

	Boston Medical Center Advantage Provider Network	Harvard Pilgrim Health Care Provider Network
Skilled Nursing Care and Inpatient Rehabilitation - Room and board, special services and physician's services - up to 100 days per calendar year at a semi-private rate for each benefit	<i>Covered in full</i>	<i>Covered in full</i>
Maternity Care - Prenatal and postpartum care - All hospital services for mother and routine nursery charges for newborn	<i>Covered in full</i> <i>Covered in full</i>	<i>Covered in full</i> <i>Subject to hospital inpatient copayment+</i>
Home Health Care Services - Home care services - Intermittent skilled nursing care	<i>Covered in full</i>	<i>Covered in full</i>
Emergency Care - You are always covered for care in a Medical Emergency. A referral for 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.	<i>\$40 copayment per visit (This copayment is waived if you are directly admitted.)</i>	<i>\$40 copayment per visit (This copayment is waived if you are directly admitted.)</i>
Emergency Admission Services - Inpatient services which are required immediately following the rendering of emergency room treatment	<i>Covered in full</i>	<i>Covered in full</i>

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<p>Mental Health and Drug and Alcohol Rehabilitation Services*</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 60 days per member per calendar year.* - Inpatient detoxification - Inpatient drug and alcohol rehabilitation services - up to 30 days per member per calendar year.* - Outpatient mental health services - up to 24 visit 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. - Outpatient drug and alcohol rehabilitation services - covered up to 20 visits or \$500 in benefit value, whichever is greater. - Psychological testing 	<p><i>Covered in full</i></p> <p><i>Covered in full</i></p> <p><i>Covered in full</i></p> <p><i>Covered in full</i></p> <p><i>Group therapy: \$5 copayment per visit</i></p> <p><i>Individual therapy: \$5 copayment per visit</i></p> <p><i>Group therapy: \$5 copayment per visit</i></p> <p><i>Individual therapy: Visits 1-8, \$5 copayment per visit After visit 8, \$25 copayment per visit</i></p> <p><i>Covered in full less applicable office visit copayment per visit</i></p>	<p><i>Subject to hospital inpatient copayment+</i></p> <p><i>Subject to hospital inpatient copayment+</i></p> <p><i>Subject to hospital inpatient copayment+</i></p> <p><i>Subject to hospital inpatient copayment+</i></p> <p><i>Group therapy: \$10 copayment per visit</i></p> <p><i>Individual therapy: \$10 copayment</i></p> <p><i>Group therapy: \$10 copayment per visit</i></p> <p><i>Individual therapy: Visits 1-8, \$10 copayment per visit After visit 8, \$25 copayment per visit</i></p> <p><i>Covered in full less applicable office visit copayment per visit</i></p>

* 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.)

* 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.

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Other Health Services <ul style="list-style-type: none"> - Cardiac rehabilitation - Dialysis - Family planning services - Infertility treatment - Outpatient detoxification - Medical treatment of temporomandibular joint dysfunction (TMJ) - Second opinions - Hospice services - Human organ transplants - Cosmetic surgery as described in the Benefit Handbook - Ambulance services - Lead testing - Low protein foods (\$2,500 per member per calendar year) - State mandated formulas - House calls by a physician - Durable medical and prosthetic equipment (including ostomy supplies) covered up to a combined maximum of \$5,000 in equipment costs per calendar year. Included in the benefit is coverage for wigs, up to a maximum of \$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. - Physical and occupational therapies - up to 90 consecutive days per condition - Speech-language and hearing services, including therapy - Early intervention services up to a maximum of \$3,200 per member per calendar year and a lifetime maximum of \$9,600 - Chiropractic care (up to \$500 per calendar year) 	<p><i>Covered in full less applicable office visit copayment per visit</i></p> <p><i>Copayment will be determined by location of service</i></p> <p><i>Covered in full</i></p> <p><i>\$15 copayment per visit</i></p> <p><i>Covered at 80% of equipment cost to HPHC - the member pays a maximum of \$1,000 per calendar year</i></p> <p><i>\$5 copayment per visit</i></p> <p><i>\$10 copayment per visit</i></p>	<p><i>Covered in full less applicable office visit copayment per visit</i></p> <p><i>Copayment will be determined by location of service</i></p> <p><i>Covered in full</i></p> <p><i>\$20 copayment per visit</i></p> <p><i>Covered at 80% of equipment cost to HPHC - the member pays a maximum of \$1,000 per calendar year</i></p> <p><i>\$20 copayment per visit</i></p> <p><i>\$10 copayment per visit</i></p>

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<p>Other Health Services Cont'd</p> <ul style="list-style-type: none"> - Vision Hardware for special conditions - Diabetes equipment and supplies Molded shoes and inserts, dosage gauges, injectors, lancets devices, voice synthesizers and visual magnifying aids are subject to the applicable copayment for durable medical and prosthetic equipment <p>Blood glucose monitors, insulin pumps and infusion devices</p> <p>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</p>	<p><i>Covered in full up to the benefit limit</i></p> <p><i>Subject to the applicable copayment for durable medical and prosthetic equipment</i></p> <p><i>Covered in full</i></p> <p><i>Diabetic supplies are subject to the prescription 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.</i></p>	<p><i>Covered in full up to the benefit limit</i></p> <p><i>Subject to the applicable copayment for durable medical and prosthetic equipment</i></p> <p><i>Covered in full</i></p> <p><i>Diabetic supplies are subject to the prescription 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.</i></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>		

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 which 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 durable medical equipment and 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 reached these limits, but have not been notified, please contact the Plan.

+Inpatient Copayment

Hospital Inpatient Copayment (including Day Surgery): \$100 per day up to an aggregate maximum of \$500 per member per calendar year.

Exclusions

- services not approved, arranged, or provided by your PCP
- cosmetic procedures
- commercial diet plans or weight loss programs
- transsexual surgery, including related procedures
- dental services including periodontal, restorative, pediatric preventive dental, tooth extractions, and orthodontic services
- 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 necessary 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
- hair removal or restoration, including, but not limited to, electrolysis, laser treatment, transplation or drug therapy
- delivery outside the service area after the 37th week of pregnancy, or after you have been told that you are at risk of early delivery