

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. If your plan includes prescription drug coverage, your prescriptions are subject to this deductible.</p>	\$2,000 per individual	\$4,000 per family (Once any individual on a family plan has paid \$2,200* towards the family deductible, the plan will begin to pay benefits for that individual.)
<p>Out-of-Pocket Maximum per Year † This is the most you will pay in a year for covered services for the combined cost of your deductible plus any copayments. If your plan includes prescription drug coverage, your copayments for prescriptions are included in this out-of-pocket maximum.</p>	\$5,000 per individual \$10,000 per family	

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

* Effective January 1, 2009 this amount is increased to \$2,300. For group plans with a Policy Year Deductible effective before January 1, 2009, this amount will remain \$2,200 until the group's renewal date in 2009.

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	\$0/admission
Outpatient Preventive Care	No	\$0
Other Outpatient Care		
PCP Office Visits <i>(non-routine)</i>	Yes	\$0/visit
Specialist Office Visits	Yes	\$0/visit
Routine Eye Exams <i>(one per calendar year)</i>	No	\$0/visit
Individual Diabetic Education	No	\$0/visit
Group Diabetic Education	No	\$0/session
Emergency Room Care <i>(copayment waived if admitted directly from ER)</i>	Yes	\$0/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	\$0/visit/treatment type
Day Rehabilitation Program <i>(limited to 15 full day or half day sessions per condition per lifetime)</i>	Yes	\$0/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	\$0/visit
Outpatient Surgical Services and Procedures	Yes	\$0/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	\$0/visit
Laboratory Tests	Yes	\$0
Inpatient Care	Yes	\$0/admission
Outpatient Surgical Services and Procedures	Yes	\$0/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	\$0
Prosthetic Limbs	Yes	\$0
Ambulance and Chair Van Services	Yes	\$0/member/day
Nutritional Counseling <i>(limited to 4 visits per calendar year)</i>	Yes	\$0/visit
Human Organ Transplants and Bone Marrow Transplants	Yes	\$0/admission
Outpatient Mental Health and Substance Abuse Services Prior to January 1, 2009: Outpatient Mental Health Services <i>(care for some conditions may be limited to 24 visits per calendar year)</i> Outpatient Substance Abuse Services <i>(limited to 20 visits per calendar year)</i> For alcohol abuse <i>(\$500 per calendar year limit)</i>	Yes Yes	\$0/visit \$0/visit
Outpatient Mental Health and Substance Abuse Services Effective January 1, 2009: Outpatient Mental Health and Substance Abuse Services (At least \$500 per calendar year can be provided for the treatment of alcoholism.)	Yes	\$0/visit