



HNE Wise^{Max} (HDHP HMO H) 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**
Out-of-Pocket Maximum per Year* (This is the most you will pay in a year for Covered Services for the combined costs of your Deductible plus any 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
* May be based on a Calendar Year or a Policy Year basis. This depends on the Group through which you enroll.	
** 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. (For plans with a Policy Year Deductible effective before January 1, 2010, this amount will remain \$2,300 until the Group's renewal date in 2010.)	

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

Benefit	Deductible Applies	Copay
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	\$0
Specialist Office Visits	Yes	\$0
Hearing Tests	Yes	\$0
Second Opinions	Yes	\$0
Diabetic-Related Items:		
Outpatient Services	Yes	\$0
Lab/Radiological Services	Yes	\$0
Durable Medical Equipment (some DME requires Prior Approval; \$3,000 annual DME maximum applies)	Yes	\$0
Individual Diabetic Education	No	\$0
Group Diabetic Education	No	\$0
Emergency Room Care (Copay waived if admitted)	Yes	\$0
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
Lab Services	Yes	\$0
Radiological Services: Ultrasound, X-rays, Nuclear Cardiology, Non-Routine Mammograms	Yes	\$0
Diagnostic Imaging: CT Scans, MRIs, MRAs, PET Scans †	Yes	\$0
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	\$0
Day Rehabilitation Program (limited to 15 full or half day sessions per condition per lifetime)	Yes	\$0
Early Intervention Services (Covered for children from birth to age 3.)	Yes	\$0
Outpatient Surgical Services and Procedures (some services require Prior Approval)	Yes	\$0
Allergy Testing and Treatment	Yes	\$0
Allergy Injections	Yes	\$0
Family Planning Services		
Office Visit	Yes	\$0
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	\$0
Outpatient Surgery/ Procedure	Yes	\$0
Lab Test	Yes	\$0
Inpatient Care †	Yes	\$0

Benefit	Deductible Applies	Copay
Maternity Care		
Non-Routine Prenatal and Postpartum Care	Yes	\$0
Delivery/Hospital Care for Mother and Child (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.)	Yes	\$0
Emergency Dental Care in a Doctor's or Dentist's Office	Yes	\$0
Emergency Dental Care in an Emergency Room	Yes	\$0
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	Yes	\$0
Prosthetic Limbs †	Yes	\$0
Ambulance and Transportation Services (non-emergency transportation requires Prior Approval)	Yes	\$0
Kidney Dialysis	Yes	\$0
Nutritional Support †	Yes	\$0
Cardiac Rehabilitation	Yes	\$0
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	\$0
Nutritional Counseling (limited to four visits per Calendar Year)	Yes	\$0
Non-Routine Immunizations	Yes	\$0
Human Organ Transplants and Bone Marrow Transplants †	Yes	\$0
Behavioral Health		
Outpatient Services (Includes Mental Health and Substance Abuse) †	Yes	\$0
Inpatient Mental Health Services †	Yes	\$0
Inpatient Substance Abuse Services †	Yes	\$0