Health New England

HMO Thrive Silver 3000 SG

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
Deductible per Plan 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.	$3,000 per individual / $6,000 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. This Out-of-Pocket Maximum does not include your cost sharing for pediatric dental services.	$7,800 per individual / $15,600 per family

Benefit	Your Cost
Inpatient Care	
Acute Hospital Care	$1,000 Copay per admission after Deductible
Skilled Nursing Facility † (limited to 100 days per Calendar Year)	$1,000 Copay per admission after Deductible
Inpatient Rehabilitation † (limited to 60 days per Calendar Year)	$1,000 Copay per admission after Deductible
Preventive Care	
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) Please note: for children under age 19, routine eye exams must be done by an EyeMed Provider.	$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 *Covered Benefits* Section of the EOC	$0
Outpatient Care	
PCP Office Visit (Non-Routine) (Deductible may apply to some office services)	$20 Copay per visit

Benefit	Your Cost
Specialist Office Visits (Deductible may apply to some office services)	$30 Copay per visit after Deductible
Second Opinions (Deductible may apply to some office services)	$30 Copay per visit after Deductible
Telephone and video consultations with internists, family practitioners, and pediatricians for non-emergency medical conditions through Teladoc®	$0
Hearing Tests in Specialist Office or Outpatient Facility (other than routine screenings covered as part of your Annual Routine Exam)	$30 Copay per visit after Deductible
Diabetic-Related Items:	
Outpatient Services	$30 Copay per visit after Deductible
Lab Services	$50 Copay after Deductible
Durable Medical Equipment †	20% Coinsurance
Individual Diabetic Education	$30 Copay per visit after Deductible
Group Diabetic Education	$20 Copay per session
Emergency Room Care (Copay waived if admitted)	$500 Copay per visit after Deductible
Diagnostic Testing	$0 after Deductible
Sleep Study †	$500 Copay after Deductible (one Copay per year, no Copay for home sleep studies)
Lab Services	$50 Copay after Deductible
Radiological Services: Ultrasound, X-rays, Non-Routine Mammograms	$100 Copay after Deductible
Diagnostic Imaging: CT Scans, MRIs, MRAs, PET Scans, Nuclear Cardiac Imaging †	$500 Copay after Deductible (maximum of three 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.)	$30 Copay per visit per treatment type 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
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.)	$1,000 Copay after Deductible
Allergy Testing and Treatment	$30 Copay per visit after Deductible
Allergy Injections	$0
Infertility Services	
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)	$30 Copay per visit after Deductible

Benefit	Your Cost
Outpatient Surgery/ Procedure	$1,000 Copay after Deductible
Lab Test	$50 Copay after Deductible
Inpatient Care †	$1,000 Copay per admission after Deductible
Maternity Care	
Non-Routine Prenatal and Postpartum Visit	$30 Copay per visit 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.)	$1,000 Copay per admission after Deductible
Dental Services	
Surgical Treatment of Non-Dental Conditions in a Doctor's Office	$30 Copay after Deductible
Emergency Dental Care in a Doctor's or Dentist's Office	$30 Copay per visit after Deductible
Emergency Dental Care in an Emergency Room	$500 Copay per visit after Deductible
Other Services	
Home Health Care †	$0 after Deductible
Hospice Services †	$0
Durable Medical Equipment †	20% Coinsurance
Prosthetic Limbs †	20% Coinsurance
Ambulance and Transportation Services (non-emergency transportation requires Prior Approval)	$100 Copay per day after Deductible
Kidney Dialysis	$0
Nutritional Support †	$0
Cardiac Rehabilitation	$30 Copay per visit 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
Speech, Hearing, and Language Disorders † (Prior Approval is required for speech therapy services after the initial evaluation)	$30 Copay per visit 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 up to $2,000 per device per ear (you are responsible for all costs beyond maximum)
Human Organ Transplants and Bone Marrow Transplants †	$1,000 Copay per admission after Deductible
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 (includes Mental Health and Substance Use Disorder)	
Outpatient Services (Some services require Prior Approval.)	$20 Copay per visit
Telephone and video consultations for non-emergency behavioral health issues and substance use disorder issues through Teladoc®	$20 Copay per consultation
Inpatient Services †	$1,000 Copay per admission after Deductible

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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).