

Schedule of Benefits

The Harvard Pilgrim Core Coverage 1750sm HMO (the Plan) Massachusetts

Services listed are covered when Medically Necessary and provided or arranged by Harvard Pilgrim Health Care providers. Please see your Benefit Handbook for details.

How your plan works

Your Plan has a calendar year Deductible, which applies to most services. Until you have paid the annual Deductible, you are responsible for paying all or part of a bill for services subject to the Deductible. *However, the Deductible does not apply to (1) initial outpatient medical office visits, (2) initial outpatient mental health or drug or alcohol rehabilitation office visits, (3) emergency room care, (4) allergy injections, (5) blood glucose monitors, insulin pumps and supplies, and infusion devices, and (6) prescription drugs, which has a separate deductible. The details of these exceptions are described below.*

(1) Outpatient medical office visits – If you have individual coverage, the first three **(3)** office visits per calendar year are not subject to the Deductible. If you have family coverage, the first three **(3)** visits per individual, up to a total limit of six **(6)** visits for the covered family are not subject to the Deductible. The Member is responsible for a \$25 Copayment. Subsequent office visits are subject to the Deductible and/or Coinsurance.

Please see the table below to determine when the Deductible applies.

<p>Medical office visits (first 3 per individual, up to 6 per family) not subject to the Deductible:</p>	<p>Services subject to the Deductible include, but are not limited to:</p>
<p>Any combination of:</p> <ul style="list-style-type: none"> ▪ Routine care ▪ Preventive care ▪ Sick visits ▪ Eye examinations ▪ Family planning ▪ Consultations with a specialist ▪ Physical, Speech, and Occupational therapies ▪ Care by a chiropractor 	<ul style="list-style-type: none"> ▪ X-rays, lab tests, and mammograms ▪ Procedures performed by your HPHC Provider during the office visit (such as giving you a shot, taking x-rays or putting a cast on your arm) ▪ Hospital outpatient department services ▪ Outpatient surgery services ▪ Maternity care ▪ The fourth and subsequent medical office visits per individual, unless the family Deductible is reached ▪ The seventh and subsequent medical office visits per family

How your plan works (continued)

(2) **Outpatient mental health or drug or alcohol rehabilitation office visits** - If you have individual coverage, the first three (3) office visits per calendar year are not subject to the Deductible. If you have family coverage, the first three (3) visits per individual, up to a total limit of six (6) visits for the covered family are not subject to the Deductible. The Member is responsible for a \$25 Copayment. Subsequent office visits are subject to the Deductible and/or Coinsurance.

Please see the table below to determine when the Deductible applies.

<p>Mental health and drug and alcohol rehabilitation office visits (first 3 per individual, up to 6 per family) not subject to the Deductible:</p>	<p>Services subject to the Deductible include, but are not limited to:</p>
<p>Any combination of:</p> <ul style="list-style-type: none"> ▪ Outpatient mental health services ▪ Outpatient drug rehabilitation services ▪ Outpatient alcohol rehabilitation services 	<p>Including, but not limited to:</p> <ul style="list-style-type: none"> ▪ Detoxification ▪ Psychological testing ▪ The fourth and subsequent mental health or drug alcohol rehabilitation office visits per individual, unless the family Deductible is reached ▪ The seventh and subsequent mental health or drug or alcohol rehabilitation office visits per family

(3) **Emergency room care** is not subject to the Deductible. You are responsible for the Copayment listed in this Schedule.

(4) **Allergy injections** are not subject to the Deductible. You are responsible for the Copayment listed in this Schedule.

(5) **Blood glucose monitors, insulin pumps and supplies, and infusion devices** are not subject to the Deductible.

(6) **Prescription drugs** are not subject to this Deductible. You are responsible for the Copayments or Coinsurance after you meet your prescription drug deductible, which are all listed on your ID card.

Questions and Answers

Q: What is Coinsurance?

A: After you have met your Deductible, Coinsurance is the percentage of covered health care costs for which you are responsible (**20%**). You will continue to pay Coinsurance until you have met your Out-of-Pocket Maximum.

Q: What is an Out-Of-Pocket Maximum?

A: The out-of-pocket maximum is the maximum amount you pay for all covered services, including Deductible, Copayment, and Coinsurance amounts (except for prescription drugs) in a calendar year. After the out-of-pocket maximum has been met, no further Deductible, Copayment, or Coinsurance amounts will apply for the remainder of the calendar year.

Q: I have individual coverage. What happens after I use my three medical outpatient office visits? Do I have to pay for future medical outpatient office visits?

A: After you have used your three medical outpatient office visits any subsequent outpatient medical office visits are subject to the Deductible and/or Coinsurance.

Q: I have individual coverage. What happens after I use my three mental health or drug or alcohol rehabilitation outpatient office visits? Do I have to pay for future mental health or drug or alcohol rehabilitation outpatient office visits?

A: After you have used your three mental health or drug or alcohol rehabilitation outpatient office visits any subsequent outpatient mental health or drug or alcohol rehabilitation office visits are subject to the Deductible and/or Coinsurance.

Q: I have family coverage. How does it work?

A: During each calendar year a family is entitled to six (**6**) outpatient medical office visits and six (**6**) outpatient mental health or drug or alcohol rehabilitation office visits before the Deductible and/or Coinsurance apply to those services.

Outpatient medical office visit example: Family member A has a physical exam, a visit with the physical therapist, and a second opinion from a medical provider. Family member A will pay the \$25 Copayment for each of those visits. Subsequent medical office visits for family member A will be subject to the Deductible and/or Coinsurance.

Family member B has an annual examination. Family member B pays the \$25 Copayment.

Family member C has two visits with a chiropractor. Family member C will pay the \$25 Copayment for each of those visits.

The family limit is now reached for outpatient medical office visits:

Family member A (3 visits) + Family member B (1 visit) + Family member C (2 visits) = 6 visits.

All subsequent outpatient medical office visits for any family member are subject to the Deductible and/or Coinsurance.

Note: If you are a Member with family coverage, the family limit of six (**6**) outpatient visits is reached by any combination of family visits (up to the individual limit of **3** visits per Member). If any number of Members in a covered family collectively meet the family limit of six (**6**), outpatient visits, then future outpatient office visits for all Members of the covered family will be subject to the Deductible and/or Coinsurance.

Questions and Answers (continued)

Q. What if I have a procedure such as an x-ray or blood test during a medical office visit that is not subject to the Deductible and/or Coinsurance?

A. Treatments and procedures (as listed in this Schedule) provided during the office visit are subject to the Deductible and/or Coinsurance. This is true even if the treatments or procedures were provided during a medical office visit not subject to the Deductible and/or Coinsurance (you would also be responsible for the office visit Copayment).

If you have any other questions, please call our Member Services department at **(888) 333-4742**. Representatives are available weekdays between 8:00 a.m. and 5:30 p.m., and until 7:30 p.m. on Monday and Wednesday evenings. For TTY service, please call **(800) 637-8257**.

Or visit us on the web at, www.harvardpilgrim.org

General cost sharing features

Deductible

Your Plan has a Deductible of **\$1,750** per Member or **\$3,500** per family per calendar year.

Exceptions: The first three (3) outpatient medical office visits per Member, up to the first (6) outpatient medical office visits per family are not subject to the Deductible.

The first three (3) outpatient mental health or drug or alcohol rehabilitation office visits per Member, up to the first (6) outpatient mental health or drug or alcohol rehabilitation office visits per family are not subject to the Deductible.

Emergency room care, allergy injections, blood glucose monitors, insulin pumps and supplies, and infusion devices, and prescription drugs also are not subject to the Deductible.

Copayment

See below

Coinsurance

See below

Out-of-Pocket Maximum

Your Plan has an Out-of-Pocket Maximum of **\$5,000** per Member or **\$10,000** per family per calendar year. The Out-of-Pocket Maximum includes Deductible, Copayment, and Coinsurance amounts paid.

The Out-of-Pocket Maximum excludes cost sharing for:

- Prescription drugs

Service

Your Cost Sharing

The following is a summary of the services covered by your plan. Please see your Benefit Handbook for the details of your coverage.

Inpatient Acute Hospital Services

All covered services including the following:

- Coronary care
- Hospital services
- Intensive care
- Semi-private room and board
- Physicians' and surgeons' services including consultations

Deductible, then 20% Coinsurance

Skilled Nursing Facility Care Services

- Covered up to 100 days per calendar year

Deductible, then 20% Coinsurance.

Inpatient Rehabilitation Services

- Covered up to 60 days per calendar year

Deductible, then 20% Coinsurance.

Emergency Services

- You are always covered for care in a Medical Emergency. A referral from your PCP is not needed. 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 your PCP within 48 hours, or as soon as you can. Please note that this requirement is met if your attending physician has already given notice to your PCP.

\$250 Copayment per visit in an emergency room. This Copayment is waived if admitted directly to the hospital from the emergency room. See "Medical Office Visits" for coverage of emergency services by a physician in any other location.

Service

Your Cost Sharing

Hospital Outpatient Department Services

All covered services including the following:

- Anesthesia services
- Chemotherapy
- Endoscopic procedures
- Laboratory tests and X-rays
- Radiation therapy

Deductible, then 20% Coinsurance

Outpatient surgery services

All covered services, including the following:

- Minor surgery
- Day surgery

Deductible, then 20% Coinsurance

Maternity Services

- Prenatal and postpartum care
- All hospital services for mother and routine nursery charges for newborn care

Deductible, then 20% Coinsurance.

Home Health Care Services

- Home care services
- Intermittent skilled nursing care

Deductible, then 20% Coinsurance.

Medical Office Visits

Some services you receive during a covered office visit, such as diagnostic tests, lab tests, x-rays, and medical or surgical procedures are subject to the Deductible and Coinsurance. These services are listed under "Treatment and Procedures".

Please note for medical office visits, this Plan provides coverage for **any combination of 3** outpatient office visits per Member per calendar year (up to **6** outpatient office visits per family per calendar year) subject to a \$25 Copayment. Subsequent office visits are subject to Deductible and/or Coinsurance.

All covered services including the following:

- Cardiac rehabilitation
- Chiropractic care - up to 10 visits per calendar year
- Consultations concerning contraception and hormone replacement therapy
- Consultations with specialists
- Early intervention services - up to a maximum of \$5,200 per Member per calendar year and a lifetime maximum of \$15,600
- Examinations for illness or injury
- Examinations for preventive care including routine physical examinations, annual gynecological examinations, school, camp, sports and premarital examinations
- Family planning consultations
- Health education including nutritional counseling and diabetes education and training
- Hearing examinations
- Medically necessary (non-routine) foot care provided by a podiatrist
- Medication management, including psychopharmacological services
- Occupational therapy - up to 20 visits per calendar year
- Physical therapy - up to 20 visits per calendar year
- Routine eye examination – covered once every 24 months
- Second opinion
- Speech-language and hearing services, including therapy

\$25 Copayment for the first **3** office visits per Member (up to **6** office visits per family).

Deductible, then 20% Coinsurance for all office visits after **3** per Member (or after **6** per family).

- Administration of allergy injections

\$10 Copayment per visit.

Treatments and procedures

All covered services including the following:

- Administration of all immunizations
- Administration of injections
- Allergy treatments and tests
- Casting, suturing and the application of dressings
- Chemotherapy
- Diagnostic screening and tests, including but not limited to mammograms, blood tests, lead screenings, lab tests, X-rays, and screenings mandated by state law
- Diagnostic procedures
- Infertility treatment and procedures
- Voluntary sterilization
- Voluntary termination of pregnancy

Deductible, then 20% Coinsurance.

Dental Services

- Initial emergency treatment (within 72 hours of injury)

Deductible, then 20% Coinsurance. If inpatient services are required, please see "Inpatient Acute Hospital Services" for cost sharing.

Diabetes Equipment and Supplies

- Therapeutic molded shoes and inserts, dosage gauges, injectors, lancet devices, voice synthesizers and visual magnifying aids
- Blood glucose monitors, insulin pumps and supplies and infusion devices
- Insulin, insulin syringes, insulin pens with insulin, lancets, oral agents for controlling blood sugar, blood test strips, and glucose, ketone and urine test strips

Deductible, then 20% Coinsurance.

Covered in full.

Subject to the applicable prescription drug cost sharing listed on your ID card.

Mental Health and Drug and Alcohol Rehabilitation Services

Please note that no day or visit limits apply to inpatient or outpatient mental health treatment for biologically-based mental disorders, rape-related mental or emotional disorders, and non-biologically-based mental, behavioral or emotional disorders for children and adolescents. No day or visit limits apply to inpatient or outpatient drug or alcohol rehabilitation services that are authorized by a Plan mental health clinician in conjunction with treatment of mental disorders. (Please see your Benefit Handbook for details.).

Please note for mental health or drug or alcohol rehabilitation services, this Plan provides coverage for **any combination of 3** outpatient office visits per Member per calendar year (up to **6** outpatient office visits per family per calendar year) subject to a \$25 Copayment. Subsequent office visits are subject to Deductible and/or Coinsurance.

<ul style="list-style-type: none"> ▪ Inpatient mental health services in a licensed general hospital - unlimited ▪ Inpatient mental health services in a psychiatric hospital – up to 60 days per calendar year¹ ▪ Inpatient drug and alcohol rehabilitation services – up to 30 days per calendar year¹ ▪ Inpatient detoxification 	<p>Deductible, then 20% Coinsurance.</p>
<ul style="list-style-type: none"> ▪ Outpatient mental health services - up to a combined maximum of 24 visits per calendar year for individual and group therapy <p>Individual and Group therapy</p> <ul style="list-style-type: none"> ▪ Outpatient drug or alcohol rehabilitation services - up to 20 visits or \$500 in benefit value per calendar year, whichever is greater <p>Individual and Group therapy</p>	<p>\$25 Copayment for the first 3 mental health or drug or alcohol rehabilitation office visits per Member (up to 6 office visits per family).</p> <p>Deductible, then 20% Coinsurance for all visits after 3 per Member (or after 6 per family).</p>

¹ Partial hospitalization services are available up to a maximum of 120 days per calendar year in place of inpatient mental health services. Partial hospitalization services are available up to a maximum of 60 days per calendar year in place of inpatient drug and alcohol rehabilitation services.

**Mental Health and Drug and Alcohol Rehabilitation Services
(continued)**

▪ Outpatient detoxification	Deductible, then 20% Coinsurance.
▪ Psychological testing	Deductible, then 20% Coinsurance.

Durable Medical Equipment including Prosthetics

Durable medical equipment (DME) including prosthetics - up to a maximum of \$1,000 per calendar year for all covered equipment. Coverage includes, but is not limited to:

- Durable medical equipment
- Prosthetic devices (the DME benefit limit does not apply to artificial arms and legs)
- Ostomy supplies
- Breast prostheses, including replacements and mastectomy bras (the DME benefit limit does not apply)
- Oxygen and respiratory equipment (the DME benefit limit does not apply)
- 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

Deductible, then 20% Coinsurance.

Hypodermic Syringes and Needles

- Hypodermic syringes and needles to the extent Medically Necessary, as required by Massachusetts law

Subject to the applicable prescription drug cost sharing listed on your ID card.

Other Health Services

- Ambulance services
- Low protein foods (\$2,500 per Member per calendar year)
- State mandated formulas
- House calls
- Dialysis

Deductible, then 20% Coinsurance.

- Vision hardware for keratoconus (please see your Benefit Handbook for details on coverage)

Deductible, then 20% Coinsurance.

- Hospice services

Deductible, then 20% Coinsurance.

If Inpatient services are required, please see "Inpatient Acute Hospital Services" for cost sharing.

Special Enrollment Rights

For Subscribers enrolled through an Employer Group:

If the Subscriber declines enrollment for himself or herself and Dependents (including spouse) because of other health insurance coverage, the Subscriber may be able to enroll in this plan in the future along with the Dependents, provided that enrollment is requested within 30 days after other coverage ends. In addition, if the Subscriber has a new Dependent as a result of marriage, birth, adoption or placement for adoption, the Subscriber may be able to enroll along with the new Dependents, provided that enrollment is requested within 30 days after the marriage, birth, adoption or placement for adoption.

Membership Requirements

There are a few important requirements that you must meet in order to be covered by the Plan. (Please see your *Benefit Handbook* for a complete description).

- Members must live in the HPHC's Enrollment Area for at least nine months of the year. An exception is made for full-time student dependents and dependents enrolled under a Qualified Medical Support Order.
- All your medical and health care needs must be provided or arranged by your Primary Care Physician (PCP), except in a Medical Emergency, when you are temporarily outside the HPHC Service Area, or when you need one of the special services which do not require a referral. The HPHC Service Area is the state in which you live.

Exclusions

- Services not approved, arranged or provided by your PCP except: (1) in a Medical Emergency; (2) when you are outside of the Service Area; or (3) the special services that do not require a referral listed in your Benefit Handbook
- 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
- Any products or services, including, but not limited to drugs, devices, treatments, procedures, and diagnostic tests, which are Experimental, Unproven, or Investigational
- 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, myotherapy, and sports medicine clinics
- Massage therapy when performed by anyone other than a licensed physical therapist/physical therapy assistant or occupational therapist/certified occupational therapy assistant
- Any treatment with crystals
- Blood and blood products
- Educational services and testing. No benefits are provided: (1) for educational services intended to enhance educational achievement; (2) to resolve problems of school performance; or (3) to treat learning disabilities
- Group diabetes training or educational programs or camps
- 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
- Sensory integrative praxis tests
- Physical examinations for insurance, licensing or employment
- Vocational rehabilitation or vocational evaluations on job adaptability, job placement or therapy to restore function for a specific occupation
- 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*), 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
- Routine maternity (prenatal and postpartum) care when you are traveling outside the Service Area
- Delivery outside the Service Area after the 37th week of pregnancy, or after you have been told that you are at risk for early delivery
- Planned home births
- Devices or special equipment needed for sports or occupational purposes

Exclusions

- 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
- Services for which no charge would be made in the absence of insurance
- 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 Benefit Handbook
- Services for non-Members
- Services after termination of membership
- 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
- Charges for missed appointments
- Services that are not Medically Necessary
- Services for which no coverage is provided in the Benefit Handbook, Schedule of Benefits or Prescription Drug Brochure
- Any home adaptations, including, but not limited to, home improvements and home adaptation equipment
- All charges over the semi-private room rate, except when a private room is Medically Necessary
- Hospital charges after the date of discharge
- Follow-up care to an emergency room visit unless provided or arranged by your PCP
- Services for a newborn who has not been enrolled as a Member, other than nursery charges for routine services provided to a healthy newborn
- Acupuncture, aromatherapy and alternative medicine
- Dentures
- Dental services, except the specific dental services listed in your Benefit Handbook and this Schedule of Benefits. Restorative, periodontal, orthodontic, endodontic, prosthodontic 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 are also not covered.
- Eyeglasses, contact lenses and fittings, except as listed in your Benefit Handbook
- Hearing aids
- Foot orthotics, except for the treatment of severe diabetic foot disease
- Methadone maintenance
- Private duty nursing
- Preventive dental care
- Extraction of teeth
- Medical and dental services for temporomandibular joint dysfunction (TMD)
- Vision hardware for pseudophakes, aphakes, and post retinal detachment surgery
- 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
- Unless otherwise specified in the *Schedule of Benefits* or *Benefit Handbook* (and required by Massachusetts law), the Plan does not cover food or nutritional supplements, including FDA-approved medical foods obtained by prescription.
- If a service is listed as requiring that it be provided at a Center of Excellence, no coverage will be provided under your *Benefit Handbook* and this *Schedule of Benefits* if that service is received from a provider that has not been designated as a Center of Excellence by HPHC.