Scantic Valley Regional Health Trust - MedPlus- EN

HMO Benefit Chart

January 1, 2024

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.

Benefit	Your Cost In-Plan HNE Providers
Inpatient Care	
Acute Hospital Care	$0
Skilled Nursing Facility and Inpatient Rehabilitation † (Limited to 100 days per Calendar Year)	$0
Preventive Care	
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 (Limited to 1 per Calendar Year)	$0
Routine Mammograms (Limited to 1 per Calendar Year)	$0
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)	$10 Copay per visit
Specialist Care Office Visit	$10 Copay per visit
Second Opinions	$10 Copay per visit
Urgent Care	$10 Copay per visit
Hearing Tests in Specialist Office or Outpatient Facility (other than routine screenings covered as part of your Annual Routine Exam)	$10 Copay per visit

Benefit	Your Cost In-Plan HNE Providers
Diabetic-Related Items:	
• Outpatient Services (Some services require Prior Approval.)	$10 Copay per visit
• Lab Services	$0
• Radiological Services	$0
• Durable Medical Equipment (some DME items require Prior Approval)	20% Coinsurance
• Individual Diabetic Education	$10 Copay per visit
• Group Diabetic Education	$10 Copay per session
Emergency Room Care (Copay waived if admitted directly from the ER.)	$50 Copay per visit
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)	
• In a doctor's office	$10 Copay
• In all other settings	$0
Sleep Study†	$0
Lab Services	$0
Radiological Services: Ultrasound, X-rays, Non-Routine Mammograms	$0
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)	$0
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.)	$10 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	$10
Applied Behavioral Analysis (ABA) to treat Autism Spectrum Disorder†	$0
Surgical Services and Procedures in an Outpatient Facility (Some services require Prior Approval.)	
• In a doctor’s office	$10 Copay
• In all other settings	$0
Allergy Testing and Treatment	$10 Copay per visit
Allergy Injections	$0

Benefit	Your Cost In-Plan HNE Providers
Family Planning Services	
Office Visit	$10 Copay
Infertility Services	
Some infertility services are covered only for Massachusetts and Connecticut residents. Some services require Prior Approval.	
• Office Visit (Some services require Prior Approval.)	$10 Copay per visit
• Lab Test	$0
• Inpatient Care	$0
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.)	$0
Dental Services	
Surgical Treatment of Non-Dental Conditions	
• In a doctor's office	$10 Copay per visit
• In an Emergency Room	$50 Copay per visit
Other Services	
Home Health Care†	$0
Hospice Services†	$0
Durable Medical Equipment (some DME items require Prior Approval)	20% Coinsurance
Prosthetic Devices†	$0
Ambulance and Transportation Services (non-emergency transportation requires Prior Approval)	$25 Copay per day
Radiation and Chemotherapy	$0
Kidney Dialysis	$0
Nutritional Support †	$0
Cardiac Rehabilitation	$10 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.)	$10 Copay per visit
Human Organ Transplants and Bone Marrow Transplants†	$0
Behavioral Health (Includes Mental Health and Substance Use Disorder)	
Outpatient Services†	$10 Copay per visit
Inpatient Services†	$0

Benefit	Your Cost In-Plan HNE Providers
Wellness Services	
The plan reimburses for certain fitness and wellness activities, including 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

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