

Schedule of Benefits

UI, 01/08

The Harvard Pilgrim Health Care of New England USNH-STAFF/FACULTY POS

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

This Schedule is part of your Benefit Handbook. It states the Cost Sharing amounts that you must pay for Covered Benefits and some important limitations on your coverage. It also identifies any supplemental medical benefits covered by your Plan.

There are two levels of coverage: In-Network and Out-of-Network.

In-Network coverage applies when you use a Participating Provider for Covered Benefits. When using Participating Providers, Covered Charges are based on the contracted rate between Harvard Pilgrim Health Care of New England and the Provider.

Out-of-Network coverage applies when you use a Non-Participating Provider for Covered Benefits. When using Non-Participating Providers, Covered Charges are based on the Providers charge for the service. In most cases, this will be higher than Harvard Pilgrim Health Care of New England's contracted rate.

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

Except for allergy injections, nutritional counseling and prenatal and postpartum care, your plan has two levels of Copayments that apply to outpatient physician services you receive while a Member of the Plan. These are **Level 1 Copayment, which is \$10** and the **Level 2 Copayment, which is \$20**. The Level 1 Copayment applies to outpatient physician services provided by your Primary Care Physician (PCP). All other outpatient physician services not provided by your PCP require you to pay the Level 2 Copayment.

General Cost Sharing Features	In-Network	Out-of-Network
Coinsurance	None	See below
Copayment	See below	None
Deductible	None	\$300 per Member \$600 per family
Out-of-Pocket Maximum	None	\$500 per Member \$1,000 per family
Lifetime Benefit Maximum	None	\$2,000,000 per Member
Penalty Payment	None	50% of the Covered Charges or \$500, whichever is less

Covered Benefits	Your Cost Sharing In-Network	Your Cost Sharing Out-of-Network
Outpatient Professional Services		
<ul style="list-style-type: none"> Ambulance Transport, Non-Emergency 	Nothing	Nothing
<ul style="list-style-type: none"> Cardiac Rehabilitation, Physical, Speech, and Occupational Therapies – combined up to 60 visits per calendar year <p>Cardiac Rehabilitation, Physical, Speech, and Occupational Therapies provided in the home are subject to the benefit limitations described above.</p>	Nothing	Deductible, then 20% Coinsurance
<ul style="list-style-type: none"> Diagnostic Laboratory and X-rays 	Nothing	Deductible, then 20% Coinsurance
<ul style="list-style-type: none"> Dialysis 	Nothing	Deductible, then 20% Coinsurance
<ul style="list-style-type: none"> Early intervention services – up to a maximum of \$3,200 per Member per calendar year and a lifetime maximum of \$9,600 	\$10 Copayment	Deductible, then 20% Coinsurance
<ul style="list-style-type: none"> Formulas and Low Protein Foods 	Nothing	Deductible, then 20% Coinsurance
<ul style="list-style-type: none"> Home Care - limited to 40 visits per calendar year for Non-Participating Providers 	Nothing	Deductible, then 20% Coinsurance
<ul style="list-style-type: none"> Hospice 	Nothing	Deductible, then 20% Coinsurance
<ul style="list-style-type: none"> Physician Services, except the three services listed below 	Level 1: \$10 Copayment Level 2: \$20 Copayment	Deductible, then 20% Coinsurance
<ul style="list-style-type: none"> Prenatal and Postpartum Care 	Nothing	Deductible, then 20% Coinsurance
<ul style="list-style-type: none"> Allergy Injections 	Nothing	Deductible, then 20% Coinsurance
<ul style="list-style-type: none"> Nutritional Counseling – limited to 3 visits per calendar year 	Nothing	Deductible, then 20% Coinsurance
<ul style="list-style-type: none"> Surgical Day Care 	\$50 Copayment	Deductible, then 20% Coinsurance
<ul style="list-style-type: none"> Vision Hardware for Special Conditions 	Nothing	Deductible, then 20% Coinsurance

Covered Benefits	Your Cost Sharing In-Network	Your Cost Sharing Out-of-Network
Emergency Services		
▪ Ambulance Transport, Emergency	Nothing	Same as In-Network
▪ Emergency Dental Care - in a professional office must be received within six months of injury	Nothing	Deductible, then 20% Coinsurance
▪ Emergency Room Care	\$75 Copayment. This Copayment is waived if admitted directly to the hospital from the emergency room.	Same as In-Network
Inpatient Services		
▪ Acute Hospital Care ▪ Maternity Care	\$200 Copayment per admission	Deductible, then 20% Coinsurance
▪ Rehabilitation Hospital Care and Skilled Nursing Facility Care - limited to a combined 100 days per calendar year	Nothing	Deductible, then 20% Coinsurance
Mental Health Services		
Important Note: Benefit limits do not apply to care for Serious Mental Illnesses. See your Benefit Handbook for details.		
▪ Inpatient Care	\$200 Copayment per admission	20% Coinsurance
▪ Outpatient Care - limited to 30 visits or \$3,000 per calendar year, whichever is greater (two group therapy visits are equal to one individual therapy visit)		
Group Therapy	\$10 Copayment	20% Coinsurance
Individual Therapy	\$10 Copayment	20% Coinsurance
▪ Psychological Testing	\$10 Copayment	Deductible, then 20% Coinsurance

Covered Benefits	Your Cost Sharing In-Network	Your Cost Sharing Out-of-Network
Drug and Alcohol Rehabilitation Services		
<ul style="list-style-type: none"> ▪ Inpatient Care - limited to 30 days per calendar year ▪ Inpatient Detoxification 	\$200 Copayment per admission	20% Coinsurance
<ul style="list-style-type: none"> ▪ Outpatient Care - limited to 30 visits per calendar year (two group therapy visits are equal to one individual therapy visit) 		
Group Therapy	\$10 Copayment	20% Coinsurance
Individual Therapy	\$10 Copayment	20% Coinsurance
<ul style="list-style-type: none"> ▪ Outpatient Detoxification 	\$10 Copayment	20% Coinsurance
Durable Medical Equipment and Prosthetic Devices		
<ul style="list-style-type: none"> ▪ Limited to \$5,000 per calendar year for all covered equipment. This limit does not apply to the following items listed below. 	Nothing	Deductible, then 20% Coinsurance
Blood Glucose Monitors, Insulin Pumps and Infusion Devices	Nothing	Deductible, then 20% Coinsurance
Breast Prostheses, including replacements and Mastectomy Bras	Nothing	Deductible, then 20% Coinsurance
Medical Equipment and Supplies for Diabetes Treatment	Nothing	Deductible, then 20% Coinsurance
Oxygen and Respiratory Equipment	Nothing	Deductible, then 20% Coinsurance
Prosthetic Arms and Legs	Nothing	Deductible, then 20% Coinsurance

Covered Benefits	Your Cost Sharing In-Network	Your Cost Sharing Out-of-Network
Supplemental Benefits		
▪ Annual Eye Examination	\$10 Copayment	Deductible, then 20% Coinsurance
▪ Hearing aids – up to age 19	Nothing	Deductible, then 20% Coinsurance
▪ Chiropractic Care - limited to 20 visits per calendar year	\$10 Copayment	Deductible, then 20% Coinsurance
▪ Voluntary Sterilization	\$20 Copayment	Deductible, then 20% Coinsurance
▪ Voluntary Termination of Pregnancy	\$20 Copayment	Deductible, then 20% Coinsurance
▪ Infertility Treatment using Therapeutic Donor Insemination – limited to six cycles per lifetime	\$20 Copayment	Deductible, then 20% Coinsurance
▪ Infertility Drugs – limited to four months supply per calendar year	Subject to the applicable prescription drug Copayment listed on your ID card.	Subject to the applicable prescription drug Copayment listed on your ID card.

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, unless services provided are related to emergency dental care and are provided within the time period stated in the Schedule of Benefits
- 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
- 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)

Benefit Exclusions (continued)

- 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
- Preventive dental care
- Extraction of teeth
- 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