Schedule of Benefits

THE HSA PPO
Apex Plan Individual
MASSACHUSETTS

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.

Prior Approval

Prior Approval is required for certain benefits. Before you receive services from a Non-Plan Provider or a Plan Provider outside the Service Area, please refer our website, **www.harvardpilgrim.org** or contact the Member Services Department at **1-888-333-4742** for the complete listing of services that require Prior Approval. To 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 substance use disorder treatment

More information about 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**.

Copayment Levels

There are two types of In-Network 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.

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:	In-Network Member Cost Sharing:	Out-of-Network Member Cost Sharing:
Coinsurance and Copayments		
	See the benefits table below	
Deductible		
	$1,500 for Individual Coverage per Calendar Year	$2,600 for Individual Coverage per Calendar Year
Out-of-Pocket Maximum		
Includes all Member Cost Sharing except: – Any charges above the Allowed Amount and any penalty for failure to receive Prior Approval when using Non-Plan Providers	$5,000 for Individual Coverage per Calendar Year	$5,200 for Individual Coverage per Calendar Year

Benefit	In-Network Plan Providers Member Cost Sharing	Out-of-Network Non-Plan Providers Member Cost Sharing
Acupuncture Treatment for Injury or Illness		
– Limited to 20 visits per Calendar Year	Deductible, then $50 Copayment per visit	Deductible, then 30% Coinsurance
Ambulance Transport		
Emergency ambulance transport	Deductible, then 20% Coinsurance	Same as In-Network
Non-emergency ambulance transport	Deductible, then 20% Coinsurance	Deductible, then 30% Coinsurance
Autism Spectrum Disorders Treatment		
Applied behavior analysis	Deductible, then Level 1: $25 Copayment per visit	Deductible, then 30% Coinsurance

Benefit	In-Network Plan Providers Member Cost Sharing	Out-of-Network Non-Plan Providers Member Cost Sharing
Chemotherapy and Radiation Therapy		
	Deductible, then 20% Coinsurance	Deductible, then 30% Coinsurance
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)	Deductible, then 20% Coinsurance	Deductible, then 30% Coinsurance
Pediatric dental care for children	Not covered	Not covered
Dialysis		
	Deductible, then 20% Coinsurance	Deductible, then 30% Coinsurance
Installation of home equipment is covered up to $300 in a Member's lifetime.	Deductible, then 20% Coinsurance	Deductible, then 30% Coinsurance
Durable Medical Equipment		
Durable medical equipment	Deductible, then 20% Coinsurance	Deductible, then 30% Coinsurance
Blood glucose monitors, infusion devices and insulin pumps (including supplies)	Deductible, then no charge	Same as In-Network
Oxygen and respiratory equipment	Deductible, then 20% Coinsurance	Deductible, then 30% Coinsurance
Early Intervention Services		
	Deductible, then 20% Coinsurance	Deductible, then 30% Coinsurance
The Plan does not cover the family participation fee required by the Massachusetts Department of Public Health.		
Emergency Admission		
	Deductible, then 20% Coinsurance	Same as In-Network
Emergency Room Care		
	Deductible, then 20% Coinsurance	Same as In-Network
Hearing Aids		
	Not covered	Not covered
Home Health Care (including Private Duty Nursing)		
– Limited to 100 visits per Calendar Year	Deductible, then 20% Coinsurance	Deductible, then 30% 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 30% Coinsurance
Hospital – Inpatient Services		
Acute hospital care	Deductible, then 20% Coinsurance	Deductible, then 30% Coinsurance

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Benefit	In-Network Plan Providers Member Cost Sharing	Out-of-Network Non-Plan Providers Member Cost Sharing
Hospital – Inpatient Services (Continued)		
Inpatient maternity care	Deductible, then 20% Coinsurance	Deductible, then 30% Coinsurance
Inpatient routine nursery care	No charge	Deductible, then 30% Coinsurance
Inpatient rehabilitation	Deductible, then 20% Coinsurance	Deductible, then 30% Coinsurance
Skilled nursing facility – limited to 100 days per Calendar Year	Deductible, then 20% Coinsurance	Deductible, then 30% Coinsurance
Infertility Services and Treatments (see the Benefit Handbook for details)		
– Limited to $10,000 per lifetime	Your Member Cost Sharing will depend upon where the service is provided, as listed in this Schedule of Benefits. For example, for services provided by a physician, see "Physician and Other Professional Office Visits." For inpatient hospital care, see "Hospital – Inpatient Services."	
Laboratory, Radiology and Other Diagnostic Services		
Laboratory	Deductible, then 20% Coinsurance	Deductible, then 30% Coinsurance
Genetic testing	Deductible, then 20% Coinsurance	Deductible, then 30% Coinsurance
Radiology	Deductible, then 20% Coinsurance	Deductible, then 30% Coinsurance
Advanced radiology, including CT scans, PET scans, MRI, MRA and nuclear medicine services	Deductible, then 20% Coinsurance	Deductible, then 30% Coinsurance
Other diagnostic services	Deductible, then 20% Coinsurance	Deductible, then 30% Coinsurance
Low Protein Foods		
	Not covered	Not covered
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.	Deductible, then 30% Coinsurance
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 when not specifically listed above, 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 physician's office or other outpatient facility	Deductible, then 20% Coinsurance	Deductible, then 30% Coinsurance
Medical drugs received in the home	Deductible, then 20% Coinsurance	Deductible, then 30% Coinsurance
Medical Formulas		
	Not covered	Not covered

Benefit	In-Network Plan Providers Member Cost Sharing	Out-of-Network Non-Plan Providers Member Cost Sharing
Mental Health and Substance Use Disorder Treatment		
Inpatient services	Deductible, then 20% Coinsurance	Deductible, then 30% Coinsurance
Intermediate services – Acute residential treatment (including detoxification), crisis stabilization and in-home family stabilization – Intensive outpatient programs, partial hospitalization and day treatment programs	Deductible, then 20% Coinsurance	Deductible, then 30% Coinsurance
Outpatient group therapy	Deductible, then $25 Copayment per visit	Deductible, then 30% Coinsurance
Outpatient individual therapy	Deductible, then $25 Copayment per visit	Deductible, then 30% Coinsurance
Outpatient treatment, including outpatient detoxification and medication management	Deductible, then Level 1: $25 Copayment per visit	Deductible, then 30% Coinsurance
Outpatient methadone maintenance	Deductible, then Level 1: $25 Copayment per week	Deductible, then 30% Coinsurance
Outpatient psychological testing and neuropsychological assessment	Deductible, then 20% Coinsurance	Deductible, then 30% Coinsurance
Observation Services		
	Deductible, then 20% Coinsurance	Same as In-Network
Ostomy Supplies		
	Deductible, then 20% Coinsurance	Deductible, then 30% Coinsurance
Physician and Other Professional Office Visits (This includes all covered Plan Providers unless otherwise listed in this Schedule of Benefits.)		
Routine examinations for preventive care, including immunizations	No charge	Deductible, then 30% 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, 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	Deductible, then Level 1: $25 Copayment per visit Level 2: $50 Copayment per visit	Deductible, then 30% Coinsurance
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		

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Benefit	In-Network Plan Providers Member Cost Sharing	Out-of-Network Non-Plan Providers Member Cost Sharing
Physician and Other Professional Office Visits (This includes all covered Plan Providers unless otherwise listed in this Schedule of Benefits.) (Continued)		
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, pregnancy testing, and surgical procedures	Deductible, then 20% Coinsurance	Deductible, then 30% Coinsurance
Administration of allergy injections	Deductible, then $50 Copayment per visit	Deductible, then 30% Coinsurance
Preventive Services and Tests		
	No charge	Deductible, then 30% Coinsurance
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.		
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	Deductible, then 30% Coinsurance
Prosthetic Devices		
	Deductible, then 20% Coinsurance	Deductible, then 30% Coinsurance
Rehabilitation and Habilitation Services - Outpatient		
Cardiac rehabilitation	Deductible, then Level 2: $50 Copayment per visit	Deductible, then 30% Coinsurance
Pulmonary rehabilitation therapy	Deductible, then Level 2: $50 Copayment per visit	Deductible, then 30% Coinsurance
Physical therapies, occupational therapies and speech-language and hearing services – combined up to 60 visits per Calendar Year	Deductible, then Level 2: $50 Copayment per visit	Deductible, then 30% Coinsurance
Outpatient physical and occupational therapy is not subject to the limit listed above and is covered to the extent Medically Necessary for: (1) children under the age of three and (2) the treatment of Autism Spectrum Disorders.		

Benefit	In-Network Plan Providers Member Cost Sharing	Out-of-Network Non-Plan Providers Member Cost Sharing
Scopic Procedures - Outpatient Diagnostic and Therapeutic		
Colonoscopy, endoscopy and sigmoidoscopy	Deductible, then 20% Coinsurance	Deductible, then 30% Coinsurance
Spinal Manipulative Therapy (including care by a chiropractor)		
– Limited to 20 visits per Calendar Year	Deductible, then Level 2: $50 Copayment per visit	Deductible, then 30% Coinsurance
Surgery – Outpatient		
	Deductible, then 20% Coinsurance	Deductible, then 30% Coinsurance
Telemedicine		
Outpatient telemedicine services	Deductible, then $25 Copayment per visit	
Urgent Care Services		
Convenience care clinic	Deductible, then Level 1: $25 Copayment per visit	Deductible, then 30% Coinsurance
Urgent care center	Deductible, then Level 2: $50 Copayment per visit	Deductible, then 30% Coinsurance
Hospital urgent care center	Deductible, then Level 2: $50 Copayment per visit	Deductible, then 30% 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, Radiology and Other Diagnostic Services."		
Vision Services		
Routine eye examinations – limited to 1 exam per Calendar Year	No charge	Deductible, then 30% Coinsurance
Vision hardware for special conditions	Deductible, then 20% Coinsurance	Deductible, then 30% Coinsurance
Voluntary Sterilization in a Physician's Office		
	Deductible, then 20% Coinsurance	Deductible, then 30% Coinsurance
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 1 synthetic monofilament wig per Calendar Year (see the Benefit Handbook for details)	Deductible, then 20% Coinsurance	Deductible, then 30% 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) ប្រសិនជាអ្នកនិយាយភាសាខ្មែរ, យើងមានសេវាកម្មបកប្រែ ជូនលោកអ្នកដោយឥតគិតថ្លៃ។ 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, ໂດຍບໍ່ສັ້ງຄ່າ, 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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APEX PLAN INDIVIDUAL
THE HSA PPO - *MASSACHUSETTS*

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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