PPO Essential 1500 National LG
PHCS PPO 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.

- Please note: When you receive services from an Out-of-Plan Provider, you are also responsible for any Remaining Balances. A Remaining Balance is that portion of an Out-of-Plan Provider's charge that is above Health New England's Maximum Allowable Fee.
- Note about Prior Approval:
  Some services may require Prior Approval. These services are marked with † in the chart. In some cases, if you fail to ask for Prior Approval, the service will not be covered at all. (See, for example, Infertility Treatment below.) In other cases, for example Acute Hospital Care at an Out-of-Plan facility, if you fail to ask for Prior Approval, you may have a Reduction of Benefit up the amount indicated below. Remember that exclusions or limitations of this plan still apply, even if you ask for Prior Approval. For example, services that are not Medically Necessary are not covered, even if you ask for Prior Approval.

	In-Plan Providers HNE and PHCS Providers	**Out-of-Plan Providers**
Deductible per Year* (You must pay this amount for Covered Services before HNE will begin to pay benefits. This is a combined amount for HNE, PHCS, and Out-of-Plan providers. As indicated in the chart below, some services are not subject to the Deductible.)	$1,500 per individual / $3,000 per family	$1,500 per individual / $3,000 per family
In-Plan Out-of-Pocket Maximum* (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. This is a combined amount for HNE and PHCS providers. Most of your In-Plan costs, including your costs for prescription drugs, apply to the Out-of-Pocket Maximum.)	$6,000 per individual / $12,000 per family	Not applicable
Out-of-Plan Out-of-Pocket Maximum* (This is the most you will pay in a year for the combined cost of your Medical Deductible and Coinsurance for Covered Services from Out-of-Plan Providers.)	Not applicable	$7,500 per individual / $15,000 per family
* May be based on a Calendar Year or a Plan Year. This depends on the Group through which you enroll.		
Reduction of Benefit (Applies to certain services if Prior Approval is required but not requested.)	$500 (Does not apply to HNE Providers)	$500

Benefit	**Your Cost In-Plan Providers HNE and PHCS Providers**	**Your Cost Out-of-Plan Providers**
Inpatient Care		

Benefit	Your Cost In-Plan Providers HNE and PHCS Providers	Your Cost Out-of-Plan Providers
Acute Hospital Care (elective admissions to Out-of-Plan facilities require Prior Approval)	$0 after Deductible; and for PHCS providers up to $500 Reduction of Benefit	20% Coinsurance after Deductible & up to $500 Reduction of Benefit
Skilled Nursing Facility† (limited to 100 days per Calendar Year; admissions to Out-of-Plan facilities require Prior Approval)	$0 after Deductible; and for PHCS providers up to $500 Reduction of Benefit	20% Coinsurance after Deductible & up to $500 Reduction of Benefit
Inpatient Rehabilitation† (limited to 60 days per Calendar Year; admissions to Out-of-Plan facilities require Prior Approval)	$0 after Deductible, and for PHCS providers up to $500 Reduction of Benefit	20% Coinsurance after Deductible & up to $500 Reduction of Benefit
Outpatient Preventive Care		
Adult Routine Exams	$0	20% Coinsurance after Deductible
Well Child Care	$0	20% Coinsurance after Deductible
Child and Adult Routine Immunizations	$0	20% Coinsurance after Deductible
Routine Prenatal and Postpartum Care	$0	20% Coinsurance after Deductible
Routine Eye Exams (limited to one per Calendar Year)	$0	20% Coinsurance after Deductible
Annual Gynecological Exams (limited to one per Calendar Year)	$0	20% Coinsurance after Deductible
Routine Mammograms (routine mammograms limited to one per Calendar Year)	$0	20% Coinsurance after Deductible
Screening Colonoscopy or Sigmoidoscopy (limited to one every five Calendar Years)	$0	20% Coinsurance after Deductible
Preventive Screenings Listed under "Outpatient Preventive Care" in the *Covered Benefits* Section of the EOC	$0	20% Coinsurance after Deductible
Nutritional Counseling (limited to four vists per Calendar Year)	$0	20% Coinsurance after Deductible
Other Outpatient Care		
Physician Office Visits (non-routine) with providers who specialize in internal medicine, family practice, or pediatrics (Deductible may apply to some In-Plan office services.)	$20 Copay per visit	20% Coinsurance after Deductible
Specialist Office Visits	$40 Copay per visit	20% Coinsurance after Deductible
Second Opinions (Deductible may apply to some In-Plan office services.)	$40 Copay per visit	20% Coinsurance after Deductible
Telephone and video consultations with internists, family practitioners, and pediatricians for non-emergency medical conditions through Teladoc	$0	Not covered

Benefit	Your Cost In-Plan Providers HNE and PHCS Providers	Your Cost Out-of-Plan Providers
Hearing Tests in a Specialist Office or Facility (other than routine screenings covered as part of your annual Routine Exam)	$40 Copay per visit after Deductible	20% Coinsurance after Deductible
Diabetic-Related Items:		
• Outpatient Services (Deductible may apply to some In-Plan office services.)	$40 Copay per visit	20% Coinsurance after Deductible
• Lab Services	$0	20% Coinsurance after Deductible
• Durable Medical Equipment†	20% Coinsurance; and for PHCS providers up to $500 Reduction of Benefit	20% Coinsurance after Deductible & up to $500 Reduction of Benefit
• Individual Diabetic Education	$40 Copay per visit	20% Coinsurance after Deductible
• Group Diabetic Education	$20 Copay per session	20% Coinsurance after Deductible
Emergency Room Care (Copay waived if admitted)	$250 Copay per visit	$250 Copay per visit
Diagnostic Testing	$0 after Deductible	20% Coinsurance after Deductible
Sleep Study†	$100 Copay after Deductible (one Copay per year; no Copay for home sleep studies; and for PHCS providers, without Prior Approval Member pays all costs)	20% Coinsurance after Deductible (without Prior Approval Member pays all costs)
Lab Services	$0	20% Coinsurance after Deductible
Radiological Services: Ultrasound, X-rays, Non-Routine Mammograms	$0 after Deductible	20% Coinsurance after Deductible
Diagnostic Imaging: CT Scans, MRIs, MRAs, PET Scans, Nuclear Cardiac Imaging†	$100 Copay after Ded, max 3 Copays/year; PHCS providers if no Prior Approval Member pays all costs	20% Coinsurance after Deductible; without Prior Approval, Member pays all costs
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.)	$40 Copay per visit per treatment type after Deductible	20% Coinsurance 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	20% Coinsurance after Deductible
Early Intervention Services (Covered for children from birth to age 3.)	$0	20% Coinsurance after Deductible
Applied Behavioral Analysis (ABA) to treat Autism Spectrum Disorder†	$0 (for PHCS providers, without Prior Approval Member pays all costs)	20% Coinsurance after Deductible (without Prior Approval Member pays all costs)

Benefit	Your Cost In-Plan Providers HNE and PHCS Providers	Your Cost Out-of-Plan Providers
Surgical Services and Procedures in an Outpatient Facility† (Some services require Prior Approval)	$0 after Deductible; and for PHCS providers up to $500 Reduction of Benefit	20% Coinsurance after Deductible & up to $500 Reduction of Benefit
Allergy Testing and Treatment	$40 Copay per visit	20% Coinsurance after Deductible
Allergy Injections	$0	20% Coinsurance after Deductible
Family Planning Services		
Office Visit (Deductible may apply to some In-Plan office services)	$40 Copay per visit	20% Coinsurance after Deductible
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 In-Plan office services)	$40 Copay per visit; and for PHCS providers without Prior Approval Member pays all costs	20% Coinsurance after Deductible; without Prior Approval, Member pays all costs
Outpatient Surgery/ Procedure	$0 after Deductible; and for PHCS providers without Prior Approval Member pays all costs	20% Coinsurance after Deductible; without Prior Approval, Member pays all costs
Lab Test	$0; and for PHCS providers without Prior Approval Member pays all costs	20% Coinsurance after Deductible; without Prior Approval, Member pays all costs
Inpatient Care†	$0 after Deductible; and for PHCS providers without Prior Approval Member pays all costs	20% Coinsurance after Deductible; without Prior Approval, Member pays all costs
Maternity Care		
Non-Routine Prenatal and Postpartum Care	$40 Copay per visit	20% Coinsurance after Deductible
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; and for PHCS providers up to $500 Reduction of Benefit	20% Coinsurance after Deductible & up to $500 Reduction of Benefit
Dental Services		
Surgical Treatment of Non-Dental Conditions in a Doctor's Office	$40 Copay after Deductible	20% Coinsurance after Deductible
Emergency Dental Care in a Doctor's or Dentist's Office	$40 Copay per visit	20% Coinsurance after Deductible
Emergency Dental Care in an Emergency Room	$250 Copay per visit	$250 Copay per visit
Other Services		

Benefit	Your Cost In-Plan Providers HNE and PHCS Providers	Your Cost Out-of-Plan Providers
Home Health Care †	$0 after Deductible; and for PHCS providers up to $500 Reduction of Benefit	20% Coinsurance after Deductible & up to $500 Reduction of Benefit
Hospice Services †	$0; and for PHCS providers up to $500 Reduction of Benefit	20% Coinsurance after Deductible & up to $500 Reduction of Benefit
Durable Medical Equipment†	20% Coinsurance; and for PHCS providers up to $500 Reduction of Benefit	20% Coinsurance after Deductible & up to $500 Reduction of Benefit
Prosthetic Limbs†	20% Coinsurance; and for PHCS providers without Prior Approval Member pays all costs	20% Coinsurance after Deductible; without Prior Approval, Member pays all costs
Ambulance and Transportation Services (non-emergency transportation requires Prior Approval; if Prior Approval is not obtained for non-emergency transportation, Member pays all costs)	$100 Copay per day after Deductible	$100 Copay per day after Deductible
Kidney Dialysis	$0	20% Coinsurance after Deductible
Nutritional Support † (not covered without Prior Approval)	$0	$0
Cardiac Rehabilitation	$40 Copay per visit after Deductible	20% Coinsurance 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	20% Coinsurance
Speech, Hearing, and Language Disorders † (Prior Approval is required for speech therapy services after the initial evaluation.)	$40 Copay per visit after Deductible; and for PHCS providers up to $500 Reduction of Benefit	20% Coinsurance after Deductible & up to $500 Reduction of Benefit
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; for PHCS providers without Prior Approval Member pays all costs	20% Coinsurance after Deductible (Without Prior Approval Member pays all costs)
Human Organ Transplants and Bone Marrow Transplants † (Without Prior Approval, payments you make to Out-of-Plan Providers for Deductible and Coinsurance do not count toward your Deductible or Maximum Coinsurance amounts.)	$0 after Deductible; and for PHCS providers up to $500 Reduction of Benefit	20% Coinsurance after Deductible & up to $500 Reduction of Benefit
Massage Therapy Reimbursement (Limited to 2 visits per Calendar Year per family.)	$0 up to 2 visits per family	$0 up to 2 visits per family
Acupuncture (Limited to 12 visits per Calendar Year.)	$20 Copay per visit	20% Coinsurance after Deductible

Benefit	Your Cost In-Plan Providers HNE and PHCS Providers	Your Cost Out-of-Plan Providers
Behavioral Health (Includes Mental Health and Substance Abuse)		
Inpatient Services†	$0 after Deductible; and for PHCS providers up to $500 Reduction of Benefit	20% Coinsurance after Deductible & up to $500 Reduction of Benefit
Telephone and video consultations for non-emergency behavioral health issues and substance use disorder issues through Teladoc®	$20 Copay per consultation	Not covered
Outpatient Services† (some services require Prior Approval)	$20 Copay per visit	20% Coinsurance after Deductible

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 In-Plan Providers	Your Cost Out-of-Plan Providers
At an In-Plan Pharmacy (up to a 30-day supply)		
Generic Drugs	$20	$20 copay, then 20%
Formulary Drugs	$50	$50 copay, then 20%
Non-Formulary Drugs	$100	$100 copay, then 20%
Through Mail Order: (up to a 90-day supply of maintenance medication)		
Generic Drugs	$40	Not Covered
Formulary Drugs	$100	Not Covered
Non-Formulary Drugs	$300	Not Covered

Chiropractic Benefit

Benefit	Your Cost In-Plan Providers	Your Cost Out-of-Plan Providers
limited to 12 visits per calendar year	$20	$20, then 20%