

**PPO Wise Max 2000 National HDHP LG**
**PPO Benefit Chart**

This chart provides a summary of key services offered by your plan. Your Member Agreement has 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 Maximum Allowable Fee.
- **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 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.

	<b>In-Plan Providers HNE and PHCS Providers</b>	<b>Out-of-Plan Providers</b>
Combined Medical/Pharmacy 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. 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.)	\$2,000 per individual / \$4,000 per family**	\$2,000 per individual / \$4,000 per family**
In-Plan Out-of-Pocket Maximum* (This is the most you pay for cost sharing each year before your plan begins to pay 100% of the allowed amount. This is a combined amount for HNE and PHCS providers. Your Copays for prescription drugs are included in this Maximum.)	\$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 year for the combined cost of your Medical/Pharmacy Deductible amount applied to Out-of-Plan services, and Coinsurance for Covered Services from Out-of-Plan Providers. Your Copays for prescription drugs are included in this Maximum.)	Not applicable	\$7,500 per individual / \$15,000 per family
* May be based on a Calendar Year or a Plan Year. This depends on the Group through which you enroll.		
** Once any individual on a family plan has paid \$2,800 towards the family deductible, the plan will begin to pay benefits for that individual.		

	<b>In-Plan Providers HNE and PHCS Providers</b>	<b>Out-of-Plan Providers</b>
Reduction of Benefit (Applies to certain services if Prior Approval is required but not requested.)	\$1,000 (Does not apply to HNE Providers)	\$1,000

<b>Benefit</b>	<b>Your Cost In-Plan Providers HNE and PHCS Providers</b>	<b>Your Cost Out-of-Plan Providers</b>
<b>Inpatient Care</b>		
Acute Hospital Care (elective admissions to Out-of-Plan facilities require Prior Approval)	\$0 after Deductible; and for PHCS providers up to \$1,000 Reduction of Benefit	20% 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)	\$0 after Deductible; and for PHCS providers up to \$1,000 Reduction of Benefit	20% 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)	\$0 after Deductible; and for PHCS providers up to \$1,000 Reduction of Benefit	20% Coinsurance after Deductible & up to \$1,000 Reduction of Benefit
<b>Outpatient Preventive Care</b>		
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 and 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
Preventive Screenings Listed under "Outpatient Preventive Care" in the <i>Covered Benefits</i> Section of the EOC	\$0	20% Coinsurance after Deductible
Nutritional Counseling (limited to four visits per Calendar Year)	\$0	20% Coinsurance after Deductible
<b>Other Outpatient Care</b>		
Physician Office Visit	\$0 after Deductible	20% Coinsurance after Deductible
Second Opinions	\$0 after Deductible	20% Coinsurance after Deductible

<b>Benefit</b>	<b>Your Cost In-Plan Providers HNE and PHCS Providers</b>	<b>Your Cost Out-of-Plan Providers</b>
Telephone and video consultations with internists, family practitioners, and pediatricians for non-emergency medical conditions through Teladoc	\$0 after Deductible	Not covered
Hearing Tests in a Specialist Office or Facility (other than routine screenings covered as part of your annual Routine Exam)	\$0 after Deductible	20% Coinsurance after Deductible
Diabetic-Related Items:		
• Outpatient Services	\$0 after Deductible	20% Coinsurance after Deductible
• Lab Services	\$0 after Deductible	20% Coinsurance after Deductible
• Durable Medical Equipment†	\$0 after Deductible; and for PHCS providers up to \$1,000 Reduction of Benefit	20% Coinsurance after Deductible & up to \$1,000 Reduction of Benefit
• Individual Diabetic Education	\$0 after Deductible	20% Coinsurance after Deductible
• Group Diabetic Education	\$0 after Deductible	20% Coinsurance after Deductible
Emergency Room Care (Copay waived if admitted)	\$0 after Deductible	\$0 after Deductible
Diagnostic Testing	\$0 after Deductible	20% Coinsurance after Deductible
Sleep Study†	\$0 after Deductible; and for PHCS 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†	\$0 after Deductible; and for PCHS 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.)	\$0 after Deductible	20% Coinsurance after Deductible
Day Rehabilitation Program (limited to 15 full day or ½ day sessions per condition per lifetime)	\$0 after Deductible	20% Coinsurance after Deductible
Early Intervention Services (Covered for children from birth to age 3.)	\$0 after Deductible	20% Coinsurance after Deductible

<b>Benefit</b>	<b>Your Cost In-Plan Providers HNE and PHCS Providers</b>	<b>Your Cost Out-of-Plan Providers</b>
Applied Behavioral Analysis (ABA) to treat Autism Spectrum Disorder†	\$0 after Deductible (for PHCS 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 PHCS providers up to \$1,000 Reduction of Benefit	20% Coinsurance after Deductible & up to \$1,000 Reduction of Benefit
Allergy Testing and Treatment	\$0 after Deductible	20% Coinsurance after Deductible
Allergy Injections	\$0 after Deductible	20% Coinsurance after Deductible
<b>Family Planning Services</b>		
Office Visit	\$0 after Deductible	20% Coinsurance after Deductible
<b>Infertility Services</b>		
Some Infertility services are covered only for Massachusetts and Connecticut residents. Some services require Prior Approval.		
Office Visit	\$0 after Deductible; and for PHCS 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 PHCS 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 PHCS 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 PHCS providers without Prior Approval Member pays all costs	20% Coinsurance after Deductible; without Prior Approval, Member pays all costs
<b>Maternity Care</b>		
Non-Routine Prenatal and Postpartum Care	\$0 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.)	\$0 after Deductible; and for PHCS providers up to \$1,000 Reduction of Benefit	20% Coinsurance after Deductible & up to \$1,000 Reduction of Benefit
<b>Dental Services</b>		
Surgical Treatment of Non-Dental Conditions in a Doctor's Office	\$0 after Deductible	20% Coinsurance after Deductible
Emergency Dental Care in a Doctor's or Dentist's Office	\$0 after Deductible	20% Coinsurance after Deductible

<b>Benefit</b>	<b>Your Cost In-Plan Providers HNE and PHCS Providers</b>	<b>Your Cost Out-of-Plan Providers</b>
Emergency Dental Care in an Emergency Room	\$0 after Deductible	\$0 after Deductible
<b>Other Services</b>		
Home Health Care †	\$0 after Deductible; and for PHCS 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 PHCS providers up to \$1,000 Reduction of Benefit	20% Coinsurance after Deductible & up to \$1,000 Reduction of Benefit
Durable Medical Equipment†	\$0 after Deductible; and for PHCS providers up to \$1,000 Reduction of Benefit	20% Coinsurance after Deductible & up to \$1,000 Reduction of Benefit
Prosthetic Limbs†	\$0 after Deductible; and for PHCS 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)	\$0 after Deductible	\$0 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	\$0 after Deductible	20% Coinsurance after Deductible
Wigs (Scalp Hair Protheses) for hair loss due to treatment of any form of cancer or leukemia. † (HNE covers one prosthesis per Calendar Year)	\$0 after Deductible	20% Coinsurance after Deductible
Speech, Hearing, and Language Disorders † (Prior Approval is required for speech therapy services after the initial evaluation.)	\$0 after Deductible; and for PHCS providers up to \$1,000 Reduction of Benefit	20% Coinsurance after Deductible & up to \$1,000 Reduction of Benefit
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; for PHCS providers without Prior Approval Member pays all costs	20% Coinsurance after Deductible (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 PHCS providers up to \$1,000 Reduction of Benefit	20% Coinsurance after Deductible & up to \$1,000 Reduction of Benefit
<b>Behavioral Health (Includes Mental Health and Substance Abuse)</b>		

<b>Benefit</b>	<b>Your Cost In-Plan Providers HNE and PHCS Providers</b>	<b>Your Cost Out-of-Plan Providers</b>
Inpatient Services†	\$0 after Deductible; and for PHCS providers up to \$1,000 Reduction of Benefit	20% Coinsurance after Deductible up to \$1,000 Reduction of Benefit
Telephone and video consultations for non-emergency behavioral health issues and substance use disorder issues through Teladoc®	\$0 after Deductible	Not covered
Outpatient Services† (some services require Prior Approval)	\$0 after Deductible	20% Coinsurance after Deductible

### **Prescription Drugs**

(Certain drugs require Prior Approval. Prescription drugs are subject to the combined Medical/Pharmacy deductible for this plan.)

Your Prescription Benefit is based on the Health New England Formulary. Please call Member Services or visit [healthnewengland.org](http://healthnewengland.org) for a copy of the Health New England Formulary.

<b>Benefit</b>	<b>Your Cost In-Plan Providers</b>	<b>Your Cost Out-Of-Plan Providers</b>
<b>At an In-Plan Pharmacy (up to a 30-day supply)</b>		
Generic Drugs	\$10	\$10 copay, then 20%
Formulary Drugs	\$25	\$25 copay, then 20%
Non-Formulary Drugs	\$45	\$45 copay, then 20%
<b>Through Mail Order: (up to a 90-day supply of maintenance medication)</b>		
Generic Drugs	\$20	Not Covered
Formulary Drugs	\$50	Not Covered
Non-Formulary Drugs	\$135	Not Covered

### **Chiropractic Benefit**

(Chiropractic services are subject to your plan deductible)

<b>Benefit</b>	<b>Your Cost In-Plan Providers</b>	<b>Your Cost Out-of-Plan Providers</b>
limited to 12 visits per calendar year	\$0 after deductible	20% after deductible