



## HNE PPO Complete 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:** When you receive services from an Out-of-Plan Provider, 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. In other cases, if you fail to ask for Prior Approval you may have a Reduction of Benefit up the amount indicated below. The chart below describes the amount you must pay if you do not get Prior Approval. 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.

|   | <b>In-Plan Providers</b>                  | <b>Out-of-Plan Providers</b>              |
|---|---|---|
| <b>Deductible per Calendar Year</b> (You must pay this amount for Covered Services from Out-of-Plan Providers before HNE will begin to pay benefits.)   | Not Applicable                            | \$1,000 per individual/\$2,000 per family |
| <b>Out-of-Pocket Maximum for Medical Services per Calendar Year</b> (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.) | \$1,000 per individual/\$2,000 per family | Not applicable                            |
| <b>Coinsurance Maximum per Calendar Year</b>  | Not applicable                            | \$2,000 per individual/\$4,000 per family |
| <b>Reduction of Benefit</b> (Applies to certain services if Prior Approval is required but not requested.)  | N/A                                       | \$500                                     |

| <b>Benefit</b>  | <b>In-Plan Providers</b> | <b>Out-of-Plan Providers</b>                           |
|---|--------------------------|--|
| <b>Inpatient Care</b>   |                          |  |
| Acute Hospital Care and Inpatient Rehabilitation † (elective admission to Out-of-Plan facilities require Prior Approval)        | \$500/admission          | Deductible + 20% & up to \$500<br>Reduction of Benefit |
| Skilled Nursing Facility † (limited to 100 days per Calendar Year; admissions to Out-of-Plan facilities require Prior Approval) | \$500/admission          | Deductible + 20% & up to \$500<br>Reduction of Benefit |

| <b>Benefit</b>   | <b>In-Plan Providers</b>  | <b>Out-of-Plan Providers</b>  |
|--|---------------------------|---|
| <b>Outpatient Preventive Care</b>  |                           |   |
| Adult Routine Exams  | \$0                       | Deductible + 20%  |
| Well Child Care  | \$0                       | Deductible + 20%  |
| Child and Adult Routine Immunizations  | \$0                       | Deductible + 20%  |
| Routine Eye Exams (limited to one per Calendar Year)   | \$0                       | Deductible + 20%  |
| Annual Gynecological Exams (limited to one per Calendar Year)  | \$0                       | Deductible + 20%  |
| Routine Mammograms   | \$0                       | Deductible + 20%  |
| <b>Other Outpatient Care</b>   |                           |   |
| Physician Office Visit   | \$20/visit                | Deductible + 20%  |
| Hearing Tests  | \$20/visit                | Deductible + 20%  |
| Second Opinions  | \$20/visit                | Deductible + 20%  |
| Diabetic-Related Items:  |                           |   |
| Outpatient Services  | \$20/visit                | Deductible + 20%  |
| Lab/Radiological Services  | \$0                       | Deductible + 20%  |
| Durable Medical Equipment† (some DME requires Prior Approval; \$3,000 annual DME maximum applies)  | 20%                       | Deductible + 20% & if Prior Approval was required & not requested, up to \$500 Reduction of Benefit |
| Individual Diabetic Education  | \$20/visit                | Deductible + 20%  |
| Group Diabetic Education   | \$20/session              | Deductible + 20%  |
| Emergency Room Care (Copay waived if admitted)   | \$50/visit                | \$50/visit  |
| Diagnostic Testing (some In-Plan services are subject to the Outpatient Surgical Services and Procedure Copay; see Outpatient Surgical Services and Procedures below)          | \$20/visit                | Deductible + 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)                       | \$0                       | Deductible + 20%  |
| Lab Services   | \$0                       | Deductible + 20%  |
| Radiological Services: Ultrasound, X-rays, Nuclear Cardiology, Non-Routine Mammograms  | \$0                       | Deductible + 20%  |
| Diagnostic Imaging: CT Scans, MRIs, MRAs, PET Scans †  | \$0                       | Deductible + 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) | \$20/visit/treatment type | Deductible + 20%  |
| Day Rehabilitation Program (limited to 15 full day or ½ day sessions per condition per lifetime)   | \$25/day or half day      | Deductible + 20%  |

| <b>Benefit</b>   | <b>In-Plan Providers</b> | <b>Out-of-Plan Providers</b>  |
|--|--------------------------|---|
| Early Intervention Services (Covered for children from birth to age 3.)  | \$20/visit               | Deductible + 20%  |
| Outpatient Surgical Services and Procedures (Some services require Prior Approval. The In-Plan 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.) | \$250/admission          | Deductible + 20% & up to \$500 Reduction of Benefit                       |
| Allergy Testing and Treatment  | \$20/visit               | Deductible + 20%  |
| Allergy Injections   | \$0                      | Deductible + 20%  |
| <b>Family Planning Services</b>  |                          |   |
| Office Visit   | \$20/visit               | Deductible + 20%  |
| <b>Infertility Services</b>  |                          |   |
| 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   | \$20/visit               | Deductible + 20% (if Prior Approval not requested, Member pays all costs) |
| Outpatient Surgery/ Procedure  | \$250/admission          | Deductible + 20% (if Prior Approval not requested, Member pays all costs) |
| Lab Test   | \$0                      | Deductible + 20% (if Prior Approval not requested, Member pays all costs) |
| Inpatient Care †   | \$500/admission          | Deductible + 20% (if Prior Approval not requested, Member pays all costs) |
| <b>Maternity Care</b>  |                          |   |
| Routine Prenatal and Postpartum Care   | \$0                      | Deductible + 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.)   | \$500/admission          | Deductible + 20%  |
| <b>Dental Services</b>   |                          |   |
| Surgical Treatment of Non-Dental Conditions in a Doctor's Office (Some services are subject to the Outpatient Surgical Services and Procedures Copay.)   | \$20/visit               | Deductible + 20%  |
| Emergency Dental Care in a Doctor's or Dentist's Office  | \$20/visit               | Deductible + 20%  |
| Emergency Dental Care in an Emergency Room   | \$50/visit               | \$50/visit  |

| <b>Benefit</b>   | <b>In-Plan Providers</b>   | <b>Out-of-Plan Providers</b>  |
|--|--|---|
| 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.) | \$0 for services from a dentist participating with HNE's contracted dental network | You pay the first \$25 per child per Calendar Year  |
| <b>Other Services</b>  |  |   |
| Home Health Care †   | \$0  | Deductible + 20% & up to \$500 Reduction of Benefit   |
| Hospice Services †   | \$0  | Deductible + 20% & up to \$500 Reduction of Benefit   |
| Durable Medical Equipment (some items require Prior Approval; \$3,000 per Calendar Year Benefit maximum)   | 20%  | Deductible + 20% & if Prior Approval was required & not requested, up to \$500 Reduction of Benefit |
| Prosthetic Limbs †   | 20%  | Deductible + 20% (without Prior Approval, Member pays all costs)                                    |
| Ambulance and Transportation Services (non-emergency transportation requires Prior Approval)   | \$25/Member/day  | \$25/Member/day   |
| Kidney Dialysis  | \$0  | Deductible + 20%  |
| Nutritional Support † (not covered without Prior Approval)   | \$0  | \$0   |
| Cardiac Rehabilitation   | \$20/visit   | Deductible + 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)  | \$0  | \$0   |
| Speech, Hearing, and Language Disorders † (Prior Approval is required for speech therapy services after the initial evaluation visit.)   | \$20/visit   | Deductible + 20% & up to \$500 Reduction of Benefit   |
| Nutritional Counseling (limited to four visits per Calendar Year)  | \$20/visit   | Deductible + 20%  |
| 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.)  | \$500/admission  | Deductible + 20% & up to \$500 Reduction of Benefit   |
| <b>Behavioral Health</b>   |  |   |
| Outpatient Services (Includes Mental Health and Substance Abuse) †   | \$20/visit   | Deductible + 20%  |
| Inpatient Mental Health Services †   | \$500/admission  | Deductible + 20% & up to \$500 Reduction of Benefit   |
| Inpatient Substance Abuse Services †   | \$500/admission  | Deductible + 20% & up to \$500 Reduction of Benefit   |