

K8, 3/04

**Schedule of Benefits**  
**The Harvard Pilgrim Health Care of New England HMO**  
**New Hampshire**

Services listed below are covered when Medically Necessary and provided or arranged by Harvard Pilgrim Health Care of New England providers.  
Please see your *Benefit Handbook* for details.

**Inpatient Acute Hospital Services (including Day Surgery)**

- Coronary care
- Hospital services
- Intensive care
- Physicians' and surgeons' services including consultation
- Semi-private room and board

Covered in full.

**Hospital Outpatient Department Services**

- Anesthesia services
- Chemotherapy
- Endoscopic procedures
- Laboratory tests and x-rays
- Physicians' and surgeons' services
- Radiation therapy

Covered in full.

**Physician Services**

- Administration of injections
- Allergy tests and treatments
- Changes and removals of casts, dressings or sutures
- Chemotherapy
- Diabetes self-management, including education and training
- Diagnostic screening and tests, including blood tests, lead screenings and screenings mandated by state law
- Family planning services
- Health education including nutritional counseling
- Medical treatment of temporomandibular joint dysfunction (TMD)
- Preventive care including routine physical examinations, immunizations, annual eye examinations, school, camp, sports and premarital examinations
- Sick and well office visits, including medication management
- Vision and hearing screenings

\$5 Copayment per visit. (Please note: diagnostic tests, x-rays, and immunizations will be covered in full if billed without an office visit and no other services are provided.)

- Administration of allergy injections

\$5 Copayment per visit.

---

### **Maternity Services**

- Prenatal and postpartum care

Covered in full.

- All hospital services for mother and routine nursery charges for newborn

Covered in full.

---

### **Mental Health and Drug and Alcohol Rehabilitation Services**

Please note that no day or visit limits apply to inpatient or outpatient mental health treatment for Serious Mental Illnesses as described in your *Benefit Handbook*.

- Inpatient mental health services in a licensed general hospital - unlimited
- Inpatient mental health services in a psychiatric hospital - up to 30 per calendar year<sup>1</sup>
- Inpatient drug and alcohol rehabilitation services - up to 30 days per calendar year<sup>1</sup>
- Inpatient detoxification

Covered in full.

- Outpatient mental health services

Covered up to 20 visits per Member per calendar year

Individual therapy: \$5 Copayment per visit.

Group therapy: \$5 Copayment per visit.

- Outpatient drug and alcohol rehabilitation services

Covered up to 20 visits per Member per calendar year

Individual therapy: \$5 Copayment per visit.

Group therapy: \$5 Copayment per visit.

- Outpatient detoxification

\$5 Copayment per visit.

- Psychological testing

\$5 Copayment per visit.

---

### **Home Health Care Services**

- Home care services
- Intermittent skilled nursing care

Covered in full.

No cost sharing or benefit limit applies to durable medical equipment, physical therapy, occupational therapy or speech therapy received as part of authorized home health care.

---



---

<sup>1</sup> Partial hospitalization services are available up to a maximum of 60 days per calendar year in place of inpatient mental health services. Partial hospitalization services are available up to a maximum of 60 days per calendar year in place of inpatient drug and alcohol rehabilitation services.

---

**Dental Services**

- Preventive care for children through the age of 12. Two visits per Member per calendar year, including examination, cleaning, x-rays and fluoride treatment

Covered in full.

- Extraction of unerupted teeth impacted in bone
- Initial emergency treatment (within 72 hours of injury)

\$5 Copayment per visit. If inpatient services are required, please see “Inpatient Acute Hospital Services” for cost sharing.

---

**Emergency Services**

- Members are required to call their Primary Care Physician before using hospital emergency room services except when the Member is in a Serious Medical Emergency or is outside the Service Area when emergency care is required. The Service Area is the state in which you live.

\$50 Copayment per visit in the emergency room. This Copayment is waived if admitted directly to the hospital from the emergency room. See “Physician Services” for coverage of emergency services by a physician in any other location.

---

**Skilled Nursing Facility Care Services**

- Covered up to 100 days per calendar year

Covered in full.

---

**Inpatient Rehabilitation Services**

- Covered up to 60 days per calendar year

Covered in full.

---

**Diabetes Equipment and Supplies**

- Therapeutic molded shoes and inserts, dosage gauges, injectors, lancet devices, voice synthesizers and visual magnifying aids

Subject to the applicable cost sharing, if any, under the durable medical and prosthetic equipment benefit.

- Blood glucose monitors, insulin pumps and supplies and infusion devices

Covered in full.

- Insulin, insulin syringes, insulin pens with insulin, lancets, oral agents for controlling blood sugar, blood test strips, and glucose, ketone and urine test strips.

Subject to the applicable prescription drug Copayment listed on your ID card, if your Employer Group has selected prescription drug coverage. If prescription drug coverage is not available, then you will pay a \$5 Copayment for Generic items, \$10 Copayment for Select Brand items and a \$25 Copayment for Non-Select Brand items.

---

---

### **Durable Medical and Prosthetic Equipment**

Durable medical and prosthetic equipment (other than prosthetic arms and legs) - up to a maximum of \$5,000 per calendar year for all covered equipment. Coverage includes, but is not limited to:

- Durable medical equipment
- Prosthetic devices
- Ostomy supplies
- Oxygen and respiratory equipment (no benefit limit or cost sharing, if any, applies)
- Wigs, as described in the *Benefit Handbook*

20% Coinsurance. There is no coverage after the \$5,000 in equipment cost have been paid, including Member Coinsurance.

---

### **Prosthetic Arms and Legs**

20% Coinsurance. No benefit limit applies.

---

### **Other Health Services**

- Ambulance services
- Low protein foods (\$1,800 per Member per calendar year)
- Special formulas as described in the *Benefit Handbook*

Covered in full.

- House calls

\$15 Copayment per visit.

- Cardiac rehabilitation
- Chiropractic care - up to 12 visits per calendar year
- Physical, speech and occupational therapies - combined up to 40 visits per calendar year
- Dialysis

\$5 Copayment per visit.

- Hospice services

Covered in full. If inpatient services are required, please see "Inpatient Acute Hospital Services" for cost sharing.

- Infertility services - limited to consultation, evaluation and therapeutic donor insemination

\$5 Copayment per visit.

- Vision hardware for special conditions

Covered in full up to the applicable benefit limits as described in the *Benefit Handbook*.

---

### **Special Enrollment Rights**

If an employee declines enrollment for the employee and his or her dependents (including his or her spouse) because of other health insurance coverage, the employee may be able to enroll in this Plan in the future along with his or her dependents, provided that enrollment is requested within 30 days after other coverage ends. In addition, if the employee has a new dependent as a result of marriage, birth, adoption or placement for adoption, the employee may be able to enroll along with his or her dependents, provided that enrollment is requested within 30 days after the marriage, birth, adoption or placement for adoption.

---

**Membership Requirements**

There are a few important requirements that you must meet in order to be covered by the Plan.

- Members must live in the HPHC-NE's Enrollment Area for at least six months of the year. An exception is made for full-time student dependents and dependents enrolled under a Qualified Medical Support Order.
- All your medical and health care needs must be provided or arranged by your Primary Care Physician (PCP), except in a Serious Medical Emergency, when you are temporarily outside the HPHC-NE Service Area or when you need one of the special services which do not require a referral. The HPHC-NE Service Area is the state in which you live.

**Exclusions**

Your Plan does not cover the following:

- services your PCP or an HPHC-NE Provider has not provided, arranged, or approved except: (1) in a Serious Medical Emergency, (2) when you are outside of the Service Area, or (3) the special services that do not require a referral listed in your *Benefit Handbook*
- cosmetic procedures, except as described in your *Benefit Handbook*
- commercial diet plans or weight loss programs
- transsexual surgery, including related procedures
- dental services including periodontal, restorative, orthodontic, endodontic, prosthodontic, and treatment for temporomandibular joint dysfunction (TMD)
- procedures which are experimental or unproven
- eyeglasses, contact lenses, and fittings, unless your employer has purchased the VisionCare Rider
- refractive eye surgery
- transportation other than by ambulance
- costs for any services for which you are entitled to treatment at government expense, including military service connected disabilities
- costs for services covered by workers' compensation, third party liability, other insurance coverage, or an employer under state or federal law
- hair removal or restoration, including, but not limited to, electrolysis, laser treatment, transplantation or drug therapy
- routine foot care, biofeedback, pain management programs, massage therapy, acupuncture, alternative medicine, and sports medicine clinics
- educational services (including problems of school performance) or testing for developmental, educational or behavioral problems
- sensory integrative praxis tests
- testing of central auditory processing
- physical examinations for insurance, licensing, or employment
- vocational rehabilitation, or vocational evaluations on job adaptability, job placement, or therapy to restore function for a specific occupation
- rest or custodial care
- personal comfort or convenience items
- non-durable medical equipment, unless used as part of the treatment at a medical facility or as part of approved home health care services

- any home adaptation equipment
- reversal of voluntary sterilization (including procedures necessary for conception as a result of voluntary sterilization)
- any form of surrogacy
- infertility treatment for Members who are not medically infertile
- routine maternity care when you are traveling outside the Service Area
- delivery outside the Service Area after the 37<sup>th</sup> week of pregnancy, or after you have been told that you are at risk for early delivery
- special equipment needed for sports or occupational purposes
- services for which no charge would be made in the absence of insurance
- services for Non-Members
- services after termination of membership
- services or supplies given to you by 1) anyone related to you by blood, marriage, or adoption, or, 2) anyone who ordinarily lives with you
- services that are not Medically Necessary
- services for which no coverage is provided in the *Benefit Handbook*, *Schedule of Benefits* or *Prescription Drug Brochure*
- any home adaptations, including, but not limited to home improvements and home adaptation equipment
- advanced reproductive technologies
- hearing aids
- foot orthotics, except for the treatment of severe diabetic foot disease
- wigs, except as described in your *Benefit Handbook*