HNE PPO Wise – HDHP
High Deductible Health Plan 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 HNE and PHCS	Out-of-Plan Providers
Combined Medical/ Pharmacy Deductible per Policy 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. If your plan includes prescription drug coverage, your prescriptions are subject to this Deductible. This amount is a combined amount for In-Plan & Out-of-Plan Providers.	\$2,000 per individual / \$4,000 per family *Once any individual on a family plan has paid \$2,500 towards the family Deductible, the plan will begin to pay benefits for that individual.*	
In-Plan Out-of-Pocket Maximum: This is the most you will pay for cost sharing on Essential Health Benefits during a Policy Year. This is a combined amount for HNE & PHCS Providers.	\$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/ Pharmacy Deductible amount applied to Out-of-Plan services, plus Copays 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. Does not count toward your Out-of-Pocket Maximum.	\$1,000 (Does not apply to HNE Providers)	\$1,000

Benefit	Your Cost In-Plan Providers HNE and PHCS	Your Cost 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; and for PHCS providers up to $1,000 Reduction of Beneift	20% Coinsurance after Deductible & up to $1,000 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; and for PHCS providers up to $1,000 Reduction of Beneift	20% Coinsurance after Deductible & up to $1,000 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 (maximum of 4 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 (Non-Routine)	$0 after Deductible	20% Coinsurance after Deductible
Second Opinions	$0 after Deductible	20% Coinsurance after Deductible

Benefit	Your Cost In-Plan Providers HNE and PHCS	Your Cost Out-of-Plan Providers
Hearing Tests in Specialist Office or Outpatient Facility (other than routine screenings covered as part of your Annual Routine Exam)	$0 after Deductible	20% Coinsurance after Deductible
Diabetic-Related Items:		
Outpatient Services	$0 after Deductible	20% Coinsurance after Deductible
Lab Services	$0 after Deductible	20% Coinsurance after Deductible
Durable Medical Equipment (some DME requires Prior Approval)	$0 after Deductible	20% Coinsurance after Deductible
Individual Diabetic Education	$0 after Deductible	20% Coinsurance after Deductible
Group Diabetic Education	$0 after Deductible	20% Coinsurance after Deductible
Emergency Room Care (Copay waived if admitted)	$0 after Deductible	$0 after Deductible
Diagnostic Testing	$0 after Deductible	20% Coinsurance after Deductible
Sleep Study (maximum of two per Calendar Year)	$0 after Deductible	20% Coinsurance after Deductible
Lab Services	$0 after Deductible	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)	$0 after Deductible; and for PHCS providers without Prior Approval, Member pays all costs	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. The limit does not apply when services are provided to treat autism spectrum disorder.)	$0 after Deductible	20% Coinsurance after Deductible
Day Rehabilitation Program (limited to 15 full day or ½ day sessions per condition per lifetime)	$0 after Deductible	20% Coinsurance after Deductible

Benefit	Your Cost In-Plan Providers HNE and PHCS	Your Cost Out-of-Plan Providers
Early Intervention Services (Covered for children from birth to age 3.)	$0 after Deductible	20% Coinsurance after Deductible
Applied Behavioral Analysis (ABA) to treat Autism Spectrum Disorder †	$0 after Deductible; and for PHCS providers up to $1,000 Reduction of Benefit	20% Coinsurance after Deductible & up to $1,000 Reduction of Benefit
Outpatient Surgical Services and Procedures (some services require Prior Approval)	$0 after Deductible	20% Coinsurance after Deductible
Allergy Testing and Treatment	$0 after Deductible	20% Coinsurance after Deductible
Allergy Injections	$0 after Deductible	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	$0 after Deductible; and for PHCS providers without Prior Approval Member pays all costs	20% Coinsurance after Deductible; without Prior Approval, Member pays all costs
Outpatient Surgery/ Procedure	$0 after Deductible; and for PHCS providers without Prior Approval Member pays all costs	20% Coinsurance after Deductible; without Prior Approval, Member pays all costs
Lab Test	$0 after Deductible; and for PHCS providers without Prior Approval Member pays all costs	20% Coinsurance after Deductible; without Prior Approval, Member pays all costs
Inpatient Care †	$0 after Deductible; and for PHCS providers without Prior Approval Member pays all costs	20% Coinsurance after Deductible; without Prior Approval, Member pays all costs
Maternity Care		
Non-Routine Prenatal and Postpartum Visit	$0 after Deductible	20% Coinsurance after Deductible
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

Benefit	Your Cost In-Plan Providers HNE and PHCS	Your Cost Out-of-Plan Providers
Dental Services		
Surgical Treatment of Non-Dental Conditions in a Doctor's Office	$0 after Deductible	20% Coinsurance after Deductible
Emergency Dental Care in a Doctor's or Dentist's Office	$0 after Deductible	20% Coinsurance after Deductible
Emergency Dental Care in an Emergency Room	$0 after Deductible	$0 after Deductible
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; and for PHCS providers up to $1,000 Reduction of Benefit	20% Coinsurance after Deductible & up to $1,000 Reduction of Benefit
Hospice Services †	$0 after Deductible and for PHCS providers up to $1,000 Reduction of Benefit	20% Coinsurance after Deductible & up to $1,000 Reduction of Benefit
Durable Medical Equipment (some items require Prior Approval)	$0 after Deductible; and for PHCS providers up to $1,000 Reduction of Benefit	20% Coinsurance after Deductible & up to $1,000 Reduction of Benefit
Prosthetic Limbs †	$0 after Deductible; and for PHCS providers without Prior Approval Member pays all costs	20% Coinsurance after Deductible 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)	$0 after Deductible	$0 after Deductible
Kidney Dialysis	$0 after Deductible	20% Coinsurance after Deductible
Nutritional Support † (not covered without Prior Approval)	$0 after Deductible	20% Coinsurance after Deductible
Cardiac Rehabilitation	$0 after Deductible	20% Coinsurance after Deductible
Wigs (Scalp Hair Prostheses) for hair loss due to treatment of any form of cancer or leukemia. (HNE covers 1 prosthesis per Calendar Year)	$0 after Deductible	20% Coinsurance after Deductible

Benefit	Your Cost In-Plan Providers HNE and PHCS	Your Cost Out-of-Plan Providers
Speech, Hearing, and Language Disorders † (Prior Approval is required for speech therapy services after the initial evaluation.)	$0 after Deductible; and for PHCS providers up to $1,000 Reduction of Benefit	20% Coinsurance after Deductible & up to $1,000 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 after Deductible up to $2,000 per device per ear (you are responsible for all costs beyond maximum); and for PHCS providers without Prior Approval Member pays all costs	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; and for PHCS providers up to $1,000 Reduction of Benefit	20% Coinsurance after Deductible & up to $1,000 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 after Deductible up to 3 visits per family	$0 after Deductible up to 3 visits per family
Behavioral Health (Includes Mental Health and Substance Abuse)		
Outpatient Services	$0 after Deductible	20% Coinsurance after Deductible
Inpatient Services	$0 after Deductible; and for PHCS providers up to $1,000 Reduction of Benefit	20% Coinsurance after Deductible & up to $1,000 Reduction of Benefit