# 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 Allowed Amount.

**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 Policy 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 | |
| **In-Plan Out-of-Pocket Maximum:** The most you pay for cost sharing on Essential Health Benefits during a Policy Year before your plan begins to pay 100% of the Allowed Amount. | $5,000 per individual / $10,000 per family | Not Applicable |
| **Out-of-Plan Out-of-Pocket Maximum:** This is the most you will pay in a Policy Year for the combined cost of your Medical Deductible and Coinsurance for Covered Services from Out-of-Plan Providers. | Not Applicable | $6,000 per individual / $12,000 per family |
| **Reduction of Benefit:** Applies to certain services if Prior Approval is required but not requested. Does not count toward your Out-of-Pocket Maximum. | Not Applicable | $500 |

| Benefit | Your Cost<br>In-Plan Providers | Your Cost<br>Out-of-Plan Providers |
|---|---|---|
| **Inpatient Care** | | |
| Acute Hospital Care and Inpatient Rehabilitation † (elective admissions to Out-of-Plan facilities require Prior Approval) | $0 after Deductible | 20% Coinsurance after Deductible & up to $500 Reduction of Benefit |
| Skilled Nursing Facility † (limited to 100 days per Calendar Year; admissions to Out-of-Plan facilities require Prior Approval) | $0 after Deductible | 20% Coinsurance after Deductible & up to $500 Reduction of Benefit |
| **Preventive Care** | | |
| Adult Routine Exams | $0 | 20% Coinsurance after Deductible |
| Well Child Care | $0 | 20% Coinsurance after Deductible |
| Child and Adult Routine Immunizations | $0 | 20% Coinsurance after Deductible |
| Routine Prenatal & Postpartum Care | $0 | 20% Coinsurance after Deductible |
| Routine Eye Exams (limited to one per Calendar Year) | $0 | 20% Coinsurance after Deductible |
| Annual Gynecological Exams (limited to one per Calendar Year) | $0 | 20% Coinsurance after Deductible |
| Routine Mammograms (routine mammograms limited to one per Calendar Year) | $0 | 20% Coinsurance after Deductible |
| Screening Colonoscopy or Sigmoidoscopy (limited to one every five Calendar Years; office visits prior to the procedure, related prep prescriptions are subject to applicable Deductible & Copays) | $0 | 20% Coinsurance after Deductible |
| Nutritional Counseling (limited to four visits per Calendar Year) | $0 | 20% Coinsurance after Deductible |
| Preventive Screenings Listed under "Outpatient Preventive Care" in the *Covered Benefits* Section of the EOC | $0 | 20% Coinsurance after Deductible |
| **Outpatient Care** | | |
| Physician Office Visit (Deductible may apply to some In-Plan office services.) | $20 Copay per visit | 20% Coinsurance after Deductible |

| Benefit | Your Cost<br>In-Plan Providers | Your Cost<br>Out-of-Plan Providers |
|---|---|---|
| Second Opinions (Deductible may apply to some In-Plan office services.) | $20 Copay per visit | 20% Coinsurance after Deductible |
| Hearing Tests in Specialist Office or Outpatient Facility (other than routine screenings covered as part of your Annual Routine Exam) | $20 Copay per visit after Deductible | 20% Coinsurance after Deductible |
| Diabetic-Related Items: | | |
| Outpatient Services (Deductible may apply to some In-Plan office services.) | $20 Copay per visit | 20% Coinsurance after Deductible |
| Lab Services | $0 | 20% Coinsurance after Deductible |
| Durable Medical Equipment (some DME requires Prior Approval) | 20% Coinsurance | 20% Coinsurance after Deductible & up to $500 Reduction of Benefit |
| Individual Diabetic Education | $20 Copay per visit | 20% Coinsurance after Deductible |
| Group Diabetic Education | $20 Copay per visit | 20% Coinsurance after Deductible |
| Emergency Room Care (Copay waived if admitted) | $150 Copay per visit | $150 Copay per visit |
| Diagnostic Testing | $0 after Deductible | 20% Coinsurance after Deductible |
| Sleep Study (maximum of two per Calendar Year) | $75 Copay after Deductible<br>(one Copay per year; no Copay for home sleep studies) | 20% Coinsurance after Deductible |
| Lab Services | $0 | 20% Coinsurance after Deductible |
| Radiological Services: Ultrasound, X-rays, Non-Routine Mammograms | $0 after Deductible | 20% Coinsurance after Deductible |
| 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) | $75 Copay after Deductible (maximum three Copays per year) | 20% Coinsurance after Deductible; 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. This limit does not apply when services are provided to treat autism spectrum disorder.) | $20 Copay per visit per treatment type after Deductible | 20% Coinsurance after Deductible |

| Benefit | Your Cost<br>In-Plan Providers | Your Cost<br>Out-of-Plan Providers |
|---|---|---|
| Day Rehabilitation Program (limited to 15 full day or ½ day sessions per condition per lifetime) | $25 Copay after Deductible for 1 day or 1/2 day | 20% Coinsurance after Deductible |
| Early Intervention Services (Covered for children from birth to age 3.) | $0 | 20% Coinsurance after Deductible |
| Applied Behavioral Analysis (ABA) to treat Autism Spectrum Disorder † | $0 | 20% Coinsurance after Deductible & up to $500 Reduction of Benefit |
| Outpatient Surgical Services and Procedures (some services require Prior Approval; office visit Copay may apply if done in an In-Plan doctor's office) | $0 after Deductible | 20% Coinsurance after Deductible |
| Allergy Testing and Treatment | $20 Copay per visit | 20% Coinsurance after Deductible |
| Allergy Injections | $0 | 20% Coinsurance after Deductible |
| **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) | $20 Copay per visit | 20% Coinsurance after Deductible; without Prior Approval, Member pays all costs |
| Outpatient Surgery/ Procedure | $0 after Deductible | 20% Coinsurance after Deductible; without Prior Approval, Member pays all costs |
| Lab Test | $0 | 20% Coinsurance after Deductible; without Prior Approval, Member pays all costs |
| Inpatient Care † | $0 after Deductible | 20% Coinsurance after Deductible; without Prior Approval, Member pays all costs |
| **Maternity Care** | | |
| Non-Routine Prenatal and Postpartum Visit | $20 Copay per visit | 20% Coinsurance after Deductible |

| Benefit | Your Cost<br>In-Plan Providers | Your Cost<br>Out-of-Plan Providers |
|---|---|---|
| Delivery/Hospital Care for Mother and Child (Coverage for child limited to routine newborn nursery charges. For continued coverage, child must be enrolled within 30 days of date of birth) | $0 after Deductible | 20% Coinsurance after Deductible |
| **Dental Services** | | |
| Surgical Treatment of Non-Dental Conditions in a Doctor's Office (Deductible may apply to some In-Plan office services.) | $20 Copay after Deductible | 20% Coinsurance after Deductible |
| Emergency Dental Care in a Doctor's or Dentist's Office | $20 Copay per visit | 20% Coinsurance after Deductible |
| Emergency Dental Care in an Emergency Room | $150 Copay per visit | $150 Copay per visit |
| Pediatric Dental services for children under age 19. ($50 deducible for non-preventive services.) | $0 preventive; 25-50% other services | 20% preventive: 45-70% other services |
| **Other Services** | | |
| Home Health Care † | $0 after Deductible | 20% Coinsurance after Deductible & up to $500 Reduction of Benefit |
| Hospice Services † | $0 | 20% Coinsurance after Deductible & up to $500 Reduction of Benefit |
| Durable Medical Equipment (some items require Prior Approval) | 20% Coinsurance | 20% Coinsurance after Deductible & up to $500 Reduction of Benefit |
| Prosthetic Limbs † | 20% Coinsurance | 20% Coinsurance after Deductible; withour 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) | $100 Copay per day after Deductible | $100 Copay per day after Deductible |
| Kidney Dialysis | $0 | 20% Coinsurance after Deductible |
| Nutritional Support † (not covered without Prior Approval) | $0 | $0 |
| Cardiac Rehabilitation | $20 Copay per visit after Deductible | 20% Coinsurance after Deductible |

| Benefit | Your Cost<br>In-Plan Providers | Your Cost<br>Out-of-Plan Providers |
|---|---|---|
| Wigs (Scalp Hair Prostheses) for hair loss due to treatment of any form of cancer or leukemia. (HNE covers 1 prosthesis per Calendar Year) | 20% Coinsurance | 20% Coinsurance |
| Speech, Hearing, and Language Disorders † (Prior Approval is required for speech therapy services after the initial evaluation.) | $20 Copay per visit after Deductible | 20% Coinsurance after Deductible & up to $500 Reduction of Benefit |
| Hearing Aids† (Covered with Prior Approval for Members age 21 and under. HNE covers the cost of one hearing aid per hearing impaired ear, every 36 months, up to a maximum of $2,000 for each hearing aid.) | $0 up to $2,000 per device per ear (you are responsible for all costs beyond maximum) | 20% Coinsurance after Deductible; up to $2,000 per device per ear (you are responsible for all costs beyond maximum). Without Prior Approval Member pays all costs. |
| 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.) | $0 after Deductible | 20% Coinsurance after Deductible & up to $500 Reduction of Benefit |
| **Wellness Services** | | |
| Acupuncture & Massage Therapy (Limited to a **total** of three visits per Calendar Year **per family**. For example, you may have three visits for acupuncture **or** three visits for massage **or** one visit for acupuncture and two visits for massage **or** two visits for acupuncture and one visit for massage.) | $0 up to 3 visits per family | $0 up to 3 visits per family |
| **Behavioral Health** (Includes Mental Health and Substance Abuse) | | |
| Outpatient Services | $20 Copay per visit | 20% Coinsurance after Deductible |
| Inpatient Services | $0 after Deductible | 20% Coinsurance after Deductible & up to $500 Reduction of Benefit |