Health New England

HMO Catastrophic Plan Connector
HMO Benefit Chart

This is a Catastrophic Plan It provides Essential Health Benefits after you have met your Deductible.

The Deductible does NOT apply to the following services:

- Preventive Care
- 3 Non-Routine PCP Visits

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.

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
Combined Medical/Pharmacy Deductible per Year: 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 you plan includes prescription drug coverage, your prescriptions are subject to this Deductible.	$8,700 per individual / $17,400 per family
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.	Medical Out-of-Pocket Maximum (includes prescription drugs and chiropractic services): $8,350 per individual / $16,700 per family Pediatric Dental Services Out-of-Pocket Maximum: $350 per child / $700 per family Total Out-of-Pocket Maximum: $8,700 per individual / $17,400 per family

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
Routine Prenatal & Postpartum Care	$0
Child and Adult Routine Immunizations	$0
Routine Eye Exams (limited to one per Calendar Year) Please note: for children under age 19, routine eye exams must be done by an EyeMed Provider.	$0
Annual Gynecological Exams (limit to one per Calendar Year)	$0

Benefit	Your Cost
Routine Mammograms (routine mammograms limited to one per Calendar Year)	$0
Screening Colonoscopy or Sigmoidoscopy (limited to one every five Calendar Years)	$0
Nutritional Counseling (limited to four visits per Calendar Year)	$0
Preventive Screenings Listed under "Outpatient Preventive Care" in the *Covered Benefits* Section of the EOC	$0
Other Outpatient Care	
PCP Office Visit (Non-Routine) first 3 visits in Policy Period	$35 Copay per visit
PCP Office Visit (Non-Routine) all other visits in Policy Period	$0 after Deductible
Specialist Office Visits	$0 after Deductible
Second Opinions	$0 after Deductible
Telephone and video consultations with internists, family practitioners, and pediatricians for non-emergency medical conditions through Teladoc®	$0 after Deductible
Hearing Tests in Specialist Office or Outpatient Facility (other than routine screenings covered as part of your Annual Routine Exam)	$0 after Deductible
Diabetic-Related Items:	
Outpatient Services	$0 after Deductible
Lab Services	$0 after Deductible
Durable Medical Equipment †	$0 after Deductible
Individual Diabetic Education	$0 after Deductible
Group Diabetic Education	$0 after Deductible
Emergency Room Care (Copay waived if admitted)	$0 after Deductible
Diagnostic Testing	$0 after Deductible
Sleep Study †	$0 after Deductible
Lab Services	$0 after Deductible
Radiological Services (such as ultrasound, x-rays, and non-routine mammograms)	$0 after Deductible
Diagnostic Imaging: CT Scans, MRIs, MRAs, PET Scans, Nuclear Cardiac Imaging †	$0 after Deductible
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.)	$0 after Deductible
Day Rehabilitation Program (limited to 15 full day or 1/2 day sessions per condition per lifetime)	$0 after Deductible
Early Intervention Services (Covered for children from birth to age 3)	$0 after Deductible
Applied Behavioral Analysis (ABA) to treat Autism Spectrum Disorder †	$0 after Deductible
Surgical Services and Procedures in an Outpatient Facility (Some services require Prior Approval.)	$0 after Deductible
Allergy Testing and Treatment	$0 after Deductible
Allergy Injections	$0 after Deductible

Benefit	Your Cost
Infertility Services	
Some Infertility services are covered only for Massachusetts and Connecticut residents. Some services require Prior Approval.	
Office Visit	$0 after Deductible
Outpatient Surgery/ Procedure	$0 after Deductible
Lab Test	$0 after Deductible
Inpatient Care †	$0 after Deductible
Maternity Care	
Non-Routine Prenatal and Postpartum Visit	$0 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
Dental Services	
Surgical Treatment of Non-Dental Conditions in a Doctor's Office (Some services are subject to the Outpatient Surgical Services and Procedures Copay.)	$0 after Deductible
Emergency Dental Care in a Doctor's or Dentist's Office	$0 after Deductible
Emergency Dental Care in an Emergency Room	$0 after Deductible
Other Services	
Home Health Care †	$0 after Deductible
Hospice Services †	$0 after Deductible
Durable Medical Equipment †	$0 after Deductible
Prosthetic Limbs †	$0 after Deductible
Ambulance and Transportation Services (non-emergency transportation requires Prior Approval)	$0 after Deductible
Kidney Dialysis	$0 after Deductible
Nutritional Support †	$0 after Deductible
Cardiac Rehabilitation	$0 after Deductible
Wigs (Scalp Hair Prostheses) for hair loss due to treatment of any form of cancer or leukemia. † (Health New England covers one prosthesis per Calendar Year.)	$0 after Deductible
Speech, Hearing, and Language Disorders † (Prior Approval is required for speech therapy services after the initial evaluation)	$0 after Deductible
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)
Human Organ Transplants and Bone Marrow Transplants †	$0 after Deductible
Wellness Services	
Massage Therapy (Limited to two visits per Calendar Year per family.)	$0 after Deductible, up to 2 visits per family
Acupuncture (Limited to 12 visits per Calendar Year.)	$0 after Deductible

Benefit	Your Cost
Behavioral Health (Includes Mental Health and Substance Use Disorder)	
Outpatient Services (Some services require Prior Approval.)	$0 after Deductible
Telephone and video consultations for non-emergency behavioral health issues and substance use disorder issues through Teladoc	$0 after Deductible
Inpatient Services †	$0 after Deductible
Chiropractic Services	
Visits to an In-Plan chiropractor (for medically necessary chiropractic services)	$0 after Deductible
Prescription Drugs	
At an In-Plan Pharmacy (up to a 30 day supply)	
Generic Drugs	$0 after Deductible
Formulary Drugs	$0 after Deductible
Non-Formulary Drugs	$0 after Deductible
Through Mail Order: (up to a 90day supply of maintenance medication)	
Generic Drugs	$0 after Deductible
Formulary Drugs	$0 after Deductible
Non-Formulary Drugs	$0 after Deductible

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