

## HMO Wise Max 3000 HDHP LG

### High Deductible Health Plan HMO 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.

#### 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.

|                                                                                                                                                                                                                                                                                                                                                       | <b>In-Plan</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. | \$3,000 per individual / \$6,000 per family<br><br><i>Once any individual on a family plan has paid \$3,000 towards the family Deductible, the plan will begin to pay benefits for that individual.</i> |
| <b>Out-of-Pocket Maximum:</b> The most you pay for cost sharing during a Plan Year before your plan begins to pay 100% of the allowed amount.                                                                                                                                                                                                         | \$6,000 per individual / \$12,000 per family                                                                                                                                                            |

| <b>Benefit</b>                                                                                                    | <b>Your Cost</b>     |
|-------------------------------------------------------------------------------------------------------------------|----------------------|
| <b>Inpatient Care</b>                                                                                             |                      |
| 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 |
| <b>Preventive Care</b>                                                                                            |                      |
| Adult Routine Exams                                                                                               | \$0                  |
| Well Child Care                                                                                                   | \$0                  |
| Child and Adult Routine Immunizations                                                                             | \$0                  |
| Routine Prenatal & 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                  |
| Nutritional Counseling (maximum of 4 visits per Calendar Year)                                                    | \$0                  |
| Preventive Screenings Listed under "Outpatient Preventive Care" in the <i>Covered Benefits</i> Section of the EOC | \$0                  |
| <b>Outpatient Care</b>                                                                                            |                      |
| PCP Office Visit (Non-Routine)                                                                                    | \$0 after Deductible |
| Specialist Office Visits                                                                                          | \$0 after Deductible |
| Second Opinions                                                                                                   | \$0 after Deductible |

| <b>Benefit</b>                                                                                                                                                                                                                                                                | <b>Your Cost</b>     |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------|
| 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 |
| <b>Diabetic-Related Items:</b>                                                                                                                                                                                                                                                |                      |
| 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: Ultrasound, X-rays, 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 ½ 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 |
| <b>Infertility Services</b>                                                                                                                                                                                                                                                   |                      |
| 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)                                                                                                                                                                                                                   | \$0 after Deductible |
| Outpatient Surgery/ Procedure                                                                                                                                                                                                                                                 | \$0 after Deductible |
| Lab Test                                                                                                                                                                                                                                                                      | \$0 after Deductible |
| Inpatient Care †                                                                                                                                                                                                                                                              | \$0 after Deductible |
| <b>Maternity Care</b>                                                                                                                                                                                                                                                         |                      |
| Non-Routine Prenatal and Postpartum Visit                                                                                                                                                                                                                                     | \$0 after Deductible |

| <b>Benefit</b>                                                                                                                                                                                                             | <b>Your Cost</b>                                                                                         |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------|
| 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                                                                                     |
| <b>Dental Services</b>                                                                                                                                                                                                     |                                                                                                          |
| Surgical Treatment of Non-Dental Conditions in a Doctor's Office                                                                                                                                                           | \$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                                                                                     |
| <b>Other Services</b>                                                                                                                                                                                                      |                                                                                                          |
| 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 1 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                                                                                     |
| <b>Wellness Services</b>                                                                                                                                                                                                   |                                                                                                          |
| 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                                                                                     |
| <b>Behavioral Health</b><br>(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                                                                                     |

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