Schedule of Benefits

Harvard Pilgrim Health Care, Inc.

Reliant Select HMO
MASSACHUSETTS

This Schedule of Benefits states any Benefit Limits and the 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.

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

Tiered Providers

In this plan, you will pay different levels of Copayments depending on the tier of the provider delivering Covered Benefits. Tier 1 includes all Reliant Select Primary Care Providers (PCPs) and Reliant Select Specialists. Tier 2 includes all other HPHC providers.

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 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 physician'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:	Tier 1: Reliant Provider Cost Sharing	Tier 2: All Other HPHC Provider Cost Sharing
Coinsurance and Copayments		
	See Covered Benefits below	
Deductible		
The following Deductibles apply to all services except where specifically noted below.	$800 per Member per Calendar Year $1,600 per family per Calendar Year	
Deductible Rollover		
Your Plan has a Deductible Rollover that applies to any Deductible amount that is incurred for services during the last 3 months of the Calendar Year and is applied toward the Deductible requirement for the next Calendar Year.		
Out-of-Pocket Maximum		
Includes all Member Cost Sharing	$1,800 per Member per Calendar Year $3,600 per family per Calendar Year	

Benefit	Tier 1: Reliant Provider Cost Sharing	Tier 2: All Other HPHC Provider Cost Sharing
Acupuncture Treatment for Injury or Illness		
– Limited to 20 visits per Calendar Year	$30 Copayment per visit	
Ambulance Transport		
Emergency ambulance transport	Deductible, then no charge	
Non-emergency ambulance transport	Deductible, then no charge	
Autism Spectrum Disorders Treatment		
Applied behavior analysis	$20 Copayment per visit	
Chemotherapy and Radiation Therapy		
Chemotherapy	Deductible, then no charge	
Radiation therapy	Deductible, then no charge	
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 (performed in a physician's office)	Your Member Cost Sharing will depend upon where the service is 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."	
Pediatric Dental Care for children	Not covered	
Dialysis		
	Deductible, then no charge	
Durable Medical Equipment		
Durable medical equipment	Deductible, then 30% Coinsurance	
Blood glucose monitors, infusion devices and insulin pumps (including supplies)	No charge	
Oxygen and respiratory equipment	No charge	

Benefit	Tier 1: Reliant Provider Cost Sharing	Tier 2: All Other HPHC Provider Cost Sharing
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		
	Deductible, then $250 Copayment per visit	
This Copayment is waived if you are (1) transferred to either Observation Services or Outpatient Surgery or (2) admitted to the hospital directly from the emergency room. Please see "Hospital - Inpatient Services," "Observation Services," or "Surgery – Outpatient" for the Member Cost Sharing that applies to these benefits.		
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 30% Coinsurance	
Home Health Care		
	Deductible, then no charge	
If services include the administration of drugs, please see the benefit for "Medical Drugs" for Member Cost Sharing details.		
Hospice – Outpatient		
	Deductible, then no charge	
Hospital – Inpatient Services		
Acute hospital care	Deductible, then $250 Copayment per admission	
Inpatient maternity care	Deductible, then $250 Copayment per admission	
Inpatient routine nursery care	No charge	
Inpatient rehabilitation – limited to 60 days per Calendar Year	Deductible, then $250 Copayment per admission	
Skilled nursing facility – limited to 100 days per Calendar Year	Deductible, then $250 Copayment per admission	
Infertility Services and Treatments (see the Benefit Handbook for details)		
The Plan covers the following diagnostic services for infertility: – Consultations – Evaluations – Laboratory tests	Your Member Cost Sharing will depend upon where the service is 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."	
Infertility treatment	Deductible, then $100 Copayment per visit	
Laboratory, Radiology and Other Diagnostic Services		
Laboratory	Deductible, then no charge	
Genetic testing	Deductible, then no charge	
Radiology	Deductible, then no charge	
Advanced radiology, including CT scans, PET scans, MRI, MRA and nuclear medicine services	Deductible, then no charge	
Other diagnostic services	Deductible, then no charge	

Benefit	Tier 1: Reliant Provider Cost Sharing	Tier 2: All Other HPHC Provider Cost Sharing
Low Protein Foods		
– Limited to $5,000 per Calendar Year	Deductible, then no charge	
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.	
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, Radiology and Other Diagnostic Services."		
Medical Drugs (drugs that cannot be self-administered)		
Medical drugs received in a doctor's office or other outpatient facility	Deductible, then no charge	
Medical drugs received in the home	Deductible, then no charge	
Some Medical Drugs may be supplied by a specialty pharmacy. When Medical Drugs are supplied by a specialty pharmacy, the Member Cost Sharing listed above will apply.		
Medical Formulas		
	Deductible, then no charge	
Mental Health and Substance Use Disorder Treatment		
Inpatient services	No charge	
Intermediate services – Acute residential treatment (including detoxification), crisis stabilization and in-home family stabilization – Intensive outpatient programs, partial hospitalization and day treatment programs for mental health and substance use disorder	No charge	
Outpatient group therapy	$20 Copayment per visit	
Outpatient treatment, including individual therapy, outpatient detoxification and medication management	$20 Copayment per visit	
Outpatient methadone maintenance	No charge	
Outpatient psychological testing and neuropsychological assessment	Deductible, then no charge	
Observation Services		
	Deductible, then $250 Copayment per observation stay	
Ostomy Supplies		
	Deductible, then 30% Coinsurance	

Benefit	Tier 1: Reliant Provider Cost Sharing	Tier 2: All Other HPHC Provider Cost Sharing
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, Radiology and Other Diagnostic Services" for the Member Cost Sharing that applies to diagnostic services not included on this list.		
Consultations, evaluations, sickness and injury care	Level 1: $20 Copayment per visit Level 2: $25 Copayment per visit	Level 1: $35 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. Additional Member Cost Sharing may apply. Please refer to the specific benefit in this Schedule of Benefits. For example, if you need sutures, please refer to office based treatments and procedures below. If you need an x-ray or have blood drawn, please refer to "Laboratory, Radiology and Other Diagnostic Services."		
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, and surgical procedures.	Deductible, then no charge	
Administration of allergy injections	No charge	
Preventive Services and Tests		
	No charge	
Under federal and state 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 and state guidance.		
Prosthetic Devices		
	Deductible, then 30% Coinsurance	
Rehabilitation and Habilitation Services - Outpatient		
Cardiac rehabilitation	Deductible, then $25 Copayment per visit	Deductible, $40 per visit
Pulmonary rehabilitation therapy	Deductible, then no charge	
Speech-language and hearing services	Deductible, then $20 Copayment per visit	Deductible, then $35 per visit
Occupational therapy – limited to 24 visits per Calendar Year	Deductible, then $20 Copayment per visit	Deductible, then $35 per visit

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Benefit	Tier 1: Reliant Provider Cost Sharing	Tier 2: All Other HPHC Provider Cost Sharing
Rehabilitation and Habilitation Services - Outpatient (Continued)		
Physical therapy – limited to 24 visits per Calendar Year	Deductible, then $20 Copayment per visit	Deductible, then $35 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 up to the age of three and (2) the treatment of Autism Spectrum Disorders.		
Scopic Procedures - Outpatient Diagnostic and Therapeutic		
Colonoscopy, endoscopy and sigmoidoscopy	Deductible, then $100 Copayment per visit	
Spinal Manipulative Therapy (including care by a chiropractor)		
– Limited to 12 visits per Calendar Year	$20 Copayment per visit	
Surgery – Outpatient		
	Deductible, then $100 Copayment per visit	
Telemedicine Virtual Visit Services – Outpatient		
	Level 1: $20 Copayment per visit Level 2: $25 Copayment per visit	Level 1: $35 Copayment per visit Level 2: $40 Copayment per visit
For inpatient hospital care, see "Hospital – Inpatient Services" for cost sharing details.		
Urgent Care Services		
Doctors On Demand	$20 Copayment per visit	
Important Note: Doctors On Demand is a specific network of providers contracted to provide virtual Urgent Care services. For more information on Doctors On Demand, including how to access them, please visit our website at **www.harvardpilgrim.org**.		
Convenience care clinic	$20 Copayment per visit	
Urgent care center	$20 Copayment per visit	
Hospital urgent care center	$20 Copayment per visit	
Additional Member Cost Sharing may apply. Please refer to the specific benefit in this Schedule of Benefit. For example, if you have an x-ray or have blood drawn, please refer to "Laboratory, Radiology and Other Diagnostic Services."		
Vision Services		
Routine eye examinations – limited to 1 exam per Calendar Year	No charge	
Vision hardware for special conditions	Deductible, then 30% Coinsurance	
Voluntary Sterilization in a Physician's Office		
	Deductible, then 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 Calendar Year (see the Benefit Handbook for details)	Deductible, then 30% Coinsurance	

General List of Exclusions
Harvard Pilgrim Health Care, Inc. | MASSACHUSETTS

The following list identifies services that are generally excluded from Harvard Pilgrim Plans. Additional services may be excluded related to access or product design. For a complete list of exclusions please refer to the specific plan's Benefit Handbook.

Exclusion
Alternative Treatments
• Acupuncture care, except when specifically listed as a Covered Benefit. • Acupuncture services that are outside the scope of standard acupuncture care. • Alternative, holistic or naturopathic services and all procedures, laboratories and nutritional supplements associated with such treatments, except when specifically listed as a Covered Benefit. • Aromatherapy, treatment with crystals and alternative medicine. • Any of the following types of programs: Health resorts, spas, recreational programs, camps, outdoor skills programs, therapeutic or educational boarding schools, educational programs for children in residential care, self-help programs, life skills programs, relaxation or lifestyle programs, and wilderness programs (therapeutic outdoor programs). • Massage therapy. • Myotherapy.
Dental Services
• Dental Care, except when specifically listed as a Covered Benefit. • All services of a dentist for Temporomandibular Joint Dysfunction (TMD). • Extraction of teeth, except when specifically listed as a Covered Benefit. • Pediatric dental care, except when specifically listed as a Covered Benefit.
Durable Medical Equipment and Prosthetic Devices
• Any devices or special equipment needed for sports or occupational purposes. • Any home adaptations, including, but not limited to home improvements and home adaptation equipment. • Non-durable medical equipment, unless used as part of the treatment at a medical facility or as part of approved home health care services. • Repair or replacement of durable medical equipment or prosthetic devices as a result of loss, negligence, willful damage, or theft.
Experimental, Unproven or Investigational Services
• Any products or services, including, but not limited to, drugs, devices, treatments, procedures, and diagnostic tests that are Experimental, Unproven, or Investigational.
Foot Care
• Foot orthotics, except for the treatment of severe diabetic foot disease. • Routine foot care. Examples include nail trimming, cutting or debriding and the cutting or removal of corns and calluses. This exclusion does not apply to preventive foot care for Members with diabetes.
Maternity Services
• 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. • Routine pre-natal and post-partum care when you are traveling outside the Service Area.

Exclusion
Mental Health and Substance Use Disorder Treatment
• Biofeedback. • Educational services or testing, except services covered under the benefit for Early Intervention Services. No benefits are provided (1) for educational services intended to enhance educational achievement or developmental functioning, (2) to resolve problems of school performance, (3) to treat learning disabilities, (4) for driver alcohol education, or (5) for community reinforcement approach and assertive continuing care. • Any of the following types of programs: programs in which the patient has a pre-defined duration of care without the Plan's ability to conduct concurrent determinations of continued medical necessity, programs that only provide meetings or activities not based on individualized treatment plans, programs that focus solely on interpersonal or other skills rather than directed toward symptom reduction and functional recovery related to specific mental health disorders, and tuition based programs that offer educational, vocational, recreational, or personal developmental activities. • Methadone maintenance, except when specifically listed as a Covered Benefit. • Sensory integrative praxis tests. • Services for any condition with only a "Z Code" designation in the Diagnostic and Statistical Manual of Mental Disorders, which means that the condition is not attributable to a mental disorder. • Mental health and substance use disorder treatment that is (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. • Services or supplies for the diagnosis or treatment of mental health and substance use disorders that, in the reasonable judgment of the Behavioral Health Access Center, are any of the following: not consistent with prevailing national standards of clinical practice for the treatment of such conditions; not consistent with prevailing professional research demonstrating that the services or supplies will have a measurable and beneficial health outcome; typically do not result in outcomes demonstrably better than other available treatment alternatives that are less intensive or more cost effective.. • Services related to autism spectrum disorders provided under an individualized education program (IEP), including any services provided under an IEP that are delivered by school personnel or any services provided under an IEP purchased from a contractor or vendor.
Physical Appearance
• Cosmetic Services, including drugs, devices, treatments and procedures, except for (1) Cosmetic Services that are incidental to the correction of Physical Functional Impairment, (2) restorative surgery to repair or restore appearance damaged by an accidental injury, and (3) post-mastectomy care. • Hair removal or restoration, including, but not limited to, electrolysis, laser treatment, transplantation or drug therapy. • Liposuction or removal of fat deposits considered undesirable. • Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures). • Skin abrasion procedures performed as a treatment for acne. • Treatment for skin wrinkles and skin tags or any treatment to improve the appearance of the skin. • Treatment for spider veins.
Procedures and Treatments
• Care by a chiropractor 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. • Spinal manipulative therapy (including care by a chiropractor), except when specifically listed as a Covered Benefit. • Commercial diet plans, weight loss programs and any services in connection with such plans or programs, except when specifically listed as a Covered Benefit. **Please note**: If you have coverage through an employer group plan, your employer may participate in other wellness and health improvement incentive programs offered by Harvard Pilgrim. Please review all your Plan documents for the amount of incentives, if any, available under your Plan. • Gender reassignment surgery and all related drugs and procedures for self-insured groups, unless covered under a separate rider. • If a service is listed as requiring that it be provided at a Center of Excellence, no In-Network coverage will be provided if that service is received from a provider that has not been designated as a Center of Excellence. • Nutritional or cosmetic therapy using vitamins, minerals or elements, and other nutrition-based therapy. Examples include supplements, electrolytes, and foods of any kind (including high protein foods and low carbohydrate foods). • Physical examinations and testing for insurance, licensing or employment. • Services for Members who are donors for non-members, except as described under Human Organ Transplant Services. • Testing for central auditory processing. • Group diabetes training, educational programs or camps.

This exclusion list is not binding and is provided exclusively for information purposes. Please see your Benefit Handbook and Schedule of Benefits.

Exclusion
Providers
• Charges for services which were provided after the date on which your membership ends. • 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 Benefit. • Charges for missed appointments. • Concierge service fees. (See the Plan's *Benefit Handbook* for more information.) • Follow-up care after an emergency room visit, unless provided or arranged by your PCP. • Inpatient charges after your hospital discharge. • Provider's charge to file a claim or to transcribe or copy your medical records. • Services or supplies provided by: (1) anyone related to you by blood, marriage or adoption, or (2) anyone who ordinarily lives with you.
Reproduction
• Any form of Surrogacy or services for a gestational carrier. • Infertility drugs if a Member is not in a Plan authorized cycle of infertility treatment. • Infertility drugs, if infertility services are not a Covered Benefit. • Infertility drugs that must be purchased at an outpatient pharmacy, unless your Plan includes outpatient pharmacy coverage. • Infertility treatment for Members who are not medically infertile. • Infertility treatment and birth control drugs, implants and devices, except when specifically listed as a Covered Benefit. • Reversal of voluntary sterilization (including any services for infertility related to voluntary sterilization or its reversal). • Sperm collection, freezing and storage except as described in the Plan's *Benefit Handbook.* • Sperm identification when not Medically Necessary (e.g., gender identification). • The following fees: wait list fees, non-medical costs, shipping and handling charges etc. • Voluntary sterilization, including tubal ligation and vasectomy, except when specifically listed as a Covered Benefit. • Voluntary termination of pregnancy, unless the life of the mother is in danger or unless it is specifically listed as a Covered Benefit.
Services Provided Under Another Plan
• Costs for any services for which you are entitled to treatment at government expense, including military service connected disabilities. • Costs for services for which payment is required to be made by a Workers' Compensation plan or an Employer under state or federal law.
Telemedicine Services
• Telemedicine services involving e-mail, fax, or audio-only telephone. • Provider fees for technical costs for the provision of telemedicine services.
Types of Care
• Custodial Care. • Recovery programs including rest or domiciliary care, sober houses, transitional support services, and therapeutic communities. • All institutional charges over the semi-private room rate, except when a private room is Medically Necessary. • Pain management programs or clinics. • Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, and diversion or general motivation, except when specifically listed as a Covered Benefit. • Private duty nursing. • Sports medicine clinics. • Vocational rehabilitation, or vocational evaluations on job adaptability, job placement, or therapy to restore function for a specific occupation.
Vision and Hearing
• Eyeglasses, contact lenses and fittings, except when specifically listed as a Covered Benefit. • Hearing aids, except when specifically listed as a Covered Benefit. • Hearing aid batteries, and any device used by individuals with hearing impairment to communicate over the telephone or internet, such as TTY or TDD. • Refractive eye surgery, including, but not limited to, lasik surgery, orthokeratology and lens implantation for the correction of naturally occurring myopia, hyperopia and astigmatism. • Routine eye examinations, except when specifically listed as a Covered Benefit.

Exclusion
All Other Exclusions
• Any drug or other product obtained at an outpatient pharmacy, except for pharmacy supplies covered under the benefit for diabetes services and hypodermic syringes and needles, as required by law, unless your Plan includes outpatient pharmacy coverage. • Any service or supply furnished in connection with a non-Covered Benefit. • Any service or supply (with the exception of contact lenses) purchased from the internet. • Beauty or barber service. • Diabetes equipment replacements when solely due to manufacturer warranty expiration. • Donated or banked breast milk. • Food or nutritional supplements, including, but not limited to, FDA-approved medical foods obtained by prescription, except as required by law and prescribed for Members who meet HPHC policies for enteral tube feedings. • Guest services. • Medical equipment, devices or supplies except as listed in this Benefit Handbook. • Medical services that are provided to Members who are confined or committed to jail, house of correction, prison, or custodial facility of the Department of Youth Services. • Services for non-Members. • Services for which no charge would be made in the absence of insurance. • Services for which no coverage is provided in the Plan's Benefit Handbook, this Schedule of Benefits, or Prescription Drug Brochure (if applicable). • Services that are not Medically Necessary. • Services your PCP or a Plan Provider has not provided, arranged or approved except as described in the *Handbook* sections *"Your PCP Manages Your Health Care"* and *"Using Plan Providers"*. • Taxes or governmental assessments on services or supplies. • Transportation other than by ambulance. • Air conditioners, air purifiers and filters, dehumidifiers and humidifiers. • Car seats. • Chairs, bath chairs, feeding chairs, toddler chairs, chair lifts, recliners. • Electric scooters. • Exercise equipment. • Home modifications including but not limited to elevators, handrails and ramps. • Hot tubs, jacuzzis, saunas or whirlpools. • Mattresses. • Medical alert systems. • Motorized beds. • Pillows. • Power-operated vehicles. • Stair lifts and stair glides. • Strollers. • Safety equipment. • Vehicle modifications including but not limited to van lifts. • Telephone. • Television.

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