



**Scantic Valley Regional Health Trust - Exclusive (FI-with deductible)
HMO Summary of Benefit Chart**

This chart provides a summary of key services offered by your plan. Consult your Member Agreement for a full description of your plan’s benefits and provisions. If any terms in this summary differ from those in your Member Agreement, the terms of the Member Agreement apply.

- Many services require you to pay a Copayment at the time of service.
- **Note about Prior Approval:**
Some services may require Prior Approval. These services are marked with † in the chart. If you do not obtain Prior Approval, benefits may be denied.

	In-Plan
Deductible per Calendar Year: You must pay this amount for Covered Services before the Plan will begin to pay benefits. The Deductibles are applied on a plan year basis, from July 1 through June 30 of the following year. As indicated in the chart below, some services are not subject to the Deductible.)	\$250 per member/ \$750 per family
In-Plan Out-of-Pocket Maximum: the most you pay for cost sharing on Essential Health Benefits during a Plan Year before your plan begins to pay 100% of the allowed amount.	Medical: \$2,000 per member/ \$4,000 per family
	Pharmacy: \$3,000 per member/ \$6,000 per family

Benefit	Deductible	Copayment
Inpatient Care		
Acute Hospital Care*	Yes	\$500/admission
Skilled Care and Inpatient Rehabilitation †* (limited to 100 days per Calendar Year)	Yes	\$0
Outpatient Preventive Care		
PCP Office Visits*	No	\$0
Adult Routine Exams* (Members age 18 and older)	No	\$0
Well Child Care*	No	\$0
Child and Adult Routine Immunizations*	No	\$0
Routine Eye Exams* (limited to one per Calendar Year)	No	\$0
Annual Gynecological Exams*	No	\$0
Routine Mammograms* (one per Calendar Year)	No	\$0
Routine Prenatal & Postpartum Care*	No	\$0
Screening Colonoscopy or Sigmoidoscopy* (limited to one every five Calendar Years; office visits prior to the procedure, related prep prescriptions and subsequent pathology are subject to applicable Copays)	No	\$0
Nutritional Counseling* (limited to four visits per Calendar Year)	No	\$0
Other Outpatient Care		
PCP Office Visit* (Non-Routine)	No	\$20/visit

* Essential Health Benefits (EHB) as defined by the Affordable Care Act (ACA).

Benefit	Deductible	Copayment
Specialist Office Visits*	No	\$35/visit
Second Opinions*	No	\$35/visit
Hearing Tests	No	\$20/visit
Diabetic-Related Items:		
• • Outpatient Services* (some services require Prior Approval)	No	\$35/visit
• • Lab/Radiological Services*	Yes	\$0
• • Durable Medical Equipment* (some items require Prior Approval)	Yes	20% coinsurance
• • Individual Diabetic Education	No	\$35/visit
• • Group Diabetic Education	No	\$35/session
Emergency Room Care * (Copay waived if admitted directly from the ER)	Yes	\$100/visit
Diagnostic Testing*		
• • In a doctor's office	No	\$35/visit
• • In all other settings	Yes	\$150/copay
Lab Services*	Yes	\$0
Radiological Services: Ultrasound, X-rays, Non-Routine Mammograms *	Yes	\$0
Sleep Study* (maximum of two per Calendar Year)	Yes	\$0
Diagnostic Imaging: CT Scans, MRIs, MRAs, PET Scans , Nuclear Cardiology †*(Nuclear Cardiac Imaging requires Prior Approval only when done in a doctor's office)		
• • Outpatient hospital based services	Yes	\$100/visit
• • Outpatient non-hospital based services	Yes	\$0
Outpatient Short-Term Rehabilitation Services* (Limited to two months or 25 visits per condition per Calendar Year for physical or occupational therapy. The limit does not apply when services are provided to treat Autism Spectrum Disorder.)	No	\$20/visit per treatment type
Day Rehabilitation Program* (limited to 15 full day or ½ day sessions per condition per lifetime)	No	\$25/day or half day
Early Intervention Services (Limited to \$5,200 per child per Calendar Year with a lifetime maximum of \$15,600. Covered for children from birth to age three.)	No	\$35/visit
Applied Behavioral Analysis (ABA) to treat Autism Spectrum Disorders	No	\$0
Outpatient Surgical Services and Procedures* (some services require Prior Approval)		
• • In a doctor's office	No	\$35/visit
• • In all other settings	Yes	\$150/copay
Allergy Testing and Treatment*	No	\$35/visit
Allergy Injections*	No	\$0
Infertility Services		
Outpatient Care	No	\$35/visit
Lab Test	Yes	\$0
Inpatient Care†	Yes	\$500/admission

Benefit	Deductible	Copayment
Maternity Care		
Delivery/Hospital Care for Mother and Child * (Coverage for child limited to routine newborn nursery charges. For continued coverage, child must be enrolled within 30 days of date of birth. Routine nursery charges not covered for child of dependent other than spouse.)	Yes	\$500/admission
Dental Services		
Surgical Treatment of Non-Dental Conditions		
• • In an Emergency Room (Copay waived if admitted directly from the ER)	Yes	\$100/visit
• • In a Doctor's or Dentist's office*	No	\$35/visit
Routine dental services for children under the age of 12. (You pay the first \$25 per child per Calendar Year.)	No	\$0
Other Services		
Home Health Care †*	Yes	\$0
Hospice Services †*	No	\$0
Durable Medical Equipment* (some items require Prior Approval)	Yes	20% coinsurance
• • Wigs (Scalp Hair Prostheses) for hair loss due to treatment of any form of cancer or leukemia.* (HNE covers 1 prosthesis per Calendar Year.)	No	\$0
• • Prosthetic Limbs†*	Yes	20% coinsurance
Ambulance and Transportation Services * (includes Chair Van services)	No	\$25/member/day
Radiation and Chemotherapy*	Yes	\$0
Kidney Dialysis*	Yes	\$0
Nutritional Support †	No	\$0
Cardiac Rehabilitation*	No	\$35/visit
Speech, Hearing, and Language Disorders †* (Prior Approval is required for speech therapy services after the initial evaluation visit)	No	\$20/visit
Hearing Aids† (Covered with Prior Approval for Members age 21 and under. HNE covers the cost of one hearing aid per hearing impaired ear, every 36 months, up to a maximum of \$2,000 for each hearing aid.)	No	\$0 up to \$2,000 per device per ear (you are responsible for all costs beyond maximum)
Human Organ Transplants and Bone Marrow Transplants †*	Yes	\$500/admission
Behavioral Health Services (Mental Health or Substance Abuse)		
Inpatient Services †*	Yes	\$500/admission
Outpatient Services †*	No	\$20/visit
Fitness and Weight Loss Reimbursement Program		
Fitness	N/A	\$150 per family per Calendar Year
Weight Loss (WeightWatchers®)	N/A	\$150 per family per Calendar Year

P R E S C R I P T I O N D R U G C O V E R A G E

Prescription Drugs (<i>certain drugs require Prior Approval</i>) Your Prescription Drug benefit covers those items described in the HNE Formulary. Please call Member Services or visit hne.com for a copy of the HNE Formulary.	Copay
At a Pharmacy (up to a 30-day supply)	
Generic Drugs	\$10
Formulary Drugs	\$25
Non-Formulary Drugs	\$50
Through Mail Order: (a 90-day supply of maintenance medication)	
Generic Drugs	\$20
Formulary Drugs	\$50
Non-Formulary Drugs	\$110