HPHC Insurance Company

# "I want a plan that complements my Medicare coverage."

## Medicare Enhance℠

The individual shown is representative only. The comment is a composite of sentiments often expressed by our members.

HPHC Insurance Company

Commonwealth of Massachusetts Group Insurance Commission

# "Easy-to-use benefits that go where I go? Sounds like a plan."

## Medicare Enhance℠ for the Group Insurance Commission

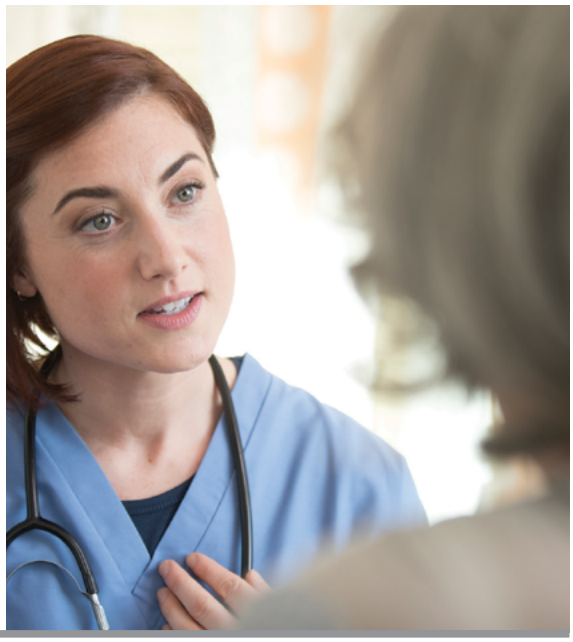
HPHC Insurance Company (HPHC) is proud to offer Medicare Enhance to the Group Insurance Commission's Medicare-eligible retirees and their spouses, including survivors. While Medicare remains your primary insurer, this plan features additional coverage for preventive care and pays the cost of your Medicare deductibles and coinsurance.

**Read on for more details.**

Harvard Pilgrim Health Care includes Harvard Pilgrim Health Care, Harvard Pilgrim Health Care of Connecticut, Harvard Pilgrim Health Care of New England and HPHC Insurance Company.

## With Medicare Enhance:

- **Doctors office visits are typically covered with just a simple copayment.***
- **You can live anywhere in the United States as long as you are enrolled in Medicare Parts A and B.**
- **You can visit any doctor or other provider that accepts Medicare patients.**
- **You'll have coverage for emergency care anywhere in the world.**
- **You'll enjoy savings on products and programs to help you live a healthier life.**



### Eligibility

To be eligible for Medicare Enhance, you can live anywhere in the United States as long as you are enrolled in Medicare Parts A and B.

### Receiving care

Medicare Enhance is an indemnity plan. That means you can receive care from any doctor, hospital or other health care provider that accepts Medicare. You're not locked into a provider network and you don't have to choose a primary care provider, which means you're free to visit specialists for covered services.

You don't need referrals or any kind of prior authorization from HPHC Insurance Company (HPHC).

* Copayments do not apply to certain types of preventive visits. See the Schedule of Benefits for details. Coverage is subject to the terms of the Benefit Handbook and Schedule of Benefits.

After you enroll, you will receive a member identification (ID) card. **It will be important for you to show both your HPHC and Medicare ID cards whenever you visit the doctor or hospital.**

### Paying for services

Most providers will charge you a fixed copayment at the time of service for office visits and emergency room visits, and then bill Medicare directly for the balance of the claim.* Some providers may bill you directly for the services after receiving Medicare's payment, and you will need to submit a claim to HPHC.

When you become a member, your Benefit Handbook will have more information about provider billing and submitting claims to HPHC. But if you need help or have questions, you can always call our Member Services department.

Please see the Schedule of Benefits for specific Medicare Enhance copayment and coverage amounts.

### Emergency coverage—wherever you go

Whenever you need emergency care, just call 911 or another local emergency number. Emergency room visits are subject to a copayment that will be waived if you are admitted to the hospital. Even if you're traveling to another part of the country or another part of the world, Medicare Enhance has you covered wherever you need care.

### Stay healthy and save money

Our discounts and savings program can help you save money on products and services such as nutrition and weight management programs, eyewear, complementary medicine services and more. Visit harvardpilgrim.org/gic for details.

## Medicare Enhance coverage highlights

**MOST OFFICE VISITS***

**$15**

**PRESCRIPTIONS**

**30 days: $10, $30 or $65**
**90 days (mail): $25, $75 or $165**

**Prescription drug coverage is an Employer Group Waiver Plan (EGWP) offered by the GIC through SilverScript.**

**HEARING AIDS**

**Medicare Enhance pays a maximum of $1,700 every two years. First $500 covered in full; next $1,500 covered at 80%.**

* Copayments do not apply to certain types of preventive visits. See the Schedule of Benefits for details. Coverage is subject to the terms of the Benefit Handbook and Schedule of Benefits.

Harvard Pilgrim Health Care

UMass | Commonwealth of Massachusetts Group Insurance Commission

# Get up to $150 in fitness reimbursement

If you belong to a qualified health and fitness club for four months in a calendar year, we'll reimburse you up to $150 for you or the dependents covered under your plan.

## What qualifies for reimbursement?

Fitness reimbursement applies to monthly fees paid to a facility that provides cardiovascular and strength-training equipment for exercising and improving physical fitness (such as health clubs and community fitness centers).

Qualified facilities also include fitness studios and facilities that offer:

- Yoga
- Pilates
- Zumba
- Aerobic/group classes
- Indoor cycling/ spinning classes
- Kickboxing
- CrossFit
- Strength training
- Tennis
- Indoor rock climbing
- Personal training (taught by a certified instructor)

## Getting reimbursed is simple.

1. Pay your monthly fees to your fitness club
2. After four months of membership, you may complete the Fitness Reimbursement Form; go to harvardpilgrim.org/fitnessreimbursement and pick one of these options:

### Online

Click on the link to submit your request online.

### Mail

Complete the paper form and mail to the address on the form, along with a copy of your fitness contract or receipt.

Read on for details ▶

Harvard Pilgrim Health Care includes Harvard Pilgrim Health Care, Harvard Pilgrim Health Care of Connecticut, Harvard Pilgrim Health Care of New England and HPHC Insurance Company.

## What does not qualify for reimbursement?

**The following are not eligible for reimbursement:**

- Fees you pay for group classes or personal training outside of a fitness facility/studio
- Health club initiation fees for instructional dance studios, country clubs, social clubs (such as ski, riding or hiking clubs), spas, gymnastics facilities, martial arts schools, pool-only facilities
- Road race fees, sport camps, ski passes, sports teams or leagues, and school sports athletic user fees

## When can I submit my request?

**You can request reimbursement:**

- Starting May 1 of the current calendar year, and after you've been enrolled in a Harvard Pilgrim plan for four continous months
- After four months of fitness club membership
- One per calendar year, submitted by March 31 of the following year

## How long will it take to be reimbursed?

Once you submit your request, reimbursement takes up to eight weeks. We'll send a check to the subscriber's address of record, made payable to the subscriber.

## For complete guidelines:

Go to **harvardpilgrim.org/fitnessreimbursement**

Call Member Services at **(888) 333-4742**

$150 maximum reimbursement per Harvard Pilgrim policy in a calendar year (individual or family contract). Must be currently enrolled in Harvard Pilgrim at time of reimbursement. If enrolled through an employer, available to the extent your employer has elected to offer this fitness reimbursement. Restrictions apply, and reimbursement is not available to all members. Certain employers will offer this program upon their annual enrollment/anniversary date. In these instances, you'll be eligible four months after the enrollment/anniversary date. For example: If your employer's enrollment/anniversary date is April 1, eligibility to submit for reimbursement begins no earlier than August 1 (as long as all other participation rules are met, including being an active member). For tax information, consult your employer or tax advisor.

Some employers, and individuals who purchase plans directly from Harvard Pilgrim, may have a fitness reimbursement amount that is different than the standard benefit. Please see your Benefit Handbook and Schedule of Benefits for details.

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Harvard Pilgrim Health Care

# Discounts & Savings

**To help you and your family on your path to well-being**

## Vision

- **Visionworks:** Get a **free** pair of prescription eyeglasses with your covered routine eye exam.[1] Also, save 40% on frames.
- **Vision discounts at popular locations:** Save 35% on frames when you buy a complete pair of glasses. Save 20% on any frame or lens options purchased separately, or save 20% on other lens add-ons and services. Locations include: Target Optical, JC Penney Optical, Pearle Vision, Lenscrafters and other EyeMed access network optical providers.[2]
- **Harvard Vanguard Medical Associates:** Save 40% on frames and 20% on prescription sunglasses.
- **Laser vision correction:** Save up to 50% on procedures from Davis Vision, QualSight LASIK and US Laser Network locations in MA, ME, NH and CT.

## Hearing

- **Amplifon Hearing Health Care:** Save on hearing services and save up to 50% on hearing aids. Plus, one year of follow-up services is included with purchase. Locations nationwide.
- **Flynn Associates:** Save up to $200 per hearing aid, and get free quarterly cleanings, adjustments and more.
- **Speech-Language and Hearing Associates of Greater Boston, PC:** Save up to $200 on each hearing aid purchase.
- **TruHearing:** Save 30-60% on hearing aids. You'll get state-of-the-art technology from top manufacturers, solutions for every type of hearing loss and personalized help.

## Healthy Eating

- **DASH for Health:** Save 50% on a six-month online subscription. DASH is a flexible and balanced eating plan that helps create a heart-healthy eating style for life.
- **Eat Right Now:** Save 25% on a subscription to this mindful eating app that combines neuroscience and mindfulness to reduce your craving-related eating by 40%.
- **Jenny Craig:** Free three-month program (food not included), plus $120 in food savings (purchase required).[3] Or, save 50% off their premium programs (food cost separate).[4]
- **InsideTracker:** Save 25% on a science-based, personalized nutrition plan based on your blood test results.
- **PlateJoy:** Save $20 on any PlateJoy plan, and get personalized meal plans and fast recipes to fit your lifestyle (expires February, 29, 2020).
- **Savor Health:** Save $15 on each week of fresh, nutritious menu plans or meals for cancer patients and their caregivers.
- **Savory Living:** Save 25% and try the first session for free. This online, healthy eating lifestyle program empowers you to take control of how you eat and feel.
- **The Dinner Daily:** Save 25% on this weekly meal planning service that makes dinnertime easy, healthy and affordable.

## Quit Smoking

- **Craving to Quit:** Save 25% on this smartphone-based program to help you quit smoking.
- **QuitSmart:** Save 30% on this program that offers hypnosis, medication recommendations and a patented simulated cigarette.

[1] You must have an eye exam and choose eyeglasses during the same visit. Additional restrictions apply.

[2] Valid at participating locations only. Restrictions apply.

[3] Valid for 3-month trial membership. Weekly full menu average $156 (before discount) and any shipping costs not included. Discount split over 12 consecutive weeks with full menu purchase. Valid at participating centers and Jenny Craig Anywhere. New members only. No cash value. Not valid with any other offers or discounts. One offer per person.

[4] 50% off enrollment and/or membership fees for eligible premium programs. Weekly full menu average $156 (before discount) and any shipping cost not included. No cash value. Not valid with any other offer or discounts. Valid at participating locations and Jenny Craig Anywhere. New members only.

These savings programs are not insurance products. Rather, they are discounts for programs and services designed to help keep members healthy and active. All programs subject to change without advance notice.

## Fitness

- **Appalachian Mountain Club:** Save 20% on individual and family memberships. Use your membership for all kinds of outdoor activities to keep you healthy and fit.
- **Boston Ski & Sports Club:** Save 23% on annual membership, with access to fun ways to stay active and healthy, such as playing sports, skiing, traveling and connecting with other enthusiasts in the region.
- **Marathon Sports:** Save 15% on athletic footwear. Multiple locations in MA.
- **ProSourceFit:** Save 20% on your entire order of high performance products for strength and resistance workouts, yoga and Pilates, and muscle recovery.
- **SplitFit:** Save 20% on quality, personalized training at leading gyms and fitness studios in Greater Boston. You'll get a customized workout at an affordable price by sharing the cost of a session with up to three other people.

## Dental

- **Universal Dental Plan:** Save up to 28% on Universal Dental Plan's membership fees, and 20-50% on all procedures from a network of participating dentists.[5]

## Holistic Wellness

- **Ava Fertility Tracker:** Save 10% on the Basic Bundle or 15% on the Plus Bundle. Both include the bracelet and app to help you find your fertile window, track your pregnancy or better understand your body.
- **Complementary and Alternative Medicine:** Save up to 30% on services offered through our partnership with WholeHealth Networks, including: acupuncture [6], chiropractic [6], tai chi, massage and body work, naturopathic medicine and more.
- **DharmaCrafts:** Save 15% on all meditation cushions and restorative yoga mats for your mindfulness meditation practice.
- **Center for Mindfulness and Compassion (Cambridge Health Alliance):** Save 15% on their eight-week Mindfulness-Based Stress Reduction and Mindful Self-Compassion courses.
- **FertilityIQ:** Save 25% on this online platform to help with your fertility and family building needs. Includes courses led by experts and access to verified patient reviews of every fertility doctor and clinic in the United States.
- **Ivy Child:** Save 15% on mindfulness health education programs that focus on meditation, yoga, art and music for children and teens.
- **Magic Weighted Blanket:** Save 25% on "the blanket that hugs you back." These blankets have a calming, comforting and soothing effect and come in a wide assortment of fabrics, colors and sizes.
- **Mighty Well:** Save 15% on products that help patients manage their lives with dignity, confidence and style, including PICC line covers, cozy wraps and more.
- **Mindful Magazine:** Get 67% off the cover price when you subscribe.
- **The Original Healing Threads by Spirited Sisters:** Save 20% on their clothing, perfect for people with knee or hip replacements, leg and foot problems, upper body radiation and chemotherapy treatments, or recovery from heart surgery. Also ideal for nursing moms and anyone who has difficulty with gross motor skills.
- **Unwinding Anxiety®:** Save 25% on a subscription to this step-by-step program, available on your smartphone or tablet. Uncover triggers, identify your habits, break the cycle of worry and panic, and learn anti-anxiety tools.
- **Ten Percent Happier:** Get the first month free. Subscribe to the rest of the program for $14.99 per month or $99.99 per year for this online meditation program.

## Family & Senior Care

- **CareScout Advocacy Program:** Save 20% on this program and connect with trained care advocates to help your family assess needs and find adult day care, home health care services or facility care.
- **Great Call:** Save 20% on innovative, easy-to-use mobile products that help aging consumers live more independent lives.
- **Home Instead Senior Care:** Get a one-time $100 credit toward charges for routine services at participating offices and get a free home safety inspection at the start-up of services.
- **SeniorAssist (Senior Resource Center, Inc.):** Save $500 on the lifetime flat fee for services.
- **Vigorous Mind:** Save 10% on this personalized, science-based, online program for maintaining brain health and quality of life after 50.

[5] Universal Dental Plan is not dental insurance and does not meet minimum creditable coverage under applicable state law. The plan provides discounts at specific dental providers for dental services. The plan does not make payments directly to the providers of dental services. The plan member is obligated to pay for all dental care services but will receive a discount from those dental care providers who have contracted with the discount dental plan organization. The range of discounts will vary depending on the services provided.

[6] Does not replace or supplement coverage under your Harvard Pilgrim medical benefits plan. Some plans include chiropractic and/or acupuncture coverage, in which case the provider networks and benefits differ. Consult your Benefit Handbook or call Member Services for details.

**Find more discounts at harvardpilgrim.org/discounts.**
**Already a member? (888) 333-4742**
**Not a member? (800) 848-9995**
**TTY: 711.**

Harvard Pilgrim Health Care includes Harvard Pilgrim Health Care, Harvard Pilgrim Health Care of Connecticut, Harvard Pilgrim Health Care of New England and HPHC Insurance Company.

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# Schedule of Benefits

COMMONWEALTH OF MASSACHUSETTS
GROUP INSURANCE COMMISSION
MEDICARE ENHANCE

Services are covered only when Medically Necessary.
Please see your Benefit Handbook for the details of your coverage.

## INTRODUCTION

This Schedule of Benefits summarizes your coverage under Medicare Enhance (the Plan) and states the Subscriber cost- sharing amounts you must pay for Covered Services. However, it is only a summary of your benefits. Please consult your *Benefit Handbook* for detailed information on the benefits covered by the Plan and the terms and conditions of coverage.

Please note that the information on Medicare benefits in this document is provided for informational purposes only. HPHC Insurance Company, Inc. (HPHC) is not responsible for Medicare Benefits. Please refer to the Medicare program handbook, *Medicare and You* or contact the Centers for Medicare and Medicaid Services (CMS), for information on your Medicare benefits. You may call CMS for information on Medicare Parts A and B at: 1-800-MEDICARE (1-800-633-4227).

## SECTION 1: SUBSCRIBER COST SHARING (WHAT YOU PAY)

Subscribers 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.

A Copayment is a dollar amount that is payable by the Subscriber for certain Covered Services. The Copayment is due at the time services are rendered or when billed by the Provider. Your identification card contains the Copayment amounts that apply to the Plan's most frequently used services. Please see the tables below for a detailed list of the Copayments that apply to your Plan.

If your Plan provides coverage for a service that is not covered by Medicare, the Plan will pay all charges up to the Payment Maximum minus the applicable Copayment.

## SECTION 2: PREVENTIVE CARE SERVICES

Medicare covers a number of preventive care services at no cost to Subcribers. The Plan will pay the Medicare Coinsurance and Deductible amounts for Medicare covered preventive care services, if any.

Medicare coverage includes a one-time "Welcome to Medicare" physical examination received within the first 12 months a beneficiary is covered by Medicare Part B. HPHC recommends that Subscribers utilize this benefit if available. After being enrolled in Medicare Part B for one year, Medicare also covers a yearly physical exam, known as a "Wellness" visit. The first yearly physical exam must take place at least 12 months after the "Welcome to Medicare" physical examination, if a beneficiary has had one.

When specific Medicare coverage criteria are met, Medicare also provides coverage for preventive services including, but not limited to: (1) Pap tests, pelvic and breast exams; (2) Mammograms; (3) Prostate cancer screenings; (4) Diabetes screenings and (5) bone mass measurements; (6) glaucoma testing; (7) medical nutrition therapy; (8) counseling to stop smoking; (9) colorectal cancer screening, including fecal occult blood tests, flexible sigmoidoscopy, colonoscopy and barium enema examinations; and (10) immunizations for flu, pneumonia and hepatitis B. Coverage for mammograms includes a baseline mammogram for women between ages 35 and 39 and an annual mammogram for women 40 years of age and older.

Please refer to Section III. D. of your Benefit Handbook for detailed information on additional preventive care services covered by the Plan. Please consult with your doctor and refer to the Medicare publication, *Medicare and You,* for additional information on preventive care services that may benefit you.

## SECTION 3: COVERAGE OUTSIDE OF THE UNITED STATES

Your Plan provides limited coverage for Subscribers traveling outside of the United States. Please refer to Section III.D.3 of your Benefit Handbook for the details of your coverage.*

* The Plan pays up to the Payment Maximum. Please see section *V.H. The Payment Maximum* in your Medicare Enhance Benefit Handbook for more information.

## SECTION 4: INPATIENT SERVICES

| Service | Medicare Parts A and B Pays: (if a Medicare covered service) | Medicare Enhance Pays: * | You Pay: * | Section:** |
|---|---|---|---|---|
| **Hospital Care (including acute, rehabilitation and psychiatric hospitalizations)** | | | | |
| Days 1-60 in a Benefit Period | All but Medicare Deductible amount | Medicare Deductible amount | Nothing | III.B.1 |
| Days 61- 90 in a Benefit Period | All but Medicare Coinsurance amount | Medicare Coinsurance amounts | Nothing | |
| Up to 60 Lifetime Reserve Days (if any) | All but Reserve Days Daily Coinsurance amount | Medicare Lifetime Reserve Days Daily Coinsurance amounts | Nothing | |
| After your 60 Lifetime Reserve Days are exhausted | Nothing | All charges to the extent Medically Necessary | Nothing | |
| **Note**: Additional coverage may be available for mental health and substance use disorder treatment. Please see Section 6 of this Schedule of Benefits. | | | | |
| **Skilled Nursing Facility Care (SNF)** | | | | |
| Days 1-20 | Medicare allowable amount | Nothing | Nothing | III.B.1.b |
| Days 21-100 | Medicare allowable amount minus SNF Daily Coinsurance amount | The SNF Daily Coinsurance amounts | Nothing | |
| Days 100 + | Nothing | Nothing | All Charges | |
| **Religious Nonmedical Health Care Institutions** | Covered less Medicare Deductible and Coinsurance amounts | Medicare Deductible and Coinsurance amounts | Nothing | III.B.1.c |
| **Physicians and Other Professionals (inpatient services only)** | Covered less Medicare Deductible and Coinsurance amounts | Medicare Deductible and Coinsurance amounts | Nothing | III.B.1 |

* The Plan pays up to the Payment Maximum. Please see section *V.H. The Payment Maximum* in your Medicare Enhance Benefit Handbook for more information.

** Section numbers refer to your Medicare Enhance Benefit Handbook.

## SECTION 4: INPATIENT SERVICES

| Service | Medicare Parts A and B Pays: (if a Medicare covered service) | Medicare Enhance Pays: * | You Pay: * | Section:** |
|---|---|---|---|---|
| **Blood Transfusions**<br>First 3 pints of blood per calendar year | Nothing | Medicare Blood Deductible | Nothing | XI |
| Beyond 3 pints per calendar year | Covered less Medicare Deductible and Coinsurance amounts | Medicare Deductible and Coinsurance amounts | Nothing | |
| **Human Organ Transplants (Including bone marrow transplants)** | Covered less Medicare Deductible and Coinsurance amounts | Medicare Deductible and Coinsurance amounts | Nothing | III.B.1.a<br>III.C.4 |

## SECTION 5: OUTPATIENT SERVICES

| Service | Medicare Parts A and B Pays: (if a Medicare covered service) | Medicare Enhance Pays: * | You Pay: * | Section:** |
|---|---|---|---|---|
| **Emergency Services** | Covered less Medicare Deductible and Coinsurance amounts | Medicare Deductible and Coinsurance amounts, less Emergency room Copayment per visit | $50 Emergency Room Copayment per visit, waived if admitted to a Hospital | II.B.2.a |
| **Urgent Care Services** | Covered less Medicare Deductible and Coinsurance amounts | Medicare Deductible and Coinsurance amounts, less applicable Copayment per visit | $15 Copayment per visit | III.B.2.b |
| **Physicians and other covered Professionals (including mental health and substance use disorder treatment)** | Covered less Medicare Deductible and Coinsurance amounts | Medicare Deductible and Coinsurance amounts, less applicable Copayment per visit | $15 Copayment per visit (Please note: No Copayment applies to diagnostic tests, x-rays, and immunizations if billed without a professional office visit and no additional services are provided.) | III.B.2.c |

* The Plan pays up to the Payment Maximum. Please see section *V.H. The Payment Maximum* in your Medicare Enhance Benefit Handbook for more information.

** Section numbers refer to your Medicare Enhance Benefit Handbook.

## SECTION 5: OUTPATIENT SERVICES

| Service | Medicare Parts A and B Pays: (if a Medicare covered service) | Medicare Enhance Pays: * | You Pay: * | Section:** |
|---|---|---|---|---|
| **House Calls by a physician** | Covered less Medicare Deductible and Coinsurance amounts | Medicare Deductible and Coinsurance amounts | $15 Copayment per visit | III |
| **Administration of Allergy Injections** | Covered less Medicare Deductible and Coinsurance amounts | Medicare Deductible and Coinsurance amounts, less applicable Copayment per visit | $5 Copayment per visit | III |
| **Medical Therapies including Outpatient Surgery** | Covered less Medicare Deductible and Coinsurance amounts | Medicare Deductible and Coinsurance amounts | Nothing | III.B.2.f |
| **Chiropractic Services** **Note:** Limited coverage provided. See your *Benefit Handbook* | Covered less Medicare Deductible and Coinsurance amounts | Medicare Deductible and Coinsurance amounts, less applicable Copayment per visit (if Medicare coverage is provided). | $15 Copayment per visit | III.B.2.c |
| **Podiatric Services** Limited coverage provided. See your *Benefit Handbook* | Covered less Medicare Deductible and Coinsurance amounts | Medicare Deductible and Coinsurance amounts, less applicable Copayment per visit | $15 Copayment per visit | III.B.2.c |
| **Physical and Occupational Therapy** | Covered less Medicare Deductible and Coinsurance amounts | Medicare Deductible and Coinsurance amounts, less applicable Copayment per visit | $15 Copayment per visit | III.B.2.l |

* The Plan pays up to the Payment Maximum. Please see section *V.H. The Payment Maximum* in your Medicare Enhance Benefit Handbook for more information.

** Section numbers refer to your Medicare Enhance Benefit Handbook.

## SECTION 5: OUTPATIENT SERVICES

| Service | Medicare Parts A and B Pays: (if a Medicare covered service) | Medicare Enhance Pays: * | You Pay: * | Section:** |
|---|---|---|---|---|
| **Dental Care and Oral Surgery Services**<br>**Note:** Limited coverage provided. See your *Benefit Handbook* | Covered less Medicare Deductible and Coinsurance amounts | Medicare Deductible and Coinsurance amounts, less applicable Copayment per visit (if Medicare coverage is provided) | $15 Copayment per visit | III.B.2.n |
| **Hospice Care (including inpatient Respite Care)** | 100% of Medicare allowable amount and 95% of the cost of outpatient drugs and respite care (Medicare Hospice Coinsurance). Benefits are covered less the Medicare Deductible | Medicare Deductible and the Hospice Coinsurance amount | Nothing | III.B.2.j |
| **Diagnostic Tests and Procedures** | Covered less Medicare Deductible and Coinsurance amounts | Medicare Deductible and Coinsurance amounts, less applicable Copayment per visit | Nothing (No Copayment applies to diagnostic tests, X-rays, and immunizations if billed without a professional office visit and no additional services are provided.) | III.B.2.e<br>III.D.2.b |
| **Ambulance** | Covered less Medicare Deductible and Coinsurance amounts | Medicare Deductible and Coinsurance amounts | Nothing | III.B.2.i |
| **Durable Medical Equipment and Prosthetic Devices** | Covered less Medicare Deductible and Coinsurance amounts | Medicare Deductible and Coinsurance amounts | Nothing | III.B.2.g |
| **Home Health Care Services** | Medicare allowable amount | Nothing | Nothing | III.B.2.h |

* The Plan pays up to the Payment Maximum. Please see section *V.H. The Payment Maximum* in your Medicare Enhance Benefit Handbook for more information.

** Section numbers refer to your Medicare Enhance Benefit Handbook.

## SECTION 5: OUTPATIENT SERVICES

| Service | Medicare Parts A and B Pays: (if a Medicare covered service) | Medicare Enhance Pays: * | You Pay: * | Section:** |
|---|---|---|---|---|
| **Home Infusion Therapy** **Note:** Very limited coverage provided. See your *Benefit Handbook* | Generally None | All charges minus any coverage by Medicare | Nothing | III.D.5 |
| **Consultations Concerning Contraception and Hormone Replacement Therapy** | Covered less Medicare Deductible and Coinsurance amounts | Medicare Deductible and Coinsurance amounts, less applicable Copayment per visit | Nothing | III.C.7 |
| **Kidney Dialysis** | Covered less Medicare Deductible and Coinsurance amounts | Medicare Deductible and Coinsurance amounts | Nothing | III.B.2.k |
| **Cardiac Rehabilitation Services** | Covered less Medicare Deductible and Coinsurance amounts | Medicare Deductible and Coinsurance amounts, less applicable Copayment per visit | $15 Copayment per visit | III.D.8 |

* The Plan pays up to the Payment Maximum. Please see section *V.H. The Payment Maximum* in your Medicare Enhance Benefit Handbook for more information.

** Section numbers refer to your Medicare Enhance Benefit Handbook.

## SECTION 6: MEDICARE ENHANCE PLAN BENEFITS

**The plan will cover the benefits in this section when Medicare coverage is not available:**

| Service | Medicare Parts A and B Pays: (if a Medicare covered service) | Medicare Enhance Pays: * | You Pay: * | Section:** |
|---|---|---|---|---|
| **Inpatient Mental Health Care** | | | | |
| For all Mental and Emotional disorders. | Nothing | Full benefits, to the extent medically necessary | Nothing | III.C.1 |
| For Biologically-Based and Rape Related Mental and Emotional Disorders **(including Substance Use Disorders).** **Note:** Benefits are provided for the same number of days as the coverage provided for a physical illness. | | | | |
| **Outpatient Mental Health Care** | | | | |
| For all Mental and Emotional disorders. | Nothing | Full benefits, less applicable Copayment per visit | $15 Copayment per visit | III.C.1 |
| For Biologically-Based and Rape Related Mental and Emotional Disorders **(including Substance Use Disorders).** Benefits are provided for unlimited visits | | | | |

* The Plan pays up to the Payment Maximum. Please see section *V.H. The Payment Maximum* in your Medicare Enhance Benefit Handbook for more information.

** Section numbers refer to your Medicare Enhance Benefit Handbook.

## SECTION 6: MEDICARE ENHANCE PLAN BENEFITS (Continued)

| Service | Medicare Parts A and B Pays: (if a Medicare covered service) | Medicare Enhance Pays: * | You Pay: * | Section:** |
|---|---|---|---|---|
| **Partial Hospitalization for Mental Health and Substance Use Disorder Treatment** | Covered less Medicare Deductible and Coinsurance amounts | Medicare Deductible and Coinsurance amounts | Nothing | III.B.1 |
| **Detoxification, Psychopharma-cological, Psychological Testing, and Neuropsychological Assessment Services** | Covered less Medicare Deductible and Coinsurance amounts | Medicare Deductible and Coinsurance amounts, less applicable Copayment per visit | $15 Copayment per visit | III.C.1.d |
| **Scalp Hair Prosthesis (Wigs)** | Nothing | Up to $350 per calendar year | All charges in excess of $350 | III.C.3 |
| **Low Protein Foods** | Nothing | Up to $5,000 per calendar year | All charges in excess of $5,000 | III.C.5 |
| **Special Formulas for Malabsorption** | Nothing | Full benefits | Nothing | III.C.2 |
| **Hearing Aids (for Subscribers up to the age of 22)**<br><br>– $2,000 per hearing aid every 36 months, for each hearing impaired ear | Nothing | Up to $2,000 per hearing aid every 36 months, for each hearing impaired ear | All charges in excess of $2,000 | III.C.10 |
| **Lipodystrophy Syndrome** | Nothing | Full benefits | Nothing | III. C.11 |

* The Plan pays up to the Payment Maximum. Please see section *V.H. The Payment Maximum* in your Medicare Enhance Benefit Handbook for more information.

** Section numbers refer to your Medicare Enhance Benefit Handbook.

## SECTION 7: ADDITIONAL COVERED SERVICES

| Service | Medicare Parts A and B Pays: (if a Medicare covered service) | Medicare Enhance Pays: * | You Pay: * | Section:** |
|---|---|---|---|---|
| **Diabetes Treatment** | Covered less Medicare Deductible and Coinsurance amounts for Medicare covered items | Medicare Deductible and Coinsurance amounts for Medicare covered items. Full benefits for non-Medicare covered items, less applicable Copayment per visit | $15 Copayment per visit | III.D.4 |
| **Medicare Covered Clinical Trials** | Covered less Medicare Deductible and Coinsurance amounts | Medicare Deductible and Coinsurance amounts | Nothing | III.B.2.p |
| **Human Leukocyte Antigen Testing** | Covered less Medicare Deductible and Coinsurance amounts | Medicare Deductible and Coinsurance amounts, less applicable Copayment per visit | Nothing | III.D.9 |
| **Hearing Aids** Limited to $2,000 every two years for both ears combined | Nothing | First $500 covered in full, then remaining $1,500 covered at 80% | 20% Coinsurance after the first $500 and all charges in excess of the benefit limit | III.D.7 |
| **Eye Exams** Limited to one routine eye examination in each 24-month period | Nothing | Full benefits, less applicable Copayment per visit | $15 Copayment per visit | III.D.2.b |
| **Smoking Cessation** See your *Benefit Handbook* | Covered less Medicare Deductible and Coinsurance amounts | Medicare Deductible and Coinsurance amounts | Nothing | III.D.11 |

* The Plan pays up to the Payment Maximum. Please see section *V.H. The Payment Maximum* in your Medicare Enhance Benefit Handbook for more information.

** Section numbers refer to your Medicare Enhance Benefit Handbook.

## SECTION 8: WHAT THE PLAN DOES NOT COVER

**A. No benefits will be provided by the Plan for any of the following**:

1. Any product or service that is not covered by Medicare unless specifically listed as a Covered Service in this *Benefit Handbook* or the *Schedule of Benefits*.
2. Any charges for products or services covered by a Medicare Advantage plan operated under Medicare Part C or a Prescription Drug Plan (PDP) under Medicare Part D.
3. Any product or service obtained at an unapproved hospital (or other facility) if Medicare requires that a service be provided at a hospital (or other facility) specifically approved for that service. This exclusion applies to weight loss (bariatric) surgery; liver, lung, heart and heart-lung transplants; and any other services Medicare determines must be obtained at a hospital (or other facility) that has been specifically approved for a specific service to be eligible for coverage by Medicare.
4. Any product or service that is provided to you after the date on which your enrollment in the plan has ended.
5. Any charges that exceed the Payment Maximum. (Please see the Glossary for the definition of "Payment Maximum.")
6. Any products or services received in a hospital not certified to provide services to Medicare beneficiaries, unless the hospital is outside the United States.
7. Any product or service for which no charge would be made in the absence of insurance.

**B. No Benefits will be provided by the Plan for any of the following unless they are covered by Medicare Parts A or B:**

1. Any product or service that is not Medically Necessary.
2. Any product or service (1) for which you are legally entitled to treatment at government expense or (2) for which payment is required to be made by a Workers' Compensation plan or laws of similar purpose.
3. Any charges for inpatient care over the semi-private room rate, except when a private room is Medically Necessary.
4. Any product or service received outside of the United States that is: (1) related to the provision of routine or preventive care of any kind; (2) a service that was, or could have been, scheduled before leaving the United States, even if such scheduling would have delayed travel plans; (3) a form of transportation, including transportation back to the United States, except road ambulance to the nearest hospital; or (4) a service that would not be a covered by Medicare or the Plan in the United States.
5. Any product or service that is Experimental or Unproven. (Please see the Glossary for the definition of "Experimental or Unproven.")
6. Any service or supply purchased from the internet.
7. Private duty nursing.

8. Chiropractic care. (Note that Medicare provides limited benefits for chiropractic services to correct a subluxation of the spine.)
9. Cosmetic services or products, including, but not limited to, cosmetic surgery, except for services required to be covered under the Women's Health and Cancer Rights Act of 1998.
10. Rest or Custodial Care.
11. Eyeglasses and contact lenses, or examinations to prescribe, fit, or change eyeglasses or contact lenses (Note that Medicare provides limited benefits for eyeglasses or contact lenses after cataract surgery.).
12. Biofeedback, massage therapy (including myotherapy), sports medicine clinics, treatment with crystals or routine foot care services such as the trimming of corns and bunions, removal of calluses, unless such care is Medically Necessary due to circulatory system disease such as diabetes.
13. Foot orthotics, except as required for the treatment of severe diabetic foot disease.
14. Any form of hair removal or restoration, including, but not limited to, electrolysis, laser treatment, transplantation or drug therapy. (Please see Section III.C.3. for the coverage provided for wigs.)
15. Dental Services, except the specific dental services listed in your *Benefit Handbook* and this *Schedule of Benefits*. This exclusion includes, but is not limited to: (a) dental services for temporomandibular joint dysfunction (TMD); (b) extraction of teeth, except when specifically listed as a Covered Service; and (c) dentures, except that (1) the Plan will cover the Medicare coinsurance and deductible amount for any Dental Service that has been covered by Medicare. (Please see the Glossary for the definition of "Dental Services.")
16. Ambulance services except as specified in this *Benefit Handbook* or the *Schedule of Benefits*. No benefits will be provided for transportation other than by ambulance.
17. Exercise equipment; or personal comfort or convenience items such as radios, telephone, television, or haircutting services.
18. Any product or service provided by (1) anyone related to you by blood, marriage or adoption, or (2) anyone who ordinarily lives with you.
19. Refractive eye surgery, including laser surgery, orthokeratology or lens implantation for correction of myopia, hyperopia and astigmatism.
20. Any products or services related to diet plans or weight loss programs, including diet foods, drinks or drugs of any kind. (However, the Plan will cover Medicare Coinsurance and Deductible amounts for professional services or surgery covered by Medicare for the treatment of obesity.)
21. Drugs or medications that can be self-administered.
22. Educational services or testing; services for problems of school performance; sensory integrative praxis tests, vocational rehabilitation, or vocational evaluations focused on job adaptability, job placement, or therapy to restore function for a specific occupation.
23. Planned home births.
24. Devices or special equipment needed for sports or occupational purposes.

25. 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 this *Benefit Handbook*.
26. Hearing aid batteries, and any device used by individuals with hearing impairment to communicate over the telephone or internet, such as TTY or TDD.
27. Acupuncture, aromatherapy, or alternative medicine
28. Mental health services that are (1) provided to Subscribers who are confined or committed to a jail, house of correction, prison, or custodial facility of the Department of Youth Services; or (2) provided by the Department of Mental Health.

## SECTION 9: IMPORTANT NOTICES

Medical Emergency: You are always covered for care you need in a medical emergency. In the event of a medical emergency, you should go to the nearest emergency facility or call 911 or the local emergency number.

Coverage will be subject to the terms, conditions, exclusions and limitation of Medicare-eligible services and supplies, and is subject to change pursuant to Medicare guidelines. This brochure is not intended as an explanation of Medicare benefits. Information and guidelines as established by the Centers for Medicare and Medicaid Services (CMS) regarding Medicare, may be obtained by contacting your local Social Security office.

This Plan is only available to Subscribers enrolled through the Group Insurance Commission (GIC). Coverage under the Plan is effective on the first day of the month chosen by the GIC and renews year to year on the GIC's anniversary date unless terminated in accordance with the terms of the contract between the GIC and HPHC. Please refer to your Benefit Handbook for information about your eligibility and continuation of coverage rights under this Plan.

## Language Assistance Services

**Español (Spanish)** ATENCIÓN: Si usted habla español, servicios de asistencia lingüística, de forma gratuita, están a su disposición. Llame al 1-888-333-4742 (TTY: 711).

**Português (Portuguese)** ATENÇÃO: Se você fala português, encontram-se disponíveis serviços linguísticos gratuitos. Ligue para 1-888-333-4742 (TTY: 711).

**Kreyòl Ayisyen (French Creole)** ATANSYON: Si nou palé Kreyòl Ayisyen, gen asistans pou sèvis ki disponib nan lang nou pou gratis. Rele 1-888-333-4742 (TTY: 711).

**繁體中文 (Traditional Chinese)** 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-888-333-4742（TTY：711）。

**Tiếng Việt (Vietnamese)** CHÚ Ý: Nếu quí vị nói Tiếng Việt, dịch vụ thông dịch của chúng tôi sẵn sàng phục vụ quí vị miễn phí. Gọi số 1-888-333-4742 (TTY: 711).

**Русский (Russian)** ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-888-333-4742 (телетайп: 711).

**العربية (Arabic)**
**إنتباه:** إذا أنت تتكلم اللغة العربية ، خدمات المساعدة اللغوية متوفرة لك مجانا. إتصل على **1 888-333-4742**
(TTY: 711)

**ខ្មែរ (Cambodian)** [ប្រសិនជាអ្នកនិយាយភាសាខ្មែរ, សេវាជំនួយភាសាដោយឥតគិតថ្លៃ។ ចូរ ទូរស័ព្ទ 1-888-333-4742 (TTY: 711)។

**Français (French)** ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-888-333-4742 (ATS: 711).

**Italiano (Italian)** ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-888-333-4742 (TTY: 711).

**한국어 (Korean)** '알림': 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-888-333-4742 (TTY: 711) 번으로 전화해 주십시오.

**ελληνικά (Greek)** ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, υπάρχουν στη διάθεσή σας δωρεάν υπηρεσίες γλωσσικής υποστήριξης. Καλέστε 1-888-333-4742 (TTY: 711).

**Polski (Polish)** UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-888-333-4742 (TTY: 711).

**हिंदी (Hindi)** ध्यान दीजिए: अगर आप हिंदी बोलते हैं तो आपके लिये भाषाकी सहायता मुफ्त में उपलब्ध है. जानकारी के लिये फोन करे. 1-888-333-4742 (TTY: 711)

**ગુજરાતી (Gujarati)** ધ્યાન આપો : જો તમે ગુજરાતી બોલતા હો તો આપને માટે ભાષાકીય સહાય તદ્દન મફત ઉપલબ્ધ છે. વિશેષ માહિતી માટે ફોન કરો. 1-888-333-4742 (TTY: 711)

**ພາສາລາວ (Lao)** ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-888-333-4742 (TTY: 711).

ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call 1-888-333-4742 (TTY: 711).

Harvard Pilgrim Health Care includes Harvard Pilgrim Health Care, Harvard Pilgrim Health Care of Connecticut, Harvard Pilgrim Health Care of New England and HPHC Insurance Company.

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**General Notice About Nondiscrimination and Accessibility Requirements**

Harvard Pilgrim Health Care and its affiliates as noted below ("HPHC") comply with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. HPHC does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

HPHC:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, audio, other formats)
- Provides free language services to people whose primary language is not English, such as qualified interpreters.

If you need these services, contact our Civil Rights Compliance Officer.

If you believe that HPHC has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with: Civil Rights Compliance Officer, 93 Worcester St, Wellesley, MA 02481, (866) 750-2074, TTY service: 711, Fax: (617) 509-3085, Email: civil_rights@harvardpilgrim.org. You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, the Civil Rights Compliance Officer is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
(800) 368-1019, (800) 537-7697 (TTY)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Harvard Pilgrim Health Care includes Harvard Pilgrim Health Care, Harvard Pilgrim Health Care of Connecticut, Harvard Pilgrim Health Care of New England and HPHC Insurance Company.

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HPHC Insurance Company

# Important information about your plan

## Appeals

You may file a complaint about a coverage decision or appeal that decision at any time with HPHC Insurance Company (HPHC). For details, see your Benefit Handbook.

To access your Benefit Handbook online, log into your personal account on harvardpilgrim.org, click on More Tasks in HPHConnect and select Plan Documents under My Documents. For assistance, call Member Services at (888) 333-4742.

## Member confidentiality

HPHC is committed to ensuring and safeguarding the confidentiality of its members' personal information, including medical information, in all settings. HPHC staff use and disclose members' personal information only in connection with providing services and benefits and in accordance with HPHC's confidentiality policies. HPHC permits only designated employees who are trained in the proper handling of member information to have access to and use of your information.

HPHC sometimes contracts with other organizations or entities to assist with the delivery of care or administration of benefits. Any such entity must agree to adhere to our confidentiality and privacy standards.

When HPHC uses or discloses your personal information, it does so using the minimum amount of information necessary to accomplish the specific activity. HPHC discloses its members' personal information only: (1) in connection with the delivery of care or administration of benefits, such as utilization review, quality assurance activities and third-party reimbursement by other payers, including self-insured employer groups; (2) when you specifically authorize the disclosure; (3) in connection with certain activities allowed under law, such as research and fraud detection; (4) when required by law; or (5) as otherwise allowed under the terms of your Benefit Handbook. Whenever possible, HPHC discloses member information without member identifiers and in all cases only discloses the amount of information necessary to achieve the purpose for which it was disclosed. HPHC will not disclose to other third parties, such as employers, member-specific information (i.e., information from which you are personally identifiable) without your specific consent unless permitted by law or as necessary to accomplish the types of activities described above.

In accordance with applicable laws, HPHC and all of its contracted health care providers agree to give members access to, and a copy of, their medical records upon a member's request. In addition, your medical records cannot be released to a third party without your consent or unless permitted by law.

Visit harvardpilgrim.org or call us for a copy of our Notice of Privacy Practices.

**MEMBERS:** (888) 333-4742
**NON-MEMBERS:** (800) 848-9995
**TTY:** 711

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# Harvard Pilgrim Health Care. Your guide to better health.

HPHC Insurance Company

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