GIC Employees/Retirees without Medicare

Effective 7/1/2016

HMO Summary of Benefits Chart

This chart provides a summary of key services offered by your Health New England plan. Consult your Member Handbook for a full description of your plan's benefits and provisions. If any terms in this summary differ from those in your Member Handbook, the terms of the Member Handbook apply.

Please read "Important Information about Copay Tiers" which precedes this Summary of Benefit Chart. If you change your specialist, your Copay may change.

Deductible

- For some services, members are responsible for meeting a Policy Year Deductible before the plan pays benefits. This Deductible is: **$300 per individual Member / $900 per family**.
- **You must pay any Copay or Coinsurance for a service.** If the Deductible applies to that service, you must pay the difference between your Copay or Coinsurance amount and the amount of Health New England's contracted payment to the provider until the Policy Year Deductible is satisfied.
- The chart below shows whether or not this Deductible applies. **Important Note:** Ancillary services such as tests and procedures performed during an office visit may be subject to the Deductible, even if the visit itself is not subject to the Deductible.
- The Deductible does not apply to prescription drugs.

In-Network Medical Out-of-Pocket Maximum

- The out-of-pocket maximum includes Copays, Coinsurance and Deductible for all in-network medical services including pharmacy and behavioral health. Once you have met the out-of-pocket maximum, you will not have to pay Copays or Coinsurance for these services for the rest of the Policy Year.
- The out-of-pocket maximum is **$5,000 per individual Member / $10,000 per family.**

BENEFIT	Deductible Applies	Copay
Inpatient Care		
Acute Hospital Care	Yes	$275/admission † ‡
Inpatient Rehabilitation	Yes	$275/admission †
Skilled Care Facility *(maximum of 100 days per Policy Year)*	Yes	$0
Outpatient Preventive Care		
Adult Routine Physical Exams by your PCP	No	$0
Pediatric Preventive Care	No	$0
Annual Gynecological Exam	No	$0
Screening Mammographic Exam	No	$0
Medically Necessary Adult and Child Immunizations by your PCP	No	$0

† Maximum of one inpatient admission Copay per quarter.

‡ If you have paid an inpatient Copay for an admission and are then readmitted to a hospital within 30 calendar days of discharge from the previous admission, the Copay for the readmission is waived if both admissions occur during the same Policy Year. See your Member Handbook for details.

BENEFIT	Deductible Applies	Copay
Screening colonoscopy	No	$0
Nutritional Counseling *(maximum of four visits per Policy Year)*	No	$0
Other Outpatient Care		
PCP Office Visits	No	$20/visit
Specialist Office Visits		
Specialists in Cardiology, Endocrinology, Gastroenterology, General Surgery, Obstetrics/Gynecology, Orthopedics, Otolaryngology, Pulmonology, and Rheumatology	No	*** Tier 1 (excellent): $30/visit ** Tier 2 (good): $60/visit * Tier 3 (standard): $90/visit
Other Specialists	No	$60/visit
Second Opinions		
Specialists in Cardiology, Endocrinology, Gastroenterology, General Surgery, Obstetrics/Gynecology, Orthopedics, Otolaryngology, Pulmonology, and Rheumatology	No	*** Tier 1 (excellent): $30/visit ** Tier 2 (good): $60/visit * Tier 3 (standard): $90/visit
Other Specialists	No	$60/visit
Telephone and video consultations with internists, family practitioners, and pediatricians for non-emergency medical conditions through Teladoc™	No	$20/consultation
Routine Eye Exams *(one each 24 months)*	No	$20/visit
Hearing Tests in your PCP's office	No	$20/visit
Diabetic-Related Items		
Endocrinology Specialist Office Visits	No	*** Tier 1 (excellent): $30/visit ** Tier 2 (good): $60/visit * Tier 3 (standard): $90/visit
Laboratory/Radiological Services	Yes	$0
Durable Medical Equipment *(diabetic-related; some items require Prior Approval)*	No	$0
Individual Diabetic Education	No	$20/visit
Group Diabetic Education	No	$20/session
Applied Behavioral Analysis (ABA) to treat Autism Spectrum Disorder	No	$0
Urgent Care Center or retail clinic visits	No	$20/visit
Emergency Room Care *(Copay waived if admitted directly from ER)*	Yes	$100/visit

BENEFIT	**Deductible Applies**	**Copay**
Diagnostic Testing *(Some services may be subject to the Outpatient Surgical Services and Procedures Copay. Not all services are subject to a Copay.)*		
In a PCP's Office	Yes	$20/visit
In a Specialist's Office		
Specialists in Cardiology, Endocrinology, Gastroenterology, General Surgery, Obstetrics/Gynecology, Orthopedics, Otolaryngology, Pulmonology, and Rheumatology	Yes	*** Tier 1 (excellent): $30/visit ** Tier 2 (good): $60/visit * Tier 3 (standard): $90/visit
Other Specialists	Yes	$60/visit
In All Other Settings	Yes	$250/visit §
Laboratory Services	Yes	$0
Radiological Services: Ultrasound, X-rays, Nuclear Cardiology (*Nuclear Cardiac Imaging requires Prior Approval*)	Yes	$0
Advanced Diagnostic Imaging: CT Scans, MRIs, MRAs, PET Scans *(requires Prior Approval)*	Yes	$100/visit (maximum one Copay per day)
Outpatient Short-Term Rehabilitation Services *(Physical and occupational therapy; covered for 90 days per acute episode, per Policy Year. The limit does not apply when services are provided to treat Autism Spectrum Disorder.)*	No	$25/visit/treatment type
Day Rehabilitation Program *(limited to 15 full day or half day sessions per condition per lifetime)*	No	$25/day or half day
Early Intervention Services *(covered for children from birth to age 3)*	No	$0
Outpatient Surgical Services and Procedures *(some services require Prior Approval)*		
In a PCP's Office	Yes	$20/visit
In a Specialist's Office		
Specialists in Cardiology, Endocrinology, Gastroenterology, General Surgery, Obstetrics/Gynecology, Orthopedics, Otolaryngology, Pulmonology, and Rheumatology	Yes	*** Tier 1 (excellent): $30/visit ** Tier 2 (good): $60/visit * Tier 3 (standard): $90/visit
Other Specialists	Yes	$60/visit
All Other Settings	Yes	$250/visit §
Allergy Testing and Treatment in an Allergist's Office	No	$60/visit; $0 for injection

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§ Maximum of four outpatient surgery Copays per Policy Year.

BENEFIT	Deductible Applies	Copay
Infertility Services *(Some infertility treatments require Prior Approval. Some Assisted Reproductive services consist of outpatient surgical procedures. If members receive these services applicable outpatient surgical services and procedures Copays will apply.)*		
Office Visits *(Deductible may apply to some office services)*	No	$60/visit
Outpatient Care	Yes	$60/visit
Laboratory Tests	Yes	$0
Inpatient Care	Yes	$275/admission † ‡
Maternity Care		
Routine Prenatal and Postpartum Care	No	$0
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.)*	Yes	$275/admission † ‡
Dental Services		
Surgical Treatment of Non-Dental Oral Conditions and Emergency Dental Care		
In a Specialist's Office	Yes	$60/visit
At an Emergency Room	Yes	$100/visit
Hospital Inpatient	Yes	$275/admission † ‡
Outpatient Surgical Facility	Yes	$250/visit §
Other Services		
Home Health Care *(requires Prior Approval)*	Yes	$0
Hospice Services *(requires Prior Approval)*	Yes	$0
Durable Medical Equipment and Prosthetic Equipment *(some items require Prior Approval)*	Yes	20% Coinsurance
Scalp Hair Prostheses (Wigs) for hair loss due to treatment of any form of cancer or leukemia *(Health New England covers one prosthesis per Policy Year)*	No	$0
Ambulance and Chair Van Services *(non-emergency transportation requires Prior Approval)*	Yes	$25/member/day
Reconstructive or Restorative Surgery	Yes	$275/admission † ‡

† Maximum of one inpatient surgery Copay per quarter.

‡ If you have paid an inpatient Copay for an admission and are then readmitted to a hospital within 30 calendar days of discharge from the previous admission, the Copay for the readmission is waived if both admissions occur during the same Policy Year. See your Member Handbook for details.

§ Maximum of four outpatient surgery Copays per Policy Year.

BENEFIT	Deductible Applies	Copay
Kidney Dialysis	No	$0
Human Organ Transplants and Bone Marrow Transplants *(requires Prior Approval)*	Yes	$275/admission † ‡
Nutritional Support *(requires Prior Approval)*	Yes	$0
Cardiac Rehabilitation	No	$20/visit
Speech, Hearing, and Language Disorders *(requires Prior Approval after the initial evaluation)*	No	$20/visit
Coronary Artery Disease Program *(Provided for members with documented coronary artery disease, this program helps participants reduce coronary artery disease risk factors through lifestyle changes. The program must be authorized by your PCP.)*	Yes	10% Coinsurance
Hearing aids		
• • Members 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. Prior Approval is required.)*	No	100% coverage up to $2,000 per device per ear (you are responsible for all costs beyond maximum)
• • Members over 21 years old *(Health New England reimburses for hearing aids at 100% for the first $500 and 80% for the next $1,500 per person, up to a maximum of $1,700, every two Policy Years.)*	No	100% coverage for the first $500 and 80% for the next $1,500 per person, every two Policy Years
Behavioral Health Services (Mental Health and Substance Abuse) *(Some services may require Prior Approval)*		
Inpatient Services	Yes	$0
Intermediate Services *(such as Partial Hospitalization)*	Yes	$0
Outpatient Services	No	$20/visit

† Maximum of one inpatient surgery Copay per quarter.

‡ If you have paid an inpatient Copay for an admission and are then readmitted to a hospital within 30 calendar days of discharge from the previous admission, the Copay for the readmission is waived if both admissions occur during the same Policy Year. See your Member Handbook for details.

PRESCRIPTION DRUG COVERAGE

Prescription Drugs *(certain drugs require Prior Approval)* Your Prescription Drug benefit covers those items described in the Health New England Formulary. Please call Member Services or visit healthnewengland.org for a copy of the Health New England Formulary.	**Copay**
At a Plan Pharmacy (up to a 30-day supply):	
Generic Drugs	$10
Formulary Drugs	$30
Non-formulary Drugs	$65
Through Mail Order (a 90-day supply of maintenance medication):	
Generic drugs	$25
Formulary drugs	$75
Non-formulary drugs	$165
At a Pharmacy Participating in the Access 90 Program (a 90-day supply of maintenance medication):	
Generic Drugs	$30
Formulary Drugs	$90
Non-formulary Drugs	$195