

HNE PPO Wise

HDHP PPO H - High Deductible Health Plan

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 HNE and PHCS Providers	Out-of-Plan Provider
Medical/Pharmacy Deductible per Year † You must pay this amount for covered services before HNE will begin to pay benefits. This deductible applies to services from both In-Plan and Out-of-Plan providers. As indicated in the chart below, some services are not subject to the deductible.	Individual Plan: \$2,000 per individual Family Plan: \$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.)	
In-Plan Out-of-Pocket Maximum per Year † This is the most you will pay in a year for the combined cost of your Medical/Pharmacy Deductible plus any copayments for covered services from In-Plan Providers.	\$5,000 per individual \$10,000 per family	Not applicable
Out-of-Plan Out-of-Pocket Maximum per Year † After you have satisfied your Medical/Pharmacy Deductible, this is the most you will pay in a year for copayments and coinsurance for covered services from Out-of-Plan providers.	Not applicable	\$7,500 per individual \$15,000 per family
Reduction of Benefit Applies to certain services if prior approval is required but not requested.	HNE Provider: Not applicable PHCS Provider: \$1,000	\$1,000

† 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	In-Plan Provider HNE and PHCS Providers		Out-of-Plan Provider	
	Deductible Applies	Copayment	Deductible Applies	Coinsurance
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	Yes	20%
Outpatient Preventive Care	No	\$0	Yes	20%
Other Outpatient Care				
Physician Office Visits <i>(non-routine)</i>	Yes	\$0	Yes	20%
Routine Eye Exams <i>(one per calendar year)</i>	No	\$0	Yes	20%
Individual Diabetic Education	No	\$0	Yes	20%
Group Diabetic Education	No	\$0	Yes	20%
Emergency Room Care <i>(copayment waived if admitted directly from ER)</i>	Yes	\$0	Yes	\$0
Laboratory Services	Yes	\$0	Yes	20%
Radiological Services: Ultrasound, X-rays, Nuclear Cardiology, Mammograms <i>(after first mammogram in each calendar year)</i>	Yes	\$0	Yes	20%
Diagnostic Imaging: CT Scans, MRIs, MRAs, PET Scans	Yes	\$0	Yes	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>	Yes	\$0	Yes	20%
Day Rehabilitation Program <i>(limited to 15 full day or half day sessions per condition per lifetime)</i>	Yes	\$0	Yes	20%

BENEFIT	In-Plan Provider HNE and PHCS Providers		Out-of-Plan Provider	
	Deductible Applies	Copayment	Deductible Applies	Coinsurance
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	Yes	20%
Outpatient Surgical Services and Procedures	Yes	\$0	Yes	20%
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>				
Office Visit	Yes	\$0	Yes	20%
Laboratory Tests	Yes	\$0	Yes	20%
Inpatient Care	Yes	\$0	Yes	20%
Outpatient Surgical Services and Procedures	Yes	\$0	Yes	20%
Children's Preventive Dental <i>(limited to preventive services for children under age 12)</i>	No	\$0 for services from a dentist participating with HNE's contracted dental network	No	You pay the first \$25 per child per calendar year.
Other Services				
Home Health Care	Yes	\$0	Yes	20%
Hospice Services	Yes	\$0	Yes	20%
Durable Medical Equipment, including ostomy supplies <i>(limited to \$3,000 per calendar year)</i>	Yes		Yes	20%
Prosthetic Limbs	Yes	\$0	Yes	20%
Ambulance and Chair Van Services	Yes	\$0	Yes	\$0
Nutritional Counseling <i>(limited to 4 visits per calendar year)</i>	Yes	\$0	Yes	20%

BENEFIT	In-Plan Provider HNE and PHCS Providers		Out-of-Plan Provider	
	Deductible Applies	Copayment	Deductible Applies	Coinsurance
Human Organ Transplants and Bone Marrow Transplants	Yes	\$0	Yes	20% (Without prior approval, payments you make for deductibles and coinsurance will not count towards the maximum deductible and coinsurance amounts.)
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>	Yes	\$0	Yes	20%
Outpatient Substance Abuse Services <i>(limited to 20 visits per calendar year)</i> For alcohol abuse <i>(\$500 per calendar year limit)</i>	Yes	\$0	Yes	20%
Outpatient Mental Health and Substance Abuse Services Effective January 1, 2009:				
Outpatient Mental Health and Substance Abuse Services <i>(At least \$500 per calendar year can be provided for the treatment of alcoholism.)</i>	Yes	\$0	Yes	20%