Health New England

## Custom HMO Essential Plus 2000
## 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.) | $2,000 per individual / $4,000 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.) | $6,800 per individual / $13,600 per family |
| * This is applied on a Calendar Year basis, from January 1 through December 31. | |

| **Benefit** | **Your Cost** |
|---|---|
| **Inpatient Care** | |
| Acute Hospital Care | $1,000 Copay per admission after Deductible |
| Skilled Nursing Facility† (limited to 100 days per Calendar Year) | $1,000 Copay per admission after Deductible |
| Inpatient Rehabilitation† (limited to 60 days per Calendar Year) | $1,000 Copay per admission 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 | $25 Copay |
| • Durable Medical Equipment† | 20% Coinsurance after Deductible |
| • 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† | $500 Copay after Deductible (one Copay per year; no Copay for home sleep studies) |
| Lab Services | $25 Copay |
| Radiological Services: Ultrasound, X-rays, Non-Routine Mammograms | $25 Copay after Deductible |
| Diagnostic Imaging: CT Scans, MRIs, MRAs, PET Scans, Nuclear Cardiac Imaging† | $250 Copay (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 |
| 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. This Copay is based on the type of service. To find out if the Copay applies to a specific procedure, please contact Health New England Member Services.) | $750 Copay after Deductible |

| Benefit | Your Cost |
|---|---|
| Allergy Testing and Treatment | $50 Copay per visit |
| Allergy Injections | $0 |
| **Family Planning Services** | |
| 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 | $750 Copay after Deductible |
| Lab Test | $25 Copay |
| Inpatient Care† | $1,000 Copay per admission 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.) | $1,000 Copay per admission after Deductible |
| **Dental Services** | |
| Surgical Treatment of Non-Dental Conditions in a Doctor's Office | $50 Copay per visit 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 after Deductible |
| Prosthetic Limbs† | 20% Coinsurance |
| Ambulance and Transportation Services (non-emergency transportation requires Prior Approval) | $150 Copay per day after Deductible |
| Kidney Dialysis | $0 |
| Nutritional Support † | $0 |
| Cardiac Rehabilitation | $50 Copay per visit |
| 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 |
| 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) |

| Benefit | Your Cost |
|---|---|
| Human Organ Transplants and Bone Marrow Transplants † | $1,000 Copay per admission after Deductible |
| Massage Therapy Reimbursement (Limited to 2 visits per Calendar Year per family.) | $0 up to 2 visits per family |
| Acupuncture (Limited to 12 visits per Calendar Year.) | $20 Copay per visit |
| **Behavioral Health (Includes Mental Health and Substance Abuse)** | |
| Inpatient Services† | $1,000 Copay per admission 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 | $25 |
| Formulary Drugs | $50 |
| Non-Formulary Drugs | $100 |
| **Through Mail Order: (up to a 90-day supply of maintenance medication)** | |
| Generic Drugs | $50 |
| Formulary Drugs | $100 |
| Non-Formulary Drugs | $300 |

## Chiropractic Benefit

| Benefit | Your Cost |
|---|---|
| limited to 12 visits per year | $20 |