

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.

	Single Plan	Family Plan
<p>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.</p>	<p>\$2,000 per individual</p>	<p>\$2,000 per individual \$4,000 per family (Once any individual on a family plan has met the individual deductible, the plan will begin to pay benefits for that individual.)</p>
<p>Out-of-Pocket Maximum per Year † The Out-of-Pocket Maximum includes your deductible and all medical services with a copayment of \$100 or more (including the coinsurance for Durable Medical Equipment (DME)* and Prosthetics). Once you have met the Out-of-Pocket Maximum, you will not have to pay copayments for those services for the remainder of the year.</p> <p>*DME coverage is limited to \$3,000 per calendar year. Once you reach this limit, you must pay 100% of the cost for DME items. Amounts you pay once you have reached your benefit limit do not apply to the Out-of-Pocket Maximum.</p>	<p>\$3,000 per individual \$6,000 per family</p>	

† May be applied on a Calendar Year basis or a Policy Year basis. This depends on the group through which you enroll.

BENEFIT	Deductible Applies	Copayment
Inpatient Care <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> 	Yes	\$500/admission
Outpatient Preventive Care	No	\$0
Other Outpatient Care		
PCP Office Visits <i>(non-routine)</i>	No	\$30/visit
Specialist Office Visits	Yes	\$40/visit
Routine Eye Exams <i>(one per calendar year)</i>	No	\$0/visit
Individual Diabetic Education	Yes	\$40/visit
Group Diabetic Education	Yes	\$30/session
Emergency Room Care <i>(copayment waived if admitted directly from ER)</i>	Yes	\$100/visit
Laboratory Services	Yes	\$0
Radiological Services: Ultrasound, X-rays, Nuclear Cardiology, Mammograms <i>(after first mammogram in each calendar year)</i>	Yes	\$0
Diagnostic Imaging: CT Scans, MRIs, MRAs, PET Scans	Yes	\$0
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>	Yes	\$40/visit/treatment type
Day Rehabilitation Program <i>(limited to 15 full day or half day sessions per condition per lifetime)</i>	Yes	\$40/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>	Yes	\$40/visit
Outpatient Surgical Services and Procedures	Yes	\$250/visit, based on specific surgical procedure

BENEFIT	Deductible Applies	Copayment
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	Yes	\$40/visit
Laboratory Tests	Yes	\$0
Inpatient Care	Yes	\$500/admission
Outpatient Surgical Services and Procedures	Yes	\$250/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.	No	\$0 for services from a dentist participating with HNE's contracted dental network
Other Services		
Home Health Care	Yes	\$0/visit
Hospice Services	Yes	\$0/visit
Durable Medical Equipment, including ostomy supplies <i>(limited to \$3,000 per calendar year)</i>	Yes	20%
Prosthetic Limbs	Yes	20%
Ambulance and Chair Van Services	Yes	\$100/member/day
Nutritional Counseling	Yes	\$40/visit
Human Organ Transplants and Bone Marrow Transplants	Yes	\$500/admission
Outpatient Mental Health Services <i>(care for some conditions may be limited to 24 visits per calendar year)</i>	No	\$30/visit
Outpatient Substance Abuse Services <i>(limited to 20 visits per calendar year)</i> For alcohol abuse <i>(\$500 per calendar year limit)</i>	Yes	\$30/visit