HMO Custom Essential 4000

Summary of Benefits Chart

This chart provides a summary of key services offered by your Health New England (HNE) plan. Your member agreement has a full description of your plan's benefits and provisions. If any terms in this summary differ from those in your member agreement, the terms of the member agreement apply.

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 Year* (You must pay this amount for Covered Services before HNE will begin to pay benefits. As indicated in the chart below, some services are not subject to the Deductible.)	$4,000 per individual / $8,000 per family. HRA provided by the City of Holyoke will pay deductible expenses as follows: Employee Responsibility - $1,000 single / $2,000 family; City Responsibility - $3,000 single / $6,000 family.
SAFETY NET: You are PROTECTED by an Out-of-Pocket Maximum each year.* (This is the most you pay for cost sharing on Essential Health Benefits each year before your plan begins to pay 100% of the allowed amount. Most of your costs, including your costs for prescription drugs, apply to the Out-of-Pocket Maximum.)	$7,350 per individual / $14,700 per family
* This is applied on a Plan Year basis, from July 1 through June 30 of the following year.	

Benefit	**Your Cost**
Inpatient Care	
Acute Hospital Care	$0 after Deductible
Skilled Nursing Facility† (limited to 100 days per Calendar Year)	$0 after Deductible
Inpatient Rehabilitation† (limited to 60 days per Calendar Year)	$0 after Deductible
Outpatient Preventive Care	
Adult Routine Exams	$0
Well Child Care	$0
Child and Adult Routine Immunizations	$0
Routine Prenatal and Postpartum Care	$0
Routine Eye Exams (limited to one per Calendar Year)	$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
Preventive Screenings Listed under "Outpatient Preventive Care" in the *Covered Benefits* Section of the EOC	$0

Benefit	Your Cost
Nutritional Counseling (maximum of 4 visits per Calendar Year)	$0
Other Outpatient Care	
PCP Office Visit (Non-Routine) (Deductible may apply to some office services)	$20 Copay per visit
Specialist Office Visits (Deductible may apply to some office services)	$25 Copay per visit
Second Opinions (Deductible may apply to some office services)	$25 Copay per visit
Telephone and video consultations with internists, family practitioners, and pediatricians for non-emergency medical conditions through Teladoc	$0
Hearing Tests in a Specialist Office or Facility (other than routine screenings covered as part of your annual Routine Exam)	$25 Copay per visit after Deductible
Diabetic-Related Items:	
• Outpatient Services (Deductible may apply to some office services)	$25 Copay per visit
• Lab Services	$0
• Durable Medical Equipment†	20% Coinsurance
• Individual Diabetic Education	$25 Copay per visit
• Group Diabetic Education	$20 Copay per session
Emergency Room Care (Copay waived if admitted)	$150 Copay per visit
Urgent Care Center	$20 Copay per visit
Diagnostic Testing	$0 after Deductible
Sleep Study†	$0 after Deductible
Lab Services	$0
Radiological Services: Ultrasound, X-rays, Non-Routine Mammograms	$0 after Deductible
Diagnostic Imaging: CT Scans, MRIs, MRAs, PET Scans, Nuclear Cardiac Imaging†	$100 Copay (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.)	$25 Copay per visit per treatment type
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
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.)	$0 after Deductible
Allergy Testing and Treatment	$25 Copay per visit
Allergy Injections	$0
Family Planning Services	
Office Visit (Deductible may apply to some office services)	$25 Copay per visit
Infertility Services	

Benefit	Your Cost
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)	$25 Copay per visit
Outpatient Surgery/ Procedure	$0 after Deductible
Lab Test	$0
Inpatient Care†	$0 after Deductible
Maternity Care	
Non-Routine Prenatal and Postpartum Care	$25 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.)	$0 after Deductible
Dental Services	
Surgical Treatment of Non-Dental Conditions in a Doctor's Office	$25 Copay per visit after Deductible
Emergency Dental Care in a Doctor's or Dentist's Office	$25 Copay per visit
Emergency Dental Care in an Emergency Room	$150 Copay per visit
Other Services	
Home Health Care †	$0 after Deductible
Hospice Services †	$0
Durable Medical Equipment†	20% Coinsurance
Prosthetic Limbs†	20% Coinsurance
Ambulance and Transportation Services (non-emergency transportation requires Prior Approval)	$0 after Deductible
Kidney Dialysis	$0
Nutritional Support †	$0
Cardiac Rehabilitation	$25 Copay per visit
Wigs (Scalp Hair Prostheses) for hair loss due to treatment of any form of cancer or leukemia. † (HNE 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)	$25 Copay per visit
Hearing Aids† (Covered for Members age 21 and under. HNE 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 after Deductible
Behavioral Health (Includes Mental Health and Substance Abuse)	
Inpatient Services†	$0 after Deductible
Telephone and video consultations for non-emergency behavioral health issues and substance use disorder issues through Teladoc®	$20 Copay per consultation
Outpatient Services† (some services require Prior Approval)	$20 Copay per visit

P R E S C R I P T I O N D R U G C O V E R A G E

Prescription Drugs (*certain drugs require Prior Approval*) Your Prescription Drug benefit covers those items described in our Formulary. Please call Member Services or visit healthnewengland.org for a copy of the Formulary.	**Copay**
At an In-Plan Pharmacy (up to a 30-day supply)	
Generic Drugs	$10
Formulary Drugs	$20
Non-Formulary Drugs	$35
Through Mail Order: (up to a 90-day supply of maintenance medication)	
Generic Drugs	$10
Formulary Drugs	$20
Non-Formulary Drugs	$35

How Your Prescription Drug Coverage Works

Health New England is committed to providing our members with access to safe and effective medications. We cover most prescription drugs and a small number of non-prescription drugs and medical supplies. Covered prescription drugs are divided into three tiers with different member copays. Copays you pay are applied toward your plan Out-of-Pocket Maximum.

The Health New England Formulary

Covered prescription drugs are divided into three tiers with different member copays.

Tier	Description	Level of Member Copay
1 - Generic	Approved by the U.S. Food and Drug Administration (FDA), Generic Drugs (Tier 1) contain the same active ingredients as brand name drugs, are just as safe and effective, and usually cost less. Health New England encourages the dispensing of generic drugs whenever possible. You pay the lowest copay for generic drugs.	Lowest
2 - Brand/ Formulary	Brand/Formulary Drugs (Tier 2) are marketed under a trademarked brand name, usually by one manufacturer, and do not have less costly generic equivalents. Brand/Formulary Drugs are selected based on a review of the relative safety, effectiveness and cost of the many FDA-approved drugs on the market. Your copay for Brand/Formulary Drugs is higher than for Generic Drugs, but lower than for Brand/Non-Formulary Drugs.	Higher than Tier 1 Lower than Tier 3
3 - Brand/ Non-Formulary	Any brand name drug that Health New England has not selected as a Brand/Formulary Drug is a Brand/Non-Formulary Drug (Tier 3). This category includes, any brand name drug that has a generic equivalent (Tier 1) or brand drugs that have formulary generic and brand alternatives. These medications are still covered, but at the highest copay level. We do not waive or reduce copays for Brand/Non-Formulary drugs.	Highest

C H I R O P R A C T I C S E R V I C E S

Office Visit Copay: $20	
What your plan covers	• We cover up to 12 visits per year for medically necessary chiropractic services. • When you receive services, your In-Plan chiropractor must notify OptumHealth Care Solutions. OptumHealth Care Solutions will work with your In-Plan chiropractor to determine the appropriate level of covered services to treat your condition. If your chiropractor does not notify OptumHealth Care Solutions, you will not be held financially liable for the services. • Health New England will cover your visits with an In-Plan chiropractor. A $20 copay applies for each visit. Copays you pay are applied toward your plan's Out-of-Pocket Maximum.
Exclusions	• Maintenance care (Care given to reduce the incidence or prevalence of illness, impairment, or risk factors, or to promote optimum function) • Orthotics • Services that are not medically necessary • Services with an Out-of-Plan chiropractor • Exclusions or limitations included in the Plan Explanation of Coverage
For more information or to find a provider	**On the web:** You can find information about OptumHealth participating chiropractors through our website. • Go to healthnewengland.org/provider-search • Go down to "Find a Chiropractic Provider" and click Search. **On the phone:** • Call Health New England Member Services at (413) 787-4004 or (800) 310-2835 • Call OptumHealth Care Solutions at (888) 676-7768