Health New England

PPO Wise 3000/10% National HDHP SG
High Deductible Health Plan 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
Combined Medical/ Pharmacy 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. If your plan includes prescription drug coverage, your prescriptions are subject to this Deductible. This amount is a combined amount for In-Plan & Out-of-Plan Providers.	$3,000 per individual / $6,000 per family *Once any individual on a family plan has paid $3,200 towards the family Deductible, the plan will begin to pay benefits for that individual.*	
In-Plan Out-of-Pocket Maximum: This is the most you will pay for cost sharing on Essential Health Benefits during a Plan Year. 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.	$7,000 per individual / $14,000 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/ Pharmacy Deductible amount applied to Out-of-Plan services, plus Copays 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	$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.	$1,000 (Does not apply to Health New England Providers)	$1,000

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)	10% Coinsurance after Deductible; and for extended network providers up to $1,000 Reduction of Benefit	30% Coinsurance after Deductible & up to $1,000 Reduction of Benefit
Skilled Nursing Facility † (limited to 100 days per Calendar Year; admissions to Out-of-Plan facilities require Prior Approval)	10% Coinsurance after Deductible; and for extended network providers up to $1,000 Reduction of Benefit	30% Coinsurance after Deductible & up to $1,000 Reduction of Benefit
Inpatient Rehabilitation † (limited to 60 days per Calendar Year; admissions to Out-of-Plan facilities require Prior Approval)	10% Coinsurance after Deductible; and for extended network providers up to $1,000 Reduction of Benefit	30% Coinsurance after Deductible & up to $1,000 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
Nutritional Counseling (maximum of 4 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

Benefit	Your Cost In-Plan Providers	Your Cost Out-of-Plan Providers
Outpatient Care		
Physician Office Visit (Non-Routine) with providers who specialize in internal medicine, family practice, or pediatrics	$25 Copay per visit after Deductible	20% Coinsurance after Deductible
Specialist Office Visit	$50 Copay per visit after Deductible	20% Coinsurance after Deductible
Second Opinions	$50 Copay per visit after Deductible	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 after Deductible	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	$50 Copay per visit after Deductible	20% Coinsurance after Deductible
Lab Services	$30 Copay after Deductible	30% Coinsurance after Deductible
Durable Medical Equipment †	20% Coinsurance after Deductible	30% Coinsurance after Deductible
Individual Diabetic Education	$50 Copay per visit after Deductible	20% Coinsurance after Deductible
Group Diabetic Education	$25 Copay per session after Deductible	20% Coinsurance after Deductible
Emergency Room Care (Copay waived if admitted)	$300 Copay per visit after Deductible	$300 Copay per visit after Deductible
Diagnostic Testing	10% Coinsurance after Deductible	30% Coinsurance after Deductible
Sleep Study †	10% Coinsurance after Deductible (No Coinsurance for home sleep studies; and for extended network, without Prior Approval, Member pays all costs.)	30% Coinsurance after Deductible (without Prior Approval, Member pays all costs.)
Lab Services	$30 Copay after Deductible	30% Coinsurance after Deductible

Benefit	Your Cost In-Plan Providers	Your Cost Out-of-Plan Providers
Radiological Services: Ultrasound, X-rays, Non-Routine Mammograms	10% Coinsurance after Deductible	30% Coinsurance after Deductible
Diagnostic Imaging: CT Scans, MRIs, MRAs, PET Scans, Nuclear Cardiac Imaging †	10% Coinsurance after Deductible; and for extended network providers without Prior Approval, Member pays all costs	30% 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 vist 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 ½ day	20% Coinsurance after Deductible
Early Intervention Services (Covered for children from birth to age 3.)	$0 after Deductible	20% Coinsurance after Deductible
Applied Behavioral Analysis (ABA) to treat Autism Spectrum Disorder †	$0 after Deductible (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.)	10% Coinsurance after Deductible; and for extended network providers up to $1,000 Reduction of Benefit	30% Coinsurance after Deductible & up to $1,000 Reduction of Benefit
Allergy Testing and Treatment	$50 Copay per visit after Deductible	20% Coinsurance after Deductible
Allergy Injections	$0 after Deductible	20% Coinsurance after Deductible
Infertility Services		
Some Infertility services are covered only for Massachusetts and Connecticut residents. Some services require Prior Approval.		
Office Visit	$50 Copay per visit 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

Benefit	Your Cost In-Plan Providers	Your Cost Out-of-Plan Providers
Outpatient Surgery/ Procedure	10% Coinsurance after Deductible; and for extended network providers without Prior Approval Member pays all costs	30% Coinsurance after Deductible; without Prior Approval, Member pays all costs
Lab Test	$30 Copay after Deductible; and for extended network providers without Prior Approval Member pays all costs	30% Coinsurance after Deductible; without Prior Approval, Member pays all costs
Inpatient Care †	10% Coinsurance after Deductible; and for extended network providers without Prior Approval Member pays all costs	30% Coinsurance after Deductible; without Prior Approval, Member pays all costs
Maternity Care		
Non-Routine Prenatal and Postpartum Visit	$50 Copay per visit after Deductible	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.)	10% Coinsurance after Deductible; and for extended network providers up to $1,000 Reduction of Benefit	30% Coinsurance after Deductible & up to $1,000 Reduction of Benefit
Dental Services		
Surgical Treatment of Non-Dental Conditions in a Doctor's Office	$50 Copay per visit after Deductible	20% Coinsurance after Deductible
Emergency Dental Care in a Doctor's or Dentist's Office	$50Copay per visit after Deductible	20% Coinsurance after Deductible
Emergency Dental Care in an Emergency Room	$300 Copay per visit after Deductible	$300 Copay per visit after Deductible
Other Services		
Home Health Care †	$0 after Deductible; and for extended network providers up to $1,000 Reduction of Benefit	20% Coinsurance after Deductible & up to $1,000 Reduction of Benefit
Hospice Services †	$0 after Deductible and for extended network providers up to $1,000 Reduction of Benefit	20% Coinsurance after Deductible & up to $1,000 Reduction of Benefit
Durable Medical Equipment †	20% Coinsurance after Deductible; and for extended network providers up to $1,000 Reduction of Benefit	30% Coinsurance after Deductible & up to $1,000 Reduction of Benefit
Prosthetic Limbs †	20% Coinsurance after Deductible; and for extended network providers without Prior Approval Member pays all costs	30% 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 after Deductible	20% Coinsurance after Deductible
Nutritional Support † (not covered without Prior Approval)	$0 after Deductible	20% Coinsurance after Deductible
Cardiac Rehabilitation	$50 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 after Deductible	20% Coinsurance after Deductible
Speech, Hearing, and Language Disorders † (Prior Approval is required for speech therapy services after the initial evaluation.)	$50 per visit after Deductible; and for extended network providers up to $1,000 Reduction of Benefit	20% Coinsurance after Deductible & up to $1,000 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 after Deductible 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.)	10% Coinsurance after Deductible; and for extended network providers up to $1,000 Reduction of Benefit	30% Coinsurance after Deductible & up to $1,000 Reduction of Benefit
Wellness Services		
Massage Therapy (Limited to two visits per Calendar Year per family.)	$0 after Deductible up to 2 visits per family	$0 after Deductible up to 2 visits per family
Acupuncture (Limited to 12 visits per Calendar Year.)	$20 Copay per visit after Deductible	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.)	$25 Copay per visit after Deductible	20% Coinsurance after Deductible
Teladoc Behavioral Health: Telephone and video consultations for non-emergency behavioral health issues and substance use disorder issues through Teladoc®.	$25 Copay per consultation after Deductible	Not covered
Inpatient Services †	10% Coinsurance after Deductible; and for extended network providers up to $1,000 Reduction of Benefit	30% Coinsurance after Deductible & up to $1,000 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).