

**HOMETOWN HEALTH AND BUILDERS ASSOCIATION OF NORTHERN NEVADA
BRIEF SUMMARY OF HEALTH SAVINGS PLANS ~ H.S.A. ~ KEY BENEFITS**



H. S. A.	HSA HD-8060 D1500X2 P 2009		HSA HD-8060 D2000X2 P 2009		HSA HD-8060 D2500X2 P 2009		HSA HD-7555 D2500X2 P 2009		HSA HD-7555 D3000X2 S 2009	
Medical & Pharmacy Plan	Preventative		Preventative		Preventative		Preventative		Standard	
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	\$ 1,500	\$ 3,000	\$ 2,000	\$ 4,000	\$ 2,500	\$ 5,000	\$ 2,500	\$ 5,000	\$ 3,000	\$ 6,000
Family	\$ 3,000	\$ 6,000	\$ 4,000	\$ 8,000	\$ 5,000	\$ 10,000	\$ 5,000	\$ 10,000	\$ 6,000	\$ 12,000
Maximum Annual Out-of-Pocket Cost –	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	\$ 5,800	\$ 11,600	\$ 5,800	\$ 11,600	\$ 5,800	\$ 11,600	\$ 5,800	\$ 11,600	\$ 5,800	\$ 11,600
Family	\$ 11,600	\$ 23,200	\$ 11,600	\$ 23,200	\$ 11,600	\$ 23,200	\$ 11,600	\$ 23,200	\$ 11,600	\$ 23,200
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
Preventative care office visits	no-charge	40% coinsurance	no-charge	40% coinsurance	no-charge	40% coinsurance	no-charge	45% coinsurance	25% coinsurance	45% coinsurance
Primary & Specialty care physician office visits	20% coinsurance	40% coinsurance	20% coinsurance	40% coinsurance	20% coinsurance	40% coinsurance	25% coinsurance	45% coinsurance	25% coinsurance	45% coinsurance
Acute care hospital inpatient admissions	20% coinsurance	40% coinsurance	20% coinsurance	40% coinsurance	20% coinsurance	40% coinsurance	25% coinsurance	45% coinsurance	25% coinsurance	45% coinsurance
Emergency room services	20% coinsurance	40% coinsurance	20% coinsurance	40% coinsurance	20% coinsurance	40% coinsurance	25% coinsurance	45% coinsurance	25% coinsurance	45% coinsurance
Urgent care center services	20% coinsurance	40% coinsurance	20% coinsurance	40% coinsurance	20% coinsurance	40% coinsurance	25% coinsurance	45% coinsurance	25% coinsurance	45% coinsurance
Imaging services (excluding CT, PET & MRI)	20% coinsurance	40% coinsurance	20% coinsurance	40% coinsurance	20% coinsurance	40% coinsurance	25% coinsurance	45% coinsurance	25% coinsurance	45% coinsurance
General laboratory services	20% coinsurance	40% coinsurance	20% coinsurance	40% coinsurance	20% coinsurance	40% coinsurance	25% coinsurance	45% coinsurance	25% coinsurance	45% coinsurance
Pharmacy 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
Formulary generic drugs	20% coinsurance	40% coinsurance	20% coinsurance	40% coinsurance	20% coinsurance	40% coinsurance	25% coinsurance	45% coinsurance	25% coinsurance	45% coinsurance
Formulary brand name drugs	20% coinsurance	40% coinsurance	20% coinsurance	40% coinsurance	20% coinsurance	40% coinsurance	25% coinsurance	45% coinsurance	25% coinsurance	45% coinsurance
Non-formulary drugs	20% coinsurance	40% coinsurance	20% coinsurance	40% coinsurance	20% coinsurance	40% coinsurance	25% coinsurance	45% coinsurance	25% coinsurance	45% coinsurance
VSP Vision Benefits										
Benefit frequency (exam / lens / frame)	12mo.		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	

D= Deductible

P= Preventative care at no charge

S= Standard / coinsurance required for Preventative care

Complete Summary of Benefits for each plan is available upon request