HNE PPO Essential^{1000}

PPO Benefit Chart

This chart provides a summary of key services offered by your plan. Consult your Member Agreement for a full description of your plan's benefits and provisions.

- Please note: for Out-of-Plan services, 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. These services are marked with † in the chart. In some cases, if you fail to ask for Prior Approval the service will not be covered at all. (See, for example, Infertility Treatment below.) In other cases, for example Acute Hospital Care at an Out-of-Plan facility, 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.

	In-Plan Providers	**Out-of-Plan Providers**
Deductible per Year* (You must pay this amount for Covered Services before HNE will begin to pay benefits. This is a combined amount for HNE and Out-of-Plan providers. As indicated in the chart below, some services are not subject to the Deductible.)	$1,000 per individual/$2,000 per family	$1,000 per individual/$2,000 per family
Safety Net for In-Plan Services: You are **protected** by a Copay Maximum each year.* Once you reach this amount you will not have to pay Copays for certain In-Plan services for the remainder of the year. (This applies to all medical services with a Copay of $100 or more, including Copays for Durable Medical Equipment and Prosthetics.)	$1,000 per individual/$2,000 per family	Not applicable
Coinsurance Maximum per Year*	Not applicable	$1,000 per individual/$2,000 per family
* May be based on a Calendar Year or a Policy Year basis. This depends on the Group through which you enroll.		
Reduction of Benefit (Applies to certain services if Prior Approval is required but not requested.)	Not applicable	$500

Benefit	In-Plan Providers		Out-of-Plan Providers	
	Deductible Applies	**Copay**	**Deductible Applies**	**Coinsurance or Copay**
Inpatient Care				
Acute Hospital Care and Inpatient Rehabilitation † (elective admissions to Out-of-Plan facilities require Prior Approval)	Yes	$0	Yes	20% & up to $500 Reduction of Benefit
Skilled Nursing Facility † (limited to 100 days per Calendar Year; admissions to Out-of-Plan Facilites require Prior Approval)	Yes	$0	Yes	20% & up to $500 Reduction of Benefit
Outpatient Preventive Care				
Adult Routine Exams	No	$0	Yes	20%
Well Child Care	No	$0	Yes	20%
Routine Prenatal & Postpartum Care	No	$0	Yes	20%
Child and Adult Routine Immunizations	No	$0	Yes	20%
Routine Eye Exams (limited to one per Calendar Year)	No	$0	Yes	20%
Annual Gynecological Exams (limited to one per Calendar Year)	No	$0	Yes	20%
Routine Mammograms (routine mammograms limited to one per Calendar Year)	No	$0	Yes	20%
Preventive Screenings Listed under "Outpatient Preventive Care" in the *Covered Benefits* Section of the EOC	No	$0	Yes	20%
Other Outpatient Care				
Physician Office Visit (Deductible may apply to some In-Plan office services.)	No	$20/visit	Yes	20%
Second Opinions (Deductible may apply to some In-Plan office services.)	No	$20/visit	Yes	20%
Hearing Tests	Yes	$20/visit	Yes	20%
Diabetic-Related Items:				
Outpatient Services (Deductible may apply to some In-Plan office services.)	No	$20/visit	Yes	20%
Lab Services	No	$0	Yes	20%
Durable Medical Equipment (some DME requires Prior Approval)	No	20%	Yes	20% & if Prior Approval was required and not requested, up to $500 Reduction of Benefit
Individual Diabetic Education	No	$20/visit	Yes	20%
Group Diabetic Education	No	$20/visit	Yes	20%

Benefit	In-Plan Providers		Out-of-Plan Providers	
	Deductible Applies	**Copay**	**Deductible Applies**	**Coinsurance or Copay**
Autism Spectrum Disorder				
Services to diagnose ASD, This includes:				
• Neuropsychological evaluations †	No	$20/visit	Yes	Deductible + 20% & up to $500 Reduction of Benefit
• Genetic testing †	No	$0	Yes	Deductible + 20% & up to $500 Reduction of Benefit
• Other tests to diagnose ASD (some tests may require Prior Approval)	Depends on type of test as listed elsewhere in this chart (Lab Services, Diagnostic Imaging, Diagnostic Testing, etc.)	Copay amount depends on type of test as listed elsewhere in this chart (Lab Services, Diagnostic Imaging, Diagnostic Testing, etc.)	Yes	Deductible + 20%
Habilitative or Rehabilitative care (includes applied behavioral analysis (ABA)) †	No	$20/visit	Yes	Deductible + 20% & up to $500 Reduction of Benefit
Pharmacy care	Medical Deductible does not apply	Please see the Prescription Drug Rider to your EOC for details about your prescription coverage	Medical Deductible does not apply	Please see the Prescription Drug Rider to your EOC for details about your prescription coverage
Psychiatric care	No	$20/visit	Yes	Deductible + 20%
Psychological care	No	$20/visit	Yes	Deductible + 20%
Therapeutic care:				
• Services provided by licensed or certified speech therapists, occupational therapists, physical therapists	Yes	$20/visit/ treatment type	Yes	Deductible + 20%
• Services provided by licensed or certified social workers	No	$20/visit	Yes	Deductible + 20%
Emergency Room Care (Copay waived if admitted)	No	$150/visit	No	$150/visit
Diagnostic Testing	Yes	$0	Yes	20%

Benefit	In-Plan Providers		Out-of-Plan Providers	
	Deductible Applies	**Copay**	**Deductible Applies**	**Coinsurance or Copay**
Screening Colonoscopy or Sigmoidoscopy (limited to one every five Calendar Years; office visit Copay may apply if done in an In-Plan doctor's office; office visits prior to the procedure, related prep prescriptions and subsequent pathology are subject to applicable Deductible & Copays)	No	$0	Yes	20%
Sleep Study (maximum of two per Calendar Year)	Yes	$75 (one Copay per year; no Copay for home sleep studies)	Yes	20%
Lab Services	No	$0	Yes	20%
Genetic testing: BRCA and Colaris tests †	Yes	$75	Yes	20% & up to $500 Reduction of Benefit
Radiological Services: Ultrasound, X-rays, Non-Routine Mammograms	Yes	$0	Yes	20%
Diagnostic Imaging: CT Scans, MRIs, MRAs, PET Scans, Nuclear Cardiac Imaging † (Nuclear Cardiac Imaging requires Prior Approval only when done in a doctor's office)	Yes	$75 (maximum three Copays per year; if Prior Approval is denied, Member is responsible for all costs)	Yes	20% (without Prior Approval, Member pays all costs)
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	Yes	20%
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	Yes	20%
Early Intervention Services (Covered for children from birth to age 3.)	No	$0	Yes	20%
Outpatient Surgical Services and Procedures (some services require Prior Approval; office visit Copay may apply if done in an In-Plan doctor's office)	Yes	$0	Yes	20%
Allergy Testing and Treatment	No	$20/visit	Yes	20%
Allergy Injections	No	$0	Yes	20%
Family Planning Services				
Office Visit (Deductible may apply to some In-Plan office services)	No	$20/visit	Yes	20%

Benefit	In-Plan Providers		Out-of-Plan Providers	
	Deductible Applies	**Copay**	**Deductible Applies**	**Coinsurance or Copay**
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 In-Plan office services)	No	$20/visit	Yes	20% (if Prior Approval is required & not requested, Member pays all costs)
Outpatient Surgery/ Procedure	Yes	$0	Yes	20% (if Prior Approval, is required & not requested, Member pays all costs)
Lab Test	No	$0	Yes	20% (if Prior Approval, is required & not requested, Member pays all costs)
Inpatient Care †	Yes	$0	Yes	20% (without Prior Approval, Member pays all costs)
Maternity Care				
Non-Routine Prenatal and Postpartum Care	No	$20/visit	Yes	20%
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	Yes	20%
Dental Services				
Surgical Treatment of Non-Dental Conditions in a Doctor's Office (Deductible may apply to some In-Plan office services.)	No	$20/visit	Yes	20%
Emergency Dental Care in a Doctor's or Dentist's Office	No	$20/visit	Yes	20%
Emergency Dental Care in an Emergency Room	No	$150/visit	No	$150/visit

Benefit	In-Plan Providers		Out-of-Plan Providers	
	Deductible Applies	Copay	Deductible Applies	Coinsurance or Copay
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. This does not count towards your Deductible. 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	No	You pay the first $25 per child per Calendar Year
Other Services				
Home Health Care †	Yes	$0	Yes	20% & up to $500 Reduction of Benefit
Hospice Services †	No	$0	Yes	20% & up to $500 Reduction of Benefit
Durable Medical Equipment (some items require Prior Approval)	No	20%	Yes	20% & if Prior Approval was required & not requested, up to $500 Reduction of Benefit
Prosthetic Limbs †	No	20%	Yes	20% (without Prior Approval, Member pays all costs)
Ambulance and Transportation Services (non-emergency transportation requires Prior Approval; if Prior Approval is not obtained for non-emergency transportation, Member pays all costs)	Yes	$100/ Member/day	Yes	$100/Member/ day
Kidney Dialysis	No	$0	Yes	20%
Nutritional Support † (not covered without Prior Approval)	No	$0	No	$0
Cardiac Rehabilitation	Yes	$20/visit	Yes	20%
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	No	$0
Speech, Hearing, and Language Disorders † (Prior Approval is required for speech therapy services after the initial evaluation.)	Yes	$20/visit	Yes	20% & up to $500 Reduction of Benefit
Nutritional Counseling (limited to four vists per Calendar Year)	No	$0	Yes	20%

Benefit	In-Plan Providers		Out-of-Plan Providers	
	Deductible Applies	**Copay**	**Deductible Applies**	**Coinsurance or Copay**
Human Organ Transplants and Bone Marrow Transplants † (Without Prior Approval, payments you make to Out-of-Plan Providers for Deductible and Coinsurance do not count toward your Deductible or Maximum Coinsurance amounts.)	Yes	$0	Yes	20% & up to $500 Reduction of Benefit
Behavioral Health				
Outpatient Services (Includes Mental Health and Substance Abuse; Prior Approval is required for services from Out-of-Plan Providers after the 15th visit)	No	$20/visit	Yes	20%
Inpatient Services (Includes Mental Health and Substance Abuse)	Yes	$0	Yes	20% & up to $500 Reduction of Benefit