

Schedule of Benefits
The HPHC Insurance Company PPO
New Hampshire

L1, 05/06

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 when you use a Participating Provider for covered services.

Out-of-Network Coverage

Out-of-Network coverage applies when you use a Non-Participating Provider 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 services to which they apply.

Your Plan has an **Out-of-Network Deductible** of \$200 per Member or \$400 per family, per calendar year, applied to the eligible expense.

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

Your Plan has an **Out-of-Network Out-of-Pocket Maximum** of \$800 per Member or \$1,600 per family per calendar year, (not including riders providing benefits for prescription drugs, adult preventive dental care or vision hardware).

Copayment amounts, and any charges in excess of the Usual, Customary and Reasonable Charge do not apply to the Out-of-Network Out-of-Pocket Maximum. Any Deductible amount incurred for services rendered during the last three months of a calendar year will be applied to the Deductible requirement for the next year.

Service	In-Network (Participating Providers) Member Cost Sharing	Out-of-Network (Non-Participating Providers) Member Cost Sharing
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 	No charge.	20% Coinsurance after the Deductible has been met.
Skilled Nursing Facility Care Services	No charge.	20% Coinsurance after the Deductible has been met.
Inpatient Rehabilitation Services	No charge.	20% Coinsurance 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 	No charge.	20% Coinsurance after the Deductible has been met.

Service	In-Network (Participating Providers) Member Cost Sharing	Out-of-Network (Non-Participating Providers) Member Cost Sharing
Physician Services <ul style="list-style-type: none"> – Administration of injections – Allergy tests and treatments – Changes and removal 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 screening 	\$15 Copayment per visit. (Please note: there is no charge for diagnostic tests, x-rays and immunizations if billed without an office visit and no other services are provided.)	20% Coinsurance after the Deductible has been met.
<ul style="list-style-type: none"> – Administration of allergy injections 	\$5 Copayment per visit.	20% Coinsurance after the Deductible has been met.

Service	In-Network (Participating Providers) Member Cost Sharing	Out-of-Network (Non-Participating Providers) Member Cost Sharing
Emergency Room Care Services – Hospital emergency room treatment	\$50 Copayment per visit. (This Copayment is waived if you are admitted directly to the hospital from the emergency room.)	\$50 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	No charge.	No charge.
Maternity Services – Prenatal and postpartum care	No charge.	20% Coinsurance after the Deductible has been met.
– All hospital services for mother, including inpatient physician services	No charge.	20% Coinsurance after the Deductible has been met.
– Routine nursery charges for newborn care	No charge.	20% Coinsurance after the Deductible has been met.

Service	In-Network (Participating Providers) Member Cost Sharing	Out-of-Network (Non-Participating Providers) Member Cost Sharing
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> .		
<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 	No charge.	20% Coinsurance.
<ul style="list-style-type: none"> – Outpatient mental health services 	Individual therapy visits 1 - 15: \$15 Copayment per visit. Individual therapy visits after visit 15: \$30 Copayment per visit. Group therapy: \$10 Copayment per visit.	20% Coinsurance.
<ul style="list-style-type: none"> – Outpatient drug and alcohol rehabilitation services 	Individual therapy visits 1 - 15: \$15 Copayment per visit. Individual therapy visits after visit 15: \$30 Copayment per visit. Group therapy: \$10 Copayment per visit.	20% Coinsurance.
<ul style="list-style-type: none"> – Outpatient detoxification 	\$15 Copayment per visit.	20% Coinsurance.
<ul style="list-style-type: none"> – Psychological testing 	\$15 Copayment per visit.	20% Coinsurance 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) Member Cost Sharing	Out-of-Network (Non-Participating Providers) Member Cost Sharing
Dental Services – Preventive care for children through the age of 12 (as described in your <i>Benefit Handbook</i>)	No charge.	20% Coinsurance after the Deductible has been met.
– Extraction of unerupted teeth impacted in bone – Initial emergency treatment (as described in your <i>Benefit Handbook</i>)	\$15 Copayment per visit. If inpatient services are required, please see “Inpatient Acute Hospital Services” for cost sharing.	20% Coinsurance after the Deductible has been met. If inpatient services are required, please see “Inpatient Acute Hospital Services” for cost sharing.
Home Health Care Services – Home care services – Intermittent skilled nursing care No cost sharing or benefit limits apply to durable medical equipment, physical therapy, occupational therapy or speech therapy received as part of authorized home health care.	No charge.	20% Coinsurance after the Deductible has been met.

Service	In-Network (Participating Providers) Member Cost Sharing	Out-of-Network (Non-Participating Providers) Member Cost Sharing
Durable Medical and Prosthetic Equipment Durable medical and prosthetic equipment (other than prosthetic arms and legs). Coverage includes, but is not limited to: <ul style="list-style-type: none"> – Durable medical equipment – Prosthetic devices – Ostomy supplies – Wigs (as described in your <i>Benefit Handbook</i>) 	No charge.	20% Coinsurance after the Deductible has been met.
<ul style="list-style-type: none"> – Oxygen and respiratory equipment 	No charge.	20% Coinsurance after the Deductible has been met.
Prosthetic Arms and Legs	No charge. No benefit limit applies.	20% Coinsurance after the Deductible has been met. No benefit limit applies.
Diabetes Equipment and Supplies <ul style="list-style-type: none"> – 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.	Subject to the applicable cost sharing, if any, under the durable medical and prosthetic equipment benefit.
<ul style="list-style-type: none"> – Blood glucose monitors, insulin pumps and supplies and infusion devices 	No charge.	No charge.
<ul style="list-style-type: none"> – 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.	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.

Service	In-Network (Participating Providers) Member Cost Sharing	Out-of-Network (Non-Participating Providers) Member Cost Sharing
Other Health Services – Cardiac rehabilitation – Chiropractic care – Dialysis – Second opinions	\$15 Copayment per visit.	20% Coinsurance after the Deductible has been met.
– Physical, speech and occupational therapies	No charge.	20% Coinsurance after the Deductible has been met.
– House calls	\$15 Copayment per visit.	20% Coinsurance after the Deductible has been met.
– Emergency ambulance services	No charge.	No charge.
– Ambulance services	No charge.	20% Coinsurance after the Deductible has been met.
– Low protein foods (\$1,800 per calendar year) – Special formulas (as described in your <i>Benefit Handbook</i>)	No charge.	20% Coinsurance after the Deductible has been met.
– Hospice services	No charge. If inpatient services are required, please see “Inpatient Acute Hospital Services” for cost sharing.	20% Coinsurance after the Deductible has been met. If inpatient services are required, please see “Inpatient Acute Hospital Services” for cost sharing.

Service	In-Network (Participating Providers) Member Cost Sharing	Out-of-Network (Non-Participating Providers) Member Cost Sharing
Other Health Services - Continued – Infertility services - limited to consultation and evaluation and therapeutic donor insemination	\$15 Copayment per visit.	20% Coinsurance after the Deductible has been met.
– Vision hardware for special conditions (as described in your <i>Benefit Handbook</i>)	No charge.	20% Coinsurance after the Deductible has been met.
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.		

Required Approvals and Penalties

Hospital Admissions

Members are responsible for obtaining approval from HPIC before any hospital admission occurs when either the doctor or facility is a Non-Participating Provider (this includes Day Surgery and day hospitalization for psychiatric or drug and alcohol rehabilitation services). If you do not get Prior Approval for the admission, you are responsible for the first \$500 of the eligible expense. The \$500 penalty payment does not count toward the Deductible or the Out-of-Pocket Maximum. Call 1-800-708-4414 for Prior Approval.

Specialized Services

When using Non-Participating Providers for the specialized services listed below, it is the Member's responsibility to obtain approval from HPIC before any costs are incurred. If you do not get Prior Approval you are responsible for the first \$500 of the eligible expense. The \$500 penalty payment does not count toward the Deductible or the Out-of-Pocket Maximum. Call 1-800-708-4414 for Prior Approval.

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

48 Hour Emergency Notification

In cases of an emergency hospital admission to a Non-Participating Provider, you must notify HPIC within 48 hours of the admission, unless notification is not possible because of your condition. If you do not notify HPIC of the admission, you will be responsible for the first \$500 of the eligible expenses. The \$500 penalty payment does not count toward your Deductible or the Out-of-Pocket Maximum. Call 1-800-708-4414 for Prior Approval.

Maternity Care

If you are pregnant and using a Non-Participating Provider, you are responsible for calling 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 as described in your *Benefit Handbook*
- Commercial diet plans, or weight loss programs and any services in connection with such programs
- Transsexual surgery, including related drugs or procedures
- Services that are not Medically Necessary
- Drugs, devices, treatments or procedures which are Experimental or Unproven
- Dental services, (except the specific services listed in your *Benefit Handbook* and this *Schedule of Benefits*), including restorative, periodontal, orthodontic, endodontic, prosthodontic, and dental services for temporomandibular joint dysfunction (TMD), removal of impacted teeth to prepare for or support orthodontic, prosthodontic, or periodontal procedures and dental fillings, crowns, gum care, including gum surgery, braces, root canals, bridges, bonding and dentures are not covered
- Eyeglasses, contact lenses and fittings, except as listed in your *Benefit Handbook* and this *Schedule of Benefits*
- Refractive eye surgery, including laser surgery and orthokeratology, for correction of myopia, hyperopia and astigmatism
- Transportation other than by ambulance
- Cost for any services for which you are entitled to treatment at government expense, including military service connected disabilities
- Costs for any 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, including myotherapy and sports medicine clinics
- Treatment with crystals
- Educational services (including problems of school performance) or testing for developmental, educational or behavioral problems
- Sensory integrative praxis tests
- Testing for central auditory processing
- Physical examinations for insurance, licensing or employment purposes
- Rest or custodial care
- Personal comfort or convenience items (including telephone and television charges)
- Exercise equipment
- Derotation knee braces
- Repair or replacement of durable medical equipment or prosthetic devices as a result of loss, negligence, willful damage, or theft
- 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 any services for infertility related to voluntary sterilization and its reversal)
- Any form of surrogacy

- Infertility treatment for Members who are not medically infertile
- Devices or 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
- Services for Non-Members
- 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 for which no coverage is provided in your *Benefit Handbook*, this *Schedule of Benefits* or *Prescription Drug Brochure* (if your Employer Group has selected this coverage)
- Any home adaptations, including, but not limited to, home improvements and home adaptation equipment
- Vocational rehabilitation or vocational evaluations on job adaptability, job placement or therapy to restore function for a specific occupation
- Charges for any products or services, including, but not limited to, professional fees, medical equipment drugs and hospital or other facility charges, that are related to any care that is not a covered service under your *Benefit Handbook*
- Charges for missed appointments
- Acupuncture, aromatherapy and alternative medicine
- Planned home births
- All charges over the semi-private room rate, except when a private room is Medically Necessary
- Hospital charges after the date of discharge
- Birth control injections, implants and devices, unless your Employer Group provides prescription drug coverage
- A provider's charge to file a claim or to transcribe or copy your medical records
- Any service or supply furnished along with a non-covered service
- Taxes or assessments on services or supplies
- Care by a chiropractor outside the scope of standard chiropractic practice, including but not limited to, surgery, prescription or dispensing of drugs or medications, internal examinations, obstetrical practice, or treatment of infections and diagnostic testing for chiropractic care other than an initial x-ray
- Hearing aids
- Foot orthotics, except for the treatment of severe diabetic foot disease
- Wigs, except as described in your *Benefit Handbook*
- Advanced reproductive technologies, including, but not limited to, in vitro fertilization, gamete intrafallopian transfer, zygote intrafallopian transfer, intra-cytoplasmic sperm injection, and donor egg procedures, including related egg and inseminated egg procurement, processing and banking