Schedule of Benefits

HPHC Insurance Company, Inc.

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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.

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.

Out-of-Network coverage applies when you use a Non-Plan Provider for Covered Benefits. If a Non-Plan Provider charges any amount in excess of the Allowed Amount, you are responsible for the excess amount.

In a Medical Emergency, you should go to the nearest emergency facility or call 911 or other local emergency access number. Your emergency room Member Cost Sharing is listed in the tables below.

Out-of-Network Notification and Prior Approval

Notification and Prior Approval is required for certain Out-of-Network benefits. Before you receive services from a Non-Plan Provider, please refer to our website, **www.harvardpilgrim.org** or contact the Member Services Department at **1-888-333-4742** for the complete listing of Out-of-Network services that require Prior Approval. To provide Notification or obtain Prior Approval please call:

- **1–800–708–4414** for medical services
- **1–844–387–1435** for Medical Drugs
- **1–888–777–4742** for mental health and drug and alcohol rehabilitation services

More information about Notification and Prior Approval can be found on our website, **www.harvardpilgrim.org** and in your Benefit Handbook.

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 at **www.harvardpilgrim.org** or by calling **1-888-888-4742 ext. 38723**.

Covered Benefits

Your Covered Benefits are administered on a Calendar Year basis. 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		
	\$2,700 for Individual Coverage per Calendar Year \$5,400 for Family Coverage per Calendar Year – with a \$2,700 embedded individual Deductible per Calendar Year	\$5,000 for Individual Coverage per Calendar Year \$10,000 for Family Coverage per Calendar Year – with a \$5,000 embedded individual Deductible per Calendar Year
Important Notice: If your Plan has a family Deductible with an embedded individual Deductible, the Deductible can be satisfied in one of two ways: a. If a Member of a covered family meets an individual embedded Deductible, then services for that Member that are subject to that Deductible are covered by the Plan for the remainder of the Calendar Year. b. If any number of Members in a covered family collectively meet the family Deductible, then all Members of the covered family receive coverage for services subject to that Deductible for the remainder of the Calendar Year. No one family member may contribute more than the individual embedded Deductible amount to the family Deductible. An embedded individual Deductible may **not** be less than the applicable minimum family Deductible, as defined by the Internal Revenue Service. Once a Deductible is met, coverage by the Plan is subject to any other Member Cost sharing that may apply.		
Out-of-Pocket Maximum		
Includes all Member Cost Sharing Any charges above the Allowed Amount and any penalty for failure to receive Prior Approval when using Non-Plan Providers do not apply to the Out-of-Pocket Maximum	\$5,000 for Individual Coverage per Calendar Year \$10,000 for Family Coverage per Calendar Year – with a \$5,000 embedded individual Out-of-Pocket Maximum per Calendar Year	\$10,000 for Individual Coverage per Calendar Year \$20,000 for Family Coverage per Calendar Year – with a \$10,000 embedded individual Out-of-Pocket Maximum per Calendar Year
Important Notice: If you are a Member with Family Coverage, 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 toward the family Out-of-Pocket Maximum.		
Out-of-Network Penalty Payment		
Does not count toward the Deductible or Out-of-Pocket Maximum.	\$500	

Benefit	In-Network Plan Providers Member Cost Sharing	Out-of-NetworkNon-Plan Providers Member Cost Sharing
Acupuncture Treatment for Injury or Illness		
– Limited to 20 visits per Calendar Year	Deductible, then 20% Coinsurance	Deductible, then 40% Coinsurance
Ambulance Transport		
Emergency ambulance transport	Deductible, then 20% Coinsurance	Same as In-Network
Non-emergency ambulance transport	Deductible, then 20% Coinsurance	Deductible, then 40% Coinsurance
Autism Spectrum Disorders Treatment		
Applied behavior analysis	Deductible, then 20% Coinsurance	Deductible, then 40% Coinsurance
Chemotherapy and Radiation Therapy		
	Deductible, then 20% Coinsurance	Deductible, then 40% Coinsurance
Chiropractic Care		
– Limited to 40 visits per Calendar Year	Deductible, then 20% Coinsurance	Deductible, then 40% Coinsurance
Dental Services		
Important Notice: Coverage of Dental Services is very limited. Please see your Benefit Handbook for the details of your coverage.		
Extraction of teeth impacted in bone (performed in a Physician's office)	Deductible, then 20% Coinsurance	Deductible, then 40% Coinsurance
Dialysis		
	Deductible, then 20% Coinsurance	Deductible, then 40% Coinsurance
Durable Medical Equipment		
Durable medical equipment	Deductible, then 20% Coinsurance	Deductible, then 40% Coinsurance
Blood glucose monitors, infusion devices, and insulin pumps (including supplies)	Deductible, then 20% Coinsurance	Deductible, then 40% Coinsurance
Oxygen and respiratory equipment	Deductible, then 20% Coinsurance	Deductible, then 40% Coinsurance
Early Intervention Services (for Members up to the age of 3)		
– Limited to $3,200 per Member per Calendar Year, up to a maximum of $9,600	Deductible, then 20% Coinsurance	Deductible, then 40% Coinsurance
Emergency Admission		
	Deductible, then 20% Coinsurance	Same as In-Network
Emergency Room Care		
	Deductible, then 20% Coinsurance	Same as In-Network

Benefit	In-Network Plan Providers Member Cost Sharing	Out-of-NetworkNon-Plan Providers Member Cost Sharing
Hearing Aids		
– Limited to $1,400 per hearing aid every 36 months, for each hearing impaired ear	Deductible, then 20% Coinsurance	Deductible, then 40% Coinsurance
Home Health Care		
	Deductible, then 20% Coinsurance	Deductible, then 40% Coinsurance
If services include the administration of drugs, please see the benefit for "Medical Drugs" for Member Cost Sharing details.		
Hospice – Outpatient		
	Deductible, then 20% Coinsurance	Deductible, then 40% Coinsurance
Hospital – Inpatient Services		
Acute Hospital care	Deductible, then 20% Coinsurance	Deductible, then 40% Coinsurance
Inpatient maternity care	Deductible, then 20% Coinsurance	Deductible, then 40% Coinsurance
Inpatient routine nursery care	No charge	20% Coinsurance
Inpatient rehabilitation – limited to 100 days per Calendar Year Day limits combined with skilled nursing facility care	Deductible, then 20% Coinsurance	Deductible, then 40% Coinsurance
Skilled nursing facility – limited to 100 days per Calendar Year Day limits combined with inpatient rehabilitation	Deductible, then 20% Coinsurance	Deductible, then 40% Coinsurance
Infertility Services and Treatments (see the Benefit Handbook for details)		
Diagnostic services including only the following: consultation, evaluation and laboratory tests	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."	
Infertility treatment – limited to 3 cycles per lifetime.	Deductible, then 20% Coinsurance	Deductible, then 40% Coinsurance
Laboratory and Radiology Services		
Laboratory and x-rays	Deductible, then 20% Coinsurance	Deductible, then 40% Coinsurance
Non-routine mammograms	No charge	20% Coinsurance
Advanced radiology, including CT scans, PET scans, MRI, MRA and nuclear medicine services	Deductible, then 20% Coinsurance	Deductible, then 40% Coinsurance
Low Protein Foods		
– Limited to $3,000 per Calendar Year	Deductible, then 20% Coinsurance	Deductible, then 40% Coinsurance
Maternity Care – Outpatient		
Routine outpatient prenatal and postpartum care	No charge	20% Coinsurance

Benefit	In-Network Plan Providers Member Cost Sharing	Out-of-NetworkNon-Plan Providers Member Cost Sharing
Maternity Care – Outpatient (Continued)		
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	Deductible, then 20% Coinsurance	Deductible, then 40% Coinsurance
Medical drugs received in the home	Deductible, then 20% Coinsurance	Deductible, then 40% Coinsurance
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 is listed on your ID Card. Please see the Prescription Drug Brochure, for a detailed explanation of your benefits.		
Medical Formulas		
State mandated formulas	Deductible, then 20% Coinsurance	Deductible, then 40% Coinsurance
Mental Health and Drug and Alcohol Rehabilitation Services		
Inpatient Services	Deductible, then 20% Coinsurance	Deductible, then 40% Coinsurance
Partial hospitalization services	Deductible, then 20% Coinsurance	Deductible, then 40% Coinsurance
Outpatient group therapy	Deductible, then 20% Coinsurance	Deductible, then 40% Coinsurance
Mental health services in the home	Deductible, then 20% Coinsurance	Deductible, then 40% Coinsurance
Outpatient treatment, including individual therapy, detoxification, and medication management	Deductible, then 20% Coinsurance	Deductible, then 40% Coinsurance
Outpatient methadone maintenance	Deductible, then 20% Coinsurance	Deductible, then 40% Coinsurance
Outpatient psychological testing and neuropsychological assessment	Deductible, then 20% Coinsurance	Deductible, then 40% Coinsurance
Ostomy Supplies		
	Deductible, then 20% Coinsurance	Deductible, then 40% Coinsurance
Physician and Other Professional Office Visits (This includes all covered Providers unless otherwise listed in this Schedule of Benefits.)		
Routine examinations for preventive care, including immunizations	No charge	20% Coinsurance
Not all In-Network 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.		

Benefit	In-Network Plan Providers Member Cost Sharing	Out-of-NetworkNon-Plan Providers Member Cost Sharing
Physician and Other Professional Office Visits (This includes all covered Providers unless otherwise listed in this Schedule of Benefits.) (Continued)		
Consultations, evaluations, Sickness and injury care	Deductible, then 20% Coinsurance	Deductible, then 40% Coinsurance
Office based treatments and procedures, including but not limited to administration of injections, casting, suturing, and the application of dressings, non-routine foot care, and surgical procedures	Deductible, then 20% Coinsurance	Deductible, then 40% Coinsurance
Administration of allergy injections	Deductible, then 20% Coinsurance	Deductible, then 40% Coinsurance
Preventive Services and Tests		
	No charge	20% Coinsurance
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.		
The following additional preventive services and tests: alpha-fetoprotein (AFP), fetal ultrasound, hepatitis C testing, lead level testing, prostate-specific antigen (PSA) screening, routine hemoglobin tests, group B streptococcus (GBS), and routine urinalysis	No charge	20% Coinsurance
Prosthetic Devices		
Prosthetic devices (other than arms and legs)	Deductible, then 20% Coinsurance	Deductible, then 40% Coinsurance
Prosthetic arms and legs	Deductible, then 20% Coinsurance	Deductible, then 40% Coinsurance
Rehabilitation and Habilitation Services – Outpatient		
Cardiac rehabilitation Pulmonary rehabilitation therapy	Deductible, then 20% Coinsurance	Deductible, then 40% Coinsurance
Physical, speech and occupational therapies combined – limited to 60 visits per Calendar Year	Deductible, then 20% Coinsurance	Deductible, then 40% Coinsurance
Outpatient physical, occupational and speech therapies are 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	Deductible, then 20% Coinsurance	Deductible, then 40% Coinsurance
Surgery – Outpatient		
	Deductible, then 20% Coinsurance	Deductible, then 40% Coinsurance

Benefit	In-Network Plan Providers Member Cost Sharing	Out-of-NetworkNon-Plan Providers Member Cost Sharing
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	Deductible, then 20% Coinsurance	Deductible, then 40% Coinsurance
Urgent care clinic	Deductible, then 20% Coinsurance	Deductible, then 40% Coinsurance
Hospital urgent care clinic	Deductible, then 20% Coinsurance	Deductible, then 40% Coinsurance
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		
Urgent eye care	Deductible, then 20% Coinsurance	Deductible, then 40% Coinsurance
Routine adult eye examinations – limited to 1 exam per Calendar Year	$20 Copayment per visit	20% Coinsurance
Routine pediatric eye examinations – limited to 1 exam per Calendar Year	$20 Copayment per visit	20% Coinsurance
Vision hardware for special conditions	Deductible, then 20% Coinsurance	Deductible, then 40% Coinsurance
Voluntary Sterilization – in a Physician's Office		
	Deductible, then 20% Coinsurance	Deductible, then 40% Coinsurance
Voluntary Termination of Pregnancy		
	Deductible, then 20% Coinsurance	Deductible, then 40% Coinsurance
Wigs and Scalp Hair Prostheses		
– Limited to $350 per Calendar Year (see the Benefit Handbook for details)	Deductible, then 20% Coinsurance	Deductible, then 40% 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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