

O3, 7/05

Schedule of Benefits
The Harvard Pilgrim Health Care of New England HMO
Best Buy HMO 250
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.

Member Cost Sharing Summary

Members are required to share the cost of the benefits provided under the Plan. The following is a summary of the cost sharing amounts under your Plan.

Copayments

Your Plan has **Copayments** that are listed in the “Covered Services” section of this *Schedule of Benefits*.

Deductibles

Your Plan has a **Deductible** of \$250 per Member or \$750 per family per calendar year.

Your Plan has a **Durable Medical and Prosthetic Equipment Deductible** of \$100 per calendar year.

Out-of-Pocket Maximum

Your Plan has an **Out-of-Pocket Maximum** of \$1,000 per Member or \$2,000 per family per calendar year.

Please refer to the section titled "Member Cost Sharing" at the end of this document for further information on your Copayments, Coinsurance, Deductibles and Out-of-Pocket Maximum.

Covered Services

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 after the Deductible has been met.

Hospital Outpatient Department Services

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

Covered in full.

- CT Scans and MRI

Covered in full after the Deductible has been met.

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 (see below for CT Scans and MRI), 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

\$10 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.

- CT Scans and MRI

Covered in full after the Deductible has been met.

Maternity Services

- Prenatal and postpartum care
Covered in full.

- All hospital services for mother including inpatient physician services
Covered in full after the Deductible has been met.

- Routine nursery charges for newborn care
Covered in full.
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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 days per calendar year¹
 - Inpatient drug and alcohol rehabilitation services - up to 30 days per calendar year¹
 - Inpatient detoxification
- Covered in full.

- Outpatient mental health services
Covered up to 20 visits per Member per calendar year
Individual therapy visits 1 - 15: \$10 Copayment per visit.
Individual therapy visits 16 - 20: 20% Coinsurance 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 visits 1 - 15: \$10 Copayment per visit.
Individual therapy visits 16 - 20: 20% Coinsurance per visit.
Group therapy: \$5 Copayment per visit.

- Outpatient detoxification
\$10 Copayment per visit.

- Psychological testing
\$10 Copayment per visit.
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¹ 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.

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.

Dental Services

- Initial emergency treatment (within 72 hours of injury)

\$10 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.

\$75 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 and Inpatient Rehabilitation Services

- Covered up to a combined maximum of 100 days per calendar year

Covered in full after the Deductible has been met.

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 \$3,500 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 applies)
- Wigs, as described in the *Benefit Handbook*

20% Coinsurance after the \$100 Durable Medical and Prosthetic Equipment Deductible is met. The coverage limit of \$3,500 is calculated by combining the amount paid by HPHC-NE and the Member Coinsurance and the Durable Medical and Prosthetic Equipment Deductible.

Prosthetic Arms and Legs

20% Coinsurance after the \$100 Durable Medical and Prosthetic Equipment Deductible is met. No benefit limit applies.

Other Health Services

- Cardiac rehabilitation
- Chiropractic care - up to 12 visits per calendar year
- Physical and occupational therapies - combined up to 25 visits per calendar year
- Speech therapy - up to 25 visits per calendar year
- Dialysis

\$10 Copayment per visit.

- House calls

\$15 Copayment per visit.

- Hospice services

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

- Ambulance services

Covered in full after the Deductible has been met.

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

Covered in full.

Other Health Services – Continued

- Infertility services limited to consultation and evaluation
\$10 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 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.

Member Cost Sharing

Copayments

As a Member of the Plan, you are responsible for a portion of the cost of certain benefits through Copayments. These Copayments are payable to the provider at the time of service. Your identification card indicates the Copayment amounts for the Plan's most frequently used services.

Deductibles

A Deductible is a specific dollar amount that is payable by the Member for Covered Benefits each calendar year before benefits subject to the Deductible are available under the Plan. Deductible amounts are incurred as of the date of service.

Each Member is responsible for the per Member Deductible for covered services each calendar year, unless a family Deductible applies. If a family Deductible applies, it is met when any combination of Members in a covered family incur expenses for services to which the Deductible applies in a calendar year. In such event, the Member Deductible is met.

Deductible carryover

A Deductible carryover allows you to apply any Deductible amount paid for covered services during the last three (3) months of a calendar year toward the Deductible for the next year. In order for a Deductible carryover to apply, the Member (or family) must have had continuous coverage under the Plan through the same Employer Group at the time the charges for the prior year were incurred.

Coinsurance

Coinsurance is a specific percentage amount that is payable by the Member for certain covered services. Coinsurance amounts are in addition to the Deductible and any applicable Copayment amounts.

Out-of-Pocket Maximums

The maximum Copayment and Deductible amounts you will be required to pay for all services, excluding riders, per calendar year. HPHC-NE will notify you if you have reached these limits. If you feel you have reached these limits, but have not been notified, please contact HPHC-NE.

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 preventive dental care, extraction of teeth, and treatment of 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 37th 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
- infertility treatment and advanced reproductive technologies and therapeutic donor insemination
- hearing aids
- foot orthotics, except for the treatment of severe diabetic foot disease
- wigs, except as described in your *Benefit Handbook*-