HNE Principle

Option 4

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.

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.	**$500 per individual** **$1,000 per family**

BENEFIT	Copayment
Inpatient Care • Acute Hospital Care • Acute Inpatient Rehabilitation • Skilled Nursing Facility *(100 day calendar year maximum)* • Infertility Services • Maternity Care • Mental Health Services *(care for some conditions may be limited to 60 days per calendar year maximum)* • Substance Abuse Services *(30 day calendar year maximum)* For alcohol abuse *(30 day calendar year maximum)*	$250/admission
Outpatient Preventive Care	$0/visit
Other Outpatient Care	
PCP Office Visits *(non-routine)*	$15/visit
Specialist Office Visits	$15/visit
Routine Eye Exams *(one per calendar year)*	$0/visit
Individual Diabetic Education	$15/visit
Group Diabetic Education	$15/session
Emergency Room Care *(copayment waived if admitted directly from ER)*	$50/visit
Laboratory Services	$0
Radiological Services: Ultrasound, X-rays, Nuclear Cardiology, Mammograms	$0
Diagnostic Imaging: CT Scans, MRIs, MRAs, PET Scans	$0

BENEFIT	Copayment
Outpatient Short-Term Rehabilitation Services *(two months or 25 visits, whichever is greater, per condition per calendar year for physical or occupational therapy)*	$15/visit/treatment type
Day Rehabilitation Program *(limited to 15 full day or half day sessions per condition per lifetime)*	$25/day or half day
Early Intervention Services *(limited to $5,200 per child per calendar year with a lifetime maximum of $15,600. Covered for children from birth to age 3)*	$15/visit
Outpatient Surgical Services and Procedures	$150/visit, based on specific surgical procedure
Family Planning Services and Infertility Treatment *(Some services are covered only for Massachusetts residents and for Connecticut residents under the age of 40.)*	Some Assisted Reproductive Services consist of outpatient surgery procedures; certain surgical procedures are subject to the outpatient surgical services and procedures copayment.
Office Visit	$15/visit
Laboratory Tests	$0
Inpatient Care	$250/admission
Outpatient Surgical Services and Procedures	$150/visit
Children's Preventive Dental *(limited to preventive services for children under age 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
Other Services	
Home Health Care	$0/visit
Hospice Services	$0/visit
Durable Medical Equipment, including ostomy supplies *(limited to $3,000 per calendar year)*	20%
Prosthetic Limbs	20%
Ambulance and Chair Van Services	$25/member/day
Nutritional Counseling *(limited to 4 visits per calendar year)*	$15/visit
Human Organ Transplants and Bone Marrow Transplants	$250/admission
Outpatient Mental Health Services *(care for some conditions may be limited to 24 visits per calendar year)*	$15/visit
Outpatient Substance Abuse Services *(limited to 20 visits per calendar year)* For alcohol abuse *($500 per calendar year limit)*	$10/visit for visits 1-8 $20/visit for visits 9-20