HNE Essential[1500]

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
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.)	$1,500 per individual/$3,000 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 certain services for the remainder 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.)	$3,000 per individual/$6,000 per family

Benefit	**Deductible Applies**	**Copay**
Inpatient Care		
Acute Hospital Care and Inpatient Rehabilitation	Yes	$0
Skilled Nursing Facility † (limited to 100 days per Calendar Year)	Yes	$0
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
Routine Mammograms (routine mammograms limited to one per Calendar Year)	No	$0
Preventive Screenings Listed under "Outpatient Preventive Care" in the *Covered Benefits* Section of the EOC	No	$0

Benefit	Deductible Applies	Copay
Other Outpatient Care		
PCP Office Visit (Non-Routine) (Deductible may apply to some office services)	No	$20/visit
Hearing Tests	Yes	$20/visit
Specialist Office Visits (Deductible may apply to some office services)	No	$20/visit
Second Opinions (Deductible may apply to some office services)	No	$20/visit
Diabetic-Related Items:		
Outpatient Services (Deductible may apply to some office services)	No	$20/visit
Lab Services	No	$0
Durable Medical Equipment (some DME requires Prior Approval)	No	20%
Individual Diabetic Education	No	$20/visit
Group Diabetic Education	No	$20/session
Emergency Room Care (Copay waived if admitted)	No	$150/visit
Diagnostic Testing	Yes	$0
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	$100 (one Copay per year; no Copay for home sleep studies)
Lab Services	No	$0
Genetic testing: BRCA and Colaris tests †	Yes	$100
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	$100 (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	$20/visit per treatment type
Day Rehabilitation Program (limited to 15 full day or ½ day sessions per condition per lifetime)	Yes	$25 for 1 day or 1/2 day
Early Intervention Services (Covered for children from birth to age 3.)	No	$0
Outpatient Surgical Services and Procedures (some services require Prior Approval; office visit Copay may apply if done in a doctor's office)	Yes	$0
Allergy Testing and Treatment	No	$20/visit
Allergy Injections	No	$0

Benefit	Deductible Applies	Copay
Family Planning Services		
Office Visit (Deductible may apply to some office services)	No	$20/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 (Deductible may apply to some office services)	No	$20/visit
Outpatient Surgery/ Procedure	Yes	$0
Lab Test	No	$0
Inpatient Care †	Yes	$0
Maternity Care		
Non-Routine Prenatal and Postpartum Care	No	$20/visit
Delivery/Hospital Care for Mother and Child (Coverage for child limited to routine newborn nursery charges. For continued coverage, child must be enrolled within 31 days of date of birth.)	Yes	$0
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. Deductible may apply to some office services.)	No	$20/visit
Emergency Dental Care in a Doctor's or Dentist's Office	No	$20/visit
Emergency Dental Care in an Emergency Room	No	$150/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. 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 †	No	$0
Durable Medical Equipment (some items require Prior Approval)	No	20%
Prosthetic Limbs †	No	20%
Ambulance and Transportation Services (non-emergency transportation requires Prior Approval)	Yes	$100/Member/day
Kidney Dialysis	No	$0
Nutritional Support †	No	$0
Cardiac Rehabilitation	Yes	$20/visit
Wigs (Scalp Hair Prostheses) for hair loss due to treatment of any form of cancer or leukemia. (HNE pays up to $350 per Calendar Year)	No	$0
Speech, Hearing, and Language Disorders † (Prior Approval is required for speech therapy services after the initial evaluation)	Yes	$20/visit
Nutritional Counseling (maximum of 4 visits per Calendar Year)	No	$0

Benefit	Deductible Applies	Copay
Human Organ Transplants and Bone Marrow Transplants †	Yes	$0
Behavioral Health		
Outpatient Services (Includes Mental Health and Substance Abuse)	No	$20/visit
Inpatient Services (Includes Mental Health and Substance Abuse)	Yes	$0