

# 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 \$250 per Member or \$500 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 \$1,500 per Member or \$3,000 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)
<b>Inpatient Acute Hospital Services (including Day Surgery)</b>		
All covered services including the following: <ul style="list-style-type: none"> <li>▪ Coronary care</li> <li>▪ Hospital services</li> <li>▪ Intensive care</li> <li>▪ Physicians' and surgeons' services including consultations</li> <li>▪ Semi-private room and board</li> </ul>	Covered in full.	20% Coinsurance after the Deductible has been met.
<b>Skilled Nursing Facility Care Services</b>		
<ul style="list-style-type: none"> <li>▪ Covered up to 100 days per calendar year</li> </ul>	Covered in full.	20% Coinsurance after the Deductible has been met.
<b>Inpatient Rehabilitation Services</b>		
<ul style="list-style-type: none"> <li>▪ Covered up to 100 days per calendar year</li> </ul>	Covered in full.	20% Coinsurance after the Deductible has been met.
<b>Maternity Services</b>		
<ul style="list-style-type: none"> <li>▪ Prenatal and postpartum care</li> <li>▪ All hospital services for mother and routine nursery charges for newborn</li> </ul>	Covered in full.	20% Coinsurance after the Deductible has been met.
<b>Hospital Outpatient Department Services</b>		
All covered services including the following: <ul style="list-style-type: none"> <li>▪ Anesthesia services</li> <li>▪ Chemotherapy</li> <li>▪ Endoscopic procedures</li> <li>▪ Laboratory tests and x-rays</li> <li>▪ Physicians' and surgeons' services</li> <li>▪ Radiation therapy</li> </ul>	Covered in full. (Unless otherwise listed under a specific benefit below.)	20% Coinsurance after the Deductible has been met.

Service	In-Network (Participating Providers)	Out-of- Network (Non- Participating Providers)
<b>Physician Services</b>		
<p>All covered services including the following:</p> <ul style="list-style-type: none"> <li>▪ Administration of injections</li> <li>▪ Allergy tests and treatments</li> <li>▪ Changes and removal of casts, dressings or sutures</li> <li>▪ Chemotherapy</li> <li>▪ Consultations concerning contraception and hormone replacement therapy</li> <li>▪ Diabetes self-management, including education and training</li> <li>▪ Family planning services</li> <li>▪ Infertility services</li> <li>▪ Diagnostic screening and tests, including but not limited to mammograms, blood tests, lead screenings and screenings mandated by state law</li> <li>▪ Health education, including nutritional counseling</li> <li>▪ Medical treatment of temporomandibular joint dysfunction (TMD)</li> <li>▪ Preventive care, including routine physical examinations, immunizations, routine annual eye examinations, school, camp, sports and premarital examinations</li> <li>▪ Sick and well office visits, including psychopharmacological services</li> <li>▪ Vision and hearing screening</li> </ul>	<p>\$10 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"> <li>▪ Administration of allergy injections</li> </ul>	<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)
<b>Emergency Room Care Services</b>		
<ul style="list-style-type: none"> <li>Hospital emergency room treatment</li> </ul> <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>	\$30 Copayment per visit. (This Copayment is waived if you are directly admitted.)	\$30 Copayment per visit. (This Copayment is waived if you are directly admitted.)
<b>Emergency Admission Services</b>		
<ul style="list-style-type: none"> <li>Inpatient services which are required immediately following the rendering of emergency room treatment</li> </ul>	Covered in full.	Covered in full.
<b>Mental Health Care (Including the Treatment of Substance Abuse Disorders)</b>		
<b>Inpatient Services</b>		
<ul style="list-style-type: none"> <li>Mental health care services</li> </ul>	Covered in full.	20% Coinsurance after the Deductible has been met.
<b>Intermediate Care Services</b>		
<ul style="list-style-type: none"> <li>Acute residential treatment (including detoxification), crisis stabilization and in-home family stabilization</li> <li>Intensive outpatient programs, partial hospitalization and day treatment programs</li> </ul>	Covered in full.	20% Coinsurance after the Deductible has been met.
<b>Outpatient Services</b>		
<ul style="list-style-type: none"> <li>Mental health care services</li> </ul> <p>Group therapy</p> <p>Individual therapy</p>	<p>\$10 Copayment per visit.</p> <p>\$10 Copayment per visit.</p>	20% Coinsurance after the Deductible has been met.

Service	In-Network (Participating Providers)	Out-of- Network (Non- Participating Providers)
<b>Mental Health Care (Including the Treatment of Substance Abuse) (Continued)</b>		
▪ Detoxification	\$10 Copayment per visit.	20% Coinsurance after the Deductible has been met.
▪ Medication management	\$10 Copayment per visit.	20% Coinsurance after the Deductible has been met.
▪ Psychological testing and neuropsychological assessment	\$10 Copayment per visit.	20% Coinsurance after the Deductible has been met.
<b>Dental Services</b>		
▪ Initial emergency treatment (within 72 hours of injury)	\$10 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.

Service	In-Network (Participating Providers)	Out-of-Network (Non- Participating Providers)
<b>Home Health Care Services</b>		
<ul style="list-style-type: none"> <li>▪ Home care services</li> <li>▪ Intermittent skilled nursing care</li> </ul>	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.		
<b>Diabetes Equipment and Supplies</b>		
<ul style="list-style-type: none"> <li>▪ Therapeutic molded shoes and inserts, dosage gauges, injectors, lancet devices, voice synthesizers and visual magnifying aids</li> </ul>	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"> <li>▪ Blood glucose monitors, insulin pumps and supplies and infusion devices</li> </ul>	Covered in full.	Covered in full.
<ul style="list-style-type: none"> <li>▪ Insulin, insulin syringes, insulin pens with insulin, lancets, oral agents for controlling blood sugar, blood test strips, and glucose, ketone and urine test strips</li> </ul>	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)
<b>Durable Medical Equipment including Prosthetics</b>		
<p>Durable medical equipment (DME) including prosthetics - up to a maximum of \$5,000 per calendar year for all covered equipment. Coverage includes, but is not limited to:</p> <ul style="list-style-type: none"> <li>▪ Durable medical equipment</li> <li>▪ Prosthetic devices</li> <li>▪ Breast prostheses, including replacements and mastectomy bras (the DME benefit limit does not apply)</li> <li>▪ Ostomy supplies</li> <li>▪ 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</li> </ul>	<p>20% Coinsurance of equipment cost to HPHC, not to exceed a Member's total expense of \$1,000 per calendar year.</p>	<p>20% Coinsurance after the Deductible has been met of equipment cost to HPHC. The Member pays a maximum of \$1,000 in Coinsurance per calendar year.</p>
<ul style="list-style-type: none"> <li>▪ Oxygen and respiratory equipment</li> </ul>	<p>Covered in full. No benefit limit applies.</p>	<p>20% Coinsurance after the Deductible has been met. No benefit limit applies.</p>
<b>Hypodermic Syringes and Needles</b>		
<ul style="list-style-type: none"> <li>▪ Hypodermic syringes and needles to the extent Medically Necessary, as required by Massachusetts law</li> </ul>	<p>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.</p>	<p>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.</p>

Service	In-Network (Participating Providers)	Out-of-Network (Non- Participating Providers)
<b>Other Health Services</b>		
<ul style="list-style-type: none"> <li>▪ Cardiac rehabilitation</li> <li>▪ Dialysis</li> <li>▪ Early intervention services - up to a maximum of \$5,200 per Member per calendar year and a lifetime maximum of \$15,600</li> <li>▪ Second opinion</li> <li>▪ Physical and occupational therapies - up to 90 consecutive days per condition</li> <li>▪ Speech-language and hearing services, including therapy</li> </ul>	\$10 Copayment per visit.	20% Coinsurance after the Deductible has been met.
<ul style="list-style-type: none"> <li>▪ House calls</li> </ul>	\$15 Copayment per visit.	20% Coinsurance after the Deductible has been met.
<ul style="list-style-type: none"> <li>▪ Hospice services</li> </ul>	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"> <li>▪ Ambulance services</li> <li>▪ Low protein foods (\$5,000 per Member per calendar year)</li> <li>▪ State mandated formulas</li> </ul>	Covered in full.	Covered in full.
<ul style="list-style-type: none"> <li>▪ Vision hardware for special conditions (please see your Benefit Handbook for details on your coverage)</li> </ul>	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 and day hospitalization for psychiatric or drug and alcohol rehabilitation services) 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

#### 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.

## 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, electronic and myoelectronic artificial arms and legs, 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

## Exclusions

- Dentures
- 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.
- Preventive dental care
- Extraction of teeth
- Chiropractic services, including osteopathic manipulation
- 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
- 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