Schedule of Benefits

Harvard Pilgrim Health Care, Inc.

THE HARVARD PILGRIM FOCUS NETWORK℠ - MA HMO
MASSACHUSETTS

Please Note: This plan includes a limited provider network called the "Focus Network - MA." This plan provides access to a network that is smaller than Harvard Pilgrim's full provider network. In this plan, Members have access to network benefits only from the providers in the Focus Network - MA. Please consult the Focus Network – MA Provider Directory or visit the provider search tool at **www.harvardpilgrim.org** to determine which providers are included in the Focus Network - MA.

This Schedule of Benefits states any Benefit Limits and Member Cost Sharing amounts you must pay for Covered Benefits. However, it is only a summary of your benefits. Please see your Benefit Handbook for details. Your Member Cost Sharing may include a Deductible, Coinsurance, and Copayments. Please see the tables below for details.

Services must be provided by a Plan Provider through our Focus Network – MA. The Focus Network – MA includes two groups of providers: (1) Easy Access Providers and (2) Authorized Access Providers. In order to receive primary care services, including internal medicine, family practice, pediatrics, routine obstetrics and gynecology, or routine or preventive care you must obtain these services from an Easy Access Provider. If you need care from a specialist, you must contact your PCP for a Referral to a specialist who is an Easy Access Provider. In order to receive Covered Benefits from designated Authorized Access Providers, your PCP or specialist must obtain Prior Approval from the Plan. Prior Approval will be provided when it has been determined that no Easy Access Provider has the professional expertise needed to provide the required services. These requirements do not apply to care needed in a Medical Emergency.

In a Medical Emergency you should go to the nearest emergency facility or call 911 or other local emergency access number. A Referral from your PCP is not needed. Your emergency room Member Cost Sharing is listed in the tables below.

Clinical Review Criteria

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 on our website **www.harvardpilgrim.org** or by calling **1-888-888-4742 ext. 38723**.

Copayment Levels

There are two types of office visit Copayments that apply to your Plan: a lower Copayment, known as "Level 1," and a higher Copayment known as "Level 2".

Level 1 applies to covered outpatient professional services from the following types of providers: all Primary Care Providers (PCPs); obstetricians and gynecologists; Licensed Mental Health Professionals; certified nurse midwives; and nurse practitioners who bill independently.

Level 2 applies to most outpatient specialty care.

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

Your Plan may have other Copayment amounts. Please see the benefit table below for specific Copayment requirements.

Covered Benefits

Your Covered Benefits are administered on a Plan Year basis. Your Plan Year begins on your Employer's Anniversary Date. Please see your Benefit Handbook for more details. If you do not know your Employer's Anniversary Date, please contact your Employer's benefits office or call the Member Services Department at **1-888-333-4742**. Your Member Cost Sharing will depend upon the type of service provided and the location the service is provided in, as listed in this Schedule of Benefits. For example, for services provided in a doctor's office, see "Physician and Other Professional Office Visits." For services provided in a hospital emergency room, see "Emergency Room Care," and for outpatient surgical procedures, please see "Surgery - Outpatient."

General Cost Sharing Features:	Member Cost Sharing:
Coinsurance and Copayments	
	See the benefits table below
Deductible	
Applies to all services except where specifically noted below	None
Deductible Rollover	
	None
Out-of-Pocket Maximum	
Includes all Member Cost Sharing	$1,000 per Member per Plan Year $2,000 per family per Plan Year

Benefit	Member Cost Sharing:
Acupuncture Treatment for Injury or Illness	
– Limited to 20 visits per Plan Year	$40 Copayment per visit
Ambulance Transport	
Emergency ambulance transport	Level 1: $100 Copayment per transport
Non-emergency ambulance transport	Level 1: $100 Copayment per transport
Autism Spectrum Disorders Treatment	
Applied behavior analysis	Level 1: $25 Copayment per visit
Chemotherapy and Radiation Therapy	
	No charge

Benefit	Member Cost Sharing:
Dental Services	
Important Notice: Coverage of Dental Care is very limited. Please see your Benefit Handbook for the details of your coverage.	
Extraction of teeth impacted in bone	Level 2: $40 Copayment per visit
Pediatric Dental Care for children (up to the age of 13) – limited to 2 preventive dental exams per Plan Year, only the following services are included: cleaning, fluoride treatment, teaching plaque control and x-rays.	Level 1: $25 Copayment per visit
Dialysis	
	No charge
Durable Medical Equipment	
Durable medical equipment	20% Coinsurance
Blood glucose monitors, infusion devices and insulin pumps (including supplies)	No charge
Oxygen and respiratory equipment	No charge
Early Intervention Services	
	No charge
The Plan does not cover the family participation fee required by the Massachusetts Department of Public Health.	
Emergency Room Care	
	$150 Copayment per visit
This Copayment is waived if admitted to the hospital directly from the emergency room.	
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
If services include the administration of drugs, please see the benefit for "Medical Drugs" for Member Cost Sharing details.	
Hospice – Outpatient	
	No charge
Hospital – Inpatient Services	
Acute hospital care	$250 Copayment per admission
Inpatient maternity care	$250 Copayment per admission
Inpatient routine nursery care	No charge
Inpatient rehabilitation – limited to 60 days per Plan Year	$250 Copayment per admission
Skilled nursing facility – limited to 100 days per Plan Year	$250 Copayment per admission

Benefit	Member Cost Sharing:
Hypodermic Syringes and Needles	
	Subject to the applicable pharmacy Member Cost Sharing listed 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 where the service is 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
Advanced radiology, including CT scans, PET scans, MRI, MRA and nuclear medicine services	$150 Copayment per procedure
Low Protein Foods	
– Limited to $5,000 per Plan Year	No charge
Maternity Care - Outpatient	
Routine outpatient prenatal and postpartum care	No charge
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, Member Cost Sharing for services provided by a specialist is listed under "Physician and Other Professional Office Visits" and Member Cost Sharing for an ultrasound billed as a specialized or non-routine service is listed under "Laboratory and Radiology Services."	
Medical Drugs (drugs that cannot be self-administered)	
Medical drugs received in a doctor's office or other outpatient facility	20% Coinsurance up to a maximum Coinsurance of $250 per treatment
Medical drugs received in the home	20% Coinsurance up to a maximum Coinsurance of $250 per treatment
Some medical drugs received in a physician's office or outpatient facility may be provided by the Specialty Pharmacy Program under your outpatient prescription drug benefit. If you have outpatient prescription drug coverage, your Member Cost Sharing will be listed on your ID Card. Please see the Prescription Drug Brochure for a detailed explanation of your benefits.	
Medical Formulas	
	No charge

Benefit	Member Cost Sharing:
Mental Health Care (Including the Treatment of Substance Abuse Disorders)	
Inpatient services	$250 Copayment per admission
Intermediate 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 group therapy	$10 Copayment per visit
Outpatient treatment, including individual therapy, outpatient detoxification and medication management	Level 1: $25 Copayment per visit
Outpatient methadone maintenance	Level 1: $25 Copayment per week
Outpatient psychological testing and neuropsychological assessment	Level 1: $25 Copayment per visit
Ostomy Supplies	
	20% Coinsurance
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	No charge
Not all services you receive during your routine exam are covered at no charge. Only preventive services designated under the Patient Protection and Affordable Care Act (PPACA) are covered at no charge. Other services not included under PPACA may be subject to additional cost sharing. For the current list of preventive services covered at no charge under PPACA, please see the Preventive Services Notice on our website at **www.harvardpilgrim.org**. Please see "Laboratory and Radiology Services" for the Member Cost Sharing that applies to diagnostic services not included on this list.	
Consultations, evaluations, sickness and injury care	Level 1: $25 Copayment per visit Level 2: $40 Copayment per visit
Copayment level varies depending on the type of provider. Please refer to the beginning of this Schedule of Benefits to determine which Copayment level applies.	
Office based treatments and procedures, including, but not limited to administration of injections, allergy treatments, casting, suturing and the application of dressings, genetic counseling, non-routine foot care, pregnancy testing, and surgical procedures	No charge
Administration of allergy injections	No charge
Preventive Services and Tests	
	No charge

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Benefit	Member Cost Sharing:
Preventive Services and Tests (Continued)	
Under federal law, many preventive services and tests are covered with no Member Cost Sharing, including preventive colonoscopies, certain labs and x-rays, voluntary sterilization for women, and all FDA approved contraceptive devices. For a complete list of covered preventive services, please see the Preventive Services Notice on our website at **www.harvardpilgrim.org**. You may also get a copy of the Preventive Services Notice by calling the Member Services Department at **1–888–333–4742**. Harvard Pilgrim will add or delete services from this benefit for preventive services and tests in accordance with Federal guidance.	
Prosthetic Devices	
	20% Coinsurance
Rehabilitation and Habilitation Services - Outpatient	
Cardiac rehabilitation	Level 2: $40 Copayment per visit
Pulmonary rehabilitation therapy	Level 1: $25 Copayment per visit
Speech-language and hearing services	Level 1: $25 Copayment per visit
Occupational therapy – limited to 60 visits per Plan Year Physical therapy – limited to 60 visits per Plan Year	Level 1: $25 Copayment per visit
Outpatient physical and occupational therapy is not subject to the limit listed above and is covered to the extent Medically Necessary for: (1) children under the age of three and (2) the treatment of Autism Spectrum Disorders.	
Scopic Procedures - Outpatient Diagnostic and Therapeutic	
Colonoscopy, 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."
Spinal Manipulative Therapy (including care by a chiropractor)	
	$25 Copayment per visit
Surgery – Outpatient	
	$150 Copayment per visit
Telemedicine	
Outpatient and inpatient telemedicine 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."
Urgent Care Services	
Convenience care clinic	Level 1: $25 Copayment per visit
Urgent care clinic (including hospital urgent care clinic)	$25 Copayment per visit
Additional Member Cost Sharing may apply. Please refer to the specific benefit in this Schedule of Benefits. For example, if you have an x-ray or have blood drawn, please refer to "Laboratory and Radiology Services."	
Vision Services	
Routine eye examinations – limited to 1 exam per Plan Year	No charge
Vision hardware for special conditions	No charge

Benefit	Member Cost Sharing:
Voluntary Sterilization in a Physician's Office	
	No charge
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 "Office based treatments and procedures." For inpatient hospital care, see "Hospital – Inpatient Services."
Wigs and Scalp Hair Prostheses as required by law	
– Limited to $350 per Plan Year (see the Benefit Handbook for details)	20% Coinsurance

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) [ប្រសូជូនដំណឹង៖ បើអ្នកនិយាយភាសាខ្មែរ, សេវាកម្មបកប្រែ ជូនលោកអ្នកដោយ គិតគិតថ្លៃ។ 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, ໂດຍບໍ່ເສັງຄ່າ, 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 Connecticut, 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.

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

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