Schedule of Benefits

The Harvard Pilgrim Bronze HMO 250 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

Deductible

A Deductible is a specific annual dollar amount that is payable by the Member before medical benefits subject to the Deductible are available under the Plan. Not all services under this Plan are subject to the Deductible. For services subject to the Deductible, you must satisfy your Deductible before Harvard Pilgrim provides coverage for these benefits. Deductible amounts are incurred as of the date of service.

Your Plan has a $250 per Member Deductible and a $500 per family Deductible per calendar year.

Unless a family Deductible applies, each Member is responsible for the per Member Deductible for covered services each calendar year. If a family Deductible applies, it is met when any combination of Members in a covered family incur expenses for services subject to the Deductible that total the annual family Deductible.

Your Deductible applies to all services covered under the Plan except the following:

- Examinations and consultations performed by physicians and podiatrists
- The Preventive Services as listed in the "Physician Services" Section of this Schedule of Benefits
- Prenatal and postpartum care in a physician's office
- Routine nursery charges for newborn care
- Outpatient mental health care (including the treatment of substance abuse disorders)
- Blood glucose monitors, insulin pumps and infusion devices
- Early intervention services

Please note that (1) treatments and procedures by physicians and podiatrists and (2) psychological testing are subject to the Deductible.

Prescription Drug Deductible

If your Plan includes prescription drug coverage, your drug benefit may be subject to a separate Deductible. Payments made toward the prescription drug Deductible are not counted toward the Deductible amounts listed above. Please refer to your *Prescription Drug Brochure* for specific information on your prescription drug Deductible, if any.

Deductible and Other Cost Sharing

For certain services, both a Deductible and Coinsurance may apply. In such cases, you must completely satisfy the Deductible before the Plan pays benefits on services subject to the Deductible. Once you have satisfied the annual Deductible, you are still responsible for any applicable Coinsurance.

Office Visit Copayments

You are responsible for a Copayment for certain services under this Plan. The Copayment applies to all services except where specifically noted below.

There are two types of office visit 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." The Level 1 and Level 2 Copayments that apply to your Plan are listed below.

Copayment Level 1: Your Plan has a $25 Copayment per visit.

Copayment Level 2: Your Plan has a $40 Copayment per visit.

Please note: Routine physical examinations, including well child care visits and annual gynecological examinations are **covered in full**.

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:

- Mental health services (including the treatment of substance abuse disorders)

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
- Audiologists

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.

Your identification card indicates the Copayment amounts for the Plan's most frequently used services. This *Schedule of Benefits* provides further detail on all Copayment requirements.

Please note: In very limited cases 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.

Coinsurance

Coinsurance is a percentage of charges payable by the Member for certain covered services. Coinsurance is due when billed by the provider. This *Schedule of Benefits* provides further detail on all Coinsurance requirements.

Out-of-Pocket Maximums

Your plan has an Out-of-Pocket Maximum of $5,000 per Member and $10,000 per covered family per calendar year. This is the total amount in Copayments, Coinsurance and Deductible you (or your covered family) are required to pay each calendar year for services covered by the Plan, not including riders providing benefits for prescription drugs 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.

The Deductible applies to all services except where specifically noted below.

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	35% Coinsurance after the Deductible has been met.
Hospital Outpatient Department Services	
▪ All covered services, except emergency room care No cost sharing applies to certain preventive care services and tests. See "Preventive Care Office Visit Services" and "Preventive Services" section below.	35% Coinsurance after the Deductible has been met.
Diagnostic Procedures (including all technical and professional charges)	
All covered services, including the following: ▪ Laboratory tests, Nuclear Magnetic Resonance Imaging, Ultrasounds* and x-rays ▪ Endoscopic procedures ▪ Blood and urine tests* ▪ Diagnostic procedures* * No cost sharing applies to fetal ultrasounds and any services and tests listed in the "Preventive Services" section below.	35% Coinsurance after the Deductible has been met.
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.

Professional Office Visit Services	
▪ Office visits for illness or injury ▪ See below for Preventive Care Office Visit Services	Copayment Level 1: $25 Copayment per visit. The Deductible does not apply to these services. Copayment Level 2: $40 Copayment per visit. The Deductible does not apply to these services.
Preventive Care Office Visit Services	
The following professional services: ▪ Routine physical examinations, including well child care visits ▪ Annual gynecological examinations	Covered in full.
▪ Routine eye examinations – covered once every 24 months	$15 Copayment per visit. The Deductible does not apply.
Treatments and Procedures (including all diagnostic procedures)	
▪ Administration of injections ▪ Allergy treatments ▪ Casting, suturing and the application of dressings ▪ Chemotherapy ▪ Radiation therapy ▪ Infertility treatment and procedures ▪ Pregnancy testing ▪ Voluntary sterilization, including tubal ligation ▪ Voluntary termination of pregnancy ▪ Genetic counseling ▪ Surgical procedures ▪ Non-routine foot care ▪ Foot care for members with severe diabetic foot disease ▪ Administration of allergy injections ▪ Medical treatment of temporomandibular joint dysfunction (TMD)	35% Coinsurance after the Deductible has been met.

Preventive Services (including all technical and professional charges)	
The following preventive services and tests as defined by federal law: ▪ Abdominal aortic aneurysm screening (for males 65-75 one time only, if ever smoked) ▪ Alcohol misuse screening and counseling (primary care visits only) ▪ Aspirin for the prevention of heart disease (primary care counseling only) ▪ Autism screening (for children at 18 and 24 months of age, primary care visits only) ▪ Behavioral assessments (children of all ages; developmental surveillance, in primary care settings) ▪ Blood pressure screening (adults, without known hypertension) ▪ Breast cancer chemoprevention (counseling only for women at high risk for breast cancer and low risk for adverse effects of chemoprevention) ▪ Breast cancer screening, including mammograms and counseling for genetic susceptibility screening ▪ Cervical cancer screening, including pap smears ▪ Cholesterol screening (for adults only) ▪ Colorectal cancer screening, including colonoscopy, sigmoidoscopy and fecal occult blood test ▪ Dental caries prevention - oral fluoride (for children to age 5 only) (Note: Coverage for fluoride is only provided if your Plan includes outpatient pharmacy coverage.) ▪ Depression screening (adults, children ages 12-18, primary care visits only) ▪ Diabetes screenings ▪ Diet behavioral counseling (included as part of annual visit and intensive counseling by primary care clinicians or by nutritionists and dieticians) ▪ Dyslipidemia screening (for children at high risk for higher lipid levels) ▪ Folic acid supplements (women planning or capable of pregnancy only) (Note: coverage for folic acid is only provided if your Plan includes outpatient pharmacy coverage.) ▪ Hemoglobin A1c ▪ Hepatitis B testing ▪ HIV screening ▪ Immunizations, including flu shots (for children and adults as appropriate) ▪ Iron deficiency prevention (primary care counseling for children age 6 to 12 months only) ▪ Lead screening (children at risk) ▪ Microalbuminuria test ▪ Obesity screening (adults and children screening only, in primary care settings) ▪ Osteoporosis screening (screening to begin at age 60 for women at increased risk) ▪ Ovarian cancer susceptibility screening ▪ Sexually transmitted diseases (STDs) – screenings and counseling ▪ Tobacco use counseling (primary care visits only) ▪ Total cholesterol tests ▪ Tuberculosis skin testing ▪ Vision screening (children to age 5 only)	Covered in full. The Deductible does not apply to these services.

Preventive Services (including all technical and professional charges) (Continued)

Under federal law the list of preventive care services covered under this benefit may change periodically based on the recommendations of the following agencies:

a. Grade "A" and "B" recommendations of the United States Preventive Services Task Force;

b. With respect to immunizations, the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention; and

c. With respect to services for woman, infants, children and adolescents, the Health Resources and Services Administration.

Information on the recommendations of these agencies may be found on the web site of the US Department of Health and Human Services at:

http://www.healthcare.gov/center/regulations/prevention/recommendations.html

Harvard Pilgrim will add or delete services from this benefit for preventive care in accordance with changes in the recommendations of the agencies listed above. You can find a list of the current recommendations for preventive care on Harvard Pilgrim's web site at www.harvardpilgrim.org.

Coverage is also provided for the following preventive services and tests: ▪ Hepatitis C testing ▪ Prostate-specific antigen (PSA) screening ▪ Fetal ultrasounds ▪ Routine hemoglobin ▪ Routine urinalysis ▪ Alpha-Fetoprotein (AFP) and Group B streptococcus (GBS) test ▪ All lab handling and venipuncture charges	Covered in full. The Deductible does not apply to these services.
Maternity Services	
▪ Prenatal and postpartum care, including counseling about alcohol and tobacco use, services to promote breastfeeding, routine urinalysis and screenings for the following: asymptomatic bacteriuria; hepatitis B infection; HIV and screenings for STDs (chlamydia, gonorrhea and syphilis); iron deficiency anemia; and Rh (D) incompatibility.	Covered in full.
▪ All hospital services for mother, including inpatient physician services	35% Coinsurance after the Deductible has been met.
▪ Routine nursery charges for newborn care, including prophylactic medication to prevent gonorrhea and screenings for the following: hearing loss; congenital hypothyroidism; phenylketonuria (PKU); and sickle cell disease.	Covered in full.

Mental Health Care (Including the Treatment of Substance Abuse Disorders)	
Please note that no day or visit limits apply to mental health care services for biologically-based mental disorders (including substance abuse disorders), rape-related mental or emotional disorders, and non-biologically-based mental, behavioral or emotional disorders for children and adolescents. (Please see your *Benefit Handbook* for details.)	
▪ Inpatient Services	
▪ Mental health care services - up to 60 days per calendar year	35% Coinsurance after the Deductible has been met.
▪ Intermediate Care Services	
▪ Acute residential treatment (including detoxification), crisis stabilization and in-home family stabilization ▪ Intensive outpatient programs, partial hospitalization and day treatment programs	35% Coinsurance after the Deductible has been met.
▪ Outpatient Services	
▪ Mental health care services - up to 24 visits per calendar year	
Group therapy	$10 Copayment per visit.
Individual therapy	$25 Copayment per visit. The Deductible does not apply to these services.
▪ Detoxification	$25 Copayment per visit. The Deductible does not apply to these services.
▪ Medication management	$25 Copayment per visit. The Deductible does not apply to these services.
▪ Psychological testing and neuropsychological assessment	35% Coinsurance after the Deductible has been met.
Home Health Care Services	
▪ Home care services ▪ Intermittent skilled nursing care	35% 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.	
Dental Services	
▪ Extraction of unerupted teeth impacted in bone ▪ Initial emergency treatment (within 72 hours of injury)	35% Coinsurance after the Deductible has been met. For emergency room care, see your "Emergency Services" Copayment below.

Skilled Nursing Facility Care Services	
▪ Covered up to 100 days per calendar year	35% Coinsurance after the Deductible has been met.
Inpatient Rehabilitation Services	
▪ Covered up to 60 days per calendar year	35% Coinsurance after the Deductible has been met.
Diabetes Equipment and Supplies	
▪ Therapeutic molded shoes and inserts, dosage gauges, injectors, lancet devices, voice synthesizers and visual magnifying aids	35% Coinsurance after the Deductible has been met.
▪ Blood glucose monitors, insulin pumps and supplies and infusion devices	Covered in full. The Deductible does not apply to these services.
▪ 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.
Durable Medical Equipment including Prosthetics	
Coverage includes, but is not limited to: ▪ Durable medical equipment ▪ Prosthetic devices (including artificial arms and legs) ▪ Ostomy supplies ▪ Breast prostheses, including replacements and mastectomy bras ▪ Oxygen and respiratory equipment ▪ 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	35% Coinsurance after the Deductible has been met.

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.
Other Health Services	
▪ Cardiac rehabilitation ▪ Dialysis ▪ Physical and occupational therapies - up to 20 visits per calendar ▪ Speech-language and hearing services, including therapy ▪ Hospice services ▪ Ambulance services ▪ Low protein foods ($5,000 per Member per calendar year) ▪ State mandated formulas ▪ House calls	35% Coinsurance after the Deductible has been met.
▪ Early intervention services	Covered in full. The Deductible does not apply to these services.
▪ Vision hardware for special conditions	35% Coinsurance after the Deductible has been met, up to the applicable benefit limits as described in the Benefit Handbook.

Special Enrollment Rights

For Subscribers enrolled through an Employer Group:

If an employee declines enrollment for the employee and his or her Dependents (including his or her spouse) because of other health insurance coverage, the employee may be able to enroll himself or herself, along with his or her Dependents in this Plan if the employee or his or her Dependents lose eligibility for that other coverage (or if the employer stops contributing toward the employee's or Dependents' other coverage). However, enrollment must be requested within 30 days after other coverage ends (or after the employer stops contributing toward the employee's or Dependents' other coverage). In addition, if an employee has a new Dependent as a result of marriage, birth, adoption or placement for adoption, the employee may be able to enroll himself or herself and his or her Dependents. However, enrollment must be requested within 30 days after the marriage, birth, adoption or placement for adoption.

Special enrollment rights may also apply to persons who lose coverage under Medicaid or the Children's Health Insurance Program (CHIP) or become eligible for state premium assistance under Medicaid or CHIP. An employee or Dependent who loses coverage under Medicaid or CHIP as a result of the loss of Medicaid or CHIP eligibility may be able to enroll in this Plan, if enrollment is requested within 60 days after Medicaid or CHIP coverage ends. An employee or Dependent who becomes eligible for group health plan premium assistance under Medicaid or CHIP may be able to enroll in this Plan if enrollment is requested within 60 days after the employee or Dependent is determined to be eligible for such premium assistance.

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 Child 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 care (including the treatment of substance abuse disorders) 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

Exclusions

- 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* (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.
- Chiropractic services, including osteopathic manipulation
- Eyeglasses, contact lenses and fittings, except as listed in your Benefit Handbook and this Schedule of Benefits
- Hearing aids
- Foot orthotics, except for the treatment of severe diabetic foot disease
- Methadone maintenance
- Private duty nursing
- 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.
- Preventive dental care
- 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.
- Services for any condition with only a "V Code" designation in the Diagnostic and Statistical Manual of Mental Disorders, which means that the condition is not attributable to a mental disorder.