NON-MEDICARE RETIREES

Medical Plan Coverage Chart (HMSA and Kaiser) - HSTA VB

SUMMARY OF YOUR PAYMENT OBLIGATIONS UNDER EACH PLAN Benefits will be administered as described in each plan's documents.			
Plan Provisions	**HMSA PPO**		**Kaiser HMO**
General			
Calendar Year Deductible Single/Family	$100 per person Maximum $300 per family		None/None
Calendar Year Out-of-pocket limit Single/Family	$2,000 per person Maximum $6,000 per family		$2,000 per person Maximum $6,000 per family
Lifetime Benefit Maximum	$2,000,000		None
	Your Copayment		
	In-Network	**Out-of-Network**	
Physician Services			
Primary Care Office Visit	10%*	30%	$15
Specialist Office Visit	10%*	30%	$15
Routine physical exams	No Charge*; limited to combined CY dollar max depending on age scale	No Charge*; limited to combined CY dollar max depending on age scale	No Charge
Mammography	10%*	30%	No Charge
Second opinion – surgery	10%*	30%	$15
Emergency Room (ER care)	10%*	10%*	$50 in area / 20% out
Ambulance	10%*	30%	20%
Inpatient Hospital Services			
Room & Board	10%*	30%	No Charge
Ancillary Services	10%*	30%	No Charge
Physician services	10%*	30%	No Charge
Surgery	10%*	30%	No Charge
Anesthesia	10%*	30%	No Charge
Outpatient Services			
Chemotherapy	10%*	30%	$15
Radiation Therapy	10%*	30%	$15
Surgery	10%*	30%	$15
Allergy Testing	10%*	30%	$15
Other Diag. Lab, X-ray & Psych Testing	10%*	30%	$15
Anesthesia	10%*	30%	No Charge; $15 office visit copay applies
Mental Health Services			
Inpatient care	10%*	30%	No Charge
Outpatient Care	10%*	30%	$15
Other Services			
Durable Medical Equipment	10%*	30%	20%
Home Health care	No Charge*	30%	No Charge
Hospice Care	No Charge*	Not Covered	No Charge
Nursing facility - skilled care	10%*; 120 days per year	30%; 120 days per year	No Charge, 100 days benefit period
Physical & Occupational Therapy	10%*	30%	$15

*Deductible does not apply.