



City of Greenfield HMO Custom Essential 250 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. | \$250 per individual / \$500 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. | \$2,000 per individual / \$4,000 per family |
| *This Plan Year begins on July 1 and ends on 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 |
| Preventive Care | |
| Adult Routine Exams | \$0 |
| Well Child Care | \$0 |
| Child and Adult Routine Immunizations | \$0 |
| Routine Prenatal & 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 |
| Nutritional Counseling (maximum of 4 visits per Calendar Year) | \$0 |
| Preventive Screenings Listed under "Outpatient Preventive Care" in the <i>Covered Benefits</i> Section of the EOC | \$0 |

| Benefit | Your Cost |
|---|--|
| 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) | \$20 Copay per visit |
| Second Opinions (Deductible may apply to some office services) | \$20 Copay per visit |
| Telephone and video consultations with internists, family practitioners, and pediatricians for non-emergency medical conditions through Teladoc® | \$0 |
| 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 |
| Diabetic-Related Items: | |
| Outpatient Services (Deductible may apply to some office services) | \$20 Copay per visit |
| Lab Services | \$0 |
| Durable Medical Equipment † | 20% Coinsurance |
| Individual Diabetic Education | \$20 Copay per visit |
| Group Diabetic Education | \$20 Copay per session |
| Emergency Room Care (Copay waived if admitted) | \$150 Copay per visit |
| Diagnostic Testing | \$0 after Deductible |
| Sleep Study † | \$75 Copay after Deductible (one Copay per year; no Copay for home sleep studies) |
| 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 | \$75 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.) | \$20 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 |
| Early Intervention Services (Covered for children from birth to age 3.) | \$0 |
| Applied Behavioral Analysis (ABA) to treat Autism Spectrum Disorders † | \$0 |
| Surgical Services and Procedures in an Outpatient Facility (Some services require Prior Approval.) | \$0 after Deductible |
| Allergy Testing and Treatment | \$20 Copay per visit |
| Allergy Injections | \$0 |

| Benefit | Your Cost |
|--|---|
| 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) | \$20 Copay per visit |
| Outpatient Surgery/ Procedure | \$0 after Deductible |
| Lab Test | \$0 |
| Inpatient Care † | \$0 after Deductible |
| Maternity Care | |
| Non-Routine Prenatal and Postpartum Visit | \$20 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 | \$20 Copay after Deductible |
| Emergency Dental Care in a Doctor's or Dentist's Office | \$20 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) | \$100 Copay per member per day after Deductible |
| Kidney Dialysis | \$0 |
| Nutritional Support † | \$0 |
| Cardiac Rehabilitation | \$20 Copay per visit 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 |
| Speech, Hearing, and Language Disorders † (Prior Approval is required for speech therapy services after the initial evaluation) | \$20 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 † | \$0 after Deductible |
| Behavioral Health (includes Mental Health and Substance Abuse) | |
| Outpatient Services † | \$20 Copay per visit |
| Telephone and video consultations for non-emergency behavioral health issues and substance use disorder issues through Teladoc® | \$20 Copay per consultation |
| Inpatient Services † | \$0 after Deductible |

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