Scantic Valley Regional Health Trust - Exclusive (FI- with Deductible)

HMO Benefit Chart

July 1, 2023

This chart provides a summary of key services offered by your Plan. Your Summary Plan Description (SPD) has a full description of your Plan's benefits and provisions. If any terms in this summary differ from those in your SPD, the terms of the SPD apply.

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 HNE Providers
Deductible per Calendar Year: You must pay this amount for Covered Services before Health New England will begin to pay benefits. As indicated in the chart below, some services are not subject to the Deductible.	$250 per Individual / $750 per Family
In-Plan Out-of-Pocket Maximum: The most you pay for Cost Sharing on Essential Health Benefits during a Calendar Year before your Plan begins to pay 100% of the Allowed Amount.	**Medical:** $2,000 per Individual / $4,000 per Family
	Pharmacy: $3,000 per Individual / $6,000 per Family

Benefit	Your Cost In-Plan HNE Providers
Inpatient Care	
Acute Hospital Care	$500 Copay per admission after Deductible
Skilled Nursing Facility and Inpatient Rehabilitation † (Limited to 100 days per Calendar Year)	$0 after Deductible
Preventive Care	
Adult Routine Exams (Members age 18 and older)	$0
Well Child Care	$0
Child and Adult Routine Immunizations	$0
Routine Prenatal & Postpartum Care	$0
Routine Eye Exams (Limited to 1 per Calendar Year)	$0
Annual Gynecological Exams	$0
Routine Mammograms (Limited to 1 per Calendar Year)	$0

Benefit	Your Cost In-Plan HNE Providers
Screening Colonoscopy or Sigmoidoscopy (Limited to 1 every 5 Years)	$0
Nutritional Counseling (Limited to 4 visits per Calendar Year)	$0
Outpatient Care	
Primary Care Office Visit (Non-Routine)	$20 Copay per visit
Specialist Care Office Visit	$35 Copay per visit
Second Opinions	$35 Copay per visit
Hearing Tests in Specialist Office or Outpatient Facility (other than routine screenings covered as part of your Annual Routine Exam)	$20 Copay per visit
Diabetic-Related Items:	
• Outpatient Services (Some services require Prior Approval.)	$35 Copay per visit
• Lab Services	$0 after Deductible
• Radiological Services	$0 after Deductible
• Durable Medical Equipment (some DME items require Prior Approval)	20% Coinsurance after Deductible
• Individual Diabetic Education	$35 Copay per visit
• Group Diabetic Education	$20 Copay per session
Emergency Room Care (Copay waived if admitted directly from the ER.)	$100 Copay per visit after Deductible
Diagnostic Testing (some services, including, but not limited to, sigmoidoscopies, endoscopies, colonoscopies, arthroscopies, needle aspirations, and biopsies, are covered under the Surgical Services and Procedures in an Outpatient Facility benefit)	$35 Copay
Sleep Study†	$0 after Deductible
Lab Services	$0 after Deductible
Radiological Services: Ultrasound, X-rays, Non-Routine Mammograms†	$0 after Deductible
Diagnostic Imaging: CT Scans, MRIs, MRAs, PET Scans, Nuclear Cardiac Imaging† (Nuclear Cardiac Imaging requires Prior Approval in all outpatient settings, including outpatient facilities and doctor's offices)	
• Outpatient hospital based services	$100 Copay after Deductible
• Outpatient non-hospital based services	$0 after Deductible

Benefit	Your Cost In-Plan HNE Providers
Outpatient Short-Term Rehabilitation Services (Limited to 60 visits per Calendar Year for physical or occupational therapy. The Calendar year limit does not apply to services that are part of a home health plan. The limit also does not apply when services are provided to treat autism spectrum disorder.) Services that are part of a home health plan and services provided to treat autism spectrum disorder require Prior Approval.)	$20 Copay per visit per treatment type
Day Rehabilitation Program (Limited to 15 full day or ½ day sessions per condition per lifetime)	$25 Copay for 1 day or 1/2 day
Early Intervention Services	$35 Copay
Applied Behavioral Analysis (ABA) to treat Autism Spectrum Disorder	$0
Surgical Services and Procedures in an Outpatient Facility	
• In a Doctor's Office	$35 Copay
• In all other settings	$150 Copay after Deductible
Allergy Testing and Treatment	$35 Copay per visit
Allergy Injections	$0
Infertility Services	
Some infertility services are covered only for Massachusetts and Connecticut residents. Some services require Prior Approval.	
• Office Visit	$35 Copay per visit
• Lab Test	$0 after Deductible
• Inpatient Care†	$500 Copay per admission after Deductible
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.)	$500 Copay after Deductible
Dental Services	
Surgical Treatment of Non-Dental Conditions	
• In a Doctor's Office	$35 Copay per visit
• In an Emergency Room (Copay waived if admitted directly from the ER)	$100 Copay per visit after Deductible
Other Services	
Home Health Care†	$0 after Deductible
Hospice Services†	$0
Durable Medical Equipment (some DME items require Prior Approval)	20% Coinsurance after Deductible

Benefit	Your Cost In-Plan HNE Providers
Prosthetic Devices†	20% Coinsurance after Deductible
Ambulance and Transportation Services	$25 Copay per day
Kidney Dialysis	$0
Nutritional Support † (not covered without Prior Approval)	$0
Cardiac Rehabilitation	$35 Copay per visit
Wigs (Scalp Hair Prostheses) for hair loss due to treatment of any form of cancer or leukemia. Limited to 1 prosthesis per Calendar Year)	$0
Speech, Hearing, and Language Disorders† (Prior Approval is required for speech therapy services after the initial evaluation.)	$20 Copay per visit
Hearing Aids† (Covered with Prior Approval for Members age 21 and under. The Plan covers the cost of one hearing aid per hearing-impaired ear, every 36 months, up to maximum of $2,000 for each hearing aid.)	$0 up to $2,000 per device per ear (you are responsible for all costs beyond maximum)
Human Organ Transplants and Bone Marrow Transplants†	$500 Copay per admission after Deductible
Chiropractic Care	
Chiropractic Care (Limited to 12 visits per Calendar Year. After your first visit to an In-Plan Provider your chiropractor must get authorization for services to be covered from OptumHealth Solutions. OptumHealth Solutions will work with your In-Plan chiropractor to determine the appropriate level of covered services to treat your condition.)	$20 Copay
Wellness Services	
The plan reimburses for certain fitness and wellness activities, including acupuncture and hypnosis related to weight loss, Weight Watchers®, gym membership, personal training, golf, ski tickets, fitness equipment, farm shares, wellness and fitness apps, nutrition apps, mindfulness apps, bike shares and more. The $400 payment for a family can be split among family members of the plan. The maximum for each member on the plan is $200.	$200 per Individual / $400 per Family
Acupuncture (limited to 12 visits per calendar year)	$20 Copay
Behavioral Health (Includes Mental Health and Substance Use Disorder)	
Outpatient Services†	$20 Copay per visit
Inpatient Services†	$500 Copay per admission after Deductible

Prescription Drugs *(certain drug require Prior Approval).* Your prescription Drug benefit is based on the Health New England (HNE) Formulary. Please call Member Services or visit healthnewengland.org for a copy of the HNE Formulary.	
At an Retail Pharmacy (up to a 30 day supply)	
Generic Drugs	$10 Copay
Formulary Drugs	$25 Copay
Non-Formulary Drugs	$50 Copay
Through Mail Order (up to a 90 day supply of maintenance medication)	
Generic Drugs	$20 Copay
Formulary Drugs	$50 Copay
Non-Formulary Drugs	$110 Copay

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You have the right to get help and information in your language at no cost. To request an interpreter, call the toll-free member phone number listed on your health plan ID card, press 0 (TTY: 711). Tiene derecho a recibir ayuda e información en su idioma sin costo. Para solicitar un intérprete, llame al número de teléfono gratuito para miembros que se encuentra en su tarjeta de identificación del plan de salud y presione 0 (TTY: 711). Você tem o direito de obter ajuda e informação em seu idioma e sem custos. Para solicitar um intérprete, ligue para o número de telefone gratuito que consta no cartão de ID do seu plano de saúde, pressione 0 (TTY: 711).