



HNE Wise^{Plus} (HDHP HMO M) High Deductible Health Plan HMO Benefit Chart

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

- Note about Prior Approval:**
 Some services require prior approval. These services are marked with † in the chart. If you do not obtain Prior Approval, benefits may be denied.

	In-Plan
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.)	\$2,000 per individual/\$4,000 per family**
* May be based on a Calendar Year or a Policy Year basis. This depends on the Group through which you enroll.	
Safety Net: You are protected by an Out-of-Pocket Maximum each year.* 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
** Once any individual on a family plan has paid \$2,400 towards the family Deductible, the plan will begin to pay benefits for that individual.	

Benefit	Deductible Applies	Copay
Inpatient Care		
Acute Hospital Care and Inpatient Rehabilitation	Yes	\$500/admission
Skilled Nursing Facility † (limited to 100 days per Calendar Year)	Yes	\$500/admission
Outpatient Preventive Care		
Adult Routine Exams	No	\$0
Well Child Care	No	\$0
Routine Prenatal & Postpartum Care	No	\$0
Child and Adult Routine Immunizations	No	\$0
Routine Eye Exams (limited to one per Calendar Year)	No	\$0
Annual Gynecological Exams (limited to one per Calendar Year)	No	\$0

Benefit	Deductible Applies	Copay
Routine Mammograms (routine mammograms limited to one per Calendar Year)	No	\$0
Preventive Screenings Listed under "Outpatient Preventive Care" in the <i>Covered Benefits</i> Section of the EOC	No	\$0
Other Outpatient Care		
PCP Office Visit (Non-Routine)	Yes	\$25/visit
Specialist Office Visits	Yes	\$25/visit
Second Opinions	Yes	\$25/visit
Hearing Tests	Yes	\$25/visit
Diabetic-Related Items:		
Outpatient Services	Yes	\$25/visit
Lab/Radiological Services	Yes	\$0
Durable Medical Equipment (some DME requires Prior Approval)	Yes	20%
Individual Diabetic Education	No	\$25/visit
Group Diabetic Education	No	\$25/session
Emergency Room Care (Copay waived if admitted)	Yes	\$100/visit
Diagnostic Testing (some services are subject to the Outpatient Surgical Services and Procedure Copay; see Outpatient Surgical Services and Procedures below)	Yes	\$25/visit
Screening Colonoscopy or Sigmoidoscopy (limited to one every five Calendar Years; office visit Copay may apply if done in a doctor's office; office visits prior to the procedure, related prep prescriptions and subsequent pathology are subject to applicable Deductible & Copays)	No	\$0
Sleep Study (maximum of two per Calendar Year)	Yes	\$75 (one Copay per year; no Copay for home sleep studies)
Lab Services	Yes	\$0
Genetic testing: BRCA and Colaris tests †	Yes	\$75
Radiological Services: Ultrasound, X-rays, Non-Routine Mammograms	Yes	\$0
Diagnostic Imaging: CT Scans, MRIs, MRAs, PET Scans, Nuclear Cardiac Imaging † (Nuclear Cardiac Imaging requires Prior Approval only when done in a doctor's office)	Yes	\$75 (maximum three Copays per year)
Outpatient Short-Term Rehabilitation Services (limited to two months or 25 visits, whichever is greater, per condition per Calendar Year for physical or occupational therapy)	Yes	\$25/visit/treatment type
Day Rehabilitation Program (limited to 15 full day or half day sessions per condition per lifetime)	Yes	\$25/day or half day
Early Intervention Services (Covered for children from birth to age 3.)	Yes	\$0
Outpatient Surgical Services and Procedures (Some services require Prior Approval. This Copay is based on the type of service, not where it is performed. To find out if this Copay applies to a specific procedure, please contact HNE Member Services.)	Yes	\$250/admission

Benefit	Deductible Applies	Copay
Allergy Testing and Treatment	Yes	\$25/visit
Allergy Injections	Yes	\$0
Family Planning Services		
Office Visit	Yes	\$25/visit
Infertility Services		
Some Infertility services are covered only for Massachusetts residents and for Connecticut residents under the age of 40. Some services require Prior Approval.		
Office Visit	Yes	\$25/visit
Outpatient Surgery/ Procedure	Yes	\$250/admission
Lab Test	Yes	\$0
Inpatient Care †	Yes	\$500/admission
Maternity Care		
Non-Routine Prenatal and Postpartum Care	Yes	\$25/visit
Delivery/Hospital Care for Mother and Child (For continued coverage, child must be enrolled within 31 days of date of birth)	Yes	\$500/admission
Dental Services		
Surgical Treatment of Non-Dental Conditions in a Doctor's Office (Some services are subject to the Outpatient Surgical Services and Procedures Copay.)	Yes	\$25/visit
Emergency Dental Care in a Doctor's or Dentist's Office	Yes	\$25/visit
Emergency Dental Care in an Emergency Room	Yes	\$100/visit
Routine dental services for children under the age of 12. (A separate \$25 per child per Calendar Year deductible applies only to services from Out-of-Plan dentists. This does not count toward your Medical/Pharmacy Deductible. Out-of-Plan dentists may also bill you for the difference between their charge and HNE's contracted dental network Maximum Allowable Fee.)	No	\$0
Other Services		
Home Health Care †	Yes	\$0
Hospice Services †	Yes	\$0
Durable Medical Equipment (some items require Prior Approval)	Yes	20%
Prosthetic Limbs †	Yes	20%
Ambulance and Transportation Services (non-emergency transportation requires Prior Approval)	Yes	\$50/Member/day
Kidney Dialysis	Yes	\$0
Nutritional Support †	Yes	\$0
Cardiac Rehabilitation	Yes	\$25/visit
Wigs (Scalp Hair Protheses) for hair loss due to treatment of any form of cancer or leukemia. (HNE pays up to \$350 per Calendar Year)	Yes	\$0
Speech, Hearing, and Language Disorders † (Prior Approval is required for speech therapy services after the initial evaluation.)	Yes	\$25/visit

Benefit	Deductible Applies	Copay
Nutritional Counseling (limited to four visits per Calendar Year)	No	\$0
Non-Routine Immunizations	Yes	\$25/visit
Human Organ Transplants and Bone Marrow Transplants	Yes	\$500/admission
Behavioral Health		
Outpatient Services (Includes Mental Health and Substance Abuse)	Yes	\$25/visit
Inpatient Services (Includes Mental Health and Substance Abuse)	Yes	\$500/admission