



**HMO Wise Max 2000 HDHP LG
HMO Benefit Chart**

This chart provides a summary of key services offered by your plan. Your Member Agreement has a full description of your plan’s benefits and provisions.

- **Note about Prior Approval:**
Some services may require prior approval. These services are marked with † in the chart. If you do not obtain Prior Approval, benefits may be denied.

	In-Plan
Combined Medical/Pharmacy 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. If your plan includes prescription drug coverage, your prescriptions are subject to this Deductible.)	\$2,000 per individual / \$4,000 per family**
SAFETY NET: You are PROTECTED by an Out-of-Pocket Maximum each year.* (This is the most you pay for cost sharing each year before your plan begins to pay 100% of the allowed amount. Your Copays for prescription drugs are included in this Maximum.)	\$5,000 per individual / \$10,000 per family
* May be based on a Calendar Year or a Plan Year. This depends on the Group through which you enroll.	
** Once any individual on a family plan has paid \$2,800 towards the family deductible, the plan will begin to pay benefits for that individual.	

Benefit	Your Cost
Inpatient Care	
Acute Hospital Care	\$0 after Deductible
Skilled Nursing Facility† (limited to 100 days per Calendar Year)	\$0 after Deductible
Inpatient Rehabilitation† (limited to 60 days per Calendar Year)	\$0 after Deductible
Outpatient Preventive Care	
Adult Routine Exams	\$0
Well Child Care	\$0
Child and Adult Routine Immunizations	\$0
Routine Prenatal and Postpartum Care	\$0
Routine Eye Exams (limited to one per Calendar Year)	\$0
Annual Gynecological Exams (limited to one per Calendar Year)	\$0
Routine Mammograms (routine mammograms limited to one per Calendar Year)	\$0
Screening Colonoscopy or Sigmoidoscopy (limited to one every five Calendar Years)	\$0
Preventive Screenings Listed under "Outpatient Preventive Care" in the <i>Covered Benefits</i> Section of the EOC	\$0

Benefit	Your Cost
Nutritional Counseling (limited to four visits per Calendar Year)	\$0
Other Outpatient Care	
PCP Office Visit (Non-Routine)	\$0 after Deductible
Specialist Office Visits	\$0 after Deductible
Second Opinions	\$0 after Deductible
Telephone and video consultations with internists, family practitioners, and pediatricians for non-emergency medical conditions through Teladoc	\$0 after Deductible
Hearing Tests in a Specialist Office or Facility (other than routine screenings covered as part of your annual Routine Exam)	\$0 after Deductible
Diabetic-Related Items:	
• Outpatient Services	\$0 after Deductible
• Lab Services	\$0 after Deductible
• Durable Medical Equipment†	\$0 after Deductible
• Individual Diabetic Education	\$0 after Deductible
• Group Diabetic Education	\$0 after Deductible
Emergency Room Care (Copay waived if admitted)	\$0 after Deductible
Diagnostic Testing	\$0 after Deductible
Sleep Study†	\$0 after Deductible
Lab Services	\$0 after Deductible
Radiological Services: Ultrasound, X-rays, Non-Routine Mammograms	\$0 after Deductible
Diagnostic Imaging: CT Scans, MRIs, MRAs, PET Scans, Nuclear Cardiac Imaging	\$0 after Deductible
Outpatient Short-Term Rehabilitation Services (Limited to 60 visits 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
Day Rehabilitation Program (limited to 15 full or half day sessions per condition per lifetime)	\$0 after Deductible
Early Intervention Services (Covered for children from birth to age 3.)	\$0 after Deductible
Applied Behavioral Analysis (ABA) to treat Autism Spectrum Disorder†	\$0 after Deductible
Surgical Services and Procedures in an Outpatient Facility† (Some services require Prior Approval)	\$0 after Deductible
Allergy Testing and Treatment	\$0 after Deductible
Allergy Injections	\$0 after Deductible
Family Planning Services	
Office Visit	\$0 after Deductible
Infertility Services	
Some Infertility services are covered only for Massachusetts and Connecticut residents. Some services require Prior Approval.	

Benefit	Your Cost
Office Visit	\$0 after Deductible
Outpatient Surgery/ Procedure	\$0 after Deductible
Lab Test	\$0 after Deductible
Inpatient Care†	\$0 after Deductible
Maternity Care	
Non-Routine Prenatal and Postpartum Care	\$0 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
Dental Services	
Surgical Treatment of Non-Dental Conditions in a Doctor's Office	\$0 after Deductible
Emergency Dental Care in a Doctor's or Dentist's Office	\$0 after Deductible
Emergency Dental Care in an Emergency Room	\$0 after Deductible
Other Services	
Home Health Care †	\$0 after Deductible
Hospice Services †	\$0 after Deductible
Durable Medical Equipment†	\$0 after Deductible
Prosthetic Limbs†	\$0 after Deductible
Ambulance and Transportation Services (non-emergency transportation requires Prior Approval)	\$0 after Deductible
Kidney Dialysis	\$0 after Deductible
Nutritional Support †	\$0 after Deductible
Cardiac Rehabilitation	\$0 after Deductible
Wigs (Scalp Hair Protheses) for hair loss due to treatment of any form of cancer or leukemia. † (HNE covers one prosthesis per Calendar Year)	\$0 after Deductible
Speech, Hearing, and Language Disorders † (Prior Approval is required for speech therapy services after the initial evaluation.)	\$0 after Deductible
Hearing Aids† (Covered 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 over maximum) after Deductible
Human Organ Transplants and Bone Marrow Transplants †	\$0 after Deductible
Behavioral Health (Includes Mental Health and Substance Abuse)	
Inpatient Services†	\$0 after Deductible
Telephone and video consultations for non-emergency behavioral health issues and substance use disorder issues through Teladoc®	\$0 after Deductible
Outpatient Services† (some services require Prior Approval)	\$0 after Deductible

Prescription Drugs

(Certain drugs require Prior Approval. Prescription drugs are subject to the combined Medical/Pharmacy deductible for this plan.)

Your Prescription Benefit is based on the Health New England Formulary. Please call Member Services or visit healthnewengland.org for a copy of the Health New England Formulary.

Benefit	Your Cost
At an In-Plan Pharmacy (up to a 30-day supply)	
Generic Drugs	\$10
Formulary Drugs	\$25
Non-Formulary Drugs	\$45
Through Mail Order: (up to a 90-day supply of maintenance medication)	
Generic Drugs	\$20
Formulary Drugs	\$50
Non-Formulary Drugs	\$135

Chiropractic Benefit

(Chiropractic services are subject to your plan deductible)

Benefit	Your Cost
limited to 12 visits per calendar year	\$0 after deductible