ID: MD0000002599
CODE: 0-SQF

Schedule of Benefits

THE HARVARD PILGRIM HMO
MASSACHUSETTS

This Schedule of Benefits summarizes your Benefits under The Harvard Pilgrim HMO (the Plan) and states the Member Cost Sharing amounts that you must pay for Covered Benefits. However, it is only a summary of your benefits. Please see your Benefit Handbook and Prescription Drug Brochure (if you have the Plan's outpatient pharmacy coverage) for detailed information on benefits covered by the Plan and the terms and conditions of coverage.

Services are covered when Medically Necessary. Subject to the exceptions listed in the section of the Benefit Handbook titled, "How The Plan Works" all services must be (1) provided or arranged by your Primary Care Provider (PCP) and (2) provided by a Plan Provider. These requirements do not apply to care needed in a Medical Emergency.

You always have coverage 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. Your emergency room Member Cost Sharing is listed below under the heading "Emergency Room Care."

We use clinical review criteria to evaluate whether certain services or procedures are Medically Necessary for a Member's care. Members or their practitioners may obtain a copy of our clinical review criteria applicable to a service or procedure for which coverage is requested. Clinical review criteria may be obtained by calling **1-888-888-4742 ext. 38723.**

Your Covered Benefits are administered on a calendar year basis.

General Cost Sharing Features:	Member Cost Sharing:
Coinsurance and Copayments	
	See Covered Benefits below
Deductible	
	None

Benefit	Member Cost Sharing:
Ambulance Transport	
– Emergency ambulance transport	No charge
– Non-emergency ambulance transport	No charge

EFFECTIVE DATE: 07/01/2013

Benefit	Member Cost Sharing:
Autism Spectrum Disorders Treatment	
Professional Services – Coverage for the treatment of Autism Spectrum Disorders is provided for all of the services otherwise covered under your Plan. However, no benefit limit applies to services for the treatment of Autism Spectrum Disorders.	Your Member cost sharing depends upon the type of service provided, as listed in this Schedule of Benefits. For example: For services provided by a physician see "Physician and Other Professional Office Visits." For services by a Licensed Mental Health Professional see "Mental Health Care (Including the Treatment of Substance Abuse Disorders)." For services by a physical therapist and occupational therapist, see "Rehabilitation Therapy - Outpatient."
Applied Behavior Analysis – No benefit limit applies to this service.	$5 Copayment per visit
Cardiac Rehabilitation	
	$5 Copayment per visit
Chemotherapy and Radiation Therapy — Outpatient	
– Chemotherapy – Radiation therapy	No charge
Clinical Trials for the Treatment of Cancer	
	Your Member Cost Sharing will depend upon the types of services provided, as listed in this Schedule of Benefits. For example, for services provided by a physician, see "Physician and Other Professional Office Visits." For inpatient hospital care, see "Hospital – Inpatient Services."
Dental Services	
– Emergency Dental Care	Your Member Cost Sharing will depend upon the types of services provided, as listed in this Schedule of Benefits. For example, for services provided in a dentist's office, see "Physician and Other Professional Office Visits." For services provided in a hospital emergency room, see "Emergency Room Care."
– Extraction of teeth impacted in bone	Your Member Cost Sharing will depend upon the types of services provided, as listed in this Schedule of Benefits. For example, for services provided in a dentist's office, see "Physician and Other Professional Office Visits."
– Preventive Dental Care for children (up to the age of 14)	No charge
Important Notice: Coverage of Dental Care is very limited. Please see your Benefit Handbook for the details of your coverage.	
Diabetes Services and Supplies	
– Self management and training/diabetic eye examinations/foot care	$5 Copayment per visit
– Diabetes equipment	Same as Durable Medical Equipment Member Cost Sharing does not apply to blood glucose monitors or insulin pumps (including supplies) and infusion devices.
– Pharmacy supplies	Subject to the applicable pharmacy Member Cost Sharing listed in your Outpatient Prescription Drug Schedule of Benefits and on your ID Card. If your Plan does not include coverage for outpatient prescription drugs, then coverage is subject to the lower of the pharmacy's retail price or a Copayment of $5 for Tier 1 drugs or supplies, $10 for Tier 2 drugs or supplies and $25

Benefit	Member Cost Sharing:
Diabetes Services and Supplies (Continued)	
	for Tier 3 drugs or supplies. All Copayments are based on a 30 day supply. For information on the drug tiers, please visit our website at **www.harvardpilgrim.org/members** and select **"pharmacy/drug tier look up"** or contact the Member Services Department at **1-888-333-4742**.
Dialysis	
– Dialysis services	$5 Copayment per visit
– Installation of home equipment is covered up to $300 in a Member's lifetime.	No charge
Durable Medical Equipment	
	20% Coinsurance in equipment cost to HPHC, not to exceed a Member's total expense of $1,000 Member Cost Sharing does not apply to the following: – Respiratory equipment – Oxygen and oxygen equipment
Early Intervention Services	
Limited to a maximum of $5,200 per Member per calendar year and a lifetime maximum of $15,600	$5 Copayment per visit
Emergency Room Care	
	$30 Copayment per visit This Copayment is waived if admitted to the hospital directly from the emergency room.
Family Planning Services	
	$5 Copayment per visit
Hearing Aids (for Members up to the age of 22)	
– Limited to $2,000 per hearing aid every 36 months, for each hearing impaired ear	No charge
Home Health Care	
	No charge
Hospice Services	
	No charge for outpatient services If inpatient services are required please see "Hospital - Inpatient Services" or "Skilled Nursing Facility Care" for Member Cost Sharing details.
Hospital – Inpatient Services	
	No charge
House Calls	
	$15 Copayment per visit
Human Organ Transplant Services	
	Your Member Cost Sharing will depend upon the types of services provided, as listed in this Schedule of Benefits. For example, for services provided by a physician, see "Physician and Other Professional Office Visits." For inpatient hospital care, see "Hospital – Inpatient Services."

Benefit	Member Cost Sharing:
Hypodermic Syringes and Needles	
	Subject to the applicable pharmacy Member Cost Sharing listed in your Outpatient Prescription Drug Schedule of Benefits and on your ID Card. If your Plan does not include coverage for outpatient prescription drugs, then coverage is subject to the lower of the pharmacy's retail price or a Copayment of $5 for Tier 1 drugs or supplies, $10 for Tier 2 drugs or supplies and $25 for Tier 3 drugs or supplies. All Copayments are based on a 30 day supply. For information on the drug tiers, please visit our website at **www.harvardpilgrim.org/members** and select **"pharmacy/drug tier look up"** or contact the Member Services Department at **1–888–333–4742**.
Infertility Services and Treatments (see the Benefit Handbook for details)	
	Your Member Cost Sharing will depend upon the types of services provided, as listed in this Schedule of Benefits. For example, for services provided by a physician, see "Physician and Other Professional Office Visits."
Laboratory and Radiology Services	
– Laboratory and x-rays	No charge
High end radiology – CT scans – PET scans – MRI – MRA – Nuclear medicine services	No charge
Low Protein Foods	
– Limited to $2,500 per calendar year	No charge
Maternity Care	
– Routine outpatient prenatal and postpartum care	No charge
Please Note: Routine prenatal and postpartum care is usually received and billed from the same Provider as a single or bundled service. Different Member Cost Sharing may apply to any specialized or non-routine service that is billed separately from your routine outpatient prenatal and postpartum care. For example, for services provided by another physician or specialist, see "Physician and Other Professional Office Visits" for your applicable Member Cost Sharing. Please see your Benefit Handbook for more information on maternity care.	
– Routine nursery care for the newborn, including prophylactic medication to prevent gonorrhea and screenings for the following: hearing loss; congenital hypothyroidism; phenylketonuria (PKU); and sickle cell disease.	No charge
– Hospital inpatient services	No charge
Medical Formulas	
	No charge

Benefit	Member Cost Sharing:
Mental Health Care (Including the Treatment of Substance Abuse Disorders)	
Please Note: Your Plan includes the benefits required under the Federal Mental Health Parity Act.	
Inpatient Mental Health Care Services	No charge
Intermediate Mental Health Care Services – Acute residential treatment (including detoxification), crisis stabilization and in-home family stabilization – Intensive outpatient programs, partial hospitalization and day treatment programs	No charge
Outpatient Mental Health Care Services – Mental health care service	Group therapy — $5 Copayment per visit Individual therapy — $5 Copayment per visit
– Detoxification	$5 Copayment per visit
– Medication management	$5 Copayment per visit
– Psychological testing and neuropsychological assessment	$5 Copayment per visit
Ostomy Supplies	
	Same as Durable Medical Equipment
Physician and Other Professional Office Visits (This includes all covered Plan Providers unless otherwise listed in this Schedule of Benefits.)	
– Routine examinations for preventive care, including immunizations	$5 Copayment per visit
– Consultations, evaluations and sickness and injury care	$5 Copayment per visit
– Administration of allergy injections	$5 Copayment per visit
Prosthetic Devices	
	Same as Durable Medical Equipment
Reconstructive Surgery	
	Your Member Cost Sharing will depend upon the types of services provided, as listed in this Schedule of Benefits. For example, for services provided by a physician, see "Physician and Other Professional Office Visits." For inpatient hospital care, see "Hospital – Inpatient Services."
Rehabilitation Hospital Care	
– Limited to 100 days per calendar year	No charge
Rehabilitation Therapy - Outpatient	
– Pulmonary rehabilitation therapy	$5 Copayment per visit
– Occupational therapy — limited to 90 consecutive days per condition – Physical therapy — limited to 90 consecutive days per condition **Please Note:** Outpatient physical and occupational therapy is covered to the extent Medically Necessary for: (1) children under the age of three and (2) the treatment of Autism Spectrum Disorders.	$5 Copayment per visit

Benefit	Member Cost Sharing:
Scopic Procedures - Outpatient Diagnostic and Therapeutic	
– Endoscopy and sigmoidoscopy	Your Member Cost Sharing will depend upon where the service is provided as listed in this Schedule of Benefits. For example, for a service provided in an outpatient surgical center, see "Surgery– Outpatient." For services provided in a physician's office, see "Physician and Other Professional Office Visits." For inpatient hospital care, see "Hospital – Inpatient Services."
– Colonoscopy	No charge
Skilled Nursing Facility Care	
– Limited to 100 days per calendar year	No charge
Speech-Language and Hearing Services	
	$5 Copayment per visit
Surgery — Outpatient	
	No charge
Temporomandibular Joint Dysfunction Services (medical treatment only)	
	Your Member Cost Sharing will depend upon where the service is provided as listed in this Schedule of Benefits. For example, for a service provided in an outpatient surgical center, see "Surgery - Outpatient." For services provided in a physician's office, see "Physician and Other Professional Office Visits." For inpatient hospital care, see "Hospital - Inpatient Services."
Vision Services	
– Routine eye examinations — limited to 1 per calendar year	$5 Copayment per visit
– Vision hardware for special conditions (see the Benefit Handbook for details)	No charge
Voluntary Sterilization	
	Your Member Cost Sharing will depend upon where the service is provided as listed in this Schedule of Benefits. For example, for a service provided in an outpatient surgical center, see "Surgery– Outpatient." For services provided in a physician's office, see "Physician and Other Professional Office Visits." For inpatient hospital care, see "Hospital – Inpatient Services."
Voluntary Termination of Pregnancy	
	Your Member Cost Sharing will depend upon where the service is provided as listed in this Schedule of Benefits. For example, for a service provided in an outpatient surgical center, see "Surgery– Outpatient." For services provided in a physician's office, see "Physician and Other Professional Office Visits." For inpatient hospital care, see "Hospital – Inpatient Services."
Wigs and Scalp Hair Prostheses (as required by law)	
When needed as a result of any form of cancer or leukemia, alopecia areata, alopecia totalis or permanent hair loss due to injury. – Limited to $350 per calendar year (see the Benefit Handbook for details)	Same as Durable Medical Equipment

Notice of Grandfathered Plan Status

Harvard Pilgrim Health Care, Inc. believes this Plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your Plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to your Employer's benefits office or human resources department. For plans governed by the Employee Retirement Income Security Act (ERISA), (generally these are plans purchased by an employer, other then a governmental entity or a church) you may also contact the Employee Benefits Security Administration, U.S. Department of Labor at **1–866–444–3272** or ***www.dol.gov/ebsa/healthreform***. This Web site has a table summarizing which protections do and do not apply to grandfathered health plans. For Plans that are not governed by ERISA, you may also contact the U.S. Department of Health and Human Services at **www.healthreform.gov**. You may also contact our Member Services Department at **1-888-333-4742** with any questions about which protections apply to your grandfathered health plan.

Prescription Drug Coverage

PREMIUM 3 TIER

Covered prescription medications are available at participating pharmacies.

	Retail	Mail (up to a 90-day supply)
Tier 1	**Up to a 30-day supply:** $5 Copayment **Up to a 90-day supply:** $15 Copayment	$10 Copayment
Tier 2	**Up to a 30-day supply:** $10 Copayment **Up to a 90-day supply:** $30 Copayment	$20 Copayment
Tier 3	**Up to a 30-day supply:** $25 Copayment **Up to a 90-day supply:** $75 Copayment	$75 Copayment

Visit **www.harvardpilgrim.org/2021Premium3T** for participating pharmacy locations and mail order details. Be sure to show your Harvard Pilgrim ID card at the pharmacy to ensure you pay the correct cost-sharing amounts.

Harvard Pilgrim Health Care includes Harvard Pilgrim Health Care, Harvard Pilgrim Health Care of New England and HPHC Insurance Company

RX0000000806

Language Assistance Services

Español (Spanish) ATENCIÓN: Si usted habla español, servicios de asistencia lingüística, de forma gratuita, están a su disposición. Llame al 1-888-333-4742 (TTY: 711).

Português (Portuguese) ATENÇÃO: Se você fala português, encontram-se disponíveis serviços linguísticos gratuitos. Ligue para 1-888-333-4742 (TTY: 711).

Kreyòl Ayisyen (French Creole) ATANSYON: Si nou palé Kreyòl Ayisyen, gen asistans pou sèvis ki disponib nan lang nou pou gratis. Rele 1-888-333-4742 (TTY: 711).

繁體中文 (Traditional Chinese) 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-888-333-4742（TTY：711）。

Tiếng Việt (Vietnamese) CHÚ Ý: Nếu quí vị nói Tiếng Việt, dịch vụ thông dịch của chúng tôi sẵn sàng phục vụ quí vị miễn phí. Gọi số 1-888-333-4742 (TTY: 711).

Русский (Russian) ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-888-333-4742 (телетайп: 711).

العربية (Arabic)
إنتباه: إذا أنت تتكلم اللغة العربية ، خدمات المساعدة اللغوية متوفرة لك مجانا." إتصل على 1 888-333-4742 (TTY: 711)

ខ្មែរ (Cambodian) ប្រសុំជូនដំណឹង៖ បើអ្នកនិយាយភាសាខ្មែរ, យើងមានសេវាកម្មបកប្រែ ជូនលោកអ្នកដោយឥតគិតថ្លៃ។ ចូរ ទូរស័ព្ទ 1-888-333-4742 (TTY: 711)។

Français (French) ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-888-333-4742 (ATS: 711).

Italiano (Italian) ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-888-333-4742 (TTY: 711).

한국어 (Korean) '알림': 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-888-333-4742 (TTY: 711) 번으로 전화해 주십시오.

Ελληνικά (Greek) ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, υπάρχουν στη διάθεσή σας δωρεάν υπηρεσίες γλωσσικής υποστήριξης. Καλέστε 1-888-333-4742 (TTY: 711).

Polski (Polish) UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-888-333-4742 (TTY: 711).

हिंदी (Hindi) ध्यान दीजिए: अगर आप हिंदी बोलते हैं तो आपके लिये भाषाकी सहायता मुफ्त में उपलब्ध है. जानकारी के लिये फोन करे. 1-888-333-4742 (TTY: 711)

ગુજરાતી (Gujarati) ધ્યાન આપો : જો તમે ગુજરાતી બોલતા હો તો આપને માટે ભાષાકીય સહાય તદ્દન મફત ઉપલબ્ધ છે. વિશેષ માહિતી માટે ફોન કરો. 1-888-333-4742 (TTY: 711)

ພາສາລາວ (Lao) ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-888-333-4742 (TTY: 711).

ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call 1-888-333-4742 (TTY: 711).

Harvard Pilgrim Health Care includes Harvard Pilgrim Health Care, Harvard Pilgrim Health Care of New England and HPHC Insurance Company.

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General Notice About Nondiscrimination and Accessibility Requirements

Harvard Pilgrim Health Care and its affiliates as noted below ("HPHC") comply with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. HPHC does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

HPHC:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, audio, other formats)
- Provides free language services to people whose primary language is not English, such as qualified interpreters.

If you need these services, contact our Civil Rights Compliance Officer.

If you believe that HPHC has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with: Civil Rights Compliance Officer, 93 Worcester St, Wellesley, MA 02481, (866) 750-2074, TTY service: 711, Fax: (617) 509-3085, Email: civil_rights@harvardpilgrim.org. You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, the Civil Rights Compliance Officer is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
(800) 368-1019, (800) 537-7697 (TTY)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

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