

City of Northampton HMO

(Plan effective July 1, 2009)

HMO Summary of Benefits Chart

This chart provides a summary of key services offered by your HNE 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.

Please Note: Some services may require prior approval from HNE. See your member agreement for a list of services that require prior approval.

<p>Out-of-Pocket Maximum per Year This applies to copayments of \$100 or more for inpatient care, emergency room care, and outpatient surgical services and procedures. Once you have paid the Out-of-Pocket Maximum, you will not have to pay a copayment for these types of services for the rest of the year.</p>	<p>\$500 per individual \$1,000 per family</p>
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BENEFIT	Copayment
Inpatient Care	
<ul style="list-style-type: none"> • Acute Hospital Care • Acute Inpatient Rehabilitation (<i>60 day calendar year maximum</i>) • Infertility Services • Maternity Care • Mental Health Services (<i>care for some conditions may be limited to 60 days per calendar year maximum</i>) • Substance Abuse Services 	\$250/admission
Skilled Nursing Facility (<i>100 day calendar year maximum</i>)	\$0/admission
Outpatient Preventive Care	\$0/visit
Other Outpatient Care	
PCP Office Visits (<i>non-routine</i>)	\$15/visit
Specialist Office Visits	\$25/visit
Routine Eye Exams (<i>one per calendar year</i>)	\$0/visit
Individual Diabetic Education	\$25/visit
Group Diabetic Education	\$15/session
Emergency Room Care (<i>copayment waived if admitted directly from ER</i>)	\$100/visit
Laboratory Services	\$0
Radiological Services: Ultrasound, X-rays, Nuclear Cardiology, Mammograms	\$0

BENEFIT	Copayment
Diagnostic Imaging: CT Scans, MRIs, MRAs, PET Scans	\$0
Outpatient Short-Term Rehabilitation Services <i>(60 visits per calendar year for physical or occupational therapy)</i>	\$25/visit/treatment type
Day Rehabilitation Program <i>(limited to 15 full day or half day sessions per condition per lifetime)</i>	\$25/day or half day
Early Intervention Services <i>(limited to \$5,200 per child per calendar year with a lifetime maximum of \$15,600. Covered for children from birth to age 3)</i>	\$25/visit
Outpatient Surgical Services and Procedures	\$150/visit, based on specific surgical procedure
Screening Colonoscopy or Sigmoidoscopy <i>(one every 5 calendar years; if done in a doctor's office, office visit copay may apply)</i>	\$150/visit
Family Planning Services and Infertility Treatment <i>(Some services are covered only for Massachusetts residents and for Connecticut residents under the age of 40.)</i>	Some Assisted Reproductive Services consist of outpatient surgery procedures; certain surgical procedures are subject to the outpatient surgical services and procedures copayment.
Office Visit	\$25/visit
Laboratory Tests	\$0
Inpatient Care	\$250/admission
Outpatient Surgical Services and Procedures	\$150/visit
Children's Preventive Dental <i>(limited to preventive services for children under age 12)</i> A separate \$25 per child per calendar year deductible applies only to services from Out-of-Plan dentists. Out-of-Plan dentists may also bill you for the difference between their charge and HNE's contracted dental network Maximum Allowable Fee.	\$0 for services from a dentist participating with HNE's contracted dental network
Other Services	
Home Health Care	\$0/visit
Hospice Services	\$0/visit
Durable Medical Equipment, including ostomy supplies <i>(limited to \$3,000 per calendar year)</i>	20%
Prosthetic Limbs	20%
Ambulance and Chair Van Services	\$0
Nutritional Counseling <i>(limited to 4 visits per calendar year)</i>	\$25/visit
Human Organ Transplants and Bone Marrow Transplants	\$250/admission
Outpatient Mental Health and Substance Abuse Services	\$15/visit