

# Schedule of Benefits

## Harvard Pilgrim Health Care, Inc.

### THE HARVARD PILGRIM PPO

### MASSACHUSETTS

This Schedule of Benefits summarizes your benefits under The Harvard Pilgrim PPO (the Plan) and states the Member Cost Sharing amounts that you must pay for Covered Benefits. However, it is only a summary of your benefits. Please see your Benefit Handbook and Prescription Drug Brochure (if you have the Plan's outpatient pharmacy coverage) for detailed information on benefits covered by the Plan and the terms and conditions of coverage.

#### **There are two levels of coverage - In-Network and Out-of-Network**

**In-Network** coverage applies when you use a Plan Provider for Covered Benefits. When using Plan Providers, coverage is based on the contracted rate between HPHC and the Provider.

**Out-of-Network** coverage applies when you use a Non-Plan Provider for Covered Benefits. When using Non-Plan Providers, the Plan pays only a percentage of the cost of the care you receive up to the Allowed Amount for the service. In most cases, this will be higher than the HPHC contracted rate. If a Non-Plan Provider charges any amount in excess of the Allowed Amount, you are responsible for the excess amount. Please refer to section I.E., titled, "Member Cost Sharing" in your Benefit Handbook for additional information about Out-of-Network Charges in excess of the Allowed Amount.

In a Medical Emergency you should go to the nearest emergency facility or call 911 or other local emergency access number. Your emergency room Member Cost Sharing, including your Deductible if applicable, is listed in the tables below.

#### **Member Responsibility for Notification and Prior Approval**

Members must contact HPHC for coverage of a number of services. These are listed below.

**Mental Health Care (Including the Treatment of Substance Abuse Disorders).** Prior Approval must be obtained before receiving certain mental health services from Non-Plan Providers. This requirement also applies to treatment of substance abuse disorders. Please refer to our internet site, [www.harvardpilgrim.org](http://www.harvardpilgrim.org), or contact the Member Services Department at **1-888-333-4742** for a list of services. To obtain Prior Approval for mental health or substance abuse services, please call the Behavioral Health Access Center at **1-888-777-4742**.

**Medical Services.** Members are required to notify HPHC before the start of any planned inpatient admission to a Non-Plan Medical Facility. Members are also required to obtain Prior Approval from HPHC for certain services. Before you receive services from a Non-Plan Provider, please refer to our Internet site, [www.harvardpilgrim.org](http://www.harvardpilgrim.org), or contact the Member Services Department at **1-888-333-4742** for a list of Out-of-Network services that require Prior Approval.

If you do not provide Notification or obtain Prior Approval when required, you will be responsible for paying the Penalty amount stated in this Schedule of Benefits in addition to any applicable Member Cost Sharing. No coverage will be provided if HPHC determines that the service is not Medically Necessary, and you will be responsible for the entire cost of the service.

**Emergency Care.** You do not need to contact HPHC before receiving care in a Medical Emergency. In the event of an emergency hospital admission to a Non-Plan Provider, you must notify HPHC within 48 hours of the admission, unless notification is not possible because of your

condition. If notice is given to HPHC by an attending emergency physician, no further notification is required. However, if notification is not received when the Member's condition permits it, the Member is responsible for the Penalty amount stated in this Schedule of Benefits. Please call **1-800-708-4414** to notify us of an emergency admission to a Non-Plan facility.

**Clinical Review Criteria**

We use clinical review criteria to evaluate whether certain services or procedures are Medically Necessary for a Member's care. Members or their practitioners may obtain a copy of our clinical review criteria applicable to a service or procedure for which coverage is requested. Clinical review criteria may be obtained by calling **1-888-888-4742 ext. 38723**.

**COPAYMENTS**

A Copayment is a dollar amount that is payable by the Member for certain covered services. The Copayment is due at the time services are rendered or when billed by the provider. Different Copayments apply depending on the type of service, the specialty of the provider and the location of service. Your identification card contains the Copayment amounts that apply to the Plan's most frequently used services.

**COVERED BENEFITS**

Your Covered Benefits are administered on a calendar year basis.

<b>General Cost Sharing Features:</b>	<b>Member Cost Sharing:</b>
<b>In-Network Deductible</b>	
	None
<b>Out-of-Network Deductible</b>	
	\$250 per Member per calendar year \$500 per family per calendar year
<b>In-Network Coinsurance and Copayments</b>	
	See Covered Benefits below
<b>Out-of-Network Coinsurance and Copayments</b>	
	See Covered Benefits below
<b>In-Network Out-of-Pocket Maximum</b>	
Includes all In-Network Member Cost Sharing	\$2,000 per Member per calendar year \$4,000 per family per calendar year
<b>Out-of-Network Out-of-Pocket Maximum</b>	
Includes all Out-of-Network Member Cost Sharing except: – Any charges above the Allowed Amount and any penalty for failure to receive Prior Approval when using Non-Plan Providers	\$2,000 per Member per calendar year \$4,000 per family per calendar year
<b>Out-of-Network Penalty Payment</b>	
– Does not count toward the Deductible or Out-of-Pocket Maximum	\$500

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General Cost Sharing Features:	Member Cost Sharing:
<b>Deductible Rollover</b>	
– Your Plan has a Deductible Rollover that applies to any Deductible amount that is incurred for services during the last 3 months of the calendar year and is applied toward the Deductible requirement for the next calendar year	

Benefit	In-Network Plan Providers Member Cost Sharing	Out-of-Network Non-Plan Providers Member Cost Sharing
<b>Acupuncture Treatment for Injury or Illness</b>		
– Limited to 20 visits per calendar year	\$25 Copayment per visit	Deductible, then 20% Coinsurance
<b>Ambulance Transport</b>		
– Emergency ambulance transport	No charge	Same as In-Network
– Non-emergency ambulance transport	No charge	Same as In-Network
<b>Autism Spectrum Disorders Treatment</b>		
– Applied behavior analysis	\$25 Copayment per visit	Deductible, then 20% Coinsurance
<b>Chemotherapy and Radiation Therapy</b>		
	No charge	Deductible, then 20% Coinsurance
<b>Dental Services</b>		
<b>Important Notice:</b> Coverage of Dental Care is very limited. Please see your Benefit Handbook for the details of your coverage.		
– Emergency Dental Care <b>Please Note:</b> Services must be received within 3 days of injury	Your Member Cost Sharing will depend upon the types of services provided, as listed in this Schedule of Benefits. For example, for services provided in a dentist’s office, see “Physician and Other Professional Office Visits.” For services provided in a hospital emergency room, see “Emergency Room Care.”	
– Extraction of teeth impacted in bone	Your Member Cost Sharing will depend upon the types of services provided, as listed in this Schedule of Benefits. For example, for services provided in a dentist’s office, see “Physician and Other Professional Office Visits.”	
– Pediatric Dental Care for children (up to the age of 13) – limited to 2 preventive dental exams per calendar year, only the following services are included: – Cleaning – Fluoride treatment – Teaching plaque control – X-rays	No charge	Deductible, then 20% Coinsurance
<b>Dialysis</b>		
– Dialysis services	\$25 Copayment per visit	Deductible, then 20% Coinsurance

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<b>Benefit</b>	<b>In-Network Plan Providers Member Cost Sharing</b>	<b>Out-of-Network Non-Plan Providers Member Cost Sharing</b>
<b>Dialysis (Continued)</b>		
- Installation of home equipment is covered up to \$300 in a Member's lifetime.	No charge	Deductible, then 20% Coinsurance
<b>Durable Medical Equipment</b>		
- Durable medical equipment	20% Coinsurance	Deductible, then 20% Coinsurance
- Blood glucose monitors, infusion devices and insulin pumps (including supplies)	No charge	No charge
- Oxygen and respiratory equipment	No charge	Deductible, then 20% Coinsurance
<b>Early Intervention Services</b>		
	No charge	No charge
	<b>Please Note:</b> The Plan does not cover the family participation fee required by the Massachusetts Department of Public Health	
<b>Emergency Admission</b>		
	No charge	Same as In-Network
<b>Emergency Room Care</b>		
	\$150 Copayment per visit This Copayment is waived if admitted to the hospital directly from the emergency room.	Same as In-Network
<b>Hearing Aids (for Members up to the age of 22)</b>		
- Limited to \$2,000 per hearing aid every 36 months, for each hearing impaired ear	No charge	Deductible, then 20% Coinsurance
<b>Home Health Care</b>		
	No charge	Deductible, then 20% Coinsurance
<b>Hospice – Outpatient Services</b>		
	Your Member Cost Sharing will depend upon the types of services provided, as listed in this Schedule of Benefits. For example, for services provided by a physician, see "Physician and Other Professional Office Visits." For inpatient hospital care, see "Hospital – Inpatient Services."	
<b>Hospital – Inpatient Services</b>		
- Acute hospital care	No charge	Deductible, then 20% Coinsurance
- Inpatient maternity care	No charge	Deductible, then 20% Coinsurance

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Benefit	In-Network Plan Providers Member Cost Sharing	Out-of-Network Non-Plan Providers Member Cost Sharing
<b>Hospital – Inpatient Services (Continued)</b>		
– Inpatient routine nursery care, including prophylactic medication to prevent gonorrhea	No charge	Deductible, then 20% Coinsurance
– Inpatient rehabilitation – limited to 60 days per calendar year	No charge	Deductible, then 20% Coinsurance
– Skilled nursing facility – limited to 100 days per calendar year	No charge	Deductible, then 20% Coinsurance
<b>Hypodermic Syringes and Needles</b>		
	<p>Subject to the applicable pharmacy Member Cost Sharing in your Outpatient Prescription Drug Schedule of Benefits and listed on your ID Card.</p> <p>If your Plan does not include coverage for outpatient prescription drugs, then coverage is subject to the lower of the pharmacy’s retail price or a Copayment of \$5 for Tier 1 drugs or supplies, \$10 for Tier 2 drugs or supplies and \$25 for Tier 3 drugs or supplies. All Copayments are based on a 30 day supply.</p> <p>For information on the different drug tiers, please visit our website at <a href="http://www.harvardpilgrim.org/members">www.harvardpilgrim.org/members</a> and select "<b>pharmacy/drug tier look up</b>" or contact our Member Services Department at <b>1-888-333-4742</b>.</p>	
<b>Infertility Services and Treatments (see the Benefit Handbook for details)</b>		
	Your Member Cost Sharing will depend upon the types of services provided, as listed in this Schedule of Benefits. For example, for services provided by a physician, see “Physician and Other Professional Office Visits.” For inpatient hospital care, see “Hospital – Inpatient Services.”	
<b>Laboratory and Radiology Services</b>		
– Laboratory and x-rays	No charge	Deductible, then 20% Coinsurance
<b>Advanced radiology</b> – CT scans – PET scans – MRI – MRA – Nuclear medicine services	No charge	Deductible, then 20% Coinsurance
<b>Please Note:</b> No In-Network Member Cost Sharing applies to certain preventive care services. For a list of covered preventive services, please see the Preventive Services notice at: <a href="http://www.harvardpilgrim.org">www.harvardpilgrim.org</a>		
<b>Low Protein Foods</b>		
– Limited to \$5,000 per calendar year	No charge	No charge

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<b>Benefit</b>	<b>In-Network Plan Providers Member Cost Sharing</b>	<b>Out-of-Network Non-Plan Providers Member Cost Sharing</b>
<b>Maternity Care - Outpatient</b>		
– Routine outpatient prenatal and postpartum care	No charge The Deductible does not apply to prenatal and postpartum care provided in a physician’s office. All other care is covered as stated in this Schedule of Benefits.	Deductible, then 20% Coinsurance
<b>Please Note:</b> Routine prenatal and postpartum care is usually received and billed from the same Provider as a single or bundled service. Different Member Cost Sharing may apply to any specialized or non-routine service that is billed separately from your routine outpatient prenatal and postpartum care. For example, for services provided by another physician or specialist, see “Physician and Other Professional Office Visits” for your applicable Member Cost Sharing. Please see your Benefit Handbook for more information on maternity care.		
<b>Medical Formulas</b>		
	No charge	No charge
<b>Mental Health Care (Including the Treatment of Substance Abuse Disorders)</b>		
<b>Inpatient Mental Health Care Services</b>	No charge	Deductible, then 20% Coinsurance
<b>Intermediate Mental Health Care Services</b> – Acute residential treatment (including detoxification), crisis stabilization and in-home family stabilization – Intensive outpatient programs, partial hospitalization and day treatment programs	No charge	Deductible, then 20% Coinsurance
– Outpatient mental health care services	<b>Group therapy</b> – \$10 Copayment per visit <b>Individual therapy</b> – \$25 Copayment per visit	<b>Group therapy</b> – Deductible, then 20% Coinsurance <b>Individual therapy</b> – Deductible, then 20% Coinsurance
– Detoxification	\$25 Copayment per visit	Deductible, then 20% Coinsurance
– Medication management	\$25 Copayment per visit	Deductible, then 20% Coinsurance
– Psychological testing and neuropsychological assessment	\$25 Copayment per visit	Deductible, then 20% Coinsurance
<b>Ostomy Supplies</b>		
	20% Coinsurance	Deductible, then 20% Coinsurance
<b>Physician and Other Professional Office Visits (This includes all covered Plan Providers unless otherwise listed in this Schedule of Benefits.)</b>		
– Routine examinations for preventive care, including immunizations	No charge	Deductible, then 20% Coinsurance

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Benefit	In-Network Plan Providers Member Cost Sharing	Out-of-Network Non-Plan Providers Member Cost Sharing
<b>Physician and Other Professional Office Visits (This includes all covered Plan Providers unless otherwise listed in this Schedule of Benefits.) (Continued)</b>		
– Consultations, evaluations, sickness and injury care	\$25 Copayment per visit	Deductible, then 20% Coinsurance
– Administration of allergy injections	\$5 Copayment per visit	Deductible, then 20% Coinsurance
<b>Preventive Services and Tests</b>		
<p>– Preventive care services, including all FDA approved contraceptive devices. Under the federal health care reform law, many preventive services and tests are covered with no Member Cost Sharing.</p> <p>For a list of covered preventive services, please see the Preventive Services notice on our website at: <a href="http://www.harvardpilgrim.org">www.harvardpilgrim.org</a>. You may also get a copy of the Preventive Services notice by calling the Member Services Department at 1-888-333-4742.</p>	No charge	Deductible, then 20% Coinsurance
<p>Under federal law the list of preventive services and tests may change periodically based on the recommendations of the following agencies:</p> <ol style="list-style-type: none"> <li>Grade "A" and "B" recommendations of the United States Preventive Services Task Force;</li> <li>With respect to immunizations, the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention; and</li> <li>With respect to services for women, infants, children and adolescents, the Health Resources and Services Administration.</li> </ol> <p>Information on the recommendations of these agencies may be found on the web site of the U.S. Department of Health and Human Services at: <a href="https://www.healthcare.gov/what-are-my-preventive-care-benefits/#part=1">https://www.healthcare.gov/what-are-my-preventive-care-benefits/#part=1</a>.</p> <p>Harvard Pilgrim will add or delete services from this benefit for preventive services and tests in accordance with changes in the recommendations of the agencies listed above. You can find a list of the current recommendations for preventive care on Harvard Pilgrim's web site at <a href="http://www.harvardpilgrim.org">www.harvardpilgrim.org</a>.</p>		
<b>Prosthetic Devices</b>		
	20% Coinsurance	Deductible, then 20% Coinsurance
<b>Rehabilitation Therapy - Outpatient</b>		
– Cardiac rehabilitation	\$25 Copayment per visit	Deductible, then 20% Coinsurance
– Pulmonary rehabilitation therapy	\$25 Copayment per visit	Deductible, then 20% Coinsurance
– Speech-language and hearing services	\$25 Copayment per visit	Deductible, then 20% Coinsurance

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<b>Benefit</b>	<b>In-Network Plan Providers Member Cost Sharing</b>	<b>Out-of-Network Non-Plan Providers Member Cost Sharing</b>
<b>Rehabilitation Therapy - Outpatient (Continued)</b>		
<ul style="list-style-type: none"> <li>- Occupational therapy – limited to 30 visits per calendar year</li> <li>- Physical therapy – limited to 30 visits per calendar year</li> </ul> <p><b>Please Note:</b> 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>	\$25 Copayment per visit	Deductible, then 20% Coinsurance
<b>Scopic Procedures - Outpatient Diagnostic and Therapeutic</b>		
<ul style="list-style-type: none"> <li>- Colonoscopy, endoscopy and sigmoidoscopy</li> </ul>	Your Member Cost Sharing will depend upon where the service is provided as listed in this Schedule of Benefits. For example, for a service provided in an outpatient surgical center, see "Surgery– Outpatient." For services provided in a physician's office, see "Physician and Other Professional Office Visits." For inpatient hospital care, see "Hospital – Inpatient Services."	
<b>Please Note:</b> No In-Network Member Cost Sharing applies to certain preventive care services. For a list of covered preventive services, please see the Preventive Services notice at: <a href="http://www.harvardpilgrim.org">www.harvardpilgrim.org</a> .		
<b>Spinal Manipulative Therapy (including care by a chiropractor)</b>		
<ul style="list-style-type: none"> <li>- Limited to \$500 per calendar year</li> </ul>	\$25 Copayment per visit	Deductible, then 20% Coinsurance
<b>Surgery – Outpatient</b>		
	No charge	Deductible, then 20% Coinsurance
<b>Vision Services</b>		
<ul style="list-style-type: none"> <li>- Routine eye examinations – limited to 1 exam per calendar year</li> </ul>	\$25 Copayment per visit	Deductible, then 20% Coinsurance
<ul style="list-style-type: none"> <li>- Vision hardware for special conditions</li> </ul>	No charge	Deductible, then 20% Coinsurance
<b>Voluntary Sterilization</b>		
	Your Member Cost Sharing will depend upon where the service is provided as listed in this Schedule of Benefits. For example, for a service provided in an outpatient surgical center, see "Surgery – Outpatient." For services provided in a physician's office, see "Physician and Other Professional Office Visits." For inpatient hospital care, see "Hospital – Inpatient Services."	
<b>Please Note:</b> No In-Network Member Cost Sharing applies to certain preventive care services. For a list of covered preventive services, please see the Preventive Services notice at: <a href="http://www.harvardpilgrim.org">www.harvardpilgrim.org</a> .		

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<b>Benefit</b>	<b>In-Network Plan Providers Member Cost Sharing</b>	<b>Out-of-Network Non-Plan Providers Member Cost Sharing</b>
<b>Voluntary Termination of Pregnancy</b>		
	Your Member Cost Sharing will depend upon where the service is provided as listed in this Schedule of Benefits. For example, for a service provided in an outpatient surgical center, see "Surgery – Outpatient." For services provided in a physician's office, see "Physician and Other Professional Office Visits." For inpatient hospital care, see "Hospital – Inpatient Services."	
<b>Wigs and Scalp Hair Protheses as required by law</b>		
– Limited to \$350 per calendar year (see the Benefit Handbook for details)	20% Coinsurance	Deductible, then 20% Coinsurance