

PPO Core 2000 National LG PPO 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.

Please note: For Out-of-Plan services, you are also responsible for any Remaining Balances. A Remaining Balance is that portion of an Out-of-Plan Provider's charge that is above Health New England's Allowed Amount.

Note about Prior Approval:

Some services may require Prior Approval. These services are marked with † in the chart. In some cases, if you fail to ask for Prior Approval the service will not be covered at all. (See, for example, Infertility Treatment below.) In other cases, for example Acute Hospital Care at an Out-of-Plan facility, if you fail to ask for Prior Approval you may have a Reduction of Benefit up to the amount indicated below. Remember that exclusions or limitations of this plan still apply, even if you ask for Prior Approval. For example, services that are not Medically Necessary are not covered, even if you ask for Prior Approval.

| | In-Plan Providers | Out-of-Plan Providers |
|---|--|---|
| Deductible per Plan Year: You must pay this amount for Covered Services before Health New England will begin to pay benefits. This is a combined amount for Health New England, extended network, and Out-of-Plan providers. As indicated in the chart below, some services are not subject to the Deductible. | \$2,000 per individual / \$4,000 per family | |
| In-Plan 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 is a combined amount for Health New England & extended network Providers. | \$6,500 per individual / \$13,000 per family | Not applicable |
| Out-of-Plan Out-of-Pocket Maximum: This is the most you will pay in a Plan Year for the combined cost of your Medical Deductible and Coinsurance for Covered Services from Out-of-Plan Providers. | Not applicable | \$7,500 per individual / \$15,000 per family |
| Reduction of Benefit: Applies to certain services if Prior Approval is required but not requested.) Does not count toward your Out-of-Pocket Maximum. | \$500 (Does not apply to Health New England Providers) | \$500 |

| Benefit | Your Cost In-Plan Providers | Your Cost Out-of-Plan Providers |
|---|---|---|
| Inpatient Care | | |
| Acute Hospital Care † (elective admissions to Out-of-Plan facilities require Prior Approval) | \$600 Copay per admission after Deductible; and for extended network providers up to \$500 Reduction of Benefit | 20% Coinsurance after Deductible & up to \$500 Reduction of Benefit |
| Skilled Nursing Facility † (limited to 100 days per Calendar Year; admissions to Out-of-Plan facilities require Prior Approval) | \$600 Copay per admission after Deductible; and for extended network providers up to \$500 Reduction of Benefit | 20% Coinsurance after Deductible & up to \$500 Reduction of Benefit |
| Inpatient Rehabilitation † (limited to 60 days per Calendar Year; admissions to Out-of-Plan facilities require Prior Approval) | \$600 Copay per admission after Deductible; and for extended network providers up to \$500 Reduction of Benefit | 20% Coinsurance after Deductible & up to \$500 Reduction of Benefit |
| Preventive Care | | |
| Adult Routine Exams | \$0 | 20% Coinsurance after Deductible |
| Well Child Care | \$0 | 20% Coinsurance after Deductible |
| Child and Adult Routine Immunizations | \$0 | 20% Coinsurance after Deductible |
| Routine Prenatal & Postpartum Care | \$0 | 20% Coinsurance after Deductible |
| Routine Eye Exams (limited to one per Calendar Year) | \$0 | 20% Coinsurance after Deductible |
| Annual Gynecological Exams (limited to one per Calendar Year) | \$0 | 20% Coinsurance after Deductible |
| Routine Mammograms (routine mammograms limited to one per Calendar Year) | \$0 | 20% Coinsurance after Deductible |
| Screening Colonoscopy or Sigmoidoscopy (limited to one every five Calendar Years) | \$0 | 20% Coinsurance after Deductible |
| Nutritional Counseling (limited to four visits per Calendar Year) | \$0 | 20% Coinsurance after Deductible |
| Preventive Screenings Listed under "Outpatient Preventive Care" in the <i>Covered Benefits</i> Section of the EOC | \$0 | 20% Coinsurance after Deductible |

| Benefit | Your Cost In-Plan Providers | Your Cost Out-of-Plan Providers |
|--|--|---|
| Outpatient Care | | |
| Physician Office Visits (non-routine) with providers who specialize in internal medicine, family practice, or pediatrics (Deductible may apply to some In-Plan office services.) | \$50 Copay per visit | 20% Coinsurance after Deductible |
| Specialist Office Visits (Deductible may apply to some In-Plan office services.) | \$50 Copay per visit | 20% Coinsurance after Deductible |
| Second Opinions (Deductible may apply to some In-Plan office services.) | \$50 Copay per visit | 20% Coinsurance after Deductible |
| 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 | Not covered |
| Hearing Tests in Specialist Office or Outpatient Facility (other than routine screenings covered as part of your Annual Routine Exam) | \$50 Copay per visit after Deductible | 20% Coinsurance after Deductible |
| Diabetic-Related Items: | | |
| Outpatient Services (Deductible may apply to some In-Plan office services.) | \$50 Copay per visit | 20% Coinsurance after Deductible |
| Lab Services | \$0 after Deductible | 20% Coinsurance after Deductible |
| Durable Medical Equipment † | 20% Coinsurance; and for extended network providers up to \$500 Reduction of Benefit | 20% Coinsurance after Deductible & up to \$500 Reduction of Benefit |
| Individual Diabetic Education | \$50 Copay per visit | 20% Coinsurance after Deductible |
| Group Diabetic Education | \$50 Copay per session | 20% Coinsurance after Deductible |
| Emergency Room Care (Copay waived if admitted) | \$300 Copay per visit | \$300 Copay per visit |
| Diagnostic Testing | \$0 after Deductible | 20% Coinsurance after Deductible |

| Benefit | Your Cost In-Plan Providers | Your Cost Out-of-Plan Providers |
|---|--|--|
| Sleep Study † | \$250 Copay after Deductible (One Copay per year; no Copay for home sleep studies; and for extended network providers without Prior Approval, Member pays all costs.) | 20% Coinsurance after Deductible; without Prior Approval, Member pays all costs. |
| Lab Services | \$0 after Deductible | 20% Coinsurance after Deductible |
| Radiological Services: Ultrasound, X-rays, Non-Routine Mammograms | \$0 after Deductible | 20% Coinsurance after Deductible |
| Diagnostic Imaging: CT Scans, MRIs, MRAs, PET Scans, Nuclear Cardiac Imaging † | \$250 Copay after Deductible (maximum three Copays per year); and for extended network providers without Prior Approval, Member pays all costs | 20% Coinsurance after Deductible; without Prior Approval, Member pays all costs |
| 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 after Deductible | 20% Coinsurance 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 | 20% Coinsurance after Deductible |
| Early Intervention Services (Covered for children from birth to age 3.) | \$0 | 20% Coinsurance after Deductible |
| Applied Behavioral Analysis (ABA) to treat Autism Spectrum Disorder † | \$0 (for extended network Providers, without Prior Approval Member pays all costs) | 20% Coinsurance after Deductible (without Prior Approval Member pays all costs) |
| 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.) | \$350 Copay after Deductible; and for extended network providers up to \$500 Reduction of Benefit | 20% Coinsurance after Deductible & up to \$500 Reduction of Benefit |
| Allergy Testing and Treatment | \$50 Copay per visit | 20% Coinsurance after Deductible |
| Allergy Injections | \$0 | 20% Coinsurance after Deductible |

| Benefit | Your Cost In-Plan Providers | Your Cost Out-of-Plan Providers |
|---|---|---|
| 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 In-Plan office services) | \$50 Copay per visit; and for extended network providers without Prior Approval Member pays all costs | 20% Coinsurance after Deductible; without Prior Approval, Member pays all costs |
| Outpatient Surgery/ Procedure | \$350 Copay after Deductible; and for extended network providers without Prior Approval Member pays all costs | 20% Coinsurance after Deductible; without Prior Approval, Member pays all costs |
| Lab Test | \$0 after Deductible; and for extended network providers without Prior Approval Member pays all costs | 20% Coinsurance after Deductible; without Prior Approval, Member pays all costs |
| Inpatient Care † | \$600 Copay after Deductible; and for extended network providers without Prior Approval Member pays all costs | 20% Coinsurance after Deductible; without Prior Approval, Member pays all costs |
| Maternity Care | | |
| Non-Routine Prenatal and Postpartum Care | \$50 Copay per visit | 20% Coinsurance 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.) | \$600 Copay after Deductible; and for extended network providers up to \$500 Reduction of Benefit | 20% Coinsurance after Deductible & up to \$500 Reduction of Benefit |
| Dental Services | | |
| Surgical Treatment of Non-Dental Conditions in a Doctor's Office | \$50 Copay after Deductible | 20% Coinsurance after Deductible |
| Emergency Dental Care in a Doctor's or Dentist's Office | \$50 Copay per visit | 20% Coinsurance after Deductible |
| Emergency Dental Care in an Emergency Room | \$300 Copay per visit | \$300 Copay per visit |
| Other Services | | |
| Home Health Care † | \$0 after Deductible; and for extended network providers up to \$500 Reduction of Benefit | 20% Coinsurance after Deductible & up to \$500 Reduction of Benefit |
| Hospice Services † | \$0; and for extended network providers up to \$500 Reduction of Benefit | 20% Coinsurance after Deductible & up to \$500 Reduction of Benefit |

| Benefit | Your Cost In-Plan Providers | Your Cost Out-of-Plan Providers |
|---|--|--|
| Durable Medical Equipment † | 20% Coinsurance; and for extended network providers up to \$500 Reduction of Benefit | 20% Coinsurance after Deductible & up to \$500 Reduction of Benefit |
| Prosthetic Limbs † | 20% Coinsurance; and for extended network providers without Prior Approval Member pays all costs | 20% Coinsurance after Deductible; without Prior Approval Member pays all costs |
| Ambulance and Transportation Services (non-emergency transportation requires Prior Approval; if Prior Approval is not obtained for non-emergency transportation, Member pays all costs) | \$100 Copay per day after Deductible | \$100 Copay per day after Deductible |
| Kidney Dialysis | \$0 | 20% Coinsurance after Deductible |
| Nutritional Support † (not covered without Prior Approval) | \$0 | \$0 |
| Cardiac Rehabilitation | \$50 Copay per visit after Deductible | 20% Coinsurance after Deductible |
| Wigs (Scalp Hair Protheses) for hair loss due to treatment of any form of cancer or leukemia. † (Health New England covers 1 prosthesis per Calendar Year) | 20% Coinsurance | 20% Coinsurance |
| Speech, Hearing, and Language Disorders † (Prior Approval is required for speech therapy services after the initial evaluation.) | \$50 Copay per visit after Deductible; and for extended network providers without Prior Approval up to \$500 Reduction of Benefit | 20% Coinsurance after Deductible & up to \$500 Reduction of Benefit |
| 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); and for extended network providers without Prior Approval Member pays all costs | 20% Coinsurance after Deductible; up to \$2,000 per device per ear (you are responsible for all costs beyond maximum). Without Prior Approval Member pays all costs. |
| Human Organ Transplants and Bone Marrow Transplants † (Without Prior Approval, payments you make to Out-of-Plan Providers for Deductible and Coinsurance do not count toward your Deductible or Maximum Coinsurance amounts.) | \$600 Copay after Deductible; and for extended network providers up to \$500 Reduction of Benefit | 20% Coinsurance after Deductible & up to \$500 Reduction of Benefit |

| Benefit | Your Cost In-Plan Providers | Your Cost Out-of-Plan Providers |
|---|---|---|
| Wellness Services | | |
| Massage Therapy (Limited to two visits per Calendar Year per family.) | \$0 up to 2 visits per family | \$0 up to 2 visits per family |
| Acupuncture (Limited to 12 visits per Calendar Year.) | \$20 Copay per visit | 20% Coinsurance after Deductible |
| Behavioral Health (Includes Mental Health and Substance Use Disorder) | | |
| Outpatient Services (Some services require Prior Approval.) | \$50 Copay per visit | 20% Coinsurance after Deductible |
| Teladoc Behavioral Health: Telephone and video consultations for non-emergency behavioral health issues and substance use disorder issues through Teladoc@. | \$40 Copay per consultation | Not covered |
| Inpatient Services † | \$600 Copay after Deductible; and for extended network providers up to \$500 Reduction of Benefit | 20% Coinsurance after Deductible & up to \$500 Reduction of Benefit |

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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).