HNE Essential[500]

Summary of Benefits Chart

This chart provides a summary of key services offered by your HNE plan. Your member agreement has 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.
Note about Prior Approval: Some services require prior approval. These services are marked with † in the chart. If you do not obtain Prior Approval, benefits may be denied.

	In-Plan
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.)	$500 per individual/$1,000 per family
Out-of-Pocket Maximum per Year* (This includes your Deductible and all medical services with a Copay of $100 or more (including the Copay for Durable Medical Equipment (DME) and Prosthetics). Once you have met the Out-of-Pocket Maximum, you will not have to pay Copays for those services for the remainder of the year.)	$2,000 per individual/$4,000 per family
* May be based on a Calendar Year or a Policy Year basis. This depends on the Group through which you enroll.	

Benefit	**Deductible Applies**	**Copay**
Inpatient Care		
Acute Hospital Care and Inpatient Rehabilitation	Yes	$0
Skilled Nursing Facility† (limited to 100 days per Calendar Year)	Yes	$0
Outpatient Preventive Care		
Adult Routine Exams	No	$0
Well Child Care	No	$0
Routine Prenatal & Postpartum Care	No	$0
Child and Adult Routine Immunizations	No	$0
Routine Eye Exams (limited to one per Calendar Year)	No	$0
Annual Gynecological Exams (limited to one per Calendar Year)	No	$0
Routine Mammograms (routine mammograms limited to one per Calendar Year)	No	$0
Preventive Screenings Listed under "Outpatient Preventive Care" in the *Covered Benefits* Section of the EOC	No	$0
Other Outpatient Care		
PCP Office Visit (Non-Routine) (Deductible may apply to some office services)	No	$20/visit

Benefit	Deductible Applies	Copay
Hearing Tests	Yes	$20/visit
Specialist Office Visits (Deductible may apply to some office services)	No	$20/visit
Second Opinions (Deductible may apply to some office services)	No	$20/visit
Diabetic-Related Items:		
• Outpatient Services (Deductible may apply to some office services)	No	$20/visit
• Lab Services	No	$0
• Durable Medical Equipment (some DME requires Prior Approval; $3,000 annual DME maximum applies)	No	20%
• Individual Diabetic Education	No	$20/visit
• Group Diabetic Education	No	$20/session
Emergency Room Care (Copay waived if admitted)	No	$100/visit
Diagnostic Testing	Yes	$0
Screening Colonoscopy or Sigmoidoscopy (limited to one every five Calendar Years; office visit Copay may apply if done in a doctor's office)	No	$0
Lab Services	No	$0
Radiological Services: Ultrasound, X-rays, Nuclear Cardiology, Non-Routine Mammograms	Yes	$0
Diagnostic Imaging: CT Scans, MRIs, MRAs, PET Scans †	Yes	$0
Outpatient Short-Term Rehabilitation Services (limited to two months or 25 visits, whichever is greater, per condition per Calendar Year for physical or occupational therapy)	Yes	$20/visit per treatment type
Day Rehabilitation Program (limited to 15 full day or ½ day sessions per condition per lifetime)	Yes	$25 for 1 day or 1/2 day
Early Intervention Services (Covered for children from birth to age 3.)	No	$20/visit
Outpatient Surgical Services and Procedures (some services require Prior Approval; office visit Copay may apply if done in a doctor's office)	Yes	$0
Allergy Testing and Treatment	No	$20/visit
Allergy Injections	No	$0
Family Planning Services		
Office Visit (Deductible may apply to some office services)	No	$20/visit
Infertility Services		
Some Infertility services are covered only for Massachusetts residents and for Connecticut residents under the age of 40. Some services require Prior Approval.		
Office Visit (Deductible may apply to some office services)	No	$20/visit
Outpatient Surgery/ Procedure	Yes	$0
Lab Test	No	$0
Inpatient Care†	Yes	$0
Maternity Care		
Non-Routine Prenatal and Postpartum Care	No	$20/visit

Benefit	Deductible Applies	Copay
Delivery/Hospital Care for Mother and Child (Coverage for child limited to routine newborn nursery charges. For continued coverage, child must be enrolled within 31 days of date of birth.)	Yes	$0
Dental Services		
Surgical Treatment of Non-Dental Conditions in a Doctor's Office (Some services are subject to the Outpatient Surgical Services and Procedures Copay. Deductible may apply to some office services.)	No	$20/visit
Emergency Dental Care in a Doctor's or Dentist's Office	No	$20/visit
Emergency Dental Care in an Emergency Room	No	$100/visit
Routine dental services for children under the age of 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.)	No	$0
Other Services		
Home Health Care †	Yes	$0
Hospice Services †	No	$0
Durable Medical Equipment (some items require Prior Approval; $3,000 per Calendar Year Benefit maximum)	No	20%
Prosthetic Limbs†	No	20%
Ambulance and Transportation Services (non-emergency transportation requires Prior Approval)	Yes	$100/Member/day
Kidney Dialysis	No	$0
Nutritional Support †	No	$0
Cardiac Rehabilitation	Yes	$20/visit
Wigs (Scalp Hair Prostheses) for hair loss due to treatment of any form of cancer or leukemia. (HNE pays up to $350 per Calendar Year)	No	$0
Speech, Hearing, and Language Disorders † (Prior Approval is required for speech therapy services after the initial evaluation)	Yes	$20/visit
Nutritional Counseling (maximum of 4 visits per Calendar Year)	No	$20/visit
Human Organ Transplants and Bone Marrow Transplants †	Yes	$0
Behavioral Health		
Outpatient Services (Includes Mental Health and Substance Abuse)†	No	$20/visit
Inpatient Mental Health Services†	Yes	$0
Inpatient Substance Abuse Services†	Yes	$0

P R E S C R I P T I O N   D R U G   C O V E R A G E

Prescription Drugs (*certain drugs require Prior Approval*)

Your Prescription Drug benefit covers those items described in the HNE Formulary.

Please call Member Services or visit hne.com for a copy of the HNE Formulary.

	Deductible Applies	**In-Plan Providers**
At an In-Plan Pharmacy (up to a 30-day supply)		
Generic Drugs	No	$10
Formulary Drugs	No	$20
Non-Formulary Drugs	No	$35
Through Mail Order: (up to a 90-day supply of maintenance medication)		
Generic Drugs	No	$10
Formulary Drugs	No	$20
Non-Formulary Drugs	No	$35

How Your Prescription Drug Coverage Works

HNE is committed to providing our members with access to safe and effective medications. HNE covers most prescription drugs and a small number of non-prescription drugs and medical supplies. Covered prescription drugs are divided into three tiers with different member copays.

The HNE Formulary

Covered prescription drugs are divided into three tiers with different member copays.

Tier	Description	Level of Member Copay
1 - Generic	Approved by the U.S. Food and Drug Administration (FDA), Generic Drugs (Tier 1) contain the same active ingredients as brand name drugs, are just as safe and effective, and usually cost less. HNE encourages the dispensing of generic drugs whenever possible. You pay the lowest copay for generic drugs.	Lowest
2 - Brand/ Formulary	Brand/Formulary Drugs (Tier 2) are marketed under a trademarked brand name, usually by one manufacturer, and do not have less costly generic equivalents. Brand/Formulary Drugs are selected based on a review of the relative safety, effectiveness and cost of the many FDA-approved drugs on the market. Your copay for Brand/Formulary Drugs is higher than for Generic Drugs, but lower than for Brand/Non-Formulary Drugs.	Higher than Tier 1 Lower than Tier 3
3 - Brand/ Non-Formulary	Any brand name drug that HNE has not selected as a Brand/Formulary Drug is a Brand/Non-Formulary Drug (Tier 3). This category includes, any brand name drug that has a generic equivalent (Tier 1) or brand drugs that have formulary generic and brand alternatives. These medications are still covered, but at the highest copay level. HNE does not waive or reduce copays for Brand/Non-Formulary drugs.	Highest

A small list of drugs is not covered. HNE limits coverage for some prescription drugs. Coverage limits include:

- Prior Approval: Your doctor has to request coverage from HNE before you can get the drug.
- Quantity limits: HNE will cover only a certain amount of the drug each month.
- Step therapy: You have to try a drug used to treat the same condition (therapeutic equivalent) before HNE will cover the drug.

To obtain a complete list of drugs that are excluded, limited, or require prior authorization, or to obtain a copy of the HNE Formulary listing, please call Member Services at 413-787-4004 or 800-310-2835 or visit hne.com.

Two easy ways to get your prescriptions...

At a Retail Pharmacy

Through our national pharmacy network, you can get medications at participating pharmacies no matter where in the country you are. Whether you're home, on vacation, or away for business or other reasons, you can fill prescriptions at any of the more than 50,000 pharmacies that participate in our national network. Participating pharmacies include CVS, Costco, Stop & Shop, Brooks/Maxi Drug, Walgreens and Target.

Just show your HNE ID card, along with your prescription or refill, and pay the applicable copay.

Through the Mail

We also offer a mail service option, in case you want to get your prescriptions through the mail - delivered to your home! Mail service is limited to those items for which a 90-day supply is appropriate. Your copays for mail service prescriptions may be different from your standard prescription copays. Each copay covers up to a 90-day supply of a prescription or refill.

- Sorry, there are some items you can't get through the mail service:
  - Any drugs for which mail service is prohibited by law; and
  - Prescriptions for which a 90-day supply may not be appropriate as determined by HNE.
  - Injectables

CHIROPRACTIC SERVICES

Office Visit Copay: $15	
What your plan covers	• We cover up to 12 visits per year for medically necessary chiropractic services. • When you receive services, your In-Plan chiropractor must notify OptumHealth. OptumHealth will work with your In-Plan chiropractor to determine the appropriate level of covered services to treat your condition. If your chiropractor does not notify OptumHealth, you will not be held financially liable for the services. • HNE will cover your visits with an In-Plan chiropractor. A $15 copay applies for each visit.
Exclusions	• Maintenance care (Care given to reduce the incidence or prevalence of illness, impairment, or risk factors, or to promote optimum function) • Orthotics • Services that are not medically necessary • Services with an Out-of-Plan chiropractor • Exclusions or limitations included in the Plan Explanation of Coverage
For more information or to find a provider	On the web: • You can find information about participating chiropractors through OptumHealth at our web site, hne.com/HNE_members/alternative.html. On the phone: • Call HNE Member Services at 413-787-4004 or 800-310-2835 • Call OptumHealth at 888-676-7768 Listings are subject to change without notice. Chiropractors are not contracted or credentialed by Health New England.