

# HNE PPO Complete

## PPO 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.

- 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 from HNE. 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 to the amount indicated below. 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. See your member agreement for a list of services that require prior approval.

	In-Plan Provider	Out-of-Plan Provider
<b>Deductible per Calendar Year</b> You must pay this amount for covered services before HNE will begin to pay benefits.	Not applicable	<b>\$1,000 per individual</b> <b>\$2,000 per family</b> (Once any individual on a family plan has met the individual deductible, the plan will begin to pay benefits for that individual.)
<b>Coinsurance Maximum per Calendar Year</b>	Not applicable	<b>\$2,000 per individual</b> <b>\$4,000 per family</b>
<b>Copayment Maximum per Calendar Year</b> This applies to services with copayments of \$100 or more*. Once you have paid the Copayment 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.	<b>\$1,000 per individual</b> <b>\$2,000 per family</b>	Not applicable
<b>Reduction of Benefit</b> Applies to certain services if prior approval is required but not requested.	Not applicable	\$500

BENEFIT	Copayment In-Plan Provider	Coinsurance Out-of-Plan Provider
<b>Inpatient Care</b> <ul style="list-style-type: none"> <li>• Acute Hospital Care</li> <li>• Acute Inpatient Rehabilitation</li> <li>• Skilled Nursing Facility <i>(100 day calendar year maximum)</i></li> <li>• Infertility Services</li> <li>• Maternity Care</li> <li>• Mental Health Services <i>(care for some conditions may be limited to 60 days per calendar year maximum)</i></li> <li>• Substance Abuse Services <i>(30 day calendar year maximum)</i> For alcohol abuse <i>(30 day calendar year maximum)</i></li> </ul>	\$500/admission	20%
<b>Outpatient Preventive Care</b>	\$0/visit	20%
<b>Other Outpatient Care</b>		
Physician Office Visits <i>(non-routine)</i>	\$20/visit	20%
Routine Eye Exams <i>(one per calendar year)</i>	\$0/visit	20%
Individual Diabetic Education	\$20/visit	20%
Group Diabetic Education	\$20/session	20%
Emergency Room Care <i>(copayment waived if admitted directly from ER)</i>	\$50/visit	\$50/visit
Laboratory Services	\$0	20%
Radiological Services: Ultrasound, X-rays, Nuclear Cardiology, Mammograms	\$0	20%
Diagnostic Imaging: CT Scans, MRIs, MRAs, PET Scans	\$0	20%
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>	\$20/visit/treatment type	20%
Day Rehabilitation Program <i>(limited to 15 full day or half day sessions per condition per lifetime)</i>	\$25/day or half day	20%
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>	\$20/visit	20%
Outpatient Surgical Services and Procedures	\$250/visit, based on specific surgical procedure	20%

BENEFIT	Copayment In-Plan Provider	Coinsurance Out-of-Plan Provider
<b>Family Planning Services and Infertility Treatment</b> <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	\$20/visit	20%
Laboratory Tests	\$0	20%
Inpatient Care	\$500/admission	20%
Outpatient Surgical Services and Procedures	\$250/visit	20%
<b>Children's Preventive Dental</b> <i>(limited to preventive services for children under age 12)</i>	\$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/visit	20%
Hospice Services	\$0/visit	20%
Durable Medical Equipment, including ostomy supplies <i>(limited to \$3,000 per calendar year)</i>	20%	20%
Prosthetic Limbs	20%	20%
Ambulance and Chair Van Services	\$25/member/day	\$25/member/day
Nutritional Counseling <i>(limited to 4 visits per calendar year)</i>	\$20/visit	20%
Human Organ Transplants and Bone Marrow Transplants	\$500/admission	20% (Without prior approval, payments you make for deductibles and coinsurance will not count towards the maximum deductible and coinsurance amounts.)
Outpatient Mental Health Services <i>(care for some conditions may be limited to 24 visits per calendar year)</i>	\$20/visit	20%
Outpatient Substance Abuse Services <i>(limited to 20 visits per calendar year)</i> For alcohol abuse <i>(\$500 per calendar year maximum)</i>	Visits 1-8: \$10/visit Visits 9-20: \$20/visit	20%