Scantic Valley Regional Health Trust – MedPlus (EN)

HMO Summary of Benefit Chart

Effective January 1, 2018

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 Copay 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.

Benefit	**Copay**
Inpatient Care	
Acute Hospital Care*	$0
Skilled Care and Inpatient Rehabilitation* (limited to 100 days per Calendar Year)	$0
Outpatient Preventive Care	
PCP Office Visits*	$0
Adult Routine Exams* (Members age 18 and older)	$0
Well Child Care*	$0
Routine Prenatal and Postpartum Care*	$0
Child and Adult Routine Immunizations*	$0
Routine Eye Exams* (limited to one per Calendar Year)	$0
Annual Gynecological Exams* (limited to one per Calendar Year)	$0
Routine Mammograms* (limited to one per Calendar Year)	$0
Screening Colonoscopy or Sigmoidoscopy* (limited to one every five Calendar Years)	$0
Nutritional Counseling* (limited to four visits per Calendar Year)	$0
Other Outpatient Care	
PCP Office Visits* (Non-Routine)	$10/visit
Specialist Office Visits*	$10/visit
Urgent Care*	$10/visit
Second Opinions*	$10/visit

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

Benefit	Copay
Telephone and video consultations with internists, family practitioners and pediatricians for non-emergency medical conditions through Teladoc®	$10/consultation
Hearing Tests	$10/visit
Diabetic-Related Items:	
• Outpatient Services* (some services require Prior Approval)	$10/visit
• Lab/Radiological Services*	$0
• Durable Medical Equipment* (some items require Prior Approval)	20% Coinsurance
• Individual Diabetic Education	$10/visit
• Group Diabetic Education	$10/session
Emergency Room Care* (Copay waived if admitted directly from the ER)	$50/visit
Diagnostic Testing:*	
• In a doctor's office	$10/visit
• In all other settings	$0
Lab Services*	$0
Radiological Services: Ultrasound, X-rays, Non-Routine Mammograms*	$0
Sleep Study† (maximum of two per Calendar Year)	$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 doctors' offices)	$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.)	$10/visit/treatment type
Day Rehabilitation Program* (limited to 15 full day or half day sessions per condition per lifetime)	$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.)	$10/visit
Applied Behavioral Analysis (ABA)†* to treat Autism Spectrum Disorders	$0
Outpatient Surgical Services and Procedures:* (some services require Prior Approval)	
• In a doctor's office	$10/visit
• In all other settings	$0
Allergy Testing and Treatment*	$10/visit
Allergy Injections*	$0
Family Planning Services	
Office Visits*	$10/visit

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Benefit	Copay
Infertility Services	
Infertility services are covered for Massachusetts and Connecticut residents only. Some services require Prior Approval.	
Outpatient Care	$10/visit
Inpatient Care	$0
Lab Test	$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. Routine nursery charges not covered for child of Dependent other than Spouse.)	$0
Dental Services	
Surgical Treatment of Non-Dental Conditions:*	
• In an Emergency Room	$50/visit
• In a doctor's or dentist's office	$10/visit
Other Services	
Home Health Care†*	$0
Hospice Services†*	$0
Durable Medical Equipment:* (some items require Prior Approval)	20% Coinsurance
• Wigs (Scalp Hair Prostheses)* for hair loss due to treatment of any form of cancer or leukemia (the Plan covers one prosthesis per Calendar Year)	The Plan pays up to $350 per Calendar Year
• Prosthetic Devices†* (some items require Prior Approval)	$0
Ambulance and Transportation Services* (includes Chair Van services)	$25/Member/day
Radiation and Chemotherapy	$0
Kidney Dialysis*	$0
Nutritional Support†	$0
Cardiac Rehabilitation*	$10/visit
Speech, Hearing and Language Disorders†* (Prior Approval is required for speech therapy services after the initial evaluation)	$10/visit
Human Organ Transplants and Bone Marrow Transplants†*	$0
Behavioral Health (Includes Mental Health and Substance Use Disorder)	
Inpatient Services†*	$0
Outpatient Services†*	$10/visit
Additional Benefits	
Fitness Reimbursement Program	$150 per family per Calendar Year
Weight Watchers® Reimbursement Program	$150 per family per Calendar Year

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PRESCRIPTION DRUG COVERAGE

Prescription Drugs* *(certain drugs require Prior Approval)* Your Prescription 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.	**Copay**
At a Pharmacy: (up to a 30-day supply)	
Generic Drugs	$10
Brand/Formulary Drugs	$20
Brand/Non-Formulary Drugs	$35
Through Mail Order: (a 90-day supply of maintenance medication)	
Generic Drugs	$20
Brand/Formulary Drugs	$40
Brand/Non-Formulary Drugs	$105

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