Schedule of Benefits

The Harvard Pilgrim Tiered-Copayment HMO 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.

Member Cost Sharing Summary

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. Your identification card contains the Copayment amounts that apply to the Plan's most frequently used services.

There are three types of Copayments that apply to your Plan. A lower Copayment, known as "Copayment Level 1," applies to some outpatient services, including most primary care, obstetrical care, gynecological care, mental health care and substance abuse rehabilitation. Most outpatient specialty care requires payment of a higher Copayment, known as "Copayment Level 2." A third type of Copayment, known as the "Hospital Inpatient Copayment" applies when you receive inpatient care or Day Surgery. The Level 1 and Level 2 Copayments that apply to your Plan are listed below.

Copayment Level 1: Your Plan has a $30 Copayment per visit.

Copayment Level 2: Your Plan has a $50 Copayment per visit.

You have a **Hospital Inpatient Copayment** of $1,000 per admission. $500 per visit for **Day Surgery.**

Out-of-Pocket Maximums

Your Plan has an Out-of-Pocket Maximum of $2,000 per Member and $4,000 per covered family per calendar year. This is the total amount in Copayments you (or your covered family) are required to pay for services covered by the Plan, not including riders providing benefits for prescription drugs, adult preventive dental care or vision hardware. The Plan will notify you when you have reached your Out-of-Pocket Maximum. If you feel you have reached the Out-of-Pocket Maximum but have not been notified, please contact the Plan.

Copayment Level 1

Special Level 1 Services: Copayment Level 1 always applies to the following outpatient services regardless of the provider or location of service:

- Routine well physical examinations (including well child care, vision and auditory screening for children, nutrition counseling and health education)
- Immunizations
- Annual preventive gynecological examinations
- Voluntary termination of pregnancy
- Voluntary sterilization
- Mental health services
- Substance abuse services
- Early intervention services
- Physical therapy
- Occupational therapy
- Speech therapy
- Audiology services
- Routine eye examinations
- Artificial insemination
- Advanced reproductive technologies

In addition to the Special Level 1 list, Copayment Level 1 applies to covered outpatient professional services, other than services received at a professional office operated by a hospital, from the following types of providers:

- All Primary Care Physicians. The term "Primary Care Physician" (PCP) includes the following specialties: Internal Medicine, Family Practitioner, General Practitioner and Pediatrician
- Obstetricians and Gynecologists
- Certified Nurse Midwives
- Nurse Practitioners who bill independently

Copayment Level 2

Copayment Level 2 applies to the following outpatient professional services:

- Any covered services or provider not listed under Copayment Level 1
- Any service provided in a hospital operated doctor's office, except the Special Level 1 Services listed above.

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

A Copayment applies to all services except where specifically noted below.

Please note: Occasionally the Copayment may exceed the contract rate payable by the Plan for a service. If the Copayment is greater than the contract rate, you are responsible for the full Copayment, and the provider keeps the entire Copayment.

Service	
Inpatient Acute Hospital Services (including Day Surgery)	
All covered services including the following: ▪ Coronary care ▪ Hospital services ▪ Intensive care ▪ Semi-private room and board ▪ Physicians' and surgeons' services including consultations	Subject to the Hospital Inpatient Copayment.
Hospital Outpatient Department Services	
All covered services including the following: ▪ Anesthesia services ▪ Chemotherapy ▪ Endoscopic procedures ▪ Laboratory tests and x-rays ▪ Radiation therapy ▪ Physicians' and surgeons' services	Covered in full.
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.	$150 Copayment per visit in an emergency room. This Copayment is waived if admitted directly to the hospital from the emergency room. See "Physician Services" for coverage of emergency services by a physician in any other location.

Physician Services (including covered services by podiatrists)	
All covered services including the following: ▪ Administration of injections ▪ Allergy tests and treatments ▪ Changes and removals of casts, dressings or sutures ▪ Chemotherapy ▪ Consultations concerning contraception and hormone replacement therapy ▪ Diabetes self-management, including education and training ▪ Diagnostic screening and tests, including but not limited to mammograms, blood tests, lead screenings and screenings mandated by state law ▪ Family planning services ▪ Health education, including nutritional counseling ▪ Infertility services ▪ Medical treatment of temporomandibular joint dysfunction (TMD) ▪ Preventive care including, routine physical examinations, immunizations, routine annual eye examinations, school, camp, sports and premarital examinations ▪ Sick and well office visits, including psychopharmacological services	Copayment Level 1: $30 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.) Copayment Level 2: $50 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.)
▪ Administration of allergy injections	$10 Copayment per visit.
Please note that Copayment Level 2 applies to physicians' services rendered in a hospital operated physician's office, except for the Special Level 1 Services listed at the beginning of this document. Please see the Section titled "Member Cost Sharing" at the beginning of this document for detailed information on Copayments and Special Level 1 Services.	
Maternity Services	
▪ Prenatal and postpartum care	Covered in full.
▪ All hospital services for mother and routine nursery charges for newborn care	Subject to the Hospital Inpatient Copayment.

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 and 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.)

▪ Inpatient mental health services in a licensed general hospital - unlimited ▪ Inpatient mental health services in a psychiatric hospital - up to 60 days per calendar year [1] ▪ Inpatient drug and alcohol rehabilitation services - up to 30 days per calendar year [1] ▪ Inpatient detoxification	Subject to the Hospital Inpatient Copayment.
▪ Outpatient mental health services - up to 24 visits per calendar year for individual therapy and up to 25 visits per calendar year for group therapy, not to exceed a combined maximum of 25 individual and group therapy visits per calendar year	
Group therapy	$10 Copayment per visit.
Individual therapy	$30 Copayment per visit.
▪ Outpatient drug and alcohol rehabilitation services - up to 20 visits or $500 in benefit value per calendar year, whichever is greater	
Group therapy	$10 Copayment per visit.
Individual therapy visits 1-8	$30 Copayment per visit.
Individual therapy after visit 8	$40 Copayment per visit.
▪ Outpatient drug and alcohol rehabilitation services in conjunction with the treatment of mental disorders	
Group therapy	$10 Copayment per visit.
Individual therapy	$30 Copayment per visit.
▪ Outpatient detoxification	$30 Copayment per visit.
▪ Psychological testing	$30 Copayment per visit.

[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. Care in a partial hospitalization program is covered in full.

Home Health Care Services	
▪ Home care services ▪ Intermittent skilled nursing care	Covered in full.
No cost sharing or benefit limit applies to durable medical equipment, physical therapy or occupational therapy received as part of authorized home health care.	
Dental Services	
▪ Preventive care for children through the age of 12. Two visits per Member per calendar year, including examination, cleaning, x-rays, and fluoride treatment.	$30 Copayment per visit.
▪ Extraction of unerupted teeth impacted in bone ▪ Initial emergency treatment (within 72 hours of injury)	Copayment Level 2: $50 Copayment per visit. If inpatient services are required, please see "Inpatient Acute Hospital Services" for cost sharing.
Skilled Nursing Facility Care Services	
▪ Covered up to 100 days per calendar year	Subject to the Hospital Inpatient Copayment.
Inpatient Rehabilitation Services	
▪ Covered up to 60 days per calendar year	Subject to the Hospital Inpatient Copayment.
Diabetes Equipment and Supplies	
▪ Therapeutic molded shoes and inserts, dosage gauges, injectors, lancet devices, voice synthesizers and visual magnifying aids	Covered in full.
▪ Blood glucose monitors, insulin pumps and supplies and infusion devices	Covered in full.
▪ Insulin, insulin syringes, insulin pens with insulin, lancets, oral agents for controlling blood sugar, blood test strips, and glucose, ketone and urine test strips	Subject to the applicable prescription drug Copayment listed on your ID card, if your Plan includes prescription drug coverage. If prescription drug coverage is not available, then you will pay a $5 Copayment for Tier 1 items, $10 Copayment for Tier 2 items and a $25 Copayment for Tier 3 items.

Durable Medical Equipment including Prosthetics	
Durable medical equipment (DME) including prosthetics - up to a maximum of $1,500 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	Covered in full.
Hypodermic Syringes and Needles	
▪ Hypodermic syringes and needles to the extent Medically Necessary, as required by Massachusetts law	Subject to the applicable prescription drug Copayment listed on your ID card, if your Plan includes prescription drug coverage. If prescription drug coverage is not available, then you will pay the lower of the pharmacy's retail price or a $5 Copayment for Tier 1 items, $10 Copayment for Tier 2 items and a $25 Copayment for Tier 3 items.

Other Health Services	
▪ Ambulance services ▪ Low protein foods ($2,500 per Member per calendar year) ▪ State mandated formulas ▪ Hospice services ▪ Dialysis	Covered in full.
▪ Vision hardware for special conditions	Covered in full up to applicable benefit limits as described in the Benefit Handbook.
▪ Cardiac rehabilitation	Copayment Level 2: $50 Copayment per visit.
▪ Physical, and occupational therapies – up to 60 combined visits per calendar year ▪ Speech-language and hearing services, including therapy ▪ Early intervention services - up to a maximum of $5,200 per Member per calendar year and a lifetime maximum of $15,600	Copayment Level 1: $30 Copayment per visit.
▪ House calls	Copayment Level 1: $30 Copayment per visit. Copayment Level 2: $50 Copayment per visit.

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
- 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, including myotherapy, 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
- 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), 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
- 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
- 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 this 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

Exclusions

- Services that are not Medically Necessary
- 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
- 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
- If your Plan does not include coverage for outpatient prescription drugs, there is no coverage for birth control drugs, implants, injections and devices
- 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 and dental services for temporomandibular joint dysfunction (TMD) are not covered. Removal of impacted teeth to prepare for or support orthodontic, prosthodontic, or periodontal procedures and dental fillings, crowns, gum care, including gum surgery, braces, root canals, bridges and bonding.
- Eyeglasses, contact lenses and fittings, except as listed in your Benefit Handbook and this Schedule of Benefits
- Chiropractic services, including osteopathic manipulation
- Hearing aids
- Foot orthotics, except for the treatment of severe diabetic foot disease
- Methadone maintenance
- Private duty nursing
- 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.