Health New England

# HMO Gold SG
## 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.

| | In-Plan |
|---|---|
| **Out-of-Pocket Maximum:** The most you pay for Cost Sharing on Essential Health Benefits during a Calendar Year before your plan begins to pay 100% of the allowed amount. | Medical Out-of-Pocket Maximum (includes prescription drugs and chiropractic services): $4,650 per individual / $9,300 per family<br><br>Pediatric Dental Services Out-of-Pocket Maximum: $350 per child / $700 per family<br><br>Total Out-of-Pocket Maximum $5,000 per individual / $10,000 per family |

| Benefit | Your Cost |
|---|---|
| **Inpatient Care** | |
| Acute Hospital Care | $750 Copay per admission |
| Skilled Nursing Facility † (limited to 100 days per Calendar Year) | $750 Copay per admission |
| Inpatient Rehabilitation † (limited to 60 days per Calendar Year) | $750 Copay per admission |
| **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 |
| 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) | $25 Copay per visit |
| Specialist Office Visits | $50 Copay per visit |
| Second Opinions | $50 Copay per visit |
| Telephone and video consultations with internists, family practitioners, and pediatricians for non-emergency medical conditions through Teladoc® | $0 |

| Benefit | Your Cost |
|---|---|
| Hearing Tests in Specialist Office or Outpatient Facility (other than routine screenings covered as part of your Annual Routine Exam) | $50 Copay per visit |
| Diabetic-Related Items: | |
| Outpatient Services | $50 Copay per visit |
| Lab Services | $50 Copay |
| Durable Medical Equipment † | 20% Coinsurance |
| Individual Diabetic Education | $50 Copay per visit |
| Group Diabetic Education | $25 Copay per session |
| Emergency Room Care (Copay waived if admitted) | $300 Copay per visit |
| Diagnostic Testing | $0 |
| Sleep Study † | $400 Copay<br>(one Copay per year; no Copay for home sleep studies) |
| Lab Services | $50 Copay |
| Radiological Services (such as ultrasound, x-rays, and non-routine mammograms) | $75 Copay |
| Diagnostic Imaging: CT Scans, MRIs, MRAs, PET Scans, Nuclear Cardiac Imaging † | $400 Copay<br>(maximum 3 Copays per year) |
| 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 |
| Day Rehabilitation Program (limited to 15 full day or 1/2 day sessions per condition per lifetime) | $25 Copay for 1 day or 1/2 day |
| Early Intervention Services (Covered for children from birth to age 3) | $0 |
| Applied Behavioral Analysis (ABA) to treat Autism Spectrum Disorder † | $0 |
| Surgical Services and Procedures in an Outpatient Facility (Some services require Prior Approval. This 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.) | $500 Copay |
| Allergy Testing and Treatment | $50 Copay per visit |
| Allergy Injections | $0 |
| **Infertility Services** | |
| Some Infertility services are covered only for Massachusetts and Connecticut residents. Some services require Prior Approval. | |
| Office Visit | $50 Copay per visit |
| Outpatient Surgery/ Procedure | $500 Copay |
| Lab Test | $50 Copay |
| Inpatient Care † | $750 Copay per admission |
| **Maternity Care** | |
| Non-Routine Prenatal and Postpartum Visit | $50 Copay per visit |
| 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) | $750 Copay per admission |

| Benefit | Your Cost |
|---|---|
| **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.) | $50 Copay per visit |
| Emergency Dental Care in a Doctor's or Dentist's Office | $50 Copay per visit |
| Emergency Dental Care in an Emergency Room | $300 Copay per visit |
| **Other Services** | |
| Home Health Care † | $0 |
| Hospice Services † | $0 |
| Durable Medical Equipment † | 20% Coinsurance |
| Prosthetic Limbs † | 20% Coinsurance |
| Ambulance and Transportation Services (non-emergency transportation requires Prior Approval) | $0 |
| Kidney Dialysis | $0 |
| Nutritional Support † | $0 |
| Cardiac Rehabilitation | $50 Copay per visit |
| 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.) | 20% Coinsurance |
| Speech, Hearing, and Language Disorders † (Prior Approval is required for speech therapy services after the initial evaluation) | $50 Copay per visit |
| 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) |
| Human Organ Transplants and Bone Marrow Transplants † | $750 Copay per admission |
| **Wellness Services** | |
| Massage Therapy (Limited to two visits per Calendar Year per family.) | $0 up to 2 visits per family |
| Acupuncture (Limited to 12 visits per Calendar Year.) | $20 Copay per visit |
| **Behavioral Health**<br>(Includes Mental Health and Substance Use Disorder) | |
| Outpatient Services (Some services require Prior Approval.) | $25 Copay per visit |
| Telephone and video consultations for non-emergency behavioral health issues and substance use disorder issues through Teladoc | $25 Copay per consultation |
| Inpatient Services † | $750 Copay per admission |

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