Health New England

Custom HMO Essential 1500
HMO Benefit Chart

This chart provides a summary of key services offered by your plan. Your Member Agreement has a full description of your plan's benefits and provisions.

- **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
Deductible per Year* (You must pay this amount for Covered Services before HNE will begin to pay benefits. As indicated in the chart below, some services are not subject to the Deductible.)	$1,500 per individual / $3,000 per family
SAFETY NET: You are PROTECTED by an Out-of-Pocket Maximum each year.* (This is the most you pay for cost sharing on Essential Health Benefits each year before your plan begins to pay 100% of the allowed amount. Most of your costs, including your costs for prescription drugs, apply to the Out-of-Pocket Maximum.)	$5,000 per individual / $10,000 per family
* This is applied on a Calendar Year basis, from January 1 through December 31.	

Benefit	**Your Cost**
Inpatient Care	
Acute Hospital Care	$0 after Deductible
Skilled Nursing Facility† (limited to 100 days per Calendar Year)	$0 after Deductible
Inpatient Rehabilitation† (limited to 60 days per Calendar Year)	$0 after Deductible
Outpatient Preventive Care	
Adult Routine Exams	$0
Well Child Care	$0
Child and Adult Routine Immunizations	$0
Routine Prenatal and Postpartum Care	$0
Routine Eye Exams (limited to one per Calendar Year)	$0
Annual Gynecological Exams (limited to one per Calendar Year)	$0
Routine Mammograms (routine mammograms limited to one per Calendar Year)	$0
Screening Colonoscopy or Sigmoidoscopy (limited to one every five Calendar Years)	$0
Preventive Screenings Listed under "Outpatient Preventive Care" in the *Covered Benefits* Section of the EOC	$0

Benefit	Your Cost
Nutritional Counseling (maximum of 4 visits per Calendar Year)	$0
Other Outpatient Care	
PCP Office Visit (Non-Routine) (Deductible may apply to some office services)	$30 Copay per visit
Specialist Office Visits (Deductible may apply to some office services)	$50 Copay per visit
Second Opinions (Deductible may apply to some office services)	$50 Copay per visit
Telephone and video consultations with internists, family practitioners, and pediatricians for non-emergency medical conditions through Teladoc	$0
Hearing Tests in a Specialist Office or Facility (other than routine screenings covered as part of your annual Routine Exam)	$50 Copay per visit after Deductible
Diabetic-Related Items:	
• Outpatient Services (Deductible may apply to some office services)	$50 Copay per visit
• Lab Services	$0
• Durable Medical Equipment†	20% Coinsurance
• Individual Diabetic Education	$50 Copay per visit
• Group Diabetic Education	$30 Copay per session
Emergency Room Care (Copay waived if admitted)	$250 Copay per visit
Diagnostic Testing	$0 after Deductible
Sleep Study†	$100 Copay after Deductible (one Copay per year; no Copay for home sleep studies)
Lab Services	$0
Radiological Services: Ultrasound, X-rays, Non-Routine Mammograms	$0 after Deductible
Diagnostic Imaging: CT Scans, MRIs, MRAs, PET Scans, Nuclear Cardiac Imaging†	$150 Copay after Deductible (maximum three Copays per year)
Outpatient Short-Term Rehabilitation Services (Limited to 60 visits per Calendar Year for physical or occupational therapy. The limit does not apply when services are provided to treat autism spectrum disorder.)	$50 Copay per visit per treatment type after Deductible
Day Rehabilitation Program (limited to 15 full day or ½ day sessions per condition per lifetime)	$25 Copay after Deductible for 1 day or 1/2 day
Early Intervention Services (Covered for children from birth to age 3.)	$0
Applied Behavioral Analysis (ABA) to treat Autism Spectrum Disorder†	$0
Surgical Services and Procedures in an Outpatient Facility† (Some services require Prior Approval)	$0 after Deductible
Allergy Testing and Treatment	$50 Copay per visit
Allergy Injections	$0
Family Planning Services	

Benefit	Your Cost
Office Visit (Deductible may apply to some office services)	$50 Copay per visit
Infertility Services	
Some Infertility services are covered only for Massachusetts and Connecticut residents. Some services require Prior Approval.	
Office Visit (Deductible may apply to some office services)	$50 Copay per visit
Outpatient Surgery/ Procedure	$0 after Deductible
Lab Test	$0
Inpatient Care†	$0 after Deductible
Maternity Care	
Non-Routine Prenatal and Postpartum Care	$50 Copay per visit
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 after Deductible
Dental Services	
Surgical Treatment of Non-Dental Conditions in a Doctor's Office	$50 Copay after Deductible
Emergency Dental Care in a Doctor's or Dentist's Office	$50 Copay per visit
Emergency Dental Care in an Emergency Room	$250 Copay per visit
Other Services	
Home Health Care †	$0 after Deductible
Hospice Services †	$0
Durable Medical Equipment†	20% Coinsurance
Prosthetic Limbs†	20% Coinsurance
Ambulance and Transportation Services (non-emergency transportation requires Prior Approval)	$100 Copay per day after Deductible
Kidney Dialysis	$0
Nutritional Support †	$0
Cardiac Rehabilitation	$50 Copay per visit after Deductible
Wigs (Scalp Hair Prostheses) for hair loss due to treatment of any form of cancer or leukemia. † (HNE covers one prosthesis per Calendar Year)	20% Coinsurance
Speech, Hearing, and Language Disorders † (Prior Approval is required for speech therapy services after the initial evaluation)	$50 Copay per visit after Deductible
Hearing Aids† (Covered for Members age 21 and under. HNE covers the cost of one hearing aid per hearing impaired ear, every 36 months, up to a 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 †	$0 after Deductible
Massage Therapy Reimbursement (Limited to 2 visits per Calendar Year per family.)	$0 up to 2 visits per family

Benefit	Your Cost
Acupuncture (Limited to 12 visits per Calendar Year.)	$20 Copay per visit
Behavioral Health (Includes Mental Health and Substance Abuse)	
Inpatient Services†	$0 after Deductible
Telephone and video consultations for non-emergency behavioral health issues and substance use disorder issues through Teladoc®	$30 Copay per consultation
Outpatient Services† (some services require Prior Approval)	$30 Copay per visit

Prescription Drugs

(certain drugs require Prior Approval)

Your Prescription Benefit is based on the Health New England Formulary. Please call Member Services or visit healthnewengland.org for a copy of the Health New England Formulary.

Benefit	Your Cost
At an In-Plan Pharmacy (up to a 30-day supply)	
Generic Drugs	$20
Formulary Drugs	$50
Non-Formulary Drugs	$100
Through Mail Order: (up to a 90-day supply of maintenance medication)	
Generic Drugs	$40
Formulary Drugs	$100
Non-Formulary Drugs	$300

Chiropractic Benefit

Benefit	Your Cost
limited to 12 visits per calendar year	$20