

# Schedule of Benefits

## THE HPHC INSURANCE COMPANY BEST BUY HSA PPO PLAN MASSACHUSETTS

This Schedule of Benefits summarizes your benefits under The HPHC Insurance Company Best Buy HSA PPO Plan (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.

### **There are two levels of coverage - In-Network and Out-of-Network**

**In-Network** coverage applies when you use a Plan Provider for Covered Benefits. When using Plan Providers, coverage is based on the contracted rate between HPHC and the Provider.

**Out-of-Network** coverage applies when you use a Non-Plan Provider for Covered Benefits. When using Non-Plan Providers, the Plan pays only a percentage of the cost of the care you receive up to the Allowed Amount for the service. In most cases, this will be higher than the HPHC contracted rate. If a Non-Plan Provider charges any amount in excess of the Allowed Amount, you are responsible for the excess amount. Please refer to section I.E.6., titled "Member Cost Sharing" in your Benefit Handbook for additional information about Out-of-Network Charges in excess of the Allowed Amount.

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."

### **Member Responsibility for Notification and Prior Approval**

Members must contact HPHC for coverage of a number of services. These are listed below.

**Mental Health Care (Including the Treatment of Substance Abuse Disorders).** Prior Approval must be obtained before receiving certain mental health services from Non-Plan Providers. This requirement also applies to treatment of substance abuse disorders. Please refer to our internet site, [www.harvardpilgrim.org](http://www.harvardpilgrim.org), or contact the Member Services Department at **1-888-333-4742** for a list of services. To obtain Prior Approval for mental health or substance abuse services, please call the Behavioral Health Access Center at **1-888-777-4742**.

**Medical Services.** Members are required to notify HPHC before the start of any planned inpatient admission to a Non-Plan Medical Facility. Members are also required to obtain Prior Approval from HPHC for certain services. Before you receive services from a Non-Plan Provider, please refer to our Internet site, [www.harvardpilgrim.org](http://www.harvardpilgrim.org), or contact the Member Services Department at **1-888-333-4742** for a list of Out-of-Network services that require Prior Approval.

If you do not provide Notification or obtain Prior Approval when required, you will be responsible for paying the Penalty amount stated in this Schedule of Benefits in addition to any applicable Member Cost Sharing. No coverage will be provided if HPHC determines that the service is not Medically Necessary, and you will be responsible for the entire cost of the service.

**Emergency Care.** You do not need to contact HPHC before receiving care in a Medical Emergency. In the event of an emergency hospital admission to a Non-Plan Provider, you must notify HPHC within 48 hours of the admission, unless notification is not possible because of your

condition. If notice is given to HPHC by an attending emergency physician, no further notification is required. However, if notification is not received when the Member's condition permits it, the Member is responsible for the Penalty amount stated in this Schedule of Benefits. Please call **1-800-708-4414** to notify us of an emergency admission to a Non-Plan facility.

### 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 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**.

## COVERED BENEFITS

Your Covered Benefits are administered on a calendar year basis.

General Cost Sharing Features:		Member Cost Sharing:
<b>In-Network Coinsurance and Copayments</b>		
		See Covered Benefits below
<b>Out-of-Network Coinsurance and Copayments</b>		
		See Covered Benefits below
<b>Deductible</b>		
Your Plan Deductible can be met by any combination of eligible In-Network and Out-of-Network expenses.		\$1,500 for Individual Coverage per calendar year \$3,000 for Family Coverage per calendar year
<b>Important Notice:</b> If you have Family Coverage, the Deductible may be met by any combination of covered family Members. The individual Deductible does not apply. No Member in the family is eligible for benefits subject to the Deductible until the Family Coverage Deductible is met.		
<b>Out-of-Pocket Maximum</b>		
Includes all In-Network and Out-of-Network Member Cost Sharing except: – Any charges above the Allowed Amount and any penalty for failure to receive Prior Approval when using Non-Plan Providers		\$10,000 for Family Coverage per calendar year – with a \$5,000 embedded individual Out-of-Pocket Maximum per calendar year
<b>Important Notice:</b> If your Plan has a family Out-of-Pocket Maximum with an embedded individual Out-of-Pocket Maximum, the Out-of-Pocket Maximum can be satisfied in one of two ways: a. If a Member of a covered family meets an individual embedded Out-of-Pocket Maximum, then that Member has no additional Member Cost Sharing for the remainder of the calendar year. b. If any number of Members in a covered family collectively meet the family Out-of-Pocket Maximum, then all Members of the covered family have no additional Member Cost Sharing for the remainder of the calendar year. No one family member may contribute more than the individual embedded Out-of-Pocket Maximum amount to the family Out-of-Pocket Maximum.		
<b>Out-of-Network Penalty Payment</b>		
– Does not count toward the Deductible or Out-of-Pocket Maximum		\$500
<b>Deductible Rollover</b>		
– None		

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<b>Benefit</b>	<b>In-Network Plan Providers Member Cost Sharing</b>	<b>Out-of-Network Non-Plan Providers Member Cost Sharing</b>
<b>Ambulance Transport</b>		
– Emergency ambulance transport	Deductible, then no charge	Same as In-Network
– Non-emergency ambulance transport	Deductible, then no charge	Deductible, then 20% Coinsurance
<b>Autism Spectrum Disorders Treatment</b>		
– Applied behavior analysis	Deductible, then no charge	Deductible, then 20% Coinsurance
<b>Chemotherapy and Radiation Therapy</b>		
	Deductible, then no charge	Deductible, then 20% Coinsurance
<b>Dental Services</b>		
<b>Important Notice:</b> Coverage of Dental Care is very limited. Please see your Benefit Handbook for the details of your coverage.		
– Emergency Dental Care	Deductible, then no charge	Deductible, then 20% Coinsurance
– Extraction of teeth impacted in bone	Deductible, then no charge	Deductible, then 20% Coinsurance
– Preventive Dental Care for children (up to the age of 13) – limited to 2 preventive dental exams per calendar year, only the following services are included: <ul style="list-style-type: none"> <li>– Cleaning</li> <li>– Fluoride treatment</li> <li>– Teaching plaque control</li> <li>– X-rays</li> </ul>	No charge	Deductible, then 20% Coinsurance
<b>Dialysis</b>		
– Dialysis services	Deductible, then no charge	Deductible, then 20% Coinsurance
– Installation of home equipment is covered up to \$300 in a Member's lifetime.	Deductible, then no charge	Deductible, then 20% Coinsurance
<b>Durable Medical Equipment</b>		
– Durable medical equipment	Deductible, then 20% Coinsurance	Deductible, then 20% Coinsurance
– Blood glucose monitors, infusion devices and insulin pumps (including supplies)	Deductible, then no charge	Deductible, then 20% Coinsurance
– Oxygen and respiratory equipment	Deductible, then 20% Coinsurance	Deductible, then 20% Coinsurance

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Early Intervention Services		
	Deductible, then no charge	Deductible, then 20% Coinsurance
	Please Note: The Plan does not cover the family participation fee required by the Massachusetts Department of Public Health	
Emergency Admission		
	Deductible, then no charge	Same as In-Network
Emergency Room Care		
	Deductible, then no charge	Same as In-Network
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	Deductible, then no charge	Deductible, then 20% Coinsurance
Home Health Care		
	Deductible, then no charge	Deductible, then 20% Coinsurance
Hospice - Outpatient Services		
	Deductible, then no charge	Deductible, then 20% Coinsurance
Hospital – Inpatient Services		
– Acute hospital care	Deductible, then no charge	Deductible, then 20% Coinsurance
– Inpatient maternity care	Deductible, then no charge	Deductible, then 20% Coinsurance
– Inpatient routine nursery care, including prophylactic medication to prevent gonorrhea	No charge	20% Coinsurance
– Home care for mother and newborn following delivery	No charge	20% Coinsurance
– Inpatient rehabilitation – limited to 60 days per calendar year	Deductible, then no charge	Deductible, then 20% Coinsurance
– Skilled nursing facility – limited to 100 days per calendar year	Deductible, then no charge	Deductible, then 20% Coinsurance
Hypodermic Syringes and Needles		
	Subject to the applicable pharmacy Member Cost Sharing in your Outpatient Prescription Drug Schedule of Benefits and 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 different drug tiers, please visit our website at <a href="http://www.harvardpilgrim.org/members">www.harvardpilgrim.org/members</a> and select	

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Benefit	In-Network Plan Providers Member Cost Sharing	Out-of-Network Non-Plan Providers Member Cost Sharing
Hypodermic Syringes and Needles (Continued)		
	"pharmacy/drug tier look up" or contact our Member Services Department at 1-888-333-4742.	
Infertility Services and Treatments (see the Benefit Handbook for details)		
	Deductible, then no charge	Deductible, then 20% Coinsurance
Laboratory and Radiology Services		
– Laboratory and x-rays	Deductible, then no charge	Deductible, then 20% Coinsurance
Advanced radiology – CT scans – PET scans – MRI – MRA – Nuclear medicine services	Deductible, then no charge	Deductible, then 20% Coinsurance
Please Note: No In-Network Member Cost Sharing applies to certain preventive care services. For a list of covered preventive services, please see the Preventive Services notice at: <a href="http://www.harvardpilgrim.org">www.harvardpilgrim.org</a>		
Low Protein Foods		
– Limited to \$5,000 per calendar year	Deductible, then no charge	Deductible, then 20% Coinsurance
Maternity Care - Outpatient		
– Routine outpatient prenatal and postpartum care	No charge The Deductible does not apply to prenatal and postpartum care provided in a physician's office. All other care is covered as stated in this Schedule of Benefits.	20% Coinsurance
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.		
Medical Formulas		
	Deductible, then no charge	Deductible, then 20% Coinsurance
Mental Health Care (Including the Treatment of Substance Abuse Disorders)		
Inpatient Mental Health Care Services	Deductible, then no charge	Deductible, then 20% Coinsurance
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	Deductible, then no charge	Deductible, then 20% Coinsurance

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<b>Benefit</b>	<b>In-Network Plan Providers Member Cost Sharing</b>	<b>Out-of-Network Non-Plan Providers Member Cost Sharing</b>
<b>Mental Health Care (Including the Treatment of Substance Abuse Disorders) (Continued)</b>		
– Outpatient mental health care services	<b>Group therapy</b> – Deductible, then no charge <b>Individual therapy</b> – Deductible, then no charge	<b>Group therapy</b> – Deductible, then 20% Coinsurance <b>Individual therapy</b> – Deductible, then 20% Coinsurance
– Detoxification	Deductible, then no charge	Deductible, then 20% Coinsurance
– Medication management	Deductible, then no charge	Deductible, then 20% Coinsurance
– Methadone maintenance	Deductible, then no charge	Deductible, then 20% Coinsurance
– Psychological testing and neuropsychological assessment	Deductible, then no charge	Deductible, then 20% Coinsurance
<b>Ostomy Supplies</b>		
	Deductible, then 20% Coinsurance	Deductible, then 20% Coinsurance
<b>Physician and Other Professional Office Visits (This includes all covered Providers unless otherwise listed in this Schedule of Benefits)</b>		
– Consultations, evaluations, sickness, and injury care	Deductible, then no charge	Deductible, then 20% Coinsurance
<b>Treatments and procedures, including but not limited to:</b> – Administration of injections – Allergy treatments – Casting, suturing and the application of dressings – Genetic counseling – Non-routine foot care – Pregnancy testing – Surgical procedures	Deductible, then no charge	Deductible, then 20% Coinsurance
– Administration of allergy injections	Deductible, then no charge	Deductible, then 20% Coinsurance
<b>Preventive Care Services – the Deductible does not apply to the preventive services listed below</b>		
– Routine examinations for preventive care, including immunizations	No charge	20% Coinsurance

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<b>Preventive Services and Tests – the Deductible does not apply to the preventive services and tests listed below</b>		
Preventive care services, including all FDA approved contraceptive devices. Under the federal health care reform law, many preventive services and tests are covered with no Member Cost Sharing. For a list of covered preventive services, please see the Preventive Services notice on our website at: <a href="http://www.harvardpilgrim.org">www.harvardpilgrim.org</a> . You may also get a copy of the Preventive Services notice by calling the Member Services Department at 1-888-333-4742.	No charge	20% Coinsurance
Under federal law the list of preventive services and tests 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 women, 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 U.S. Department of Health and Human Services at: <a href="https://www.healthcare.gov/what-are-my-preventive-care-benefits/#part=1">https://www.healthcare.gov/what-are-my-preventive-care-benefits/#part=1</a> . Harvard Pilgrim will add or delete services from this benefit for preventive services and tests 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 <a href="http://www.harvardpilgrim.org">www.harvardpilgrim.org</a> .		
<b>Additional Preventive Services and Tests</b> – Fetal ultrasound – Hepatitis C testing – Lead level testing – Prostate-specific antigen (PSA) screening – Routine hemoglobin tests – Routine urinalysis	No charge	20% Coinsurance
<b>Prosthetic Devices</b>		
	Deductible, then 20% Coinsurance	Deductible, then 20% Coinsurance
<b>Rehabilitation Therapy - Outpatient</b>		
– Cardiac rehabilitation	Deductible, then no charge	Deductible, then 20% Coinsurance
– Pulmonary rehabilitation therapy	Deductible, then no charge	Deductible, then 20% Coinsurance
– Speech-language and hearing services	Deductible, then no charge	Deductible, then 20% Coinsurance

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<b>Rehabilitation Therapy - Outpatient (Continued)</b>		
<ul style="list-style-type: none"> <li>– Occupational therapy – limited to 30 visits per calendar year</li> <li>– Physical therapy – limited to 30 visits per calendar year</li> </ul> <p><b>Please Note:</b> 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.</p>	Deductible, then no charge	Deductible, then 20% Coinsurance
<b>Scopic Procedures - Outpatient Diagnostic and Therapeutic</b>		
– Colonoscopy, endoscopy and sigmoidoscopy	Deductible, then no charge	Deductible, then 20% Coinsurance
<b>Please Note:</b> No In-Network Member Cost Sharing applies to certain preventive care services. For a list of covered preventive services, please see the Preventive Services notice at: <a href="http://www.harvardpilgrim.org">www.harvardpilgrim.org</a> .		
<b>Spinal Manipulative Therapy (including care by a chiropractor)</b>		
– Limited to 20 visits per calendar year	Deductible, then no charge	Deductible, then 20% Coinsurance
<b>Surgery – Outpatient</b>		
	Deductible, then no charge	Deductible, then 20% Coinsurance
<b>Vision Services</b>		
– Routine eye examinations – limited to 1 exam per calendar year	\$25 Copayment per visit	Deductible, then 20% Coinsurance
– Vision hardware for special conditions	Deductible, then no charge	Deductible, then 20% Coinsurance
<b>Voluntary Sterilization</b>		
	Deductible, then no charge	Deductible, then 20% Coinsurance
<b>Please Note:</b> No In-Network Member Cost Sharing applies to certain preventive care services. For a list of covered preventive services, please see the Preventive Services notice at: <a href="http://www.harvardpilgrim.org">www.harvardpilgrim.org</a> .		
<b>Voluntary Termination of Pregnancy</b>		
	Deductible, then no charge	Deductible, then 20% Coinsurance
<b>Wigs and Scalp Hair Prostheses as required by law</b>		
– Limited to \$350 per calendar year (see the Benefit Handbook for details)	Deductible, then 20% Coinsurance	Deductible, then 20% Coinsurance