

**HSTA VEBA TRUST
HMSA 90/10 PPO MEDICAL & DRUG PLAN
FOR ACTIVES**

(Please refer to the plan document for a complete description of the benefits)

PLAN BENEFITS	PARTICIPATING PROVIDER	NON-PARTICIPATING PROVIDER
	(Based on Eligible Charge)	(Based on Eligible Charge)
	MEMBER COPAYMENT	MEMBER COPAYMENT
Annual Deductible per Calendar Year	None	\$100/person; \$300 per family
Physician Visits	10% Copayment	Annual Deductible, 30% Copay and charges exceeding Eligible Charge
Immunizations	None	Annual Deductible, 30% Copay and charges exceeding Eligible Charge
Surgery	10% Copayment	Annual Deductible, 30% Copay and charges exceeding Eligible Charge
Anesthesiology	10% Copayment	Annual Deductible, 30% Copay and charges exceeding Eligible Charge
Hospital Room & Care (Semi-Private Room)	10% Copayment	Annual Deductible, 30% Copay and charges exceeding Eligible Charge
Isolation, Intensive, Coronary Care Unit	10% Copayment	Annual Deductible, 30% Copay and charges exceeding Eligible Charge
Lab, X-ray & Radiation Therapy	10% Copayment	Annual Deductible, 30% Copay and charges exceeding Eligible Charge
Physical, Occupational & Speech Therapy	10% Copayment	Annual Deductible, 30% Copay and charges exceeding Eligible Charge
Emergency Room	10% Copayment	30% Copay and charges exceeding Eligible Charge
Ambulance – Ground Service	10% Copayment	Annual Deductible, 30% Copay and charges exceeding Eligible Charge
Screening Mammography	10% Copayment	30% Copay and charges exceeding Eligible Charge
Chemotherapy	10% Copayment	Annual Deductible, 30% Copay and charges exceeding Eligible Charge
Home Health Care (150 Visits/C.Y.)	None	Annual Deductible, 30% Copay and charges exceeding Eligible Charge
Skilled Nursing Facility (120 Days/C.Y.)	10% Copayment	Annual Deductible, 30% Copay and charges exceeding Eligible charge
Hospice Care	None	Not Available

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Physical Exam	Benefit Based on Age	All charges exceeding Plan Benefits
Health Pass Exam & Screening	Free annual health assessment	Not Available
Care Connection	Disease management programs for chronic medical conditions & diseases	Not Available
Annual Copayment Maximum (Paid by the Member)	\$2,000/Single; \$6,000/Family	\$2,000/Single; \$6,000/Family
Lifetime Maximum (Paid by the Plan)	\$2,000,000 per Person	\$2,000,000 per Person
PRESCRIPTION DRUGS – RETAIL	30 Day Supply	30 Day Supply
Generic Drugs	\$5.00 Copayment	\$5.00 Copay plus 30% of Charge
Brand Name Drugs	\$15.00 Copayment	\$15.00 Copay plus 30% of Charge
PRESCRIPTION DRUGS - MAIL ORDER	90 Day Supply	Not Available
Generic Drugs	\$9.00 Copayment	Not Available
Brand Name Drugs	\$27.00 Copayment	Not Available

For Non-Participating Provider Services:

- You must pay a one-time Annual Deductible per calendar year.
- Annual Deductible *does not* apply to Well Child visits, labs and immunizations.

For more information or assistance in finding a Participating Providers please visit the HMSA website at: www.hmsa.com