PPO Essential 500 National SG
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.	$500 per individual / $1,000 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. This Out-of-Pocket Maximum does not include your cost sharing for pediatric dental services.	$5,000 per individual / $10,000 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. This Out-of-Pocket Maximum does not include your cost sharing for pediatric dental services.	Not Applicable	$6,000 per individual / $12,000 per family

	In-Plan Providers	Out-of-Plan Providers
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)	$0 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)	$0 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)	$0 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) Please note: for children under age 19, In-Plan routine eye exams must be done by an EyeMed Provider.	$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

Benefit	Your Cost In-Plan Providers	Your Cost Out-of-Plan Providers
Nutritional Counseling (limited to four visits per Calendar Year)	$0	20% Coinsurance after Deductible
Preventive Screenings Listed under "Outpatient Preventive Care" in the *Covered Benefits* Section of the EOC	$0	20% Coinsurance after Deductible
Outpatient Care		
Physician Office Visit (Deductible may apply to some In-Plan office services.)	$20 Copay per visit	20% Coinsurance after Deductible
Second Opinions (Deductible may apply to some In-Plan office services.)	$20 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)	$20 Copay per visit after Deductible	20% Coinsurance after Deductible
Diabetic-Related Items:		
Outpatient Services (Deductible may apply to some In-Plan office services.)	$20 Copay per visit	20% Coinsurance after Deductible
Lab Services	$0	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	$20 Copay per visit	20% Coinsurance after Deductible
Group Diabetic Education	$20 Copay per session	20% Coinsurance after Deductible
Emergency Room Care (Copay waived if admitted)	$150 Copay per visit	$150 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 †	$75 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	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 †	$75 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.)	$20 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.)	$0 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	$20 Copay per visit	20% Coinsurance after Deductible
Allergy Injections	$0	20% Coinsurance after Deductible
Infertility Services		
Some Infertility services are covered only for Massachusetts and Connecticut residents. Some services require Prior Approval.		

Benefit	Your Cost In-Plan Providers	Your Cost Out-of-Plan Providers
Office Visit (Deductible may apply to some In-Plan office services)	$20 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	$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
Lab Test	$0; 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 †	$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
Maternity Care		
Non-Routine Prenatal and Postpartum Visit	$20 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.)	$0 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	$20 Copay after Deductible	20% Coinsurance after Deductible
Emergency Dental Care in a Doctor's or Dentist's Office	$20 Copay per visit	20% Coinsurance after Deductible
Emergency Dental Care in an Emergency Room	$150 Copay per visit	$150 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
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

Benefit	Your Cost In-Plan Providers	Your Cost Out-of-Plan Providers
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	$20 Copay per visit after Deductible	20% Coinsurance 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	20% Coinsurance
Speech, Hearing, and Language Disorders † (Prior Approval is required for speech therapy services after the initial evaluation.)	$20 Copay per visit after Deductible; and for EXTENDED NETWORK providers 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.)	$0 after Deductible; and for EXTENDED NETWORK providers up to $500 Reduction of Benefit	20% Coinsurance after Deductible & up to $500 Reduction of Benefit
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

Benefit	Your Cost In-Plan Providers	Your Cost Out-of-Plan Providers
Behavioral Health (Includes Mental Health and Substance Use Disorder**)**		
Outpatient Services (Some services require Prior Approval.)	$20 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®.	$20 Copay per consultation	Not covered
Inpatient Services †	$0 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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