= Standard Plan
P= Plus Plan

Complete Summary of Benefits for each plan is available upon request