Health New England

# HMO ConnectorCare 1
## 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 |
|---|---|
| **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. | $0<br>This plan does not have a Deductible |
| **Medical 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 does not include your cost sharing for pharmacy benefits. | $0<br>This plan does not have a Medical Out-of-Pocket Maximum |
| **Pharmacy Out-of-Pocket Maximum:** The most you pay for cost sharing for pharmacy benefits during a Plan Year before your plan begins to pay 100% of the allowed amount. | $250 per individual / $500 per family |

| Benefit | Your Cost |
|---|---|
| **Inpatient Care** | |
| Acute Hospital Care | $0 |
| Skilled Nursing Facility † (limited to 100 days per Calendar Year) | $0 |
| Inpatient Rehabilitation † (limited to 60 days per Calendar Year) | $0 |
| **Outpatient 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)<br>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 |

| Benefit | Your Cost |
|---|---|
| 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 |
| **Other Outpatient Care** | |
| PCP Office Visit (Non-Routine) | $0 |
| Specialist Office Visits | $0 |
| Second Opinions | $0 |
| Teladoc Urgent Medical: Telephone and video consultations with internists, family practitioners, and pediatricians for non-emergency medical conditions through Teladoc®. Teladoc is a network of providers contracted to provide virtual Urgent Care services. Teladoc is not intended to replace your PCP. | $0 |
| Hearing Tests in Specialist Office or Outpatient Facility (other than routine screenings covered as part of your Annual Routine Exam) | $0 |
| Diabetic-Related Items: | |
| Outpatient Services | $0 |
| Lab Services | $0 |
| Durable Medical Equipment † | $0 |
| Individual Diabetic Education | $0 |
| Group Diabetic Education | $0 |
| Emergency Room Care (Copay waived if admitted) | $0 |
| Diagnostic Testing | $0 |
| Sleep Study † | $0 |
| Lab Services | $0 |
| Radiological Services: Ultrasound, X-rays, Non-Routine Mammograms | $0 |
| Diagnostic Imaging: CT Scans, MRIs, MRAs, PET Scans, Nuclear Cardiac Imaging † | $0 |
| 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 |
| Day Rehabilitation Program (limited to 15 full day or ½ day sessions per condition per lifetime) | $0 |
| Early Intervention Services (Covered for children from birth to age 3) | $0 |
| Applied Behavioral Analysis (ABA) to treat Autism Spectrum Disorder † | $0 |
| Outpatient Surgical Services and Procedures (Some services require Prior Approval.) | $0 |
| Allergy Testing and Treatment | $0 |
| Allergy Injections | $0 |

| Benefit | Your Cost |
|---|---|
| **Infertility Services** | |
| Some Infertility services are covered only for Massachusetts and Connecticut residents. Some services require Prior Approval. | |
| Office Visit | $0 |
| Outpatient Surgery/ Procedure | $0 |
| Lab Test | $0 |
| Inpatient Care † | $0 |
| **Maternity Care** | |
| Non-Routine Prenatal and Postpartum Visit | $0 |
| 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 |
| **Dental Services** | |
| Surgical Treatment of Non-Dental Conditions in a Doctor's Office | $0 |
| Emergency Dental Care in a Doctor's or Dentist's Office | $0 |
| Emergency Dental Care in an Emergency Room | $0 |
| **Other Services** | |
| Home Health Care † | $0 |
| Hospice Services † | $0 |
| Durable Medical Equipment † | $0 |
| Prosthetic Limbs † | $0 |
| Ambulance and Transportation Services (non-emergency transportation requires Prior Approval) | $0 |
| Kidney Dialysis | $0 |
| Nutritional Support † | $0 |
| Cardiac Rehabilitation | $0 |
| 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 |
| Speech, Hearing, and Language Disorders † (Prior Approval is required for speech therapy services after the initial evaluation) | $0 |
| 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 † | $0 |
| **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.) | $0 |

| Benefit | Your Cost |
|---|---|
| **Behavioral Health**<br>(Includes Mental Health and Substance Use Disorder) | |
| Outpatient Services (Some services require Prior Approval.) | $0 |
| Teladoc Behavioral Health: Telephone and video consultations for non-emergency behavioral health issues and substance use disorder issues through Teladoc®. | $0 |
| Inpatient Services † | $0 |
| **Chiropractic Services** | |
| Visits to an In-Plan chiropractor (for medically necessary chiropractic services) | $0 |
| **Prescription Drugs** | |
| At an In-Plan Pharmacy (up to a 30 day supply) | |
| Generic Drugs | $1.00 Copay |
| Formulary Drugs | $3.65 Copay |
| Non-Formulary Drugs | $3.65 Copay |
| Through Mail Order: (up to a 90day supply of maintenance medication) | |
| Generic Drugs | $2.00 Copay |
| Formulary Drugs | $7.30 Copay |
| Non-Formulary Drugs | $7.30 Copay |

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