City of Westfield - Wise Max HDHP

HMO Benefit Chart

July 1, 2022

This chart provides a summary of key services offered by your Plan. Your Summary Plan Description (SPD) has a full description of your Plan's benefits and provisions. If any terms in this summary differ from those in your SPD, the terms of the SPD 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 HNE Providers
Out-of-Pocket Maximum: The most you pay for Cost Sharing on Essential Health Benefits during a Policy Year before your Plan begins to pay 100% of the Allowed Amount. Once you reach this amount you will not have to pay copays for the remainder of the year. (Included in your Out-of-Pocket Maximum are: your Deductible and all copays; If your Plan has prescription drug coverage, your copays for prescriptions are included in this Out-of-Pocket Maximum.)	$5,000 per Individual / $10,000 per Family
Combined Medical/Pharmacy Deductible per Year: You must pay this amount for Covered Services before Health New England will begin to pay benefits. The Deductibles are applied on a Policy Year basis, from July 1 through June 30 of the following year. 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	$2,000 per Individual / $4,000 per Family *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.*

Benefit	Your Cost In-Plan HNE Providers
Inpatient Care	
Acute Hospital Care†	$0 after Deductible
Skilled Nursing Facility† (Limited to 100 days per Calendar Year)	$0 after Deductible
Inpatient Rehabilitation†	$0 after Deductible

Benefit	Your Cost In-Plan HNE Providers
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 1 per Calendar Year)	$0
Annual Gynecological Exams (Limited to 1 per Calendar Year)	$0
Routine Mammograms (Limited to 1 per Calendar Year)	$0
Screening Colonoscopy or Sigmoidoscopy (Limited to 1 every 5 Years)	$0
Nutritional Counseling (Limited to 4 visits per Calendar Year)	$0
Preventive Screenings Listed under "Outpatient Preventive Care" in the Covered Benefits Section of the SPD	$0
Outpatient Care	
Primary Care Office Visit (Non-Routine)	$0 after Deductible
Specialist Care Office Visit	$0 after Deductible
Second Opinions	$0 after Deductible
Hearing Tests in Specialist Office or Outpatient Facility (other than routine screenings covered as part of your Annual Routine Exam)	$0 after Deductible
Diabetic-Related Items:	
• Outpatient Services	$0 after Deductible
• Lab Services	$0 after Deductible
• Radiological Services	$0 after Deductible
• Durable Medical Equipment (some DME items require Prior Approval)	$0 after Deductible
• Individual Diabetic Education	$0
• Group Diabetic Education	$0
Emergency Room Care	$0 after Deductible
Diagnostic Testing (some services, including, but not limited to, sigmoidoscopies, endoscopies, colonoscopies, arthroscopies, needle aspirations, and biopsies, are covered under the Outpatient Surgical Services and Procedures benefit)	$0 after Deductible
Sleep Study†	$0 after Deductible (without Prior Approval, Member pays all costs)

Benefit	Your Cost In-Plan HNE Providers
Lab Services	$0 after Deductible
Radiological Services: Ultrasound, X-rays, Non-Routine Mammograms	$0 after Deductible
Diagnostic Imaging: CT Scans, MRIs, MRAs, PET Scans, Nuclear Cardiac Imaging† (Nuclear Cardiac Imaging requires Prior Approval in all outpatient settings, including outpatient facilities and doctor's offices)	$0 after Deductible
Outpatient Short-Term Rehabilitation Services (Limited to 60 visits per calendar year for physical or occupational therapy. The calendar year limit does not apply to services that are part of a home health plan. The limit also does not apply when services are provided to treat autism spectrum disorder. Services that are part of a home health plan and services provided to treat autism spectrum disorder require Prior Approval.)	$0 after Deductible
Day Rehabilitation Program (Limited to 15 full day or ½ day sessions per condition per lifetime)	$0 after Deductible
Early Intervention Services (Covered for children from birth to age 3.)	$0 after Deductible
Applied Behavioral Analysis (ABA) to treat Autism Spectrum Disorder†	$0 after Deductible
Surgical Services and Procedures in an Outpatient Facility (Some services require Prior Approval)	$0 after Deductible
Allergy Testing and Treatment	$0 after Deductible
Allergy Injections	$0 after Deductible
Infertility Services	
Some infertility services are covered only for Massachusetts and Connecticut residents. Some services require Prior Approval.	
• Office Visit	$0 after Deductible
• Outpatient Surgery/ Procedure †	$0 after Deductible (without Prior Approval, Member pays all costs)
• Lab Test	$0 after Deductible
• Inpatient Care†	$0 after Deductible (without Prior Approval, Member pays all costs)

Benefit	Your Cost In-Plan HNE Providers
Non-Routine Prenatal and Postpartum Visit	$0 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
Dental Services	
Surgical Treatment of Non-Dental Conditions	
Emergency Dental Care	
• In a Doctor's or Dentist's Office	$0 after Deductible
• In a Hospital	$0 after Deductible
• In an Outpatient Surgical Facility	$0 after Deductible
Removal of impacted wisdom teeth	
• In a Doctor's or Dentist's Office	$0 after Deductible
Other Services	
Home Health Care†	$0 after Deductible
Hospice Services†	$0 after Deductible
Durable Medical Equipment (some DME items require Prior Approval)	$0 after Deductible
Prosthetic Devices†	$0 after Deductible (without Prior Approval, Member pays all costs)
Ambulance and Transportation Services (non-emergency transportation requires Prior Approval)	$0 after Deductible
Kidney Dialysis	$0 after Deductible
Nutritional Support † (not covered without Prior Approval)	$0 after Deductible
Cardiac Rehabilitation	$0 after Deductible
Wigs (Scalp Hair Prostheses) for hair loss due to treatment of any form of cancer or leukemia. (Limited to 1 prosthesis per Calendar Year)	$0 after Deductible
Speech, Hearing, and Language Disorders† (Prior Approval is required for speech therapy services after the initial evaluation.)	$0 after Deductible

Benefit	Your Cost In-Plan HNE Providers
Hearing Aids† (Covered with Prior Approval for Members age 21 and under. The Plan covers the cost of one hearing aid per hearing-impaired ear, every 36 months, up to maximum of $2,000 for each hearing aid.)	$0 up to $2,000 per device per ear after Deductible (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 Use Disorder)	
Outpatient Services (Some services require Prior Approval.)	$0 after Deductible
Inpatient Services	$0 after Deductible
Additional Services	
Fitness Reimbursement Program	$150 per family per Calendar year
Weight Watchers Reimbursement Program	$150 per family per Calendar year

Prescription Drugs *(certain drug require Prior Approval).* Your prescription Drug benefit is based on the Health New England (HNE) Formulary. Please call Member Services or visit healthnewengland.org for a copy of the HNE Formulary.	
At an Retail Pharmacy (up to a 30 day supply)	
Generic Drugs	$10 Copay after Deductible
Formulary Drugs	$25 Copay after Deductible
Non-Formulary Drugs	$45 Copay after Deductible
Through Mail Order (up to a 90 day supply of maintenance medication)	
Generic Drugs	$20 Copay after Deductible
Formulary Drugs	$50 Copay after Deductible
Non-Formulary Drugs	$135 Copay after Deductible