HNE Wise PPO (HDHP PPO H)

High Deductible Health Plan PPO 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.

- 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 HNE's Maximum Allowable Fee.
- Note about Prior Approval:
  Some services 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 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		**Out-of-Plan Providers**
	HNE Providers	**PHCS Providers**	
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. This amount is a combined amount for In-Plan & Out-of-Plan Providers.)	$2,000 per individual/$4,000 per family**	$2,000 per individual/$4,000 per family**	$2,000 per individual/$4,000 per family**
In-Plan Out-of-Pocket Maximum per Year * (This is the most you will pay in a year for the combined cost of your Medical/Pharmacy Deductible plus any Copays for Covered Services from In-Plan Providers. This is a combined amount for HNE & PHCS Providers.)	$5,000 per individual/$10,000 per family	$5,000 per individual/$10,000 per family	Not applicable

	In-Plan Providers		Out-of-Plan Providers
	HNE Providers	PHCS Providers	
Out-of-Plan Out-of-Pocket Maximum per Year * (After you have satisfied your Medical/Pharmacy deductible, this is the most you will pay in a year for Copays and Coinsurance for Covered Services from Out-of-Plan Providers.)	Not applicable	Not applicable	$7,500 per individual/$15,000 per family
Reduction of Benefit (Applies to certain services if Prior Approval is required but not requested.)	N/A	$1,000	$1,000
* 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.)			

	In-Plan			Out-of-Plan Providers	
Benefit	**Deductible Applies**	**HNE Providers Copay**	**PHCS Providers Copay**	**Deductible Applies**	**Copay**
Inpatient Care					
Acute Hospital Care and Inpatient Rehabilitation † (elective admissions to Out-of-Plan facilities require Prior Approval)	Yes	$0	$0 & up to $1,000 Reduction of Benefit	Yes	20% & up to $1,000 Reduction of Benefit
Skilled Nursing Facility † (limited to 100 days per Calendar Year; admissions to Out-of-Plan Facilites require Prior Approval)	Yes	$0	$0 & up to $1,000 Reduction of Benefit	Yes	20% & up to $1,000 Reduction of Benefit
Outpatient Preventive Care					
Adult Routine Exams	No	$0	$0	Yes	20%
Well Child Care	No	$0	$0	Yes	20%
Routine Prenatal & Postpartum Care	No	$0	$0	Yes	20%
Child and Adult Routine Immunizations	No	$0	$0	Yes	20%

Benefit	In-Plan			Out-of-Plan Providers	
	Deductible Applies	HNE Providers Copay	PHCS Providers Copay	Deductible Applies	Copay
Routine Eye Exams (limited to one per Calendar Year)	No	$0	$0	Yes	20%
Annual Gynecological Exams (limited to one per Calendar Year)	No	$0	$0	Yes	20%
Routine Mammograms (routine mammograms limited to one per Calendar Year)	No	$0	$0	Yes	20%
Preventive Screenings Listed under "Outpatient Preventive Care" in the *Covered Benefits* Section of the EOC	No	$0	$0	Yes	20%
Other Outpatient Care					
Physician Office Visit	Yes	$0	$0	Yes	20%
Second Opinions	Yes	$0	$0	Yes	20%
Hearing Tests	Yes	$0	$0	Yes	20%
Diabetic-Related Items:					
Outpatient Services	Yes	$0	$0	Yes	20%
Lab/Radiological Services	Yes	$0	$0	Yes	20%
Durable Medical Equipment (some DME requires Prior Approval; $3,000 annual DME maximum applies)	Yes	$0	$0	Yes	20%
Individual Diabetic Education	No	$0	$0	Yes	20%
Group Diabetic Education	No	$0	$0	Yes	20%
Emergency Room Care (Copay waived if admitted)	Yes	$0	$0	Yes	$0
Diagnostic Testing	Yes	$0	$0	Yes	20%
Screening Colonoscopy or Sigmoidoscopy (limited to one every five Calendar Years; an office visit Copay may apply if done in an In-Plan doctor's office; office visits prior to the procedure, related prep prescriptions and subsequent pathology are subject to applicable Deductible & Copays)	No	$0	$0	Yes	20%
Lab Services	Yes	$0	$0	Yes	20%
Radiological Services: Ultrasound, X-rays, Nuclear Cardiology, Non-Routine Mammograms	Yes	$0	$0	Yes	20%

Benefit	In-Plan			Out-of-Plan Providers	
	Deductible Applies	HNE Providers Copay	PHCS Providers Copay	Deductible Applies	Copay
Diagnostic Imaging: CT Scans, MRIs, MRAs, PET Scans †	Yes	$0 (if Prior Approval is denied, Member is responsible for all costs)	$0 (without Prior Approval, Member pays all costs)	Yes	20% (without Prior Approval, Member pays all costs)
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	$0	Yes	20%
Day Rehabilitation Program (limited to 15 full day or ½ day sessions per condition per lifetime)	Yes	$0	$0	Yes	20%
Early Intervention Services (Covered for children from birth to age 3.)	Yes	$0	$0	Yes	20%
Outpatient Surgical Services and Procedures (some services require Prior Approval)	Yes	$0	$0	Yes	20%
Allergy Testing and Treatment	Yes	$0	$0	Yes	20%
Allergy Injections	Yes	$0	$0	Yes	20%
Family Planning Services					
Office Visit	Yes	$0	$0	Yes	20%
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	$0 (if Prior Approval is required & not requested, Member pays all costs)	Yes	20% (if Prior Approval is required & not requested, Member pays all costs)
Outpatient Surgery/ Procedure	Yes	$0	$0 (if Prior Approval, is required & not requested, Member pays all costs)	Yes	20% (if Prior Approval, is required & not requested, Member pays all costs)

Benefit	In-Plan			Out-of-Plan Providers	
	Deductible Applies	**HNE Providers Copay**	**PHCS Providers Copay**	**Deductible Applies**	**Copay**
Lab Test	Yes	$0	$0 (if Prior Approval, is required & not requested, Member pays all costs)	Yes	20% (if Prior Approval, is required & not requested, Member pays all costs)
Inpatient Care †	Yes	$0	$0 (without Prior Approval, Member pays all costs)	Yes	20% (without Prior Approval, Member pays all costs)
Maternity Care					
Non-Routine Prenatal and Postpartum Care	Yes	$0	$0	Yes	20%
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	$0	Yes	20%
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	$0	Yes	20%
Emergency Dental Care in a Doctor's or Dentist's Office	Yes	$0	$0	Yes	20%
Emergency Dental Care in an Emergency Room	Yes	$0	$0	Yes	20%
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 towards 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 for services from a dentist participating with HNE's contracted dental network	$0 for services from a dentist participating with HNE's contracted dental network	No	You pay the first $25 per child per Calendar Year

Benefit	In-Plan			Out-of-Plan Providers	
	Deductible Applies	HNE Providers Copay	PHCS Providers Copay	Deductible Applies	Copay
Other Services					
Home Health Care †	Yes	$0	$0 & up to $1,000 Reduction of Benefit	Yes	20% & up to $1,000 Reduction of Benefit
Hospice Services †	Yes	$0	$0 & up to $1,000 Reduction of Benefit	Yes	20% & up to $1,000 Reduction of Benefit
Durable Medical Equipment (some items require Prior Approval; $3,000 per Calendar Year benefit maximum)	Yes	$0	20% & if Prior Approval was required & not requested, up to $1,000 Reduction of Benefit	Yes	20% & if Prior Approval was required & not requested, up to $1,000 Reduction of Benefit
Prosthetic Limbs †	Yes	$0	$0 (without Prior Approval, Member pays all costs)	Yes	20% (without Prior Approval, Member pays all costs)
Ambulance and Transportation Services (non-emergency transportation requires Prior Approval; If Prior Approval is not obtained for non-emergency transportation, Member pays all costs)	Yes	$0	$0	Yes	$0
Kidney Dialysis	Yes	$0	$0	Yes	20%
Nutritional Support † (not covered without Prior Approval)	Yes	$0	$0	Yes	20%
Cardiac Rehabilitation	Yes	$0	$0	Yes	20%
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)	Yes	$0	$0	Yes	$0
Speech, Hearing, and Language Disorders † (Prior Approval is required for speech therapy services after the initial evaluation.)	Yes	$0	$0 & up to $1,000 Reduction of Benefit	Yes	20% & up to $1,000 Reduction of Benefit
Nutritional Counseling (limited to four vists per Calendar Year)	Yes	$0	$0	Yes	20%

Benefit	In-Plan			Out-of-Plan Providers	
	Deductible Applies	HNE Providers Copay	PHCS Providers Copay	Deductible Applies	Copay
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 Maximum Coinsurance amounts.)	Yes	$0	$0 & up to $1,000 Reduction of Benefit	Yes	20% & up to $1,000 Reduction of Benefit
Behavioral Health					
Outpatient Services (Includes Mental Health and Substance Abuse) †	Yes	$0	$0	Yes	20%
Inpatient Mental Health Services †	Yes	$0	$0 & up to $1,000 Reduction of Benefit	Yes	20% & up to $1,000 Reduction of Benefit
Inpatient Substance Abuse Services †	Yes	$0	$0 & up to $1,000 Reduction of Benefit	Yes	20% & up to $1,000 Reduction of Benefit