Schedule of Benefits

The Harvard Pilgrim Best Buy HMO 500 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 $500 per Member Deductible and a $1,000 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 Plan has a Deductible carryover

A Deductible carryover allows you to apply any Deductible amount incurred for covered services during the last three (3) months of a year toward the Deductible for the next year. In order for a Deductible carryover to apply, the Member (or family) must have had continuous coverage under the Plan through the same Employer Group at the time the charges for the prior year were incurred.

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 services
- Outpatient drug and alcohol rehabilitation services
- Pediatric preventive dental care
- Blood glucose monitors, insulin pumps and infusion devices

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 amount[s] 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 Copayment 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 Copayments.

Copayments

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

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 Copayment does not apply to your Deductible.

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.

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 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, 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.

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	Covered in full after the Deductible has been met.
Hospital Outpatient Department Services	
▪ All covered services, except emergency room care	Covered in full 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 (except for x-rays provided as part of a pediatric preventive dental visit) ▪ Endoscopic procedures ▪ Blood and urine tests* ▪ Diagnostic procedures*	Covered in full after the Deductible has been met.
*The Deductible does not apply to fetal ultrasounds and any tests and procedures listed in the "Preventive Services" section below.	
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.	$100 Copayment per visit in an emergency room after the Deductible has been met. 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) **Examinations and Consultations**	
▪ Examinations for preventive care, including routine physical examinations, annual gynecological examinations, school, camp, sports and premarital examinations ▪ Examinations for illness or injuries ▪ Routine eye examinations, including glaucoma screenings ▪ Routine hearing examinations and tests ▪ Health education, including nutritional counseling and diabetes education and training ▪ Family planning consultations ▪ Medication management, including psychopharmacological services ▪ Consultation with specialists ▪ Consultations concerning contraception and hormone replacement therapy	$20 Copayment per visit. The Deductible does <u>not</u> apply to these services.
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)	Covered in full after the Deductible has been met.

Preventive Services (including all technical and professional charges)	
The preventive services under this benefit are limited to the following: ▪ Administration of all immunizations ▪ Pap Smear ▪ Screenings for Chlamydia and all other sexually transmitted diseases, including gonorrhea, syphilis, herpes and Human Papilloma Virus (HPV) ▪ Total cholesterol, LDL, HDL and triglycerides ▪ Hepatitis C testing ▪ HIV testing ▪ Lead testing ▪ Mammogram ▪ Fecal occult blood test, 3 samples annually ▪ Microalbuminuria test (dip stick, urine) for diabetes ▪ Hemoglobin A1c ▪ Prostate-specific antigen (PSA) screening ▪ Tuberculosis skin testing ▪ Fetal ultrasounds ▪ Routine hemoglobin ▪ Routine urinalysis ▪ Alpha-Fetoprotein (AFP) and Group B streptococcus (GBS) test ▪ Blood glucose monitors, insulin pumps and infusion devices ▪ All lab handling and venipuncture charges	Covered in full. The Deductible does not apply to these services.
Maternity Services	
▪ Prenatal and postpartum care	Covered in full. The Deductible does not apply to prenatal and postpartum care provided in a physician's office. All other services are covered as stated in this Schedule of Benefits.
▪ All hospital services for mother, including inpatient physician services	Covered in full after the Deductible has been met.
▪ Routine nursery charges for newborn care	Covered in full.

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 an HPHC mental health clinician in conjunction with treatment of mental disorders. (Please see your Benefit Handbook for details.)

▪ Inpatient mental health services - up to 60 days per calendar year [1] ▪ Inpatient drug and alcohol rehabilitation services - up to 30 days per calendar year[1] ▪ Inpatient detoxification	Covered in full after the Deductible has been met.
▪ 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	$20 Copayment per visit. The Deductible does not apply to these services.
▪ 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	$20 Copayment per visit. The Deductible does not apply to these services.
▪ Outpatient drug and alcohol rehabilitation services in conjunction with the treatment of mental disorders	
Group therapy	$10 Copayment per visit.
Individual therapy	$20 Copayment per visit. The Deductible does not apply to these services.
▪ Outpatient detoxification	$20 Copayment per visit. The Deductible does not apply to these services.
▪ Psychological testing	Covered in full 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.

Home Health Care Services	
▪ Home care services ▪ Intermittent skilled nursing care	Covered in full 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	
▪ Preventive care for children through age 12. Two visits per Member per calendar year, including examination, cleaning, x-rays and fluoride treatment.	$20 Copayment per visit. The Deductible does not apply to pediatric preventive dental care.
▪ Extraction of unerupted teeth impacted in bone ▪ Initial emergency treatment (within 72 hours of injury)	Covered in full after the Deductible has been met. For emergency room care, see your "Emergency Services" Copayment below. For care in any other location, covered in full after the Deductible has been met.
Skilled Nursing Facility Care Services	
▪ Covered up to 100 days per calendar year	Covered in full after the Deductible has been met.
Inpatient Rehabilitation Services	
▪ Covered up to 60 days per calendar year	Covered in full 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	Covered in full 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, 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. The Deductible does not apply to these services.

Durable Medical Equipment including Prosthetics	
Durable medical equipment (DME) including prosthetics up to a maximum of $2,500 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 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, 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	
▪ Cardiac rehabilitation ▪ Dialysis ▪ Physical and occupational therapies - up to 60 consecutive days per condition ▪ Speech-language and hearing services, including therapy ▪ Hospice services ▪ Ambulance services ▪ Low protein foods ($2,500 per Member per calendar year) ▪ State mandated formulas ▪ Early intervention services - up to a maximum of $5,200 per Member per calendar year and a lifetime maximum of $15,600 ▪ House calls	Covered in full after the Deductible has been met.
▪ Vision hardware for special conditions	Covered in full 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 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.
- 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