Health New England

HMO Essential Max LG
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.	$1,000 per individual / $2,000 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.	$5,000 per individual / $10,000 per family

Benefit	Your Cost
Inpatient Care	
Acute Hospital Care	
• Physician Charges	$0
• Facility Charges	$0 after Deductible
Skilled Nursing Facility † (limited to 100 days per Calendar Year)	
• Physician Charges	$0
• Facility Charges	$0 after Deductible
Inpatient Rehabilitation † (limited to 60 days per Calendar Year)	
• Physician Charges	$0
• Facility Charges	$0 after Deductible
Preventive Care	
Adult Routine Exams	$0
Well Child Care	$0
Child and Adult Routine Immunizations	$0
Annual Gynecological Exams (limited to one per Calendar Year)	$0
Routine Eye Exams (limited to one per Calendar Year)	$0
Routine Mammograms (routine mammgrams 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

Benefit	Your Cost
Preventive Screenings Listed under "Outpatient Preventive Care" in the *Covered Benefits* Section of the EOC	$0
Outpatient Care	
PCP Office Visit (Non-Routine)	$20 Copay per visit
Specialist Office Visits	$40 Copay per visit
Second Opinions	$40 Copay per visit
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 (other than routine screenings covered as part of your Annual Routine Exam)	
• Physician Charges	$40 Copay per visit
• Facility Charges	$0 after Deductible
Diabetic-Related Items:	
Outpatient Physician Charges	$40 Copay per visit
Individual Diabetic Education	$40 Copay per visit
Lab Services	$0
Durable Medical Equipment †	20% Coinsurance
Group Diabetic Education	$20 Copay per session
Emergency Room Care (Copay waived if admitted)	$150 Copay per visit after Deductible
Diagnostic Testing	
• Physician Charges	$40 Copay per visit
• Facility Charges	$0 after Deductible
Sleep Study †	$100 Copay after Deductible (one Copay per year; no Copay for home sleep studies)
Lab Services	$0
Radiological Services: Ultrasound, X-rays, Non-Routine Mammograms	
• Physician Charges	$0
• Facility Charges	$0 after Deductible
Diagnostic Imaging: CT Scans, MRIs, MRAs, PET Scans, Nuclear Cardiac Imaging †	$100 Copay after Deductible (maximum 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.)	
• Physician Charges	$40 Copay per visit per treatment type
• Facility Charges	$40 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 1/2 day

Benefit	Your Cost
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.)	
• Physician Charges	$0
• Facility Charges	$0 after Deductible
Allergy Testing and Treatment	
• In a Doctor's office	$40 Copay per visit
• In a Facility	$40 Copay per visit after Deductible
Allergy Injections	
• In a Doctor's Office	$0
• In a Facility	$0 after Deductible
Family Planning Services	
Office Visit	$40 Copay per visit
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)	$40 Copay per visit
Outpatient Surgery/ Procedure †	
• Physician Charges	$0
• Facility Charges	$0 after Deductible
Lab Test	$0
Inpatient Care †	
• Physician Charges	$0
• Facility Charges	$0 after Deductible
Maternity Care	
Non-Routine Prenatal and Postpartum Visit	$40 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)	
• Physician Charges	$0
• Facility Charges	$0 after Deductible
Dental Services	
Surgical Treatment of Non-Dental Conditions in a Doctor's Office	$40 Copay per visit
Emergency Dental Care in a Doctor's or Dentist's Office	$40 Copay per visit
Emergency Dental Care in an Emergency Room	$150 Copay per visit after Deductible
Other Services	
Home Health Care †	$0 Copay after Deductible
Hospice Services †	$0

Benefit	Your Cost
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	
• Physician Charges	$40 Copay per visit
• Facility Charges	$40 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 one prosthesis per Calendar Year)	20% Coinsurance
Speech, Hearing, and Language Disorders † (Prior Approval is required for speech therapy services after the initial evaluation.)	
• Physician Charges	$40 Copay per visit
• Facility Charges	$40 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 †	
• Physician Charges	$0
• Facility Charges	$0 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
Teladoc Behavioral Health: Telephone and video consultations for non-emergency behavioral health issues and substance use disorder issues through Teladoc®.	$20 Copay per consultation
Inpatient Services †	
• Physician Charges	$0
• Facility Charges	$0 after Deductible

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