

GIC Medicare Enrolled Retirees

Effective 7/1/2017

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.

BENEFIT	Copay
Inpatient Care	
Acute Hospital Care	\$0
Inpatient Rehabilitation	\$0
Skilled Care Facility (<i>maximum of 100 days per Policy Year</i>)	\$0
Outpatient Preventive Care	
Adult Routine Physical Exams by your PCP	\$0
Pediatric Preventive Care	\$0
Annual Gynecological Exam	\$0
Screening Mammographic Exam	\$0
Medically Necessary Adult and Child Immunizations by your PCP	\$0
Nutritional Counseling (<i>maximum of four visits per Policy Year</i>)	\$0
Other Outpatient Care	
PCP Office Visits	\$15/visit
Specialist Office Visits	\$15/visit
Second Opinions	\$15/visit
Telephone and video consultations with internists, family practitioners, and pediatricians for non-emergency medical conditions through Teladoc™	\$15/consultation
Routine Eye Exam (<i>one per Policy Year</i>)	\$15/visit
Hearing Tests in your PCP's office	\$15/visit
Diabetic-Related Items	
Outpatient Services	\$15/visit
Laboratory/Radiological Services	\$0
Durable Medical Equipment (<i>diabetic-related; some items require Prior Approval</i>)	\$0
Group Diabetic Education	\$15/session
Applied Behavioral Analysis (ABA) to treat Autism Spectrum Disorder	\$0
Urgent Care Center or retail clinic visits	\$15/visit
Emergency Room Care (<i>Copay waived if admitted directly from ER</i>)	\$50/visit

BENEFIT	Copay
Diagnostic Testing	
In a Doctor's Office	\$15/visit
In All Other Settings	\$0
Laboratory Services	\$0
Radiological Services: Ultrasound, X-rays, Nuclear Cardiology <i>(Nuclear Cardiac Imaging requires Prior Approval)</i>	\$0
Advanced Diagnostic Imaging: CT Scans, MRIs, MRAs, PET Scans <i>(requires Prior Approval)</i>	\$0
Outpatient Short-Term Rehabilitation Services <i>(Covered for 90 days per acute episode, per Policy Year. The limit does not apply when services are provided to treat Autism Spectrum Disorder.)</i>	\$15/visit/treatment type
Day Rehabilitation Program <i>(limited to 15 full day or half day sessions per condition per lifetime)</i>	\$25/day or half day
Early Intervention Services <i>(covered for children from birth to age 3)</i>	\$0
Outpatient Surgical Services and Procedures <i>(some services require Prior Approval)</i>	
In a Doctor's Office	\$15/visit
All Other Settings	\$0
Allergy Testing and Treatment in an Allergist's Office	\$15/visit; \$0 for injection
Infertility Services <i>(some infertility treatments require Prior Approval)</i>	
Outpatient Care	\$15/visit
Laboratory Tests	\$0
Inpatient Care	\$0
Maternity Care	
Routine Prenatal and Postpartum Care	\$0
Delivery/Hospital Care for Mother and Child <i>(Coverage for child limited to routine newborn nursery charges. For continued coverage, child must be enrolled within 30 days of date of birth.)</i>	\$0
Dental Services	
Surgical Treatment of Non-Dental Conditions <i>(requires Prior Approval)</i> and Emergency Dental Care	
In a Doctor's Office	\$15/visit
At an Emergency Room	\$50/visit
Hospital Inpatient	\$0
Outpatient Surgical Facility	\$0

BENEFIT	Copay
Other Services	
Home Health Care <i>(requires Prior Approval)</i>	\$0
Hospice Services <i>(requires Prior Approval)</i>	\$0
Durable Medical Equipment and Prosthetic Equipment <i>(some items require Prior Approval)</i>	20% Coinsurance
Scalp Hair Prostheses (Wigs) for hair loss due to treatment of any form of cancer or leukemia <i>(Health New England covers one prosthesis per Policy Year)</i>	\$0
Ambulance and Chair Van Services <i>(non-emergency transportation requires Prior Approval)</i>	\$25/member/day
Reconstructive or Restorative Surgery	\$0
Kidney Dialysis	\$0
Human Organ Transplants and Bone Marrow Transplants <i>(requires Prior Approval)</i>	\$0
Nutritional Support <i>(requires Prior Approval)</i>	\$0
Cardiac Rehabilitation	\$15/visit
Speech, Hearing, and Language Disorders <i>(requires Prior Approval after the initial evaluation)</i>	\$15/visit
Coronary Artery Disease Program <i>(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.)</i>	10% Coinsurance
Hearing aids	
<ul style="list-style-type: none"> • • Members 21 and under <i>(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.)</i> 	100% coverage up to \$2,000 per device per ear (you are responsible for all costs beyond maximum)
<ul style="list-style-type: none"> • • Members over 21 years old <i>(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.)</i> 	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) <i>(Some services may require Prior Approval)</i>	
Inpatient Services	\$0
Intermediate Services <i>(such as Partial Hospitalization)</i>	\$0
Outpatient Services	\$15/visit

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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).