HNE PHARMACY RIDERS

PRESCRIPTION DRUGS (Listed as Generic/Formulary/Non-Formulary Drugs)

NOTE: *If you already have a rate proposal, the rate is based on the Pharmacy Rider selected when the proposal was generated. Please check your rate proposal for the Pharmacy Rider listed.*

HMO				
Deductible then: $10/$25/$45 Mail Order $20/$50/$135	Deductible then: $10/$30/$60 Mail Order $20/$60/$180	$10/$25/$45 Mail Order $20/$50/$135	$10/$30/$60 Mail Order $20/$60/$180	PERFORMANCE FORMULARY $10/$30 Mail Order $25/$75
HDHP ONLY *Prescription drugs are subject to the combined Medical/Pharmacy deductible for* HNE Wise[Plus] *and* HNE Wise[Max].				

PPO			
Deductible then: $10/$25/$45 Mail Order $20/$50/$135 Out-of-Plan Retail Only Copay + 20%	Deductible then: $10/$30/$60 Mail Order $20/$60/$180 Out-of-Plan Retail Only Copay + 20%	$10/$25/$45 Mail Order $20/$50/$135 Out-of-Plan Retail Only Copay + 20%	$10/$30/$60 Mail Order $20/$60/$180 Out-of-Plan Retail Only Copay + 20%
HDHP ONLY *Prescription drugs are subject to the combined Medical/Pharmacy deductible for HNE PPO Wise.*			

Copayments for prescriptions filled at a Plan Pharmacy reflect up to a 30-day supply. Copayments for prescriptions filled through mail order reflect up to a 90-day supply of maintenance medication. Please Call Member Services or visit hne.com for a copy of the HNE Formulary.

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1/01/10/BD/IKON

HNE PLAN COMPARISON

Employer Groups and Intermediaries

HNE HEALTH NEW ENGLAND

Plan Comparison Chart

Effective 1/01/10

Plans	Basic HMO					Value HMO				Premium HMO	Preferred Provider Organization (PPO)			
											HNE PPO Focus*		HNE PPO Complete*	
	HNE Wise[Plus] HDHP M HMO	HNE Wise[Max] HDHP H HMO	HNE Essential[1500]	HNE Essential[1000]	HNE Essential[500]	HNE Focus Option 8H	HNE Choice[Plus] Option 7M	HNE Complete[Max] Option 5	HNE Complete[Plus] Option 7H	HNE Principle Option 4	In-Plan	Out-of-Plan	In-Plan	Out-of-Plan
Up-front Deductible	$2,000 per Individual $4,000 per Family *per policy* ***or*** *calendar year*	$2,000 per Individual $4,000 per Family *per policy* ***or*** *calendar year*	$1,500 per Individual $3,000 per Family *per policy* ***or*** *calendar year*	$1,000 per Individual $2,000 per Family *per policy* ***or*** *calendar year*	$500 per Individual $1,000 per Family *per policy* ***or*** *calendar year*	N/A	N/A	N/A	N/A	N/A	N/A	$1,000 per Individual $2,000 per Family *per calendar year*	N/A	$1,000 per Individual $2,000 per Family *per calendar year*
Doctor's Office	$0 Preventive Services $25 after deductible for all other office visits	$0 Preventive Services $0 after deductible for all other office visits	$0 Preventive Services $20 All other office visits	$0 Preventive Services $20 All other office visits	$0 Preventive Services $20 All other office visits	$0 Preventive Services $25 All other office visits	$0 Preventive Services $20 PCP $40 Specialist	$0 Preventive Services $20 All other office visits	$0 Preventive Services $10 PCP $25 Specialist	$0 Preventive Services $15 All other office visits	$0 Preventive Services $25 All other office visits	20% after deductible	$0 Preventive Services $20 All other office visits	20% after deductible
Emergency *(Waived if admitted directly from ER)*	$75 after deductible	$0 after deductible	$100 per visit	$100 per visit	$100 per visit	$100 per visit	$75 per visit	$50 per visit	$50 per visit	$50 per visit	$100 per visit	$100 per visit	$50 per visit	$50 per visit
Diagnostic Imaging: *CT Scans, MRI, PET Scans*	$0 after deductible	$0 after deductible	$0 after deductible	$0 after deductible	$0 after deductible	$150	$0	$0	$0	$0	$100 per visit	20% after deductible	$0	20% after deductible
Outpatient Surgical	$250 after deductible	$0 after deductible	$0 after deductible	$0 after deductible	$0 after deductible	$500	$250	$250	$250	$150	$500	20% after deductible	$250	20% after deductible
Hospital Stay	$500 after deductible	$0 after deductible	$0 after deductible	$0 after deductible	$0 after deductible	$1,000	$500	$500	$500	$250	$1,000	20% after deductible	$500	20% after deductible
Out-of-Pocket Maximum	$5,000 per Individual $10,000 per Family	$5,000 per Individual $10,000 per Family	$3,000 per Individual $6,000 per Family	$2,000 per Individual $4,000 per Family	$2,000 per Individual $4,000 per Family	$2,000 per Individual $4,000 per Family	$1,000 per Individual $2,000 per Family	$1,000 per Individual $2,000 per Family	$1,000 per Individual $2,000 per Family	$500 per Individual $1,000 per Family	$2,000 per Individual $4,000 per Family	$4,000 per Individual $8,000 per Family	$1,000 per Individual $2,000 per Family	$3,000 per Individual $6,000 per Family
Out-of-Pocket Includes:	Deductible and copayments	Deductible and copayments	Deductible and services with a copayment of $100 or greater	Deductible and services with a copayment of $100 or greater	Deductible and services with a copayment of $100 or greater	Services with a copayment of $100 or greater	Services with a copayment of $250 or greater	Services with a copayment of $250 or greater	Services with a copayment of $250 or greater	Services with a copayment of $150 or greater	Services with a copayment of $100 or greater	Deductible and 20% coinsurance	Services with a copayment of $250 or greater	Deductible and 20% coinsurance
Prescription Drugs	*Pharmacy Riders are available for all Plans. The back of this brochure lists these Riders.*										* *HNE offers a PHCS PPO version of these plans. PHCS is a national PPO network of over 450,000 providers and 4,000 facilities to choose from.*			