

05, 7/05

Schedule of Benefits
The Harvard Pilgrim Health Care of New England POS
Best Buy POS 250
New Hampshire

Services listed below are covered when Medically Necessary.
Please see your *Benefit Handbook* for details.

Your Plan offers two levels of coverage: In-Network and Out-of-Network.

In-Network Coverage

In-Network coverage applies to all your medical and health care needs provided or arranged by your Primary Care Physician (PCP). The only exceptions are a Serious Medical Emergency or when you use a Participating Provider for one of the special services that do not require a referral. A list of these special services can be found in your *Benefit Handbook*.

Out-of-Network Coverage

Out-of-Network coverage applies when you use a Non-Participating Provider or Participating Provider without a referral when a referral is required for covered services.

Please refer to your *Benefit Handbook* for further information about how your In-Network and Out-of-Network coverage works.

Member Cost Sharing

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.

Your Plan has **Copayments** that are listed in the table below with the service to which they apply.

You have an **In-Network Deductible** of \$250 per Member or \$750 per family per calendar year.

You have an **Out-of-Network Deductible** of \$500 per Member or \$1,500 per family per calendar year.

You have an **In-Network Durable Medical and Prosthetic Equipment Deductible** of \$100 per calendar year.

You have **Out-of-Network Coinsurance** of 20% of Covered Charges after the Out-of-Network Deductible is met until the Out-of-Pocket Maximum is reached.

You have an **Out-of-Pocket Maximum** of \$1,000 per Member or \$3,000 per family per calendar year including the Deductible, Copayments and Coinsurance (excluding prescription drugs).

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

Service	In-Network (Participating Providers with a proper referral)	Out-of-Network (Non-Participating Providers and Participating Providers without a referral)
Inpatient Acute Hospital Services (including Day Surgery) <ul style="list-style-type: none"> – Coronary care – Hospital services – Intensive care – Physicians’ and surgeons’ services including consultations – Semi-private room and board 	Covered in full after the Deductible has been met.	Covered at 80% after the Deductible has been met.
Skilled Nursing Facility Care and Inpatient Rehabilitation Services <ul style="list-style-type: none"> – Covered up to a combined maximum of 100 days per calendar year 	Covered in full after the Deductible has been met.	Covered at 80% after the Deductible has been met.
Hospital Outpatient Department Services <ul style="list-style-type: none"> – Anesthesia services – Chemotherapy – Endoscopic procedures – Laboratory tests and x-rays – Physicians’ and surgeons’ services – Radiation therapy – CT Scans and MRI 	Covered in full. (Unless otherwise listed under a specific benefit below.) Covered in full after the Deductible has been met.	Covered at 80% after the Deductible has been met. Covered at 80% after the Deductible has been met.

Service	In-Network (Participating Providers with a proper referral)	Out-of-Network (Non-Participating Providers and Participating Providers without a referral)
Emergency Room Care Services – Hospital emergency room treatment	\$75 Copayment per visit. (This Copayment is waived if you are admitted directly to the hospital from the emergency room.)	\$75 Copayment per visit. (This Copayment is waived if you are admitted directly to the hospital from the emergency room.)
Emergency Admission Services – Inpatient services which are required immediately following the rendering of emergency room treatment	Covered in full after the Deductible has been met.	Covered in full after the In-Network Deductible has been met.
Maternity Services – Prenatal and postpartum care – All hospital services for mother, including inpatient physician services – Routine nursery charges for newborn care	Covered in full. Covered in full after the Deductible has been met. Covered in full.	Covered at 80% after the Deductible has been met. Covered at 80% after the Deductible has been met. Covered at 80% after the Deductible has been met.

Service	In-Network (Participating Providers with a proper referral)	Out-of-Network (Non-Participating Providers and Participating Providers without a referral)
<p>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 <i>Benefit Handbook</i>.</p>		
<ul style="list-style-type: none"> – 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.	Covered at 80%.
<ul style="list-style-type: none"> – Outpatient mental health services - up to a total of 20 visits per calendar year 	Individual therapy: \$10 Copayment per visit. Group Therapy: \$5 Copayment per visit.	Covered at 80%.
<ul style="list-style-type: none"> – Outpatient drug and alcohol rehabilitation services - up to a total of 20 visits per calendar year 	Individual therapy: \$10 Copayment per visit. Group Therapy: \$5 Copayment per visit.	Covered at 80%.
<ul style="list-style-type: none"> – Outpatient detoxification 	\$10 Copayment per visit.	Covered at 80%.
<ul style="list-style-type: none"> – Psychological testing 	\$10 Copayment per visit.	Covered at 80% after the Deductible has been met.

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.

Service	In-Network (Participating Providers with a proper referral)	Out-of-Network (Non-Participating Providers and Participating Providers without a referral)
<p>Dental Services</p> <ul style="list-style-type: none"> – Initial emergency treatment (within 72 hours of injury) 	<p>\$10 Copayment per visit. If inpatient services are required, please see “Inpatient Acute Hospital Services” for cost sharing.</p>	<p>Covered at 80% after the Deductible has been met. If inpatient services are required, please see “Inpatient Acute Hospital Services” for cost sharing.</p>
<p>Home Health Care Services</p> <ul style="list-style-type: none"> – Home care services – Intermittent skilled nursing care <p>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.</p>	<p>Covered in full.</p>	<p>Covered at 80% after the Deductible has been met.</p>
<p>Durable Medical and Prosthetic Equipment</p> <p>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:</p> <ul style="list-style-type: none"> – Durable medical equipment – Prosthetic devices – Ostomy supplies – Wigs, as described in the <i>Benefit Handbook</i> – Oxygen and respiratory equipment 	<p>20% Coinsurance after the \$100 Durable Medical and Prosthetic Equipment Deductible has been met.</p> <p>Covered in full. No benefit limit applies.</p>	<p>Covered at 80% after the Deductible has been met.</p> <p>Covered at 80% after the Deductible has been met. No benefit limit applies.</p>
<p>Prosthetic Arms and Legs</p>	<p>20% Coinsurance after the \$100 Durable Medical and Prosthetic Equipment Deductible has been met. No benefit limit applies.</p>	<p>Covered at 80% after the Deductible has been met. No benefit limit applies.</p>

Service	In-Network (Participating Providers with a proper referral)	Out-of-Network (Non-Participating Providers and Participating Providers without a referral)
<p>Diabetes Equipment and Supplies</p> <ul style="list-style-type: none"> – Therapeutic molded shoes and inserts, dosage gauges, injectors, lancet devices, voice synthesizers and visual magnifying aids – Blood glucose monitors, insulin pumps and supplies and infusion devices – Insulin, insulin syringes, insulin pens with insulin, lancets, oral agents for controlling blood sugar, blood test strips, and glucose, ketone and urine test strips 	<p>Subject to the applicable cost sharing, if any, under the durable medical and prosthetic equipment benefit.</p> <p>Covered in full.</p> <p>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.</p>	<p>Subject to the applicable cost sharing, if any, under the durable medical and prosthetic equipment benefit.</p> <p>Covered in full.</p> <p>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.</p>

Service	In-Network (Participating Providers with a proper referral)	Out-of-Network (Non-Participating Providers and Participating Providers without a referral)
<p>Other Health Services</p> <ul style="list-style-type: none"> – Chiropractic care - up to 25 visits per calendar year – Cardiac rehabilitation – Second opinions – Dialysis – Physical and occupational therapies - up to a combined maximum of 25 visits per calendar year – Speech therapy - up to 25 visits per calendar year – House calls – Hospice services – Vision hardware for special conditions (please see your <i>Benefit Handbook</i> for details of your coverage) 	<p>\$10 Copayment per visit.</p> <p>Covered in full.</p> <p>\$15 Copayment per visit.</p> <p>Covered in full. If inpatient services are required, please see “Inpatient Acute Hospital Services” for cost sharing.</p> <p>Covered in full up to the benefit limit.</p>	<p>Covered at 80% after the Deductible has been met.</p> <p>Covered at 80% after the Deductible has been met.</p> <p>Covered at 80% after the Deductible has been met.</p> <p>Covered at 80% after the Deductible has been met. If inpatient services are required, please see “Inpatient Acute Hospital Services” for cost sharing.</p> <p>Covered at 80% after the Deductible has been met, up to the benefit limit.</p>

Service	In-Network (Participating Providers with a proper referral)	Out-of-Network (Non-Participating Providers and Participating Providers without a referral)
<p>Other Health Services - Continued</p> <ul style="list-style-type: none"> – Infertility services - limited to consultation and evaluation – Emergency ambulance services – Ambulance services – Low protein foods (\$1,800 per Member per calendar year) – Special formulas as described in the <i>Benefit Handbook</i> 	<p>\$10 Copayment per visit.</p> <p>Covered in full after the Deductible has been met.</p> <p>Covered in full after the Deductible has been met.</p> <p>Covered in full.</p>	<p>Covered at 80% after the Deductible has been met.</p> <p>Covered in full after the In-Network Deductible is met.</p> <p>Covered at 80% after the Deductible has been met.</p> <p>Covered at 80% after the Deductible has been met.</p>
<p>Special Enrollment Rights</p> <p>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.</p>		

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.

Deductible

A Deductible is a specific dollar amount that you pay for covered services each calendar year before benefits subject to the Deductible are available under the Plan. Deductible amounts are incurred as of the date of service.

Your Plan has separate Deductibles that apply to your In-Network and Out-of-Network benefits.

Any eligible expenses you incur toward the Deductible in a calendar year apply to both the In-Network and the Out-of-Network Deductibles. Once you meet the In-Network Deductible, which is usually the lower of the two, you may begin to receive coverage for In-Network services. If you later meet the Out-of-Network Deductible you may also receive coverage for Out-of-Network services.

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 to which the Deductible applies in a calendar year. In such event, the Member Deductible is met.

Your plan has a Deductible carryover which 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 Maximum

The total maximum Copayment, Deductibles, and Coinsurance 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.

Required Approvals**Hospital Admissions**

Members are responsible for obtaining approval from HPHC-NE before any hospital admission (including Day Surgery and day hospitalization for mental health or drug and alcohol rehabilitation services) occurs when either the doctor or facility is a Non-Participating Provider. If approval of the admission is not received, the Member is responsible for the first \$500 of the eligible expense. The \$500 payment does not count toward the Out-of-Network Deductible or the Out-of-Pocket Maximum.

Specialized Services

When using Non-Participating Providers it is the Member's responsibility to obtain approval from HPHC-NE for the following services before any costs are incurred. If approval is not obtained, the Member is responsible for the first \$500 of the eligible expense. The \$500 payment does not count toward the Out-of-Network Deductible or the Out-of-Pocket Maximum.

- All inpatient services
- All services provided in the Member's home
- Human organ transplants
- Advanced reproductive technologies
- Physical, speech and occupational therapies

48 Hour Emergency Notification

In cases of an emergency hospital admission to a Non-Participating Provider, HPHC-NE must be notified within 48 hours of the admission. If notification is not received, the Member is responsible for the first \$500 of the eligible expense. The \$500 payment does not count toward the Out-of-Network Deductible or the Out-of-Pocket Maximum.

Maternity Care

Members who are pregnant and using a Non-Participating Provider may call the Brighter Infant Beginnings Program, at 1-800-742-2423, after the first prenatal visit.

Benefit Exclusions

The Plan does not provide coverage for:

- cosmetic procedures, except has 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 for temporomandibular joint dysfunction (TMD)
- services that are not medically necessary or procedures which are experimental or unproven
- eyeglasses, contact lenses, and fittings, unless your employer group 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 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 test
- testing for 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
- 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
- special equipment needed for sports or occupational purposes
- services for which no charge would be made in the absence of insurance
- services after termination of membership or for Non-Members
- services or supplies given to you 1) by anyone related to you by blood, marriage, or adoption, or 2) anyone who ordinarily lives with you

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