

## PPO Wise Saver 3450 National HDHP SG High Deductible Health Plan 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.

|  | <b>In-Plan Providers<br/>Health New England &amp; PHCS</b>  | <b>Out-of-Plan<br/>Providers</b>                |
|--|---|---|
| <b>Combined Medical/ Pharmacy Deductible per Plan Year:</b> You must pay this amount for Covered Services before Health New England will begin to pay benefits. As indicated in the chart below, some services are not subject to the Deductible. If your plan includes prescription drug coverage, your prescriptions are subject to this Deductible. This amount is a combined amount for In-Plan & Out-of-Plan Providers. | \$3,450 per individual / \$6,900 per family<br><br><i>Once any individual on a family plan has paid \$3,450 towards the family Deductible, the plan will begin to pay benefits for that individual.</i> |   |
| <b>In-Plan Out-of-Pocket Maximum:</b> This is the most you will pay for cost sharing on Essential Health Benefits during a Plan Year. This is a combined amount for Health New England & PHCS Providers. This Out-of-Pocket Maximum does not include your cost sharing for pediatric dental services.  | \$6,300 per individual /<br>\$12,600 per family   | Not applicable                                  |
| <b>Out-of-Plan Out-of-Pocket Maximum:</b> This is the most you will pay in a Plan Year for the combined cost of your Medical/ Pharmacy Deductible amount applied to Out-of-Plan services, plus Copays 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  | \$8,000 per individual /<br>\$16,000 per family |
| <b>Reduction of Benefit:</b> Applies to certain services if Prior Approval is required but not requested. Does not count toward your Out-of-Pocket Maximum.  | \$1,000<br>(Does not apply to<br>Health New England Providers)  | \$1,000   |

| <b>Benefit</b>  | <b>Your Cost<br/>In-Plan Providers<br/>Health New England &amp; PHCS</b>                                    | <b>Your Cost<br/>Out-of-Plan Providers</b>                                  |
|---|---|---|
| <b>Inpatient Care</b>   |   |   |
| Acute Hospital Care †<br>(elective admissions to Out-of-Plan facilities require Prior Approval)   | \$500 Copay per admission after Deductible;<br>and for PHCS providers up to \$1,000<br>Reduction of Benefit | 20% Coinsurance after<br>Deductible & up to \$1,000<br>Reduction of Benefit |
| Skilled Nursing Facility †<br>(limited to 100 days per<br>Calendar Year; admissions to<br>Out-of-Plan facilities require<br>Prior Approval)                               | \$500 Copay per admission after Deductible;<br>and for PHCS providers up to \$1,000<br>Reduction of Benefit | 20% Coinsurance after<br>Deductible & up to \$1,000<br>Reduction of Benefit |
| Inpatient Rehabilitation †<br>(limited to 60 days per<br>Calendar Year; admissions to<br>Out-of-Plan facilities require<br>Prior Approval.)                               | \$500 Copay per admission after Deductible;<br>and for PHCS providers up to \$1,000<br>Reduction of Benefit | 20% Coinsurance after<br>Deductible & up to \$1,000<br>Reduction of Benefit |
| <b>Preventive Care</b>  |   |   |
| Adult Routine Exams   | \$0   | 20% Coinsurance after<br>Deductible   |
| Well Child Care   | \$0   | 20% Coinsurance after<br>Deductible   |
| Child and Adult Routine<br>Immunizations  | \$0   | 20% Coinsurance after<br>Deductible   |
| Routine Prenatal &<br>Postpartum Care   | \$0   | 20% Coinsurance after<br>Deductible   |
| Routine Eye Exams (limited<br>to one per Calendar Year)<br>Please note: for children under<br>age 19, In-Plan routine eye<br>exams must be done by an<br>EyeMed Provider. | \$0   | 20% Coinsurance after<br>Deductible   |
| Annual Gynecological Exams<br>(limited to one per Calendar<br>Year)   | \$0   | 20% Coinsurance after<br>Deductible   |
| Routine Mammograms<br>(routine mammograms limited<br>to one per Calendar Year)  | \$0   | 20% Coinsurance after<br>Deductible   |
| Screening Colonoscopy or<br>Sigmoidoscopy (limited to<br>one every five Calendar<br>Years)  | \$0   | 20% Coinsurance after<br>Deductible   |
| Nutritional Counseling<br>(maximum of 4 visits per<br>Calendar Year)  | \$0   | 20% Coinsurance after<br>Deductible   |
| Preventive Screenings Listed<br>under "Outpatient Preventive<br>Care" in the <i>Covered Benefits</i><br>Section of the EOC  | \$0   | 20% Coinsurance after<br>Deductible   |

| <b>Benefit</b>   | <b>Your Cost<br/>In-Plan Providers<br/>Health New England &amp; PHCS</b>  | <b>Your Cost<br/>Out-of-Plan Providers</b>  |
|--|---|---|
| <b>Outpatient Care</b>   |   |   |
| Physician Office Visit with providers who specialize in internal medicine, family practice, or pediatrics  | \$25 Copay per visit after Deductible   | 20% Coinsurance after Deductible  |
| Specialist Office Visit  | \$50 Copay per visit after Deductible   | 20% Coinsurance after Deductible  |
| Second Opinions  | \$50 Copay per visit after Deductible   | 20% Coinsurance after Deductible  |
| Telephone and video consultations with internists, family practitioners, and pediatricians for non-emergency medical conditions through Teladoc® | \$0 after Deductible  | Not covered   |
| Hearing Tests in Specialist Office or Outpatient Facility (other than routine screenings covered as part of your Annual Routine Exam)            | \$50 Copay per visit after Deductible   | 20% Coinsurance after Deductible  |
| <b>Diabetic-Related Items:</b>   |   |   |
| Outpatient Services  | \$50 Copay per visit after Deductible   | 20% Coinsurance after Deductible  |
| Lab Services   | \$25 Copay after Deductible   | 20% Coinsurance after Deductible  |
| Durable Medical Equipment †  | 20% Coinsurance after Deductible  | 20% Coinsurance after Deductible  |
| Individual Diabetic Education  | \$50 Copay per visit after Deductible   | 20% Coinsurance after Deductible  |
| Group Diabetic Education   | \$25 Copay per session after Deductible   | 20% Coinsurance after Deductible  |
| Emergency Room Care (Copay waived if admitted)   | \$300 Copay per visit after Deductible  | \$300 Copay per visit after Deductible  |
| Diagnostic Testing   | \$0 after Deductible  | 20% Coinsurance after Deductible  |
| Sleep Study †  | \$500 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   | \$25 Copay after Deductible   | 20% Coinsurance after Deductible  |
| 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 †   | \$500 Copay after Deductible (maximum three Copays per year); and for PHCS providers without Prior Approval, Member pays all costs                        | 20% Coinsurance after Deductible; without Prior Approval, Member pays all costs   |

| <b>Benefit</b>  | <b>Your Cost<br/>In-Plan Providers<br/>Health New England &amp; PHCS</b>                                   | <b>Your Cost<br/>Out-of-Plan Providers</b>                                      |
|---|--|---|
| 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.) | \$50 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 ½ day   | 20% Coinsurance after Deductible  |
| Early Intervention Services (Covered for children from birth to age 3.)   | \$0 after Deductible   | 20% Coinsurance after Deductible  |
| Applied Behavioral Analysis (ABA) to treat Autism Spectrum Disorder †   | \$0 after Deductible (for PHCS Providers, without Prior Approval Member pays all costs)                    | 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.)            | \$250 Copay after Deductible; and for PHCS Providers up to \$1,000 Reduction of Benefit                    | 20% Coinsurance after Deductible & up to \$1,000 Reduction of Benefit           |
| Allergy Testing and Treatment   | \$50 Copay per visit after Deductible  | 20% Coinsurance after Deductible  |
| Allergy Injections  | \$0 after Deductible   | 20% Coinsurance after Deductible  |
| <b>Infertility Services</b>   |  |   |
| Some Infertility services are covered only for Massachusetts and Connecticut residents. Some services require Prior Approval.   |  |   |
| Office Visit  | \$50 Copay per visit after Deductible; 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   | \$250 Copay after Deductible; and for PHCS providers without Prior Approval Member pays all costs          | 20% Coinsurance after Deductible; without Prior Approval, Member pays all costs |

| <b>Benefit</b>  | <b>Your Cost<br/>In-Plan Providers<br/>Health New England &amp; PHCS</b>  | <b>Your Cost<br/>Out-of-Plan Providers</b>                                      |
|---|---|---|
| Lab Test  | \$25 Copay after Deductible; and for PHCS providers without Prior Approval Member pays all costs                | 20% Coinsurance after Deductible; without Prior Approval, Member pays all costs |
| Inpatient Care †  | \$500 Copay per admission after Deductible; and for PHCS providers without Prior Approval Member pays all costs | 20% Coinsurance after Deductible; without Prior Approval, Member pays all costs |
| <b>Maternity Care</b>   |   |   |
| Non-Routine Prenatal and Postpartum Visit   | \$50 Copay per visit after Deductible   | 20% Coinsurance after Deductible  |
| Delivery/Hospital Care for Mother and Child †<br>(Coverage for child limited to routine newborn nursery charges. For continued coverage, child must be enrolled within 30 days of date of birth.) | \$500 Copay per admission after Deductible; and for PHCS providers up to \$1,000 Reduction of Benefit           | 20% Coinsurance after Deductible & up to \$1,000 Reduction of Benefit           |
| <b>Dental Services</b>  |   |   |
| Surgical Treatment of Non-Dental Conditions in a Doctor's Office  | \$50 Copay per visit after Deductible   | 20% Coinsurance after Deductible  |
| Emergency Dental Care in a Doctor's or Dentist's Office   | \$50 Copay per visit after Deductible   | 20% Coinsurance after Deductible  |
| Emergency Dental Care in an Emergency Room  | \$300 Copay per visit after Deductible  | \$300 Copay per visit after Deductible  |
| <b>Other Services</b>   |   |   |
| Home Health Care †  | \$0 after Deductible; and for PHCS providers up to \$1,000 Reduction of Benefit                                 | 20% Coinsurance after Deductible & up to \$1,000 Reduction of Benefit           |
| Hospice Services †  | \$0 after Deductible and for PHCS providers up to \$1,000 Reduction of Benefit                                  | 20% Coinsurance after Deductible & up to \$1,000 Reduction of Benefit           |
| Durable Medical Equipment †   | 20% Coinsurance after Deductible; and for PHCS providers up to \$1,000 Reduction of Benefit                     | 20% Coinsurance after Deductible & up to \$1,000 Reduction of Benefit           |
| Prosthetic Limbs †  | 20% Coinsurance after Deductible; 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  |

| <b>Benefit</b>   | <b>Your Cost<br/>In-Plan Providers<br/>Health New England &amp; PHCS</b>  | <b>Your Cost<br/>Out-of-Plan Providers</b>   |
|--|---|--|
| Kidney Dialysis  | \$0 after Deductible  | 20% Coinsurance after Deductible   |
| Nutritional Support † (not covered without Prior Approval)   | \$0 after Deductible  | 20% Coinsurance after Deductible   |
| Cardiac Rehabilitation   | \$50 Copay per visit after Deductible   | 20% Coinsurance after Deductible   |
| Wigs (Scalp Hair Protheses) for hair loss due to treatment of any form of cancer or leukemia. † (Health New England covers 1 prosthesis per Calendar Year)   | 20% Coinsurance after Deductible  | 20% Coinsurance after Deductible   |
| Speech, Hearing, and Language Disorders † (Prior Approval is required for speech therapy services after the initial evaluation.)   | \$50 Copay per visit after Deductible; and for PHCS providers up to \$1,000 Reduction of Benefit  | 20% Coinsurance after Deductible & up to \$1,000 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 after Deductible up to \$2,000 per device per ear (you are responsible for all costs beyond maximum); and for PHCS providers without Prior Approval Member pays all costs | 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.)  | \$500 Copay per admission after Deductible; and for PHCS providers up to \$1,000 Reduction of Benefit   | 20% Coinsurance after Deductible & up to \$1,000 Reduction of Benefit  |
| <b>Wellness Services</b>   |   |  |
| Before January 1, 2021: Acupuncture & Massage Therapy (Limited to a <b>total</b> of three visits per Calendar Year <b>per family</b> . For example, you may have three visits for acupuncture <b>or</b> three visits for massage <b>or</b> one visit for acupuncture and two visits for massage <b>or</b> two visits for acupuncture and one visit for massage.) | \$0 after Deductible up to 3 visits per family  | \$0 after Deductible up to 3 visits per family   |

| <b>Benefit</b>  | <b>Your Cost<br/>In-Plan Providers<br/>Health New England &amp; PHCS</b>                                    | <b>Your Cost<br/>Out-of-Plan Providers</b>                                  |
|---|---|---|
| Effective January 1, 2021:<br>Massage Therapy (Limited to<br>two visits per Calendar Year<br>per family.)                                       | \$0 after Deductible<br>up to 2 visits per family   | \$0 after Deductible<br>up to 2 visits per family                           |
| Effective January 1, 2021:<br>Acupuncture (Limited to 12<br>visits per Calendar Year.)  | \$20 Copay per visit after Deductible   | 20% Coinsurance after<br>Deductible   |
| <b>Behavioral Health</b><br>(Includes Mental Health<br>and Substance Use<br>Disorder)   |   |   |
| Outpatient Services (Some<br>services require Prior<br>Approval.)   | \$25 Copay per visit after Deductible   | 20% Coinsurance after<br>Deductible   |
| Telephone and video<br>consultations for non-<br>emergency behavioral health<br>issues and substance use<br>disorder issues through<br>Teladoc® | \$25 Copay per consultation after Deductible  | Not covered   |
| Inpatient Services †  | \$500 Copay per admission after Deductible;<br>and for PHCS providers up to \$1,000<br>Reduction of Benefit | 20% Coinsurance after<br>Deductible & up to \$1,000<br>Reduction of Benefit |

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