# Schedule of Benefits

THE PPO PLAN
MASSACHUSETTS

This Schedule of Benefits states any Benefit Limits and the Member Cost Sharing amounts you must pay for Covered Benefits. However, it is only a summary of your benefits. Please see your Benefit Handbook for details. Your Member Cost Sharing may include a Deductible, Coinsurance, and Copayments. Please see the tables below for details.

### 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.

**Out-of-Network** coverage applies when you use a Non-Plan Provider for Covered Benefits. If a Non-Plan Provider charges any amount in excess of the Allowed Amount, you are responsible for the excess 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 is listed in the tables below.

### Out-of-Network Notification and Prior Approval

Notification and Prior Approval is required for certain Out-of-Network benefits. Before you receive services from a Non-Plan Provider, please refer our website, **www.harvardpilgrim.org** or contact the Member Services Department at **1-888-333-4742** for the complete listing of Out-of-Network services that require Prior Approval. To provide Notification or obtain Prior Approval please call **1–800–708–4414** for medical services or call **1-888-777-4742** for mental health or substance abuse services. More information about Notification and Prior Approval can be found on our website, **www.harvardpilgrim.org** and in your Benefit Handbook.

### 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 on our website at **www.harvardpilgrim.org** or by calling **1-888-888-4742 ext. 38723**.

### Copayment Levels

There are two types of In-Network office visit Copayments that apply to your Plan: a lower Copayment, known as "Level 1," and a higher Copayment known as "Level 2."

Level 1 applies to covered outpatient professional services from the following types of providers: all Primary Care Providers (PCPs); obstetricians and gynecologists; Licensed Mental Health Professionals; certified nurse midwives; and nurse practitioners who bill independently.

Level 2 applies to most outpatient specialty care.

If a provider is categorized as both a Level 1 provider and a Level 2 provider, Level 1 applies. For example, if a provider is both a PCP and a cardiologist, you will be responsible for a Level 1 Copayment.

Your Plan may have other Copayment amounts. Please see the benefit table below for specific Copayment requirements.

### Covered Benefits

Your Covered Benefits are administered on a Plan Year basis. Your Plan Year begins on your Employer's Anniversary Date. Please see your Benefit Handbook for more details. If you do not know your Employer's Anniversary Date, please contact your Employer's benefits office or call the Member Services Department at **1-888-333-4742**. Your Member Cost Sharing will depend upon the type of service provided and the location the service is provided in, as listed in this Schedule of Benefits. For example, for services provided in a doctor's office, see "Physician and Other Professional Office Visits." For services provided in a hospital emergency room, see "Emergency Room Care," and for outpatient surgical procedures, please see "Surgery - Outpatient."

| General Cost Sharing Features: | In-Network Member Cost Sharing: | Out-of-Network Member Cost Sharing: |
|---|---|---|
| **Coinsurance and Copayments** | | |
| | See the benefits table below | |
| **Deductible** | | |
| | $300 per Member per Plan Year<br>$900 per family per Plan Year | $400 per Member per Plan Year<br>$800 per family per Plan Year |
| **Out-of-Pocket Maximum** | | |
| Includes all Member Cost Sharing except: Member Cost Sharing for prescription drugs, which has a separate Out-of-Pocket Maximum<br>– 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 Plan Year<br>$4,000 per family per Plan Year | $3,000 per Member per Plan Year |
| **Out-of-Network Penalty Payment** | | |
| Does not count toward the Deductible or Out-of-Pocket Maximum | $500 | |
| **Deductible Rollover** | | |
| None | | |

| Benefit | In-Network Plan Providers Member Cost Sharing | Out-of-Network Non-Plan Providers Member Cost Sharing |
|---|---|---|
| **Acupuncture Treatment for Injury or Illness** | | |
| | Not covered | Not covered |
| **Ambulance Transport** | | |
| Emergency ambulance transport | Deductible, then no charge | Same as In-Network |
| Non-emergency ambulance transport | Deductible, then no charge | Deductible, then 20% Coinsurance |

| Benefit | In-Network Plan Providers Member Cost Sharing | Out-of-Network Non-Plan Providers Member Cost Sharing |
|---|---|---|
| **Autism Spectrum Disorders Treatment** | | |
| Applied behavior analysis | Level 1: $20 Copayment per visit | Deductible, then 20% Coinsurance |
| **Chemotherapy and Radiation Therapy** | | |
| | No charge | Deductible, then 20% Coinsurance |
| **Dental Services** | | |
| **Important Notice:** Coverage of Dental Care is very limited. Please see your Benefit Handbook for the details of your coverage. | | |
| Extraction of teeth impacted in bone | Level 2: $45 Copayment per visit | Deductible, then 20% Coinsurance |
| Pediatric dental care for children (up to the age of 13) – limited to 2 preventive dental exams per Plan Year, only the following services are included: cleaning, fluoride treatment, teaching plaque control and x-rays. | No charge | Deductible, then 20% Coinsurance |
| **Dialysis** | | |
| Dialysis services | Deductible, then no charge | Deductible, then 20% Coinsurance |
| Installation of home equipment is covered up to $300 in a Member's lifetime. | No charge | Deductible, then 20% Coinsurance |
| **Durable Medical Equipment** | | |
| Durable medical equipment | Deductible, then 20% Coinsurance in equipment cost to HPHC, not to exceed a Member's total expense of $1,000 | Deductible, then 20% Coinsurance in equipment cost to HPHC, not to exceed a Member's total expense of $1,000 |
| Blood glucose monitors, infusion devices and insulin pumps (including supplies) | No charge | Same as In-Network |
| Oxygen and respiratory equipment | No charge | No charge |
| **Early Intervention Services** | | |
| | No charge | No charge |
| The Plan does not cover the family participation fee required by the Massachusetts Department of Public Health. | | |
| **Emergency Admission** | | |
| | Deductible, then $500 Copayment per admission | Same as In-Network |
| **Emergency Room Care** | | |
| | Deductible, then $100 Copayment per visit | Same as In-Network |
| This Copayment is waived if admitted to the hospital directly from the emergency room. | | |
| **Hearing Aids (for Members up to the age of 22)** | | |
| – Limited to $2,000 per hearing aid every 36 months, for each hearing impaired ear | Deductible, then no charge | Deductible, then 20% Coinsurance |

| Benefit | In-Network Plan Providers Member Cost Sharing | Out-of-Network Non-Plan Providers Member Cost Sharing |
|---|---|---|
| **Home Health Care** | | |
| | Deductible, then no charge | Deductible, then 20% Coinsurance |
| If services include the administration of drugs, please see the benefit for "Medical Drugs" for Member Cost Sharing details. | | |
| **Hospice - Outpatient** | | |
| | Deductible, then no charge | Deductible, then 20% Coinsurance |
| **Hospital – Inpatient Services** | | |
| Acute hospital care | Deductible, then $500 Copayment per admission | Deductible, then 20% Coinsurance |
| Inpatient maternity care | Deductible, then $500 Copayment per admission | Deductible, then 20% Coinsurance |
| Inpatient routine nursery care | No charge | Deductible, then 20% Coinsurance |
| Inpatient rehabilitation – limited to 60 days per Plan Year | Deductible, then $500 Copayment per admission | Deductible, then 20% Coinsurance |
| Skilled nursing facility – limited to 100 days per Plan Year | Deductible, then $500 Copayment per admission | Deductible, then 20% Coinsurance |
| **Hypodermic Syringes and Needles** | | |
| | Subject to the applicable pharmacy Member Cost Sharing listed on your ID Card.<br>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. | |
| For information on the different drug tiers, please visit our website at **www.harvardpilgrim.org/members** and select "**pharmacy/drug tier look up**" or contact our Member Services Department at **1-888-333-4742**. | | |
| **Infertility Services and Treatments (see the Benefit Handbook for details)** | | |
| The Plan covers the following diagnostic services for infertility:<br>– Consultation<br>– Evaluation<br>– Laboratory tests | Level 1: $20 Copayment per visit<br>Level 2: $45 Copayment per visit | Deductible, then 20% Coinsurance |
| Infertility treatment (see the Benefit Handbook for details) | Your Member Cost Sharing will depend upon where the service is provided and the tier placement of the provider rendering services, as listed in this Schedule of Benefits. For example, for services provided by a physician, see "Physician and Other Professional Office Visits." | Deductible, then 20% Coinsurance |

| Benefit | In-Network Plan Providers Member Cost Sharing | Out-of-Network Non-Plan Providers Member Cost Sharing |
|---|---|---|
| **Laboratory and Radiology Services** | | |
| Laboratory and x-rays | Deductible, then no charge | Deductible, then 20% Coinsurance |
| Advanced radiology, including CT scans, PET scans, MRI, MRA and nuclear medicine services | Deductible, then $100 Copayment per procedure | Deductible, then 20% Coinsurance |
| **Low Protein Foods** | | |
| – Limited to $5,000 per Plan Year | Deductible, then no charge | Deductible, then 20% Coinsurance |
| **Maternity Care - Outpatient** | | |
| Routine outpatient prenatal and postpartum care | No charge | Deductible, then 20% Coinsurance |
| | 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. | |
| 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, Member Cost Sharing for services provided by a specialist is listed under "Physician and Other Professional Office Visits" and Member Cost Sharing for an ultrasound billed as a specialized or non-routine service is listed under "Laboratory and Radiology Services." | | |
| **Medical Drugs (drugs that cannot be self-administered)** | | |
| Medical drugs received in a doctor's office or other outpatient facility | No charge | Deductible, then 20% Coinsurance |
| Medical drugs received in the home | No charge | Deductible, then 20% Coinsurance |
| Some medical drugs received in a physician's office or outpatient facility may be provided by the Specialty Pharmacy Program under your outpatient prescription drug benefit. If you have outpatient prescription drug coverage, your Member Cost Sharing will be listed on your ID Card. Please see the Prescription Drug Brochure for a detailed explanation of your benefits. | | |
| **Medical Formulas** | | |
| | Deductible, then no charge | Deductible, then 20% Coinsurance |

| Benefit | In-Network Plan Providers Member Cost Sharing | Out-of-Network Non-Plan Providers Member Cost Sharing |
|---|---|---|
| **Mental Health Care (Including the Treatment of Substance Abuse Disorders)** | | |
| Inpatient services | Deductible, then $500 Copayment per admission | Deductible, then 20% Coinsurance |
| Intermediate services<br>– Acute residential treatment (including detoxification), crisis stabilization and in-home family stabilization<br>– Intensive outpatient programs, partial hospitalization and day treatment programs | Deductible, then no charge | Deductible, then 20% Coinsurance |
| Outpatient group therapy | $10 Copayment per visit | Deductible, then 20% Coinsurance |
| Outpatient treatment, including individual therapy, outpatient detoxification and medication management | Level 1: $20 Copayment per visit | Deductible, then 20% Coinsurance |
| Outpatient methadone maintenance | Deductible, then no charge | Deductible, then 20% Coinsurance |
| Outpatient psychological testing and neuropsychological assessment | Deductible, then no charge | Deductible, then 20% Coinsurance |
| **Ostomy Supplies** | | |
| | Same as Durable medical equipment | Same as Durable medical equipment |
| **Physician and Other Professional Office Visits (This includes all covered Plan Providers unless otherwise listed in this Schedule of Benefits.)** | | |
| Routine examinations for preventive care, including immunizations | No charge | Deductible, then 20% Coinsurance |
| Not all **In-Network** services you receive during your routine exam are covered at no charge. Only preventive services designated under the Patient Protection and Affordable Care Act (PPACA) are covered at no charge. Other services not included under PPACA may be subject to additional cost sharing. For the current list of preventive services covered at no charge under PPACA, please see the Preventive Services Notice on our website at **www.harvardpilgrim.org**. Please see "Laboratory and Radiology Services" for the Member Cost Sharing that applies to diagnostic services not included on this list. | | |
| Consultations, evaluations, sickness and injury care | Level 1: $20 Copayment per visit<br>Level 2: $45 Copayment per visit | Deductible, then 20% Coinsurance |
| Copayment level varies depending on the type of provider. Please refer to the beginning of this Schedule of Benefits to determine which Copayment level applies. | | |
| Office based treatments and procedures, including, but not limited to administration of injections, allergy treatments, casting, suturing and the application of dressings, genetic counseling, non-routine foot | No charge | Deductible, then 20% Coinsurance |

**(Continued on next page)**

| Benefit | In-Network Plan Providers Member Cost Sharing | Out-of-Network Non-Plan Providers Member Cost Sharing |
|---|---|---|
| **Physician and Other Professional Office Visits (This includes all covered Plan Providers unless otherwise listed in this Schedule of Benefits.) (Continued)** | | |
| care, pregnancy testing, and surgical procedures | | |
| Administration of allergy injections | No charge | Deductible, then 20% Coinsurance |
| **Preventive Services and Tests** | | |
| | No charge | Deductible, then 20% Coinsurance |
| Under federal law, many preventive services and tests are covered with no Member Cost Sharing, including preventive colonoscopies, certain labs and x-rays, voluntary sterilization for women, and all FDA approved contraceptive devices. For a complete list of covered preventive services, please see the Preventive Services Notice on our website at **www.harvardpilgrim.org**. You may also get a copy of the Preventive Services Notice by calling the Member Services Department at **1–888–333–4742**. Harvard Pilgrim will add or delete services from this benefit for preventive services and tests in accordance with Federal guidance. | | |
| **Prosthetic Devices** | | |
| | Same as Durable medical equipment | Same as Durable medical equipment |
| **Rehabilitation and Habilitation Services - Outpatient** | | |
| Cardiac rehabilitation | Deductible, then no charge | Deductible, then 20% Coinsurance |
| Pulmonary rehabilitation therapy | Level 1: $20 Copayment per visit | Deductible, then 20% Coinsurance |
| Speech-language and hearing services | Level 1: $20 Copayment per visit | Deductible, then 20% Coinsurance |
| Occupational therapy – limited to 30 visits per Plan Year<br>Physical therapy – limited to 30 visits per Plan Year | Level 1: $20 Copayment per visit | Deductible, then 20% Coinsurance |
| Outpatient physical and occupational therapy is not subject to the limit listed above and is covered to the extent Medically Necessary for: (1) children under the age of three and (2) the treatment of Autism Spectrum Disorders. | | |
| **Scopic Procedures - Outpatient Diagnostic and Therapeutic** | | |
| Colonoscopy, endoscopy and sigmoidoscopy | 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." | |
| **Spinal Manipulative Therapy (including care by a chiropractor)** | | |
| | Not covered | Not covered |
| **Surgery – Outpatient** | | |
| | Deductible, then $250 Copayment per visit | Deductible, then 20% Coinsurance |

| Benefit | In-Network Plan Providers Member Cost Sharing | Out-of-Network Non-Plan Providers Member Cost Sharing |
|---|---|---|
| **Telemedicine** | | |
| Outpatient and inpatient telemedicine services | 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." | |
| **Urgent Care Services** | | |
| Convenience care clinic | Level 1: $20 Copayment per visit | Deductible, then 20% Coinsurance |
| Urgent care clinic (including hospital urgent care clinic) | $45 Copayment per visit | Deductible, then 20% Coinsurance |
| Additional Member Cost Sharing may apply. Please refer to the specific benefit in this Schedule of Benefits. For example, if you have an x-ray or have blood drawn, please refer to "Laboratory and Radiology Services." | | |
| **Vision Services** | | |
| Routine eye examinations – limited to 1 exam per Plan Year | No charge | Deductible, then 20% Coinsurance |
| Vision hardware for special conditions | Deductible, then no charge | Deductible, then 20% Coinsurance |
| **Voluntary Sterilization in a Physician's Office** | | |
| | $20 Copayment per visit | Deductible, then 20% Coinsurance |
| **Voluntary Termination of Pregnancy** | | |
| | 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 "Office based treatments and procedures." For inpatient hospital care, see "Hospital – Inpatient Services." | |
| **Wigs and Scalp Hair Prostheses as required by law** | | |
| | No charge | Deductible, then 20% Coinsurance |

## 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)** ប្រយ័ត្នដំណឹង៖ បើអ្នកនិយាយភាសាខ្មែរ, យើងមានសេវាកម្មបកប្រែ ជូនលោកអ្នកដោយឥតគិតថ្លៃ។ 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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