

HMO Summary of Benefits Chart

This chart provides a summary of key services offered by your HNE 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: Some services may require prior approval from HNE. See your member agreement for a list of services that require prior approval.

<p>Out-of-Pocket Maximum per Year This applies to services with copayments of \$100 or more*. Once you have paid the Out-of-Pocket Maximum, you will not have to pay a copayment for these types of services for the rest of the year. *Does not apply to Durable Medical Equipment (DME) and Prosthetics.</p>	<p>\$2,000 per individual \$4,000 per family</p>
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BENEFIT	Copayment
<p>Inpatient Care</p> <ul style="list-style-type: none"> • Acute Hospital Care • Acute Inpatient Rehabilitation • Skilled Nursing Facility (<i>100 day calendar year maximum</i>) • Infertility Services • Maternity Care • Mental Health Services <i>(care for some conditions may be limited to 60 days per calendar year maximum)</i> • Substance Abuse Services (<i>30 day calendar year maximum</i>) For alcohol abuse (<i>30 day calendar year maximum</i>) 	<p>\$1,000/admission</p>
<p>Outpatient Preventive Care</p>	<p>\$0/visit</p>
<p>Other Outpatient Care</p>	
<p>PCP Office Visits (<i>non-routine</i>)</p>	<p>\$20/visit</p>
<p>Specialist Office Visits</p>	<p>\$40/visit</p>
<p>Routine Eye Exams (<i>one per calendar year</i>)</p>	<p>\$0/visit</p>
<p>Individual Diabetic Education</p>	<p>\$40/visit</p>
<p>Group Diabetic Education</p>	<p>\$20/session</p>
<p>Emergency Room Care (<i>copayment waived if admitted directly from ER</i>)</p>	<p>\$100/visit</p>
<p>Laboratory Services</p>	<p>\$0</p>
<p>Radiological Services: Ultrasound, X-rays, Nuclear Cardiology, Mammograms</p>	<p>\$0</p>
<p>Diagnostic Imaging: CT Scans, MRIs, MRAs, PET Scans</p>	<p>\$0</p>

BENEFIT	Copayment
Outpatient Short-Term Rehabilitation Services <i>(two months or 25 visits, whichever is greater, per condition per calendar year for physical or occupational therapy)</i>	\$40/visit/treatment type
Day Rehabilitation Program <i>(limited to 15 full day or half day sessions per condition per lifetime)</i>	\$25/day or half day
Early Intervention Services <i>(limited to \$5,200 per child per calendar year with a lifetime maximum of \$15,600. Covered for children from birth to age 3)</i>	\$40/visit
Outpatient Surgical Services and Procedures	\$500/visit, based on specific surgical procedure
Family Planning Services and Infertility Treatment <i>(Some services are covered only for Massachusetts residents and for Connecticut residents under the age of 40.)</i>	Some Assisted Reproductive Services consist of outpatient surgery procedures; certain surgical procedures are subject to the outpatient surgical services and procedures copayment.
Office Visit	\$40/visit
Laboratory Tests	\$0
Inpatient Care	\$1,000/admission
Outpatient Surgical Services and Procedures	\$500/visit
Children's Preventive Dental <i>(limited to preventive services for children under age 12)</i> 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
Other Services	
Home Health Care	\$0/visit
Hospice Services	\$0/visit
Durable Medical Equipment, including ostomy supplies <i>(limited to \$3,000 per calendar year)</i>	20%
Prosthetic Limbs	20%
Ambulance and Chair Van Services	\$50/member/day
Nutritional Counseling <i>(limited to 4 visits per calendar year)</i>	\$40/visit
Human Organ Transplants and Bone Marrow Transplants	\$1,000/admission
Outpatient Mental Health Services <i>(care for some conditions may be limited to 24 visits per calendar year)</i>	\$20/visit
Outpatient Substance Abuse Services <i>(limited to 20 visits per calendar year)</i> For alcohol abuse <i>(\$500 per calendar year limit)</i>	\$20/visit for visits 1-8 \$40/visit for visits 9-20