

### HMO 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.

Please Note: Some services may require prior approval from HNE. See your member agreement for a list of services that require prior approval.

	Single Plan	Family Plan
<p><b>Deductible per Year †</b> 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. This deductible will be applied to most services provided at (or billed through) a facility.</p>	<p><b>\$500 per individual</b></p>	<p><b>\$500 per individual \$1,000 per family</b> (Once any individual on a family plan has met the individual deductible, the plan will begin to pay benefits for that individual.)</p>
<p><b>Out-of-Pocket Maximum per Year †</b> The Out-of-Pocket Maximum includes your deductible and all medical services with a copayment of \$100 or more (including the coinsurance for Durable Medical Equipment (DME)* and Prosthetics). Once you have met the Out-of-Pocket Maximum, you will not have to pay copayments for those services for the remainder of the year.</p> <p>*DME coverage is limited to \$3,000 per calendar year. Once you reach this limit, you must pay 100% of the cost for DME items. Amounts you pay once you have reached your benefit limit do not apply to the Out-of-Pocket Maximum.</p>	<p><b>\$2,000 per individual \$4,000 per family</b></p>	

† May be applied on a Calendar Year basis or a Policy Year basis. This depends on the group through which you enroll.

BENEFIT	Deductible Applies	Copayment
<b>Inpatient Care</b> <ul style="list-style-type: none"> <li>• Acute Hospital Care</li> <li>• Acute Inpatient Rehabilitation</li> <li>• Skilled Nursing Facility <i>(100 day calendar year maximum)</i></li> <li>• Infertility Services</li> <li>• Maternity Care</li> <li>• Mental Health Services <i>(care for some conditions may be limited to 60 days per calendar year maximum)</i></li> <li>• Substance Abuse Services</li> </ul>	Yes	\$0/admission
<b>Outpatient Preventive Care</b>	No	\$0
<b>Other Outpatient Care</b>		
PCP Office Visits <i>(non-routine)</i> <i>(Deductible may apply to some office services.)</i>	No	\$20/visit
Specialist Office Visits <i>(Deductible may apply to some office services.)</i>	No	\$20/visit
Routine Eye Exams <i>(one per calendar year)</i>	No	\$0/visit
Individual Diabetic Education	No	\$20/visit
Group Diabetic Education	No	\$20/session
Emergency Room Care <i>(copayment waived if admitted directly from ER)</i>	No	\$100/visit
Laboratory Services	No	\$0
Radiological Services: Ultrasound, X-rays, Nuclear Cardiology, Mammograms <i>(after first mammogram in each calendar year)</i>	Yes	\$0
Diagnostic Imaging: CT Scans, MRIs, MRAs, PET Scans	Yes	\$0
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	\$20/visit/treatment type
Day Rehabilitation Program <i>(limited to 15 full day or half day sessions per condition per lifetime)</i>	Yes	\$25/day or half day
Early Intervention Services <i>(Covered for children from birth to age 3)</i>	No	\$20/visit
Outpatient Surgical Services and Procedures	Yes	\$0/visit

BENEFIT	Deductible Applies	Copayment
<b>Family Planning Services and Infertility Treatment</b> <i>(Some services are covered only for Massachusetts residents and for Connecticut residents under the age of 40.)</i>	Some Assisted Reproductive Services consist of outpatient surgery procedures; certain surgical procedures are subject to the outpatient surgical services and procedures copayment.	
Office Visit <i>(Deductible may apply to some office services.)</i>	No	\$20/visit
Laboratory Tests	No	\$0
Inpatient Care	Yes	\$0/admission
Outpatient Surgical Services and Procedures	Yes	\$0/visit
<b>Children's Preventive Dental</b> <i>(limited to preventive services for children under age 12)</i> 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 for services from a dentist participating with HNE's contracted dental network
<b>Other Services</b>		
Home Health Care	Yes	\$0/visit
Hospice Services	No	\$0/visit
Durable Medical Equipment, including ostomy supplies <i>(limited to \$3,000 per calendar year)</i>	No	20%
Prosthetic Limbs	No	20%
Ambulance and Chair Van Services	Yes	\$100/member/day
Nutritional Counseling <i>(limited to 4 visits per calendar year)</i>	No	\$20/visit
Human Organ Transplants and Bone Marrow Transplants	Yes	\$0/admission
Outpatient Mental Health and Substance Abuse Services	No	\$20/visit