Health New England

PPO Essential 2000 SG
PPO Benefit Chart

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.

Please note: For Out-of-Plan services, 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 Allowed Amount.

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 to 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	Out-of-Plan Providers
Deductible per Plan Year: You must pay this amount for Covered Services before Health New England will begin to pay benefits. This is a combined amount for Health New England and Out-of-Plan providers. As indicated in the chart below, some services are not subject to the Deductible.	$2,000 per individual / $4,000 per family	
In-Plan Out-of-Pocket Maximum: The most you pay for cost sharing on Essential Health Benefits during a Plan Year before your plan begins to pay 100% of the Allowed Amount. This Out-of-Pocket Maximum does not include your cost sharing for pediatric dental services.	$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 Plan Year for the combined cost of your Medical Deductible and Coinsurance for Covered Services from Out-of-Plan Providers. This Out-of-Pocket Maximum does not include your cost sharing for pediatric dental services.	Not Applicable	$7,500 per individual / $15,000 per family
Reduction of Benefit: Applies to certain services if Prior Approval is required but not requested.) Does not count toward your Out-of-Pocket Maximum.	Not Applicable	$500

Benefit	Your Cost In-Plan Providers	Your Cost Out-of-Plan Providers
Inpatient Care		
Acute Hospital Care † (elective admissions to Out-of-Plan facilities require Prior Approval)	$100 Copay per admission after Deductible	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)	$100 Copay per admission after Deductible	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)	$100 Copay per admission after Deductible	20% Coinsurance after Deductible & up to $500 Reduction of Benefit
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 & Postpartum Care	$0	20% Coinsurance after Deductible
Routine Eye Exams (limited to one per Calendar Year) Please note: for children under age 19, In-Plan routine eye exams must be done by an EyeMed Provider.	$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
Nutritional Counseling (limited to four visits per Calendar Year)	$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

Benefit	Your Cost In-Plan Providers	Your Cost Out-of-Plan Providers
Outpatient Care		
Physician Office Visit with providers who specialize in internal medicine, family practice, or pediatrics (Deductible may apply to some In-Plan office services.)	$25 Copay per visit	20% Coinsurance after Deductible
Specialist Office Visit (Deductible may apply to some In-Plan office services.)	$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
Hearing Tests in Specialist Office or Outpatient 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	$25 Copay	20% Coinsurance after Deductible
Durable Medical Equipment †	20% Coinsurance	20% Coinsurance after Deductible & up to $500 Reduction of Benefit
Individual Diabetic Education	$40 Copay per visit	20% Coinsurance after Deductible
Group Diabetic Education	$25 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)	20% Coinsurance after Deductible (without Prior Approval, Member pays all costs.)
Lab Services	$25 Copay	20% Coinsurance after Deductible

Benefit	Your Cost In-Plan Providers	Your Cost Out-of-Plan Providers
Radiological Services: Ultrasound, X-rays, Non-Routine Mammograms	$50 Copay after Deductible	20% Coinsurance after Deductible
Diagnostic Imaging: CT Scans, MRIs, MRAs, PET Scans, Nuclear Cardiac Imaging †	$100 Copay after Deductible (maximum three Copays per year)	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, or when provided as part of the home health care benefit.)	$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	20% Coinsurance after Deductible (without Prior Approval Member pays all costs)
Surgical Services and Procedures in an Outpatient Facility (Some services require Prior Approval. The In-Plan 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.)	$50 Copay after Deductible	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
Infertility Services		
Some Infertility services are covered only for Massachusetts and Connecticut residents. Some services require Prior Approval.		

Benefit	Your Cost In-Plan Providers	Your Cost Out-of-Plan Providers
Office Visit (Deductible may apply to some In-Plan office services)	$40 Copay per visit	20% Coinsurance after Deductible; without Prior Approval, Member pays all costs
Outpatient Surgery/ Procedure	$50 Copay after Deductible	20% Coinsurance after Deductible; without Prior Approval, Member pays all costs
Lab Test	$25 Copay	20% Coinsurance after Deductible; without Prior Approval, Member pays all costs
Inpatient Care †	$100 Copay per admission after Deductible	20% Coinsurance after Deductible; without Prior Approval, Member pays all costs
Maternity Care		
Non-Routine Prenatal and Postpartum Visit	$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.)	$100 Copay per admission after Deductible	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		
Home Health Care †	$0 after Deductible	20% Coinsurance after Deductible & up to $500 Reduction of Benefit
Hospice Services †	$0	20% Coinsurance after Deductible & up to $500 Reduction of Benefit
Durable Medical Equipment †	20% Coinsurance	20% Coinsurance after Deductible & up to $500 Reduction of Benefit
Prosthetic Limbs †	20% Coinsurance	20% Coinsurance after Deductible; without Prior Approval Member pays all costs

Benefit	Your Cost In-Plan Providers	Your Cost Out-of-Plan Providers
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. † (Health New England covers 1 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	20% Coinsurance after Deductible & up to $500 Reduction of Benefit
Hearing Aids† (Covered with Prior Approval for Members age 21 and under. Health New England 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)	20% Coinsurance after Deductible; up to $2,000 per device per ear (you are responsible for all costs beyond maximum). 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.)	$100 Copay per admission after Deductible	20% Coinsurance after Deductible & up to $500 Reduction of Benefit

Benefit	Your Cost In-Plan Providers	Your Cost Out-of-Plan Providers
Wellness Services		
Before January 1, 2021: Acupuncture & Massage Therapy (Limited to a **total** of three visits per Calendar Year **per family**. For example, you may have three visits for acupuncture **or** three visits for massage **or** one visit for acupuncture and two visits for massage **or** two visits for acupuncture and one visit for massage.)	$0 up to 3 visits per family	$0 up to 3 visits per family
Effective January 1, 2021: Massage Therapy (Limited to two visits per Calendar Year per family.)	$0 up to 2 visits per family	$0 up to 2 visits per family
Effective January 1, 2021: Acupuncture (Limited to 12 visits per Calendar Year.)	$20 Copay per visit	20% Coinsurance after Deductible
Behavioral Health (Includes Mental Health and Substance Use Disorder)		
Outpatient Services (Some services require Prior Approval.)	$25 Copay per visit	20% Coinsurance after Deductible
Telephone and video consultations for non-emergency behavioral health issues and substance use disorder issues through Teladoc®	$25 Copay per consultation	No covered
Inpatient Services †	$100 Copay per admission after Deductible	20% Coinsurance after Deductible & up to $500 Reduction of Benefit

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You have the right to get help and information in your language at no cost. To request an interpreter, call the toll-free member phone number listed on your health plan ID card, press 0 (TTY: 711). Tiene derecho a recibir ayuda e información en su idioma sin costo. Para solicitar un intérprete, llame al número de teléfono gratuito para miembros que se encuentra en su tarjeta de identificación del plan de salud y presione 0 (TTY: 711). Você tem o direito de obter ajuda e

informação em seu idioma e sem custos. Para solicitar um intérprete, ligue para o número de telefone gratuito que consta no cartão de ID do seu plano de saúde, pressione 0 (TTY: 711).