



BENEFIT TRANSMITTAL SHEET – HOT SPRINGS VILLAGE  
HSVPOMED01

---

**CONFIDENTIAL**

---

**IMPORTANT:** THE ATTACHED IS THE HealthSCOPE BENEFITS COVERAGE INFORMATION YOU REQUESTED. THIS MESSAGE AND ANY ATTACHMENTS ARE INTENDED ONLY FOR THE USE OF THE INDIVIDUAL OR ENTITY TO WHICH IT IS ADDRESSED AND MAY CONTAIN INFORMATION THAT IS PRIVILEGED, CONFIDENTIAL AND EXEMPT FROM DISCLOSURE UNDER APPLICABLE LAW. IF THE READER OF THIS MESSAGE IS NOT THE INTENDED RECIPIENT, OR THE EMPLOYEE OR AGENT RESPONSIBLE FOR DELIVERING THE MESSAGE TO THE INTENDED RECIPIENT, YOU ARE HEREUNDER NOTIFIED THAT ANY DISSEMINATION, DISTRIBUTION OR COPYING OF THIS COMMUNICATION IS STRICTLY PROHIBITED. IF YOU ARE NOT THE INTENDED RECIPIENT, PLEASE NOTIFY THE SENDER UNDER REPLYING TO THIS MESSAGE, AND THEN DELETE IT FROM YOUR SYSTEM. THANK YOU.

THIS INFORMATION IS BEING PROVIDED TO YOU AT YOUR REQUEST AND IS BEING DISCLOSED UNDER HealthSCOPE BENEFITS TO FACILITATE THE TREATMENT, PAYMENT OR HEALTH CARE OPERATIONS IN CONNECTION WITH MEMBER.

Total number of pages including this page: 03



BENEFIT COVERAGE INFORMATION

Verification of coverage or eligibility is not a guarantee of benefits. All claims are subject to review in accordance with the plan's provisions, limitations and exclusions

BENEFIT INFORMATION				
		<u>Calendar Year Deductible</u>	<u>Calendar Year Out of Pocket</u>	
Network(s): EHC Network Type:PPO (Preferred Provider Organization). No referral required. Drug Vendor: Catalyst RX 888-869-4600 Precertification Vendor: AHH, 866-478-0053				
PPO In-Network Individual		\$750	\$3,000	
PPO In-Network Family		\$1,500	\$6,000	
PPO Out-of-Network Individual		\$2,000	Unlimited	
PPO Out-of-Network Family		\$4,000	Unlimited	
<b>Annual Maximum</b>	<b>Unlimited</b>			
<b>Lifetime Maximum</b>	<b>Unlimited</b>			
<u>Benefit Description:</u>	<u>Co-Pay:</u>	<u>Deductible:</u>	<u>Coinsurance:</u>	<u>Benefit Year Limit:</u>
In Network Anesthetist- In-Patient		<b>Yes</b>	80%	
Out of Network Anesthetist- In-Patient		<b>Yes</b>	50%	
In Network Anesthetist- Out-Patient		<b>Yes</b>	80%	
Out of Network Anesthetist- Out-Patient		<b>Yes</b>	50%	
In Network Diagnostic & Lab Office	\$25 GP \$40 Specialist	<b>No</b>	100%	Copay will apply to testing if no OV is billed
Out of Network Diagnostic & Lab Office		<b>Yes</b>	50%	
In Network Diagnostic & Lab In-Patient		<b>Yes</b>	80%	
Out of Network Diagnostic & Lab In-Patient		<b>Yes</b>	50%	
In Network Diagnostic & Lab Out-Patient		<b>Yes</b>	80%	
Out of Network Diagnostic & Lab Out-Patient		<b>Yes</b>	50%	
In Network Emergency Room Services True Emergency	\$200	<b>NO</b>	100%	

Out of Network Emergency Room Services True Emergency	\$200	<u>NO</u>	100%	
In Network Emergency Room Services Non emergency	\$200	<u>NO</u>	100%	
Out of Network Emergency Room Services Non emergency		<u>Yes</u>	50%	
In Network Facility – In-Patient		<u>Yes</u>	80%	Pre-Cert Required. Failure to Pre-Certify will result in a 50% Reduction of Charges
Out of Network Facility – In-Patient		<u>Yes</u>	60%	
In Network Facility – Out-Patient		<u>Yes</u>	80%	
Out of Network Facility – Out-Patient		<u>Yes</u>	60%	
In Network DME		<u>Yes</u>	80%	Precert over \$1,000
Out of Network DME		<u>Yes</u>	60%	
In Network Office Visit General Practitioner	\$25	<u>NO</u>	100%	
Out of Network Office Visit General Practitioner		<u>Yes</u>	50%	
In Network Office Visit Specialist	\$40	<u>NO</u>	100%	
Out of Network Office Visit Specialist		<u>Yes</u>	50%	
In Network Chiropractic	\$25	<u>NO</u>	80%	<b>\$300 ANNUAL MAX</b>
Out of Network Chiropractic		<u>No</u>	Not covered	
In Network Mental/Nervous In-Patient		<u>Yes</u>	80%	Pre-Cert Required. Failure to Pre-Certify will result in a 50% Reduction of Charges
Out of Network Mental/Nervous In-Patient		<u>Yes</u>	50%	
In Network Chemical Dependency/Substance Abuse In-Patient		<u>Yes</u>	80%	
Out of Network Chemical Dependency/Substance Abuse In-Patient		<u>Yes</u>	50%	
In Network Mental/Nervous Out-Patient	\$40 copay per visit	<u>NO</u>	100%	
Out of Network Mental/Nervous Out-Patient		<u>Yes</u>	50%	
In Network Chemical Dependency/Substance Abuse Out-Patient	\$40 copay per visit	<u>NO</u>	100%	
Out of Network Chemical Dependency/Substance Abuse Out-Patient		<u>Yes</u>	50%	
In Network Physician – In-Patient		<u>Yes</u>	80%	
Out of Network Physician – In-Patient		<u>Yes</u>	50%	
Prescriptions		<u>N/A</u>	<u>N/A</u>	Covered under Rx Plan
In Network Preventive/Well Child/Well Baby		<u>NO</u>	100%	
Out of Network Preventive/Well		<u>NO</u>	Not covered	

Child/Well Baby				
In Network Podiatry		<u>Yes</u>	80%	
Out of Network Podiatry		<u>Yes</u>	50%	
Speech Therapy/Occupational Therapy/Physical Therapy In Network		<u>Yes</u>	80%	Therapies for Developmental Delay is Not Covered <b>Precertification required prior to 1<sup>st</sup> visit and every 15 thereafter</b>
Speech Therapy/Occupational Therapy/Physical Therapy Out of Network		<u>Yes</u>	50%	
In Network Surgeon- In-Patient		<u>Yes</u>	80%	
Out of Network Surgeon- In-Patient		<u>Yes</u>	50%	
In Network Surgeon-Out-Patient		<u>Yes</u>	80%	
Out of Network Surgeon-Out-Patient		<u>Yes</u>	50%	

---

Payor ID: 71063  
 Claims Mailing Address: HealthSCOPE Benefits; PO Box  
 99006; Lubbock, TX 79490-9006

---

Do you need help understanding this form?

Please call HealthSCOPE Benefits Customer Service at 800-508-5144