

Schedule of Benefits

THE HARVARD PILGRIM HMO

Services listed are covered when medically necessary and provided or arranged by Harvard Pilgrim Health Care Providers. Please see your Benefit Handbook for details.

Inpatient Acute Hospital Services (including day surgery)	
<p>All covered services, including the following:</p> <ul style="list-style-type: none"> Coronary care Hospital services Intensive care Physicians' and surgeons' services including consultation Semi-private room and board 	\$250 copayment per admission.
Hospital Outpatient Department Services	
<p>All covered services, including the following:</p> <ul style="list-style-type: none"> Anesthesia services Chemotherapy Endoscopic procedures Laboratory tests and x-rays Physicians' and surgeons' services Radiation therapy 	Covered in full.
Physician services (including covered services by a podiatrist)	
<p>All covered services, including the following:</p> <ul style="list-style-type: none"> Chemotherapy Administration of injections Allergy tests and treatments Changes and removals of casts, dressings or sutures Diagnostic screening and tests, including but not limited to mammograms, blood tests and screenings mandated by state law Health education including nutritional counseling Preventive care including routine physical examinations, immunizations, annual eye examinations, school, camp, sports and premarital examinations Sick and well office visits, including psychopharmacological services Vision and hearing screenings 	<p>\$15 copayment per visit.</p> <p>(Please note: diagnostic tests, mammograms, x-rays, and immunizations will be covered in full if billed without an office visit and no other services are provided.)</p>
Administration of allergy injections	\$5 copayment per visit.
Maternity Services	
<p>Prenatal and postpartum care</p> <p>All hospital services for mother and routine nursery charges for newborn</p>	\$250 copayment per admission.
Home Health Care Services	
<p>Home care services</p> <p>Intermittent skilled nursing care</p>	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 biologically-based mental disorders, rape-related mental or emotional disorders, and non-biologically-based mental, behavioral or emotional disorders for children and adolescents. No day or visit limits apply to inpatient or outpatient drug and alcohol rehabilitation services that are authorized by an HPHC mental health clinician in conjunction with treatment of mental disorders. (Please see your Benefit Handbook for details.)

Inpatient mental health services Services provided in a licensed general hospital	\$250 copayment per admission.
Services provided in a psychiatric hospital up to 60 days per member per calendar year*	\$250 copayment per admission.
Detoxification Inpatient services	\$250 copayment per admission.
Outpatient services	\$15 copayment per visit.
Inpatient drug and alcohol rehabilitation services Covered up to 30 days per member per calendar year*	\$250 copayment per admission.
Outpatient mental health services Covered up to 24 visits per calendar year for individual therapy and 25 visits per calendar year for group therapy with a combined maximum not to exceed 25 individual and group therapy visits per calendar year.	
Individual Therapy	\$15 copayment per visit.
Group therapy	\$10 copayment per visit.
Psychological testing	\$15 copayment per visit.
Outpatient drug and alcohol rehabilitation services Covered up to 20 visits or \$500 in benefit value, whichever is greater.	
Visits 1-8 for individual therapy	\$15 copayment per visit.
Individual therapy after visit 8	\$25 copayment per visit.
Group therapy	\$10 copayment per visit.

* Note: Partial hospitalization services are available up to a maximum of 120 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 teeth impacted in bone. Initial emergency treatment (within 72 hours of injury) necessary to repair oral injuries including x-rays, surgical procedures, extractions, and suturing.	The applicable copayment will be determined by location of service.

Emergency Services	
<p>You are always covered for care in a Medical Emergency. A referral from your PCP is not needed. In a Medical Emergency, you should go to the nearest emergency facility or call 911 or other local emergency number. If you are hospitalized, you must call your PCP within 48 hours, or as soon as you can. Please note that this requirement is met if your attending physician has already given notice to your PCP.</p>	<p>\$50 copayment per visit in the emergency room or a \$15 copayment per visit in a doctor's office or hospital outpatient department. This copayment is waived if admitted directly to the hospital from the emergency room.</p>
Skilled Nursing Care and Inpatient Rehabilitation	
<p>Room and board, special services and physicians' services up to 100 days per calendar year for skilled nursing care and up to 60 days per calendar year for inpatient rehabilitation services at a semi-private rate for each benefit.</p>	<p>\$250 copayment per admission.</p>
Other Health Services	
<p>Ambulance services Lead testing Low protein foods (\$2,500 per member per calendar year) State mandated formulas</p>	<p>Covered in full.</p>
<p>Vision Hardware for special conditions</p>	<p>Covered in full up to the applicable benefit limits as described in the Benefit Handbook.</p>
<p>Cardiac rehabilitation Dialysis Family planning services/Infertility services Medical treatment of temporomandibular joint dysfunction (TMJ) Physical and occupational therapies - up to 60 consecutive days per condition Speech-language and hearing services including therapy Chiropractic care - up to \$500 per member per calendar year House calls by a physician Early intervention services - up to a maximum of \$3,200 per member per calendar year and a lifetime maximum of \$9,600</p>	<p>\$15 copayment per visit.</p>
<p>Hospice services Human organ transplants Cosmetic surgery as described in the Benefit Handbook</p>	<p>The applicable copayment will be determined by location of service.</p>
<p>Durable medical and prosthetic equipment (including ostomy supplies) – up to \$1,500 per member per calendar year. Included in this benefit is coverage for wigs, up to a maximum \$350 per member per calendar year when needed as a result of any form of cancer or leukemia, alopecia areata, alopecia totalis, or permanent hair loss due to injury.</p>	<p>Covered in full.</p>

Other Health Services (continued)

Diabetes equipment and supplies

Molded shoes and inserts; dosage gauges; injectors; lancet devices; voice synthesizers and visual magnifying aids for the treatment of diabetes

Subject to the applicable copayment for durable medical and prosthetic equipment.

Blood glucose monitors, insulin pumps and infusion devices

Covered in full.

Insulin; insulin syringes; insulin pump supplies; 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, a \$10 copayment for Select Brand items and a \$25 copayment for Non-Select Brand items.

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. (Please see your Benefit Handbook for a complete description).

- Members must live in the Plan's Enrollment Area for at least nine 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 medical emergency, when you are temporarily outside the Plan Service Area, or when you need one of the special services that do not require a referral. The Plan Service Area is the state in which you live.

Annual Out-of-Pocket Maximums

The total maximum copayments you will be required to pay for all covered services, excluding riders, (e.g. prescription drugs, adult preventive dental and vision hardware) shall not exceed \$2,000 per Member per calendar year or a total of \$4,000 per Family per calendar year. The Plan will notify you if you reach these limits. If you feel that you have reached these limits, but have not been notified, please contact the Plan.

Exclusions

The Plan does not provide coverage for:

- services not approved, arranged, or provided by your PCP
- cosmetic procedures
- commercial diet plans or weight loss programs
- transsexual surgery, including related procedures
- procedures which are experimental or unproven
- eyeglasses, contact lenses, and fittings, unless your Employer Group has purchased the Vision 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
- osteopathic manipulation, routine foot care, biofeedback, pain management programs, massage therapy, acupuncture, and sports medicine clinics
- blood and blood products
- educational services (including problems of school performance) or testing for developmental, educational, or behavioral problems
- sensory integrative praxis tests
- 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 a 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) and 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 for non-Members
- services after the 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
- hearing aids
- foot orthotics, except as required by law
- dental services including periodontal, restorative, and orthodontic services
- 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
- hair removal or restoration, including, but not limited to, electrolysis, laser treatment, transplantation or drug therapy



Harvard Pilgrim
HealthCare

1600 Crown Colony Drive
Quincy, MA 02169