

Schedule of Benefits

The Harvard Pilgrim PPO

Massachusetts

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 service to which they apply.

You have an **Out-of-Network Deductible** of \$400 per Member or \$1,100 per family, per calendar year, applied to the eligible expense.

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

You have an **Out-of-Network Out-of-Pocket Maximum** of \$2,000 per Member or \$7,500 per family, including the Deductible and Coinsurance (not including riders providing benefits for prescription drugs, adult preventive dental or vision hardware and Coinsurance for durable medical and prosthetic equipment and vision hardware for special conditions).

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 3 months of a calendar year will be applied to the Deductible requirement for the next year.

Service	In-Network (Participating Providers)	Out-of-Network (Non-Participating Providers)
Inpatient Acute Hospital Services (including Day Surgery)		
All covered services including the following: <ul style="list-style-type: none"> ▪ Coronary care ▪ Hospital services ▪ Intensive care ▪ Physicians' and surgeons' services including consultations ▪ Semi-private room and board 	Covered in full.	20% Coinsurance after the Deductible has been met.
Skilled Nursing Facility Care Services		
<ul style="list-style-type: none"> ▪ Covered up to 100 days per calendar year 	Covered in full.	20% Coinsurance after the Deductible has been met.
Inpatient Rehabilitation Services		
<ul style="list-style-type: none"> ▪ Covered up to 60 days per calendar year 	Covered in full.	20% Coinsurance after the Deductible has been met.
Maternity Services		
<ul style="list-style-type: none"> ▪ Prenatal and postpartum care 	Covered in full.	20% Coinsurance after the Deductible has been met.
<ul style="list-style-type: none"> ▪ All hospital services for mother and routine nursery charges for newborn 	Covered in full.	20% Coinsurance after the Deductible has been met.

Service	In-Network (Participating Providers)	Out-of-Network (Non-Participating Providers)
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 	<p>Covered in full. (Unless otherwise listed under a specific benefit below.)</p>	<p>20% Coinsurance after the Deductible has been met.</p>
Physician Services		
<p>All covered services including the following:</p> <ul style="list-style-type: none"> ▪ Administration of injections ▪ Allergy tests and treatments ▪ Changes and removal of casts, dressings or sutures ▪ Chemotherapy ▪ Consultations concerning contraception and hormone replacement therapy ▪ Diabetes self-management, including education and training ▪ Family planning services ▪ Infertility services ▪ Diagnostic screening and tests, including but not limited to mammograms, blood tests, lead screenings and screenings mandated by state law ▪ Health education, including nutritional counseling ▪ Medical treatment of temporomandibular joint dysfunction (TMD) ▪ Preventive care, including routine physical examinations, immunizations, routine annual eye examinations, school, camp, sports and premarital examinations ▪ Sick and well office visits, including psychopharmacological services ▪ Vision and hearing screening 	<p>\$20 Copayment per visit. (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>	<p>20% Coinsurance after the Deductible has been met.</p>
<ul style="list-style-type: none"> ▪ Administration of allergy injections 	<p>\$5 Copayment per visit.</p>	<p>20% Coinsurance after the Deductible has been met.</p>

Service	In-Network (Participating Providers)	Out-of-Network (Non-Participating Providers)
Emergency Room Care Services		
<ul style="list-style-type: none"> Hospital emergency room treatment 	\$100 Copayment per visit. (This Copayment is waived if you are directly admitted.)	\$100 Copayment per visit. (This Copayment is waived if you are directly admitted.)
<p>You are always covered in a Medical Emergency. 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 the Plan within 48 hours, or as soon as you can.</p>		
Emergency Admission Services		
<ul style="list-style-type: none"> Inpatient services which are required immediately following the rendering of emergency room treatment 	Covered in full.	Covered in full.
Mental Health Care (Including the Treatment of Substance Abuse Disorders)		
Inpatient Services		
<ul style="list-style-type: none"> Mental health care services 	Covered in full.	20% Coinsurance after the Deductible has been met.
Intermediate Care Services		
<ul style="list-style-type: none"> Acute residential treatment (including detoxification), crisis stabilization and in-home family stabilization Intensive outpatient programs, partial hospitalization and day treatment programs 	Covered in full.	20% Coinsurance after the Deductible has been met.
Outpatient Services		
<ul style="list-style-type: none"> Mental health care services <ul style="list-style-type: none"> Group therapy Individual therapy 	\$10 Copayment per visit. \$20 Copayment per visit.	20% Coinsurance after the Deductible has been met.
<ul style="list-style-type: none"> Detoxification 	\$20 Copayment per visit.	20% Coinsurance after the Deductible has been met.
<ul style="list-style-type: none"> Medication management 	\$20 Copayment per visit.	20% Coinsurance after the Deductible has been met.
<ul style="list-style-type: none"> Psychological testing and neuropsychological assessment 	\$20 Copayment per visit.	20% Coinsurance after the Deductible has been met.

Service	In-Network (Participating Providers)	Out-of-Network (Non-Participating Providers)
Dental Services		
<ul style="list-style-type: none"> Preventive care for children through the age of 12. Two visits per Member per calendar year, including examination, cleaning, x-rays, and fluoride treatment. 	\$20 Copayment per visit.	20% Coinsurance after the Deductible has been met.
<ul style="list-style-type: none"> Extraction of unerupted teeth impacted in bone Initial emergency treatment (within 72 hours of injury) 	\$20 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		
<ul style="list-style-type: none"> Home care services Intermittent skilled nursing care 	Covered in full.	20% Coinsurance after the Deductible has been met.
No cost sharing or benefit limit applies to durable medical equipment, physical therapy or occupational therapy received as part of authorized home health care.		
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, for durable medical and prosthetic equipment benefit.	Subject to the applicable cost sharing, if any, for durable medical and prosthetic equipment benefit.
<ul style="list-style-type: none"> Blood glucose monitors, insulin pumps and supplies and infusion devices 	Covered in full.	Covered in full.
<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 Plan includes prescription drug coverage. If prescription drug coverage is not available, then you will pay a \$5 Copayment for Tier 1 items, a \$10 Copayment for Tier 2 items, and a \$25 Copayment for Tier 3 items.	Subject to the applicable prescription drug Copayment listed on your ID card, if your Plan includes prescription drug coverage. If prescription drug coverage is not available, then you will pay a \$5 Copayment for Tier 1 items, a \$10 Copayment for Tier 2 items, and a \$25 Copayment for Tier 3 items.

Service	In-Network (Participating Providers)	Out-of-Network (Non- Participating Providers)
Durable Medical Equipment including Prosthetics		
<p>Coverage includes, but is not limited to:</p> <ul style="list-style-type: none"> ▪ Durable medical equipment ▪ Prosthetic devices (including artificial arms and legs) ▪ Breast prostheses, including replacements and mastectomy bras ▪ Ostomy supplies ▪ Wigs - up to a limit of \$350 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 ▪ Oxygen and respiratory equipment 	Covered in full.	20% Coinsurance after the Deductible has been met.
Hypodermic Syringes and Needles		
<ul style="list-style-type: none"> ▪ Hypodermic syringes and needles to the extent Medically Necessary, as required by Massachusetts law 	Subject to the applicable prescription drug Copayment listed on your ID card, if your Plan includes prescription drug coverage. If prescription drug coverage is not available, then you will pay the lower of the pharmacy's retail price or a \$5 Copayment for Tier 1 items, \$10 Copayment for Tier 2 items and a \$25 Copayment for Tier 3 items.	Subject to the applicable prescription drug Copayment listed on your ID card, if your Plan includes prescription drug coverage. If prescription drug coverage is not available, then you will pay the lower of the pharmacy's retail price or a \$5 Copayment for Tier 1 items, \$10 Copayment for Tier 2 items and a \$25 Copayment for Tier 3 items.

Service	In-Network (Participating Providers)	Out-of-Network (Non-Participating Providers)
Autism Spectrum Disorders		
Professional Services		
<ul style="list-style-type: none"> Coverage for the treatment of Autism Spectrum Disorders is provided for all of the services otherwise covered under your Plan. However, no benefit limit applies to services for the treatment of Autism Spectrum Disorders. 	<p>Your Member cost sharing depends upon the type of service provided, as listed in this Schedule of Benefits. For example: For services provided by a physician see “Physician Services.” For services by a Licensed Mental Health Professional see “Mental Health Care (Including the Treatment of Substance Abuse Disorders).” For services by a speech therapist, physical therapist and occupational therapist, see “Other Health Services.”</p>	<p>Your Member cost sharing depends upon the type of service provided, as listed in this Schedule of Benefits. For example: For services provided by a physician see “Physician Services.” For services by a Licensed Mental Health Professional see “Mental Health Care (Including the Treatment of Substance Abuse Disorders).” For services by a speech therapist, physical therapist and occupational therapist, see “Other Health Services.”</p>
Applied Behavior Analysis		
<ul style="list-style-type: none"> No benefit limit applies to this service 	\$20 Copayment per visit.	20% Coinsurance after the Deductible has been met.

Service	In-Network (Participating Providers)	Out-of-Network (Non-Participating Providers)
Other Health Services		
<ul style="list-style-type: none"> ▪ Cardiac rehabilitation ▪ Chiropractic care - up to \$750 per calendar year ▪ Dialysis ▪ Second opinion ▪ Physical and occupational therapies - up to 60 visits per calendar year <p>Please note: Outpatient physical and occupational therapy is covered to the extent Medically Necessary for: (1) children under the age of three and (2) the treatment of Autism Spectrum Disorders.</p> <ul style="list-style-type: none"> ▪ Speech-language and hearing services, including therapy 	\$20 Copayment per visit.	20% Coinsurance after the Deductible has been met.
<ul style="list-style-type: none"> ▪ Early intervention services 	Covered in full.	Covered in full.
<ul style="list-style-type: none"> ▪ House calls 	\$20 Copayment per visit.	20% Coinsurance after the Deductible has been met.
<ul style="list-style-type: none"> ▪ Hospice services 	Covered in full per outpatient 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.
<ul style="list-style-type: none"> ▪ Ambulance services ▪ Low protein foods (\$5,000 per Member per calendar year) ▪ State mandated formulas 	Covered in full.	Covered in full.
<ul style="list-style-type: none"> ▪ Vision hardware for special conditions (please see your Benefit Handbook for details on your coverage) 	Covered in full up to the benefit limit.	20% Coinsurance after the Deductible has been met up to the benefit limit.

Special Enrollment Rights

For Subscribers enrolled through an Employer Group:

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 himself or herself, along with his or her Dependents in this Plan if the employee or his or her Dependents lose eligibility for that other coverage (or if the employer stops contributing toward the employee's or Dependents' other coverage). However, enrollment must be requested within 30 days after other coverage ends (or after the employer stops contributing toward the employee's or Dependents' other coverage). In addition, if an employee has a new Dependent as a result of marriage, birth, adoption or placement for adoption, the employee may be able to enroll himself or herself and his or her Dependents. However, enrollment must be requested within 30 days after the marriage, birth, adoption or placement for adoption.

Special enrollment rights may also apply to persons who lose coverage under Medicaid or the Children's Health Insurance Program (CHIP) or become eligible for state premium assistance under Medicaid or CHIP. An employee or Dependent who loses coverage under Medicaid or CHIP as a result of the loss of Medicaid or CHIP eligibility may be able to enroll in this Plan, if enrollment is requested within 60 days after Medicaid or CHIP coverage ends. An employee or Dependent who becomes eligible for group health plan premium assistance under Medicaid or CHIP may be able to enroll in this Plan if enrollment is requested within 60 days after the employee or Dependent is determined to be eligible for such premium assistance.

Required Approvals

Hospital Admissions

Members are responsible for obtaining approval from HPHC before any hospital admission (including Day Surgery) occurs when either the doctor or facility is a Non-Participating Provider. If approval of the admission is not received, the Member is responsible for the first \$500 of the eligible expense. The \$500 payment does not count toward the Deductible or the Out-of-Pocket Maximum limit.

Specialized Services

When using Non-Participating Providers it is the Member's responsibility to obtain approval from HPHC for the following services before any costs are incurred. If approval is not obtained, the Member is responsible for the first \$500 of the eligible expense. The \$500 payment does not count toward the Deductible or the Out-of-Pocket Maximum limit.

- All inpatient services
- Physical, speech, and occupational therapies
- Advanced reproductive technologies
- All services provided in the Member's home
- Human organ transplants
- The following outpatient mental health services: intensive outpatient program treatment (treatment programs at an outpatient clinic or other facility generally lasting three or more hours a day for two or more days a week), partial hospitalization and day treatment programs, extended outpatient treatment visits (outpatient visits of more than 50 minutes duration with or without medication management or any treatment routinely involving more than one outpatient visit in a day), outpatient electro-convulsive treatment (ECT), psychological testing and neuropsychological assessment, and effective January 1, 2011, applied behavior analysis (ABA) for the treatment of autism.

48 Hour Emergency Notification

In cases of an emergency hospital admission to a Non-Participating Provider, HPHC must be notified within 48 hours of the admission. If notification is not received, the Member is responsible for the first \$500 of the eligible expense. The \$500 payment does not count toward the Deductible or the Out-of-Pocket Maximum limit.

Notice of Grandfathered Plan Status

Harvard Pilgrim Health Care believes this Plan is a “grandfathered health plan” under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your Plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to your Employer’s benefits office or human resources department. For plans governed by the Employee Retirement Income Security Act (ERISA), (generally these are plans purchased by an employer, other than a governmental entity or a church) you may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This Web site has a table summarizing which protections do and do not apply to grandfathered health plans. For Plans that are not governed by ERISA, you may also contact the U.S. Department of Health and Human Services at www.healthreform.gov.

Exclusions

- Cosmetic procedures, except as described in your Benefit Handbook
- Commercial diet plans or weight loss programs and any services in connection with such plans or programs
- Transsexual surgery, including related drugs or procedures
- Services that are not Medically Necessary
- Drugs, devices, treatments or procedures which are Experimental or Unproven
- Refractive eye surgery, including laser surgery and orthokeratology, for correction of myopia, hyperopia and astigmatism
- 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
- 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 and sports medicine clinics
- Any treatment with crystals
- Blood and blood products
- Educational services (including problems of school performance) or testing for developmental, educational or behavioral problems, except services covered under Early Intervention
- Sensory integrative praxis tests
- Physical examinations for insurance, licensing or employment
- Rest or custodial care
- Personal comfort or convenience items (including telephone and television charges), exercise equipment, wigs (except as required by state law and specifically covered in this Schedule of Benefits), derotation knee braces and 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 procedures necessary for conception as a result of voluntary sterilization)
- 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 the Benefit Handbook, Schedule of Benefits or Prescription Drug Brochure (if your Plan includes prescription drug 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
- Care 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
- 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 Handbook
- Services for a newborn who has not been enrolled as a Member, other than nursery charges for routine services provided to a healthy newborn
- Charges for missed appointments
- Acupuncture, aromatherapy and alternative medicine
- Planned home births
- Dentures

Exclusions

- Mental health services that are (1) provided to Members 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
- All charges over the semi-private room rate, except when a private room is Medically Necessary
- Hospital charges after the date of discharge
- If your Plan does not include coverage for outpatient prescription drugs, there is no coverage for birth control drugs, implants, injections and devices
- 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
- Dental services, except the specific dental services listed in your Benefit Handbook and this Schedule of Benefits. Restorative, periodontal, orthodontic, endodontic, prosthodontic and dental services for temporomandibular joint dysfunction (TMD) are not covered. 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 and bonding.
- Eyeglasses, contact lenses and fittings, except as listed in your Benefit Handbook and this Schedule of Benefits
- Hearing aids
- Foot orthotics, except for the treatment of severe diabetic foot disease
- Methadone maintenance
- Private duty nursing
- Health resorts, recreational programs, camps, wilderness programs, outdoor skills programs, relaxation or lifestyle programs, including any services provided in conjunction with, or as part of such types of programs.
- Services for any condition with only a "V Code" designation in the Diagnostic and Statistical Manual of Mental Disorders, which means that the condition is not attributable to a mental disorder
- Services related to autism spectrum disorders provided under an individualized education program (IEP), including any services provided under an IEP that are delivered by school personnel or any services provided under an IEP purchased from a contractor or vendor.