City of Westfield - Premier PHCS PPO
PPO 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.

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 Allowed Amount.

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 to 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.

	In-Plan Providers (HNE & PHCS)	Out-of-Plan Providers
Deductible per Policy Year: You must pay this amount for Covered Services before Health New England will begin to pay benefits. The Deductible is 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.	$250 per Individual / $750 per Family per Policy Year	
In-Plan 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. **(Pharmacy Included)**	$6,350 per Individual / $12,700 per Family	Not Applicable
Reduction of Benefit: Applies to certain services if Prior Approval is required but not requested. Does not count toward your Out-of-Pocket Maximum.	$250	
Maximum Responsibility for Copays of $100 or more: Once you reach this amount, you will not have to pay Copays for certain services for the rest of the year. (Included in your Out-of-Pocket Maximum are: your Deductible and all medical services with a Copay of $100 or more, including Copays for Durable Medical Equipment and Prosthetics.)	$1,500 per Individual / $3,000 per Family per Policy Year	

Benefit	Your Cost In-Plan Providers (HNE & PHCS)	Your Cost Out-of-Plan Providers
Inpatient Care		
Acute Hospital Care (elective admissions to Out-of-Plan facilities require Prior Approval)	$300 Copay per admission after Deductible	20% Coinsurance after Deductible
Skilled Nursing Facility and Inpatient Rehabilitation † (Limited to 100 days per Calendar Year)	$0 after Deductible & up to $250 Reduction of Benefit	20% Coinsurance after Deductible & up to $250 Reduction of Benefit
Preventive Care		
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 & Postpartum Care	$0	20% Coinsurance after Deductible
Routine Eye Exams (Limited to 1 per Calendar Year)	$0	20% Coinsurance after Deductible
Annual Gynecological Exams	$0	20% Coinsurance after Deductible
Routine Mammograms	$0	20% Coinsurance after Deductible
Screening Colonoscopy or Sigmoidoscopy (Limited to 1 every 5 Years)	$0	20% Coinsurance after Deductible
Nutritional Counseling (Limited to 4 visits per Calendar Year)	$0	20% Coinsurance after Deductible
Preventive Screenings Listed under "Outpatient Preventive Care" in the Covered Benefits Section of the SPD	$0	20% Coinsurance after Deductible
Outpatient Care		
Primary Care Office Visit (Non-Routine)	$20 Copay per visit	20% Coinsurance after Deductible
Specialist Care Office Visit	$35 Copay per visit	20% Coinsurance after Deductible
Second Opinions	$35 Copay per visit	20% Coinsurance after Deductible
Hearing Tests in Specialist Office or Outpatient Facility (other than routine screenings covered as part of your Annual Routine Exam)	$35 Copay per visit	20% Coinsurance after Deductible
Diabetic-Related Items:		
Outpatient Services	$35 Copay per visit	20% Coinsurance after Deductible
Lab Services	$0	20% Coinsurance after Deductible

Benefit	Your Cost In-Plan Providers (HNE & PHCS)	Your Cost Out-of-Plan Providers
Radiological Services	$0	20% Coinsurance after Deductible
Durable Medical Equipment (some DME items require Prior Approval)	20% Coinsurance	20% Coinsurance after Deductible
Individual Diabetic Education	$35 Copay per visit	20% Coinsurance after Deductible
Group Diabetic Education	$20 Copay per session	20% Coinsurance after Deductible
Emergency Room Care (Copay waived if admitted directly from the ER.)	$100 Copay per visit after Deductible	$100 Copay per visit 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	20% Coinsurance after Deductible
Sleep Study†	$0; 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	20% Coinsurance after Deductible
Radiological Services: Ultrasound, X-rays, Non-Routine Mammograms	$0	20% Coinsurance 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)	$100 Copay after Deductible 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 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.	$20 Copay per visit per treatment type	20% Coinsurance after Deductible

Benefit	Your Cost In-Plan Providers (HNE & PHCS)	Your Cost Out-of-Plan Providers
Day Rehabilitation Program (Limited to 15 full day or ½ day sessions per condition per lifetime)	$25 Copay for 1 day or 1/2 day	20% Coinsurance after Deductible
Early Intervention Services (Covered for children from birth to age 3.)	$0	20% Coinsurance after Deductible
Applied Behavioral Analysis (ABA) to treat Autism Spectrum Disorder†	$0	20% Coinsurance
Surgical Services and Procedures in an Outpatient Facility		
In a doctor's office	$35 Copay	20% Coinsurance after Deductible
In all other settings	$150 Copay after Deductible	20% Coinsurance after Deductible
Allergy Testing and Treatment	$35 Copay per visit	20% Coinsurance after Deductible
Allergy Injections	$0	20% Coinsurance after Deductible
Infertility Services		
Some infertility services are covered only for Massachusetts and Connecticut residents. Some services require Prior Approval.		
Office Visit	$35 Copay per visit	20% Coinsurance after Deductible
Outpatient Surgery/ Procedure	$150 Copay after Deductible and for PHCS providers without Prior Approval, Member pays all costs.	20% Coinsurance after Deductible and for PHCS providers without Prior Approval, Member pays all costs.
Lab Test	$0 and for PHCS providers without Prior Approval, Member pays all costs.	20% Coinsurance after Deductible
Inpatient Care†	$300 Copay per admission and for PHCS providers without Prior Approval, Member pays all costs.	20% Coinsurance after Deductible; without Prior Approval, Member pays all costs.
Maternity Care		
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.)	$300 Copay per admission after Deductible	20% Coinsurance after Deductible
Dental Services		
Surgical Treatment of Non-Dental Conditions		
In a Doctor's or Dentist's Office	$35 Copay per visit	20% Coinsurance after Deductible

Benefit	Your Cost In-Plan Providers (HNE & PHCS)	Your Cost Out-of-Plan Providers
In a Hospital	$300 Copay per admission after Deductible	20% Coinsurance after Deductible
In an Outpatient Surgical Facility	$150 Copay per visit after Deductible	20% Coinsurance after Deductible
Emergency Dental Care		
In a Doctor's or Dentist's Office	$35 Copay per visit	20% Coinsurance after Deductible
In an Emergency Room (copay waived if admitted directly from the ER)	$100 Copay per visit after Deductible	$100 Copay per visit after Deductible
Removal of impacted wisdom teeth		
In a Doctor's or Dentist's Office	$35 Copay	20% Coinsurance after Deductible
In a Hospital†	$300 Copay per admission after Deductible	20% Coinsurance after Deductible
In an Outpatient Surgical Facility†	$150 Copay per visit after Deductible	20% Coinsurance after Deductible
Other Services		
Home Health Care†	$0; and up to $250 Reduction of Benefit	20% Coinsurance after Deductible & up to $250 Reduction of Benefit
Hospice Services†	$0; and up to $250 Reduction of Benefit	20% Coinsurance after Deductible & up to $250 Reduction of Benefit
Durable Medical Equipment (some DME items require Prior Approval)	20% Coinsurance	20% Coinsurance after Deductible
Prosthetic Devices†	20% Coinsurance & up to $250 Reduction of Benefit	20% Coinsurance after Deductible & up to $250 Reduction of Benefit
Ambulance and Transportation Services (non-emergency transportation requires Prior Approval)	$50 Copay per day	$50 Copay per day
Kidney Dialysis	$0	20% Coinsurance after Deductible
Nutritional Support † (not covered without Prior Approval)	$0	$0
Cardiac Rehabilitation	$35 Copay per visit	20% Coinsurance 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	20% Coinsurance after Deductible

Benefit	Your Cost In-Plan Providers (HNE & PHCS)	Your Cost Out-of-Plan Providers
Speech, Hearing, and Language Disorders† (Prior Approval is required for speech therapy services after the initial evaluation.)	$20 Copay per visit; and up to $250 Reduction of Benefit	20% Coinsurance after Deductible & up to $250 Reduction of Benefit
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.)	100% coverage up to $2,000 per device per ear (you are responsible for all costs beyond maximum); and for PHCS providers without Prior Approval, Member pays all costs.	100% coverage up to $2,000 per device per ear after Deductible (you are responsible for all costs beyond maximum). 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 Out-of-Pocket Maximum amounts.)	$300 Copay per admission after Deductible; and up to $250 Reduction of Benefit	20% Coinsurance after Deductible & up to $250 Reduction of Benefit
Behavioral Health (Includes Mental Health and Substance Use Disorder)		
Outpatient Services†	$20 Copay per visit	20% Coinsurance after Deductible
Inpatient Services†	$300 Copay per admission after Deductible and up to $250 Reduction of Benefit	20% Coinsurance after Deductible and up to $250 Reduction of Benefit
Chiropractic Services		
Visits to a chiropractor (Limited to 20 visits per Calendar Year. After your first visit to an In-Plan Provider, your chiropractor must get authorization for services to be covered by OptumHealth. OptumHealth will work with your In-Plan chiropractor to determine the appropriate level of Covered Services to treat your condition.)	$35 Copay per visit (chiropractors participating with OptumHealth)	$35 Copay per visit then, 20% Coinsurance
Wellness 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	$10 Copay then 20% Coinsurance
Formulary Drugs	$25 Copay	$25 Copay then 20% Coinsurance
Non-Formulary Drugs	$50 Copay	$50 Copay then 20% Coinsurance
Through Mail Order (up to a 90 day supply of maintenance medication)		
Generic Drugs	$20 Copay	Not Covered
Formulary Drugs	$50 Copay	Not Covered
Non-Formulary Drugs	$110 Copay	Not Covered