

Schedule of Benefits

The Harvard Pilgrim PPO

Massachusetts

Services listed 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 a **Hospital Inpatient Copayment (including Day Surgery)** of \$500 per admission.

You have an **Out-of-Network Deductible** of \$400 per Member or \$800 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 \$2,000 per Member or \$4,000 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) |
|---|--|---|
| Inpatient Acute Hospital Services (including Day Surgery) | | |
| All covered services including the following: <ul style="list-style-type: none"> ▪ Coronary care ▪ Hospital services ▪ Intensive care ▪ Physicians' and surgeons' services including consultations ▪ Semi-private room and board | Subject to the Hospital Inpatient Copayment. | 20% Coinsurance after the Deductible has been met, subject to the Hospital Inpatient Copayment. |
| Skilled Nursing Facility Care Services | | |
| <ul style="list-style-type: none"> ▪ Covered up to 100 days per calendar year | Subject to the Hospital Inpatient Copayment. | 20% Coinsurance after the Deductible has been met, subject to the Hospital Inpatient Copayment. |
| Inpatient Rehabilitation Services | | |
| <ul style="list-style-type: none"> ▪ Covered up to 60 days per calendar year | Subject to the Hospital Inpatient Copayment. | 20% Coinsurance after the Deductible has been met, subject to the Hospital Inpatient Copayment. |
| Maternity Services | | |
| <ul style="list-style-type: none"> ▪ Prenatal and postpartum care ▪ All hospital services for mother and routine nursery charges for newborn | Covered in full. | 20% Coinsurance after the Deductible has been met. 20% Coinsurance after the Deductible has been met, subject to the Hospital Inpatient Copayment. |

| Service | In-Network (Participating Providers) | Out-of- Network (Non- Participating Providers) |
|--|---|---|
| Hospital Outpatient Department Services | | |
| <p>All covered services including the following:</p> <ul style="list-style-type: none"> ▪ Anesthesia services ▪ Chemotherapy ▪ Endoscopic procedures ▪ Laboratory tests and x-rays ▪ Physicians' and surgeons' services ▪ Radiation therapy | Covered in full. (Unless otherwise listed under a specific benefit below.) | 20% Coinsurance after the Deductible has been met. |
| Physician Services | | |
| <p>All covered services including the following:</p> <ul style="list-style-type: none"> ▪ Administration of injections ▪ Allergy tests and treatments ▪ Changes and removal of casts, dressings or sutures ▪ Chemotherapy ▪ Consultations concerning contraception and hormone replacement therapy ▪ Diabetes self-management, including education and training ▪ Family planning services ▪ Infertility services ▪ Diagnostic screening and tests, including but not limited to mammograms, blood tests, lead screenings and screenings mandated by state law ▪ Health education, including nutritional counseling ▪ Medical treatment of temporomandibular joint dysfunction (TMD) ▪ Preventive care, including routine physical examinations, immunizations, annual eye examinations, school, camp, sports and premarital examinations ▪ Sick and well office visits, including psychopharmacological services ▪ Vision and hearing screening | \$20 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.) | 20% Coinsurance after the Deductible has been met. |
| <ul style="list-style-type: none"> ▪ Administration of allergy injections | \$5 Copayment per visit. | 20% Coinsurance after the Deductible has been met. |

| Service | In-Network (Participating Providers) | Out-of- Network (Non- Participating Providers) |
|---|--|---|
| Emergency Room Care Services | | |
| <ul style="list-style-type: none"> Hospital emergency room treatment <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> | \$50 Copayment per visit. (This Copayment is waived if you are directly admitted.) | \$50 Copayment per visit. (This Copayment is waived if you are directly admitted.) |
| Emergency Admission Services | | |
| <ul style="list-style-type: none"> Inpatient services which are required immediately following the rendering of emergency room treatment | Subject to the Hospital Inpatient Copayment. | Subject to the Hospital Inpatient Copayment. |
| Mental Health and Drug and Alcohol Rehabilitation Services | | |
| <p>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 an HPHC mental health clinician in conjunction with treatment of mental disorders. (Please see your Benefit Handbook for details.)</p> | | |
| <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 year ¹ Inpatient drug and alcohol rehabilitation services - up to 30 days per calendar year ¹ Inpatient detoxification | Subject to the Hospital Inpatient Copayment. | 20% Coinsurance after the Deductible has been met, subject to the Hospital Inpatient Copayment. |
| <ul style="list-style-type: none"> 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 <p>Group therapy</p> <p>Individual therapy</p> | <p>\$10 Copayment per visit.</p> <p>\$20 Copayment per visit.</p> | 20% Coinsurance after the Deductible has been met. |

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.

| Service | In-Network (Participating Providers) | Out-of- Network (Non- Participating Providers) |
|---|---|---|
| Mental Health and Drug and Alcohol Rehabilitation Services (Continued) | | |
| <ul style="list-style-type: none"> ▪ Outpatient drug and alcohol rehabilitation services - up to 20 visits or \$500 in benefit value per calendar year, whichever is greater | \$10 Copayment per visit. | 20% Coinsurance after the Deductible has been met. |
| Group therapy | \$20 Copayment per visit. | |
| Individual therapy visits 1-8 | \$25 Copayment per visit. | |
| Individual therapy after visit 8 | \$10 Copayment per visit. | 20% Coinsurance after the Deductible has been met. |
| <ul style="list-style-type: none"> ▪ Outpatient drug and alcohol rehabilitation services in conjunction with the treatment of mental disorders | \$20 Copayment per visit. | 20% Coinsurance after the Deductible has been met. |
| Group therapy | \$20 Copayment per visit. | |
| Individual therapy | \$20 Copayment per visit. | 20% Coinsurance after the Deductible has been met. |
| <ul style="list-style-type: none"> ▪ Outpatient detoxification | \$20 Copayment per visit. | |
| <ul style="list-style-type: none"> ▪ Psychological testing | Covered in full. | 20% Coinsurance after the Deductible has been met. |
| Dental Services | | |
| <ul style="list-style-type: none"> ▪ Preventive care for children through the age of 12. Two visits per Member per calendar year, including examination, cleaning, x-rays, and fluoride treatment. | <ul style="list-style-type: none"> ▪ Extraction of unerupted teeth impacted in bone ▪ Initial emergency treatment (within 72 hours of injury) | 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) |
|--|---|---|
| Home Health Care Services | | |
| <ul style="list-style-type: none"> ▪ Home care services ▪ Intermittent skilled nursing care | 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. | | |
| Diabetes Equipment and Supplies | | |
| <ul style="list-style-type: none"> ▪ Therapeutic molded shoes and inserts, dosage gauges, injectors, lancet devices, voice synthesizers and visual magnifying aids | 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"> ▪ Blood glucose monitors, insulin pumps and supplies and infusion devices | Covered in full. | Covered in full. |
| <ul style="list-style-type: none"> ▪ 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 Employer has selected 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 Employer has selected 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) |
|---|--|---|
| Durable Medical and Prosthetic Equipment | | |
| <p>Durable medical and prosthetic equipment - up to a maximum of \$1,500 per calendar year for all covered equipment. Coverage includes, but is not limited to:</p> <ul style="list-style-type: none"> ▪ Durable medical equipment ▪ Prosthetic devices ▪ Breast prostheses, including replacements and mastectomy bras (no benefit limit applies) ▪ Ostomy supplies ▪ 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. | 20% Coinsurance after the Deductible has been met. |
| <ul style="list-style-type: none"> ▪ Oxygen and respiratory equipment | Covered in full. No benefit limit applies. | 20% Coinsurance after the Deductible has been met. No benefit limit applies. |
| Other Health Services | | |
| <ul style="list-style-type: none"> ▪ Cardiac rehabilitation ▪ Chiropractic care – up to \$500 per calendar year ▪ Dialysis ▪ Early intervention services - up to a maximum of \$5,200 per Member per calendar year and a lifetime maximum of \$15,600 ▪ Second opinion ▪ Physical and occupational therapies - up to 60 consecutive days per condition ▪ Speech-language and hearing services, including therapy | \$20 Copayment per visit. | 20% Coinsurance after the Deductible has been met. |
| <ul style="list-style-type: none"> ▪ House calls | \$20 Copayment per visit. | 20% Coinsurance after the Deductible has been met. |
| <ul style="list-style-type: none"> ▪ Hospice services | 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. |

| Service | In-Network (Participating Providers) | Out-of-Network (Non- Participating Providers) |
|---|--|--|
| Other Health Services (Continued) | | |
| <ul style="list-style-type: none"> ▪ Ambulance services ▪ Low protein foods (\$2,500 per Member per calendar year) ▪ State mandated formulas | Covered in full. | 20% Coinsurance after the Deductible has been met. |
| <ul style="list-style-type: none"> ▪ Vision hardware for special conditions (please see your Benefit Handbook for details on your coverage) | Covered in full up to the benefit limit. | 20% Coinsurance after the Deductible has been met up to the benefit limit. |

Special Enrollment Rights

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 in this Plan in the future along with his or her dependents, provided that enrollment is requested within 30 days after other coverage ends. In addition, if the employee has a new dependent as a result of marriage, birth, adoption or placement for adoption, the employee may be able to enroll along with his or her dependents, provided that enrollment is requested within 30 days after the marriage, birth, adoption or placement for adoption.

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.

Maternity Care

Members who are pregnant, and using a Non-Participating Provider, are responsible for calling the Brighter Infant Beginnings Program, at 1-800-742-2342 after the first prenatal visit.

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 Employer has selected this 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
- Dentures
- Mental health services that are (1) provided to

Exclusions

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
- Pre-implantation genetic diagnosis
- 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.
- 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