Buy-Up PPO

Schedule of Benefits

schedule of benefits

Harvard Pilgrim Health Care

Schedule of Benefits

The Harvard Pilgrim PPO
Massachusetts

Services listed below are covered when Medically Necessary. Please see your Benefit Handbook for details.

Your Plan offers two levels of coverage: In-Network and Out-of-Network.

In-Network Coverage
In-Network coverage applies when you use a Participating Provider for covered services.

Out-of-Network Coverage
Out-of-Network coverage applies when you use a Non-Participating Provider for covered services.

Please refer to your *Benefit Handbook* for further information about how your In-Network and Out-of-Network coverage works.

Member Cost Sharing
Members are required to share the cost of the benefits provided under the Plan. The following is a summary of the cost sharing amounts under your Plan.

Your Plan has **Copayments** that are listed in the table below with the service to which they apply.

You have a **Hospital Inpatient Copayment** of $250 per admission. $150 per visit for Day Surgery.

You have an **Out-of-Network Deductible** of $250 per Member or $500 per family, per calendar year, applied to the eligible expense.

You have **Out-of-Network Coinsurance** of 20% of Covered Charges after the Deductible is met until the Out-of-Pocket Maximum is reached.

You have an **In-Network Out-of-Pocket Maximum** of $1,000 per Member and $2,000 per covered family per calendar year. This is the total amount in Copayments you (or your covered family) are required to pay each calendar year for In-Network services covered by the Plan, not including riders providing benefits for prescription drugs, adult preventive dental care or vision hardware. HPHC will notify you when you have reached your In-Network Out-of-Pocket Maximum. If you feel you have reached the In-Network Out-of-Pocket Maximum but have not been notified, please contact the HPHC.

You have an **Out-of-Network Out-of-Pocket Maximum** of $1,700 per Member or $3,400 per family, including the Deductible and Coinsurance (not including riders providing benefits for prescription drugs, adult preventive dental or vision hardware and Coinsurance for durable medical and prosthetic equipment and vision hardware for special conditions).

Copayment amounts, and any charges in excess of the Usual, Customary and Reasonable Charge do not apply to the Out-of-Network Out-of-Pocket Maximum. Any Deductible amount incurred for services rendered during the last 3 months of a calendar year will be applied to the Deductible requirement for the next year.

Service	In-Network (Participating Providers)	Out-of-Network (Non-Participating Providers)
Inpatient Acute Hospital Services (including Day Surgery)		
All covered services including the following: ▪ Coronary care ▪ Hospital services ▪ Intensive care ▪ Physicians' and surgeons' services including consultations ▪ Semi-private room and board	Subject to the Hospital Inpatient Copayment.	20% Coinsurance after the Deductible has been met, subject to the Hospital Inpatient Copayment.
Skilled Nursing Facility Care Services		
▪ Covered up to 100 days per calendar year	Subject to the Hospital Inpatient Copayment.	20% Coinsurance after the Deductible has been met, subject to the Hospital Inpatient Copayment.
Inpatient Rehabilitation Services		
▪ Covered up to 60 days per calendar year	Subject to the Hospital Inpatient Copayment.	20% Coinsurance after the Deductible has been met, subject to the Hospital Inpatient Copayment.
Maternity Services		
▪ Prenatal and postpartum care, including counseling about alcohol and tobacco use, services to promote breastfeeding, routine urinalysis and screenings for the following: asymptomatic bacteriuria; hepatitis B infection; HIV and screenings for STDs (chlamydia, gonorrhea and syphilis); iron deficiency anemia; and Rh (D) incompatibility.	Covered in full.	20% Coinsurance after the Deductible has been met.
▪ All hospital services for mother	Subject to the Hospital Inpatient Copayment.	20% Coinsurance after the Deductible has been met, subject to the Hospital Inpatient Copayment.
▪ Routine nursery charges for newborn, including prophylactic medication to prevent gonorrhea and screenings for the following: hearing loss; congenital hypothyroidism; phenylketonuria (PKU); and sickle cell disease.	Covered in full.	20% Coinsurance after the Deductible has been met.

Service	In-Network (Participating Providers)	Out-of-Network (Non-Participating Providers)
Hospital Outpatient Department Services		
All covered services including the following: ▪ Anesthesia services ▪ Chemotherapy ▪ Endoscopic procedures ▪ Laboratory tests and x-rays ▪ Physicians' and surgeons' services ▪ Radiation therapy	Covered in full. (Unless otherwise listed under a specific benefit below.) No cost sharing applies to certain preventive care services and tests. See "Physician Services" for details.	20% Coinsurance after the Deductible has been met.
Physician Services		
All covered services including the following: ▪ Administration of injections ▪ Allergy tests and treatments ▪ Changes and removal of casts, dressings or sutures ▪ Chemotherapy ▪ Consultations concerning contraception and hormone replacement therapy ▪ Diabetes self-management, including education and training ▪ Family planning services ▪ Infertility services ▪ Diagnostic screening and tests, including but not limited to mammograms, blood tests, lead screenings and screenings mandated by state law ▪ Health education, including nutritional counseling ▪ Medical treatment of temporomandibular joint dysfunction (TMD) ▪ Routine annual eye examinations ▪ Sick visits, including psychopharmacological services ▪ Vision and hearing screening	$15 Copayment per visit. (Please note: diagnostic tests, mammograms, x-rays and immunizations will be covered in full if billed without an office visit and no other services are provided.)	20% Coinsurance after the Deductible has been met.
▪ Administration of allergy injections	$5 Copayment per visit.	20% Coinsurance after the Deductible has been met.
▪ Preventive care, including routine physical, gynecological, well child, school, camp, sports and premarital examinations	Covered in full.	20% Coinsurance after the Deductible has been met.

Service	In-Network (Participating Providers)	Out-of-Network (Non-Participating Providers)
Physician Services (Continued)		
The following preventive services and tests as defined by federal law: ▪ Abdominal aortic aneurysm screening (for males 65-75 one time only, if ever smoked) ▪ Alcohol misuse screening and counseling (primary care visits only) ▪ Aspirin for the prevention of heart disease (primary care counseling only) ▪ Autism screening (for children at 18 and 24 months of age, primary care visits only) ▪ Behavioral assessments (children of all ages; developmental surveillance, in primary care settings) ▪ Blood pressure screening (adults, without known hypertension) ▪ Breast cancer chemoprevention (counseling only for women at high risk for breast cancer and low risk for adverse effects of chemoprevention) ▪ Breast cancer screening, including mammograms and counseling for genetic susceptibility screening ▪ Cervical cancer screening, including pap smears ▪ Cholesterol screening (for adults only) ▪ Colorectal cancer screening, including colonoscopy, sigmoidoscopy and fecal occult blood test ▪ Dental caries prevention - oral fluoride (for children to age 5 only) (Note: Coverage for fluoride is only provided if your Plan includes outpatient pharmacy coverage.) ▪ Depression screening (adults, children ages 12-18, primary care visits only) ▪ Diabetes screenings ▪ Diet behavioral counseling (included as part of annual visit and intensive counseling by primary care clinicians or by nutritionists and dieticians) ▪ Dyslipidemia screening (for children at high risk for higher lipid levels) ▪ Folic acid supplements (women planning or capable of pregnancy only) (Note: coverage for folic acid is only provided if your Plan includes outpatient pharmacy coverage.) ▪ Hemoglobin A1c ▪ Hepatitis B testing	Covered in full	20% Coinsurance after the Deductible has been met.

Service	In-Network (Participating Providers)	Out-of-Network (Non-Participating Providers)
Physician Services (Continued)		
▪ HIV screening ▪ Immunizations, including flu shots (for children and adults as appropriate) ▪ Iron deficiency prevention (primary care counseling for children age 6 to 12 months only) ▪ Lead screening (for children at risk) ▪ Microalbuminuria test ▪ Obesity screening (adults and children screening only, in primary care settings) ▪ Osteoporosis screening (screening to begin at age 60 for women at increased risk) ▪ Ovarian cancer susceptibility screening ▪ Sexually transmitted diseases (STDs) – screenings and counseling ▪ Tobacco use counseling (primary care visits only) ▪ Total cholesterol tests ▪ Tuberculosis skin testing ▪ Vision screening (children to age 5 only)	Covered in full.	20% Coinsurance after the Deductible has been met.

Under federal law the list of preventive care services covered under this benefit 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 woman, 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 US Department of Health and Human Services at:

http://www.healthcare.gov/center/regulations/prevention/recommendations.html

Harvard Pilgrim will add or delete services from this benefit for preventive care 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 www.harvardpilgrim.org.

Service	In-Network (Participating Providers)	Out-of-Network (Non-Participating Providers)
Emergency Room Care Services		
▪ Hospital emergency room treatment You are always covered in a Medical Emergency. In a Medical Emergency, you should go to the nearest emergency facility or call 911 or other local emergency number. If you are hospitalized, you must call the Plan within 48 hours, or as soon as you can.	$100 Copayment per visit. (This Copayment is waived if you are directly admitted.)	$100 Copayment per visit. (This Copayment is waived if you are directly admitted.)
Emergency Admission Services		
▪ Inpatient services which are required immediately following the rendering of emergency room treatment	Subject to the Hospital Inpatient Copayment.	Subject to the Hospital Inpatient Copayment.
Mental Health Care (Including the Treatment of Substance Abuse Disorders)		
Inpatient Services		
▪ Mental health care services	Subject to the Hospital Inpatient Copayment.	20% Coinsurance after the Deductible has been met, subject to the Hospital Inpatient Copayment.
Intermediate Care Services		
▪ Acute residential treatment (including detoxification), crisis stabilization and in-home family stabilization ▪ Intensive outpatient programs, partial hospitalization and day treatment programs	Covered in full.	20% Coinsurance after the Deductible has been met.
Outpatient Services		
▪ Mental health care services		
Group therapy	$10 Copayment per visit.	20% Coinsurance after the Deductible has been met.
Individual therapy	$15 Copayment per visit.	
▪ Detoxification	$15 Copayment per visit.	20% Coinsurance after the Deductible has been met.
▪ Medication management	$15 Copayment per visit.	20% Coinsurance after the Deductible has been met.
▪ Psychological testing and neuropsychological assessment	$15 Copayment per visit.	20% Coinsurance after the Deductible has been met.

Service	In-Network (Participating Providers)	Out-of-Network (Non-Participating Providers)
Dental Services		
▪ Preventive care for children through the age of 12. Two visits per Member per calendar year, including examination, cleaning, x-rays and fluoride treatment.	Covered in full.	20% Coinsurance after the Deductible has been met.
▪ Extraction of unerupted teeth impacted in bone ▪ Initial emergency treatment (within 72 hours of injury)	$15 Copayment per visit. If inpatient services are required, please see "Inpatient Acute Hospital Services" for cost sharing.	20% Coinsurance after the Deductible has been met. If inpatient services are required, please see "Inpatient Acute Hospital Services" for cost sharing.
Home Health Care Services		
▪ Home care services ▪ Intermittent skilled nursing care	Covered in full.	20% Coinsurance after the Deductible has been met.
No cost sharing or benefit limit applies to durable medical equipment, physical therapy or occupational therapy received as part of authorized home health care.		
Diabetes Equipment and Supplies		
▪ Therapeutic molded shoes and inserts, dosage gauges, injectors, lancet devices, voice synthesizers and visual magnifying aids	Subject to the applicable cost sharing, if any, for durable medical and prosthetic equipment benefit.	Subject to the applicable cost sharing, if any, for durable medical and prosthetic equipment benefit.
▪ Blood glucose monitors, insulin pumps and supplies and infusion devices	Covered in full.	Covered in full.
▪ Insulin, insulin syringes, insulin pens with insulin, lancets, oral agents for controlling blood sugar, blood test strips, and glucose, ketone and urine test strips	Subject to the applicable prescription drug Copayment listed on your ID card, if your Plan includes prescription drug coverage. If prescription drug coverage is not available, then you will pay a $5 Copayment for Tier 1 items, a $10 Copayment for Tier 2 items, and a $25 Copayment for Tier 3 items.	Subject to the applicable prescription drug Copayment listed on your ID card, if your Plan includes prescription drug coverage. If prescription drug coverage is not available, then you will pay a $5 Copayment for Tier 1 items, a $10 Copayment for Tier 2 items, and a $25 Copayment for Tier 3 items.

Service	In-Network (Participating Providers)	Out-of-Network (Non-Participating Providers)
Durable Medical Equipment including Prosthetics		
Coverage includes, but is not limited to: ▪ Durable medical equipment ▪ Prosthetic devices (including artificial arms and legs) ▪ Breast prostheses, including replacements and mastectomy bras ▪ Ostomy supplies ▪ Wigs - up to a limit of $350 per calendar year when needed as a result of any form of cancer or leukemia, alopecia areata, alopecia totalis or permanent hair loss due to injury	20% Coinsurance	20% Coinsurance after the Deductible has been met.
▪ Oxygen and respiratory equipment	Covered in full.	20% Coinsurance after the Deductible has been met.
Hypodermic Syringes and Needles		
▪ Hypodermic syringes and needles to the extent Medically Necessary, as required by Massachusetts law	Subject to the applicable prescription drug Copayment listed on your ID card, if your Plan includes prescription drug coverage. If prescription drug coverage is not available, then you will pay the lower of the pharmacy's retail price or a $5 Copayment for Tier 1 items, $10 Copayment for Tier 2 items and a $25 Copayment for Tier 3 items.	Subject to the applicable prescription drug Copayment listed on your ID card, if your Plan includes prescription drug coverage. If prescription drug coverage is not available, then you will pay the lower of the pharmacy's retail price or a $5 Copayment for Tier 1 items, $10 Copayment for Tier 2 items and a $25 Copayment for Tier 3 items.

Service	In-Network (Participating Providers)	Out-of-Network (Non-Participating Providers)
Autism Spectrum Disorders		
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 Services." For services by a Licensed Mental Health Professional see "Mental Health Care (Including the Treatment of Substance Abuse Disorders)." For services by a speech therapist, physical therapist and occupational therapist, see "Other Health Services."	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 Services." For services by a Licensed Mental Health Professional see "Mental Health Care (Including the Treatment of Substance Abuse Disorders)." For services by a speech therapist, physical therapist and occupational therapist, see "Other Health Services."
Applied Behavior Analysis		
▪ No benefit limit applies to this service	$15 Copayment per visit.	20% Coinsurance after the Deductible has been met.

Service	In-Network (Participating Providers)	Out-of-Network (Non-Participating Providers)
Other Health Services		
▪ Cardiac rehabilitation ▪ Chiropractic care up to $1,000 per calendar year ▪ Dialysis ▪ Second opinion ▪ Physical and occupational therapies – up to 60 visits per calendar year 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. ▪ Speech-language and hearing services, including therapy ▪ House calls	$15 Copayment per visit.	20% Coinsurance after the Deductible has been met.
▪ Early intervention services	Covered in full.	Covered in full.
▪ Hospice services	Covered in full per outpatient visit. If inpatient services are required, please see "Inpatient Acute Hospital Services" for cost sharing.	20% Coinsurance after the Deductible has been met. If inpatient services are required, please see "Inpatient Acute Hospital Services" for cost sharing.
▪ Ambulance services ▪ Low protein foods ($5,000 per Member per calendar year) ▪ State mandated formulas	Covered in full.	Covered in full.
▪ Vision hardware for special conditions (please see your Benefit Handbook for details on your coverage)	Covered in full up to the benefit limit.	20% Coinsurance after the Deductible has been met up to the benefit limit.

Special Enrollment Rights

For Subscribers enrolled through an Employer Group:

If an employee declines enrollment for the employee and his or her Dependents (including his or her spouse) because of other health insurance coverage, the employee may be able to enroll himself or herself, along with his or her Dependents in this Plan if the employee or his or her Dependents lose eligibility for that other coverage (or if the employer stops contributing toward the employee's or Dependents' other coverage). However, enrollment must be requested within 30 days after other coverage ends (or after the employer stops contributing toward the employee's or Dependents' other coverage). In addition, if an employee has a new Dependent as a result of marriage, birth, adoption or placement for adoption, the employee may be able to enroll himself or herself and his or her Dependents. However, enrollment must be requested within 30 days after the marriage, birth, adoption or placement for adoption.

Special enrollment rights may also apply to persons who lose coverage under Medicaid or the Children's Health Insurance Program (CHIP) or become eligible for state premium assistance under Medicaid or CHIP. An employee or Dependent who loses coverage under Medicaid or CHIP as a result of the loss of Medicaid or CHIP eligibility may be able to enroll in this Plan, if enrollment is requested within 60 days after Medicaid or CHIP coverage ends. An employee or Dependent who becomes eligible for group health plan premium assistance under Medicaid or CHIP may be able to enroll in this Plan if enrollment is requested within 60 days after the employee or Dependent is determined to be eligible for such premium assistance.

Required Approvals

Hospital Admissions

Members are responsible for obtaining approval from HPHC before any hospital admission (including Day Surgery) occurs when either the doctor or facility is a Non-Participating Provider. If approval of the admission is not received, the Member is responsible for the first $500 of the eligible expense. The $500 payment does not count toward the Deductible or the Out-of-Pocket Maximum limit.

Specialized Services

When using Non-Participating Providers it is the Member's responsibility to obtain approval from HPHC for the following services before any costs are incurred. If approval is not obtained, the Member is responsible for the first $500 of the eligible expense. The $500 payment does not count toward the Deductible or the Out-of-Pocket Maximum limit.

- All inpatient services
- Physical, speech, and occupational therapies
- Advanced reproductive technologies
- All services provided in the Member's home
- Human organ transplants
- The following outpatient mental health services: intensive outpatient program treatment (treatment programs at an outpatient clinic or other facility generally lasting three or more hours a day for two or more days a week), partial hospitalization and day treatment programs, extended outpatient treatment visits (outpatient visits of more than 50 minutes duration with or without medication management or any treatment routinely involving more than one outpatient visit in a day), outpatient electro-convulsive treatment (ECT), psychological testing and neuropsychological assessment, and effective January 1, 2011, applied behavior analysis (ABA) for the treatment of autism.

48 Hour Emergency Notification

In cases of an emergency hospital admission to a Non-Participating Provider, HPHC must be notified within 48 hours of the admission. If notification is not received, the Member is responsible for the first $500 of the eligible expense. The $500 payment does not count toward the Deductible or the Out-of-Pocket Maximum limit.

Exclusions

- Cosmetic procedures, except as described in your Benefit Handbook
- Commercial diet plans or weight loss programs and any services in connection with such plans or programs
- Transsexual surgery, including related drugs or procedures
- Services that are not Medically Necessary
- Drugs, devices, treatments or procedures which are Experimental or Unproven
- Refractive eye surgery, including laser surgery and orthokeratology, for correction of myopia, hyperopia and astigmatism
- Transportation other than by ambulance
- Costs for any services for which you are entitled to treatment at government expense, including military service connected disabilities
- Costs for services covered by workers' compensation, third party liability, other insurance coverage or an employer under state or federal law
- Hair removal or restoration, including, but not limited to, electrolysis, laser treatment, transplantation or drug therapy
- Routine foot care, biofeedback, pain management programs, massage therapy and sports medicine clinics
- Any treatment with crystals
- Blood and blood products
- Educational services (including problems of school performance) or testing for developmental, educational or behavioral problems, except services covered under Early Intervention
- Sensory integrative praxis tests
- Physical examinations for insurance, licensing or employment
- Rest or custodial care
- Personal comfort or convenience items (including telephone and television charges), exercise equipment, wigs (except as required by state law and specifically covered in this Schedule of Benefits), derotation knee braces and repair or replacement of durable medical equipment or prosthetic devices as a result of loss, negligence, willful damage or theft
- Non-durable medical equipment, unless used as part of the treatment at a medical facility or as part of approved home health care services
- Reversal of voluntary sterilization (including procedures necessary for conception as a result of voluntary sterilization)
- Any form of surrogacy
- Infertility treatment for Members who are not medically infertile
- Devices or special equipment needed for sports or occupational purposes
- Services for which no charge would be made in the absence of insurance
- Services after termination of membership
- Services for non-Members
- Services or supplies given to you by: (1) anyone related to you by blood, marriage or adoption or (2) anyone who ordinarily lives with you
- Services for which no coverage is provided in the Benefit Handbook, Schedule of Benefits or Prescription Drug Brochure (if your Plan includes prescription drug coverage)
- Any home adaptations, including, but not limited to, home improvements and home adaptation equipment
- Vocational rehabilitation or vocational evaluations on job adaptability, job placement or therapy to restore function for a specific occupation
- Care 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
- 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 service under your Handbook
- Services for a newborn who has not been enrolled as a Member, other than nursery charges for routine services provided to a healthy newborn
- Charges for missed appointments
- Acupuncture, aromatherapy and alternative medicine
- Planned home births
- Dentures

Exclusions

- Mental health services that are (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
- All charges over the semi-private room rate, except when a private room is Medically Necessary
- Hospital charges after the date of discharge
- If your Plan does not include coverage for outpatient prescription drugs, there is no coverage for birth control drugs, implants, injections and devices
- A provider's charge to file a claim or to transcribe or copy your medical records
- Any service or supply furnished along with a non-covered service
- Taxes or assessments on services or supplies
- Dental services, except the specific dental services listed in your Benefit Handbook and this Schedule of Benefits. Restorative, periodontal, orthodontic, endodontic, prosthodontic and dental services for temporomandibular joint dysfunction (TMD) are not covered. Removal of impacted teeth to prepare for or support orthodontic, prosthodontic or periodontal procedures and dental fillings, crowns, gum care, including gum surgery, braces, root canals, bridges and bonding.
- Eyeglasses, contact lenses and fittings, except as listed in your Benefit Handbook and this Schedule of Benefits
- Hearing aids
- Foot orthotics, except for the treatment of severe diabetic foot disease
- Methadone maintenance
- Private duty nursing
- Health resorts, recreational programs, camps, wilderness programs, outdoor skills programs, relaxation or lifestyle programs, including any services provided in conjunction with, or as part of such types of programs.
- Services for any condition with only a “V Code” designation in the Diagnostic and Statistical Manual of Mental Disorders, which means that the condition is not attributable to a mental disorder
- 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.

Prescription Drug Coverage

Covered prescription medications are available at participating pharmacies.

Your copayments for up to a 30-day supply are:

- **Tier 1:** **$10**
- **Tier 2:** **$25**
- **Tier 3:** **$50**

These copayment amounts will be shown on your Plan identification (ID) card. Bring your prescription or refill to a participating pharmacy, along with your ID card, and pay the applicable copayment.

Harvard Pilgrim's mail service prescription drug program (Maintenance medications ONLY)

If you have a condition (e.g., high blood pressure) that requires maintenance medications, you can order up to a 90-day supply of these drugs through Harvard Pilgrim's mail service prescription drug program. When you order a 90-day supply, you'll save money on your copayments as well as trips to the pharmacy.

Your copayments for a 90-day supply are:

- **Tier 1:** **$20**
- **Tier 2:** **$50**
- **Tier 3:** **$100**

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