HNE Focus (HMO Option 8H)

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
Out-of-Pocket Maximum for Medical Services per Calendar Year (This applies to medical services with Copays of $100 or more. Once you have paid the Out-of-Pocket Maximum, you will not have to pay a Copay for these types of services for the rest of the year.)	$2,000 per individual/$4,000 per family

Benefit	Copay
Inpatient Care	
Acute Hospital Care and Inpatient Rehabilitation	$1,000/admission
Skilled Nursing Facility † (limited to 100 days per Calendar Year)	$1,000/admission
Outpatient Preventive Care	
PCP Office Visits	$0
Adult Routine Exams	$0
Well Child Care	$0
Routine Eye Exams (limited to one per Calendar Year)	$0
Annual Gynecological Exams (limited to one per Calendar Year)	$0
Routine Mammograms	$0
Other Outpatient Care	
PCP Office Visit (Non-Routine)	$25/visit
Hearing Tests (in a PCP's office)	$25/visit
Specialist Office Visits	$25/visit
Second Opinions	$25/visit
Diabetic-Related Items:	
Outpatient Services	$25/visit
Lab/Radiological Services	$0
Durable Medical Equipment (some DME requires prior approval; $3,000 annual DME maximum applies)	20%
Individual Diabetic Education	$25/visit
Group Diabetic Education	$25/session
Emergency Room Care (Copay waived if admitted)	$100/visit

Benefit	Copay
Diagnostic Testing (some services are subject to the Outpatient Surgical Services and Procedure Copay; see Outpatient Surgical Services and Procedures below)	$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)	$0
Lab Services	$0
Radiological Services: Ultrasound, X-rays, Nuclear Cardiology, Non-Routine Mammograms	$0
Diagnostic Imaging: CT Scans, MRIs, MRAs, PET Scans †	$150
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)	$25/visit/treatment type
Day Rehabilitation Program (limited to 15 full day or ½ day sessions per condition per lifetime)	$25/day or half day
Early Intervention Services (Covered for children from birth to age 3.)	$25/visit
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.)	$500/admission
Allergy Testing and Treatment	$25/visit
Allergy Injections	$0
Family Planning Services	
Office Visit	$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	$25/visit
Outpatient Surgery/ Procedure	$500/admission
Lab Test	$0
Inpatient Care †	$1,000/admission
Maternity Care	
Routine Prenatal and Postpartum Care	$0
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)	$1,000/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.)	$25/visit
Emergency Dental Care in a Doctor's or Dentist's Office	$25/visit
Emergency Dental Care in an Emergency Room	$100/visit
Routine dental services for children under the age of 12. (For Out-of-Plan Providers, you pay the first $25 per child per Calendar Year. Out-of-Plan dentists may also bill you for the difference between their charge and HNE's contracted dental network Maximum Allowable Fee)	$0

Benefit	Copay
Other Services	
Home Health Care †	$0
Hospice Services †	$0
Durable Medical Equipment (some items require Prior Approval; $3,000 per Calendar Year benefit maximum)	20%
Prosthetic Limbs †	20%
Ambulance and Transportation Services (non-emergency transportation requires Prior Approval)	$50/Member/day
Kidney Dialysis	$0
Nutritional Support †	$0
Cardiac Rehabilitation	$25/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.)	$0
Speech, Hearing, and Language Disorders † (Prior Approval is required for speech therapy services after the initial evaluation.)	$25/visit
Nutritional Counseling (limited to four visits per Calendar Year)	$25/visit
Human Organ Transplants and Bone Marrow Transplants †	$1,000/admission
Behavioral Health	
Outpatient Services (Includes Mental Health and Substance Abuse) †	$25/visit
Inpatient Mental Health Services †	$1,000/admission
Inpatient Substance Abuse Services †	$1,000/admission