Schedule of Benefits

Harvard Pilgrim – BILH Basic Out-of-Area PPO
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.

This plan does not provide coverage for outpatient prescription drugs. Your coverage for prescription drugs is administered by a third party named ScriptWellRx. If you have questions regarding your pharmacy coverage, ScriptWellRx can be reached at **1-855–542–1819**.

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 to 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
- **1–888–333–4742** for Medical Drugs
- **1–800–708–4414** 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.

Medical Necessity Guidelines

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 Medical Necessity Guidelines on our website at **www.harvardpilgrim.org** or by calling the Member Services Department at **1-888-333-4742**.

Office Visit Cost Sharing Levels

Office visit cost sharing may include Copayments, Coinsurance, or Deductible amounts, as described throughout this Schedule of Benefits. There are two types of In-Network office visit cost sharing that apply to your Plan: a lower cost sharing, known as "Level 1," and a higher cost sharing known as "Level 2."

Level 1 applies to covered outpatient professional services received 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 covered outpatient professional services received from specialty care providers.

Your Plan may have other cost sharing amounts. Please see the benefit table below for specific cost sharing 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". For inpatient hospital care, see "Hospital – Inpatient Services," and for outpatient surgical procedures, please see "Surgery - Outpatient."

When you receive a service at your home (other than home health care), your Member Cost Sharing will be the same as when the service is provided in an office or facility. For example, if you have a physician visit in your home, see "Physician and Other Professional Office Visits." If you have blood drawn at home, see "Laboratory, Radiology and Other Diagnostic Services."

General Cost Sharing Features:	In-Network Member Cost Sharing:	Out-of-Network Member Cost Sharing:
Coinsurance and Copayments		
	See the benefits table below	
Deductible		
The following Deductibles apply to all eligible medical expenses except where specifically noted below.	$1,500 per Member per Calendar Year $3,000 per family per Calendar Year	$4,000 per Member per Calendar Year $8,000 per family per Calendar Year
Any eligible medical expenses you incur toward the In-Network Deductible in a Calendar Year applies to both the In-Network and the Out-of-Network Deductibles. Likewise, any eligible medical expenses you incur toward the Out-of-Network Deductible in a Calendar Year applies to both the In-Network and the Out-of-Network Deductibles.		
Out-of-Pocket Maximum		
Includes all Member Cost Sharing except: – Charges for prescription drugs. – Any charges above the Allowed Amount and any penalty for failure to receive Prior Approval when using Non-Plan Providers	$7,000 per Member per Calendar Year $14,000 per family per Calendar Year	
Out-of-Network Penalty Payment		
Applies when the Member fails to obtain required Prior Approval for services from a Non-Plan Provider. Does not count toward the Deductible or Out-of-Pocket Maximum	$500	
Deductible Rollover		
None		

Benefit	In-Network Plan Providers Member Cost Sharing	Out-of-Network Non-Plan Providers Member Cost Sharing
Acupuncture Treatment		
– Limited to 20 visits per Calendar Year	$60 Copayment per visit	Deductible, then 40% Coinsurance
Ambulance and Medical Transport		
Emergency ambulance transport	Deductible, then 20% Coinsurance	Same as In-Network
Non-emergency air ambulance transport	Deductible, then 20% Coinsurance	Same as In-Network
Non-emergency medical transport	Deductible, then 20% Coinsurance	Deductible, then 40% Coinsurance
Autism Spectrum Disorders Treatment		
Applied behavior analysis	No charge	Deductible, then 40% Coinsurance
Chemotherapy and Radiation Therapy		
	Deductible, then 20% Coinsurance	Deductible, then 40% Coinsurance
COVID-19 Services		
COVID-19 Testing	No charge	No charge
COVID-19 testing is covered without the use of Prior Approval processes when Medically Necessary and provided by either Plan or Non-Plan Providers.		
COVID-19 Treatment	No charge	No charge
COVID-19 treatment is covered without the use of Prior Approval processes when Medically Necessary and provided by either Plan or Non-Plan Providers.		
COVID-19 Vaccines	No charge	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)	Deductible, then 20% Coinsurance	Deductible, then 40% Coinsurance
Pediatric dental care for children (up to the age of 13) – limited to 2 preventive dental exams per Calendar Year.	$30 Copayment per visit	Deductible, then 40% Coinsurance
Dialysis		
	Deductible, then 20% Coinsurance	Deductible, then 40% Coinsurance
Durable Medical Equipment		
Durable medical equipment	No charge	Deductible, then 40% Coinsurance
Blood glucose monitors, infusion devices and insulin pumps (including supplies)	No charge	Deductible, then 40% Coinsurance
Oxygen and respiratory equipment	No charge	Deductible, then 40% Coinsurance

Benefit	In-Network Plan Providers Member Cost Sharing	Out-of-Network Non-Plan Providers Member Cost Sharing
Early Intervention Services		
	No charge	Deductible, then 40% 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		
	$200 Copayment per visit	Same as In-Network
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.		
Fertility Services (See the Benefit Handbook for details)		
	Deductible, then 20% Coinsurance	Deductible, then 40% Coinsurance
Gender Affirming Services		
	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 a service provided in an outpatient surgical center, see "Surgery–Outpatient." For services provided in a physician's office, see "Physician and Other Professional Office Visits." For inpatient hospital care, see "Hospital – Inpatient Services."	
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	No charge	Deductible, then 40% Coinsurance
Home Health Care		
	No charge	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		
	No charge	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	Deductible, then 40% Coinsurance
Inpatient rehabilitation – limited to 60 days per Calendar Year	Deductible, then 20% Coinsurance	Deductible, then 40% Coinsurance
Skilled nursing facility – limited to 100 days per Calendar Year	Deductible, then 20% Coinsurance	Deductible, then 40% Coinsurance

Benefit	In-Network Plan Providers Member Cost Sharing	Out-of-Network Non-Plan Providers Member Cost Sharing
Infertility Treatment (see the Benefit Handbook for details)		
	Deductible, then 20% Coinsurance	Deductible, then 40% Coinsurance
Laboratory, Radiology and Other Diagnostic Services		
Laboratory	$60 Copayment per visit	Deductible, then 40% Coinsurance
Genetic testing	$60 Copayment per visit	Deductible, then 40% Coinsurance
Radiology	$60 Copayment per visit	Deductible, then 40% Coinsurance
Advanced radiology, including CT scans, PET scans, MRI, MRA and nuclear medicine services	$60 Copayment per visit	Deductible, then 40% Coinsurance
Other diagnostic services	$60 Copayment per visit	Deductible, then 40% Coinsurance
Low Protein Foods		
– Limited to $5,000 per Calendar Year	Deductible, then 20% Coinsurance	Deductible, then 40% Coinsurance
Maternity Care - Outpatient		
Childbirth classes	Harvard Pilgrim will reimburse you up to $150 annually for a childbirth class taken at any Harvard Pilgrim Health Care affiliated provider. Just send a copy of your receipt and completion certificate to: Harvard Pilgrim Health Care P.O. Box 9185 Quincy, MA 02269	
Routine outpatient prenatal and postpartum care	No charge	Deductible, then 40% Coinsurance
Please Note: Routine prenatal and postpartum care is usually received and billed from the same Provider as a single or bundled service. Different Member Cost Sharing may apply to any specialized or non-routine service that is billed separately from your routine outpatient prenatal and postpartum care. For example, 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	No charge	Deductible, then 40% Coinsurance
Medical drugs received in the home	No charge	Deductible, then 40% Coinsurance
Please Note: Your Employer Group also provides a separate outpatient prescription drug plan through ScriptWellRx. That benefit provides coverage for most prescription drugs purchased at an outpatient pharmacy. Some medical drugs received in a physician's office or outpatient facility may be provided under your ScriptWellRx outpatient prescription drug benefit. Please contact ScriptWellRx at **1–855–542–1819** for information on outpatient prescription drugs.		

Benefit	In-Network Plan Providers Member Cost Sharing	Out-of-Network Non-Plan Providers Member Cost Sharing
Medical Formulas		
	No charge	Deductible, then 40% Coinsurance
Mental Health and Substance Use Disorder Treatment		
Inpatient services	Deductible, then 20% Coinsurance	Deductible, then 40% Coinsurance
Intermediate care services	Deductible, then 20% Coinsurance	Deductible, then 40% Coinsurance
Annual mental health wellness examination performed by a licensed mental health professional **Please Note:** Your annual mental health wellness examination may also be provided by a PCP as part of your annual routine examination for preventive care.	No charge	Deductible, then 40% Coinsurance
Outpatient group therapy	No charge	Deductible, then 40% Coinsurance
Outpatient treatment, including individual therapy, outpatient detoxification and medication management	No charge	Deductible, then 40% Coinsurance
Outpatient methadone maintenance	No charge	Deductible, then 40% Coinsurance
Outpatient psychological testing and neuropsychological assessment	No charge	Deductible, then 40% Coinsurance
Outpatient telemedicine virtual visit – group therapy	No charge	Deductible, then 40% Coinsurance
Outpatient telemedicine virtual visit services – including individual therapy, detoxification, and medication management	No charge	Deductible, then 40% Coinsurance
Observation Services		
	Deductible, then 20% Coinsurance	Same as In-Network
Ostomy Supplies		
	No charge	Deductible, then 40% Coinsurance

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.)		
Routine examinations for preventive care, including immunizations	No charge	Deductible, then 40% 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	Level 1: $30 Copayment per visit Level 2: $60 Copayment per visit	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 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, casting, suturing and the application of dressings, genetic counseling, non-routine foot care, and surgical procedures	Deductible, then 20% Coinsurance	Deductible, then 40% Coinsurance
Administration of allergy injections	$15 Copayment per visit	Deductible, then 40% Coinsurance
Preventive Services and Tests		
	No charge	Deductible, then 40% 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.		
Prosthetic Devices		
	No charge	Deductible, then 40% Coinsurance
Rehabilitation and Habilitation Services - Outpatient		
Cardiac rehabilitation	$60 Copayment per visit	Deductible, then 40% Coinsurance
Pulmonary rehabilitation therapy	$60 Copayment per visit	Deductible, then 40% Coinsurance
Speech-language and hearing services	$60 Copayment per visit	Deductible, then 40% Coinsurance
Physical and occupational therapies – combined up to 72 visits per Calendar Year	$60 Copayment per visit	Deductible, then 40% Coinsurance

Benefit	In-Network Plan Providers Member Cost Sharing	Out-of-Network Non-Plan Providers Member Cost Sharing
Rehabilitation and Habilitation Services - Outpatient (Continued)		
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 20% Coinsurance	Deductible, then 40% Coinsurance
Spinal Manipulative Therapy (including care by a chiropractor)		
– Limited to 12 visits per Calendar Year	$60 Copayment per visit	Deductible, then 40% Coinsurance
Surgery – Outpatient		
	Deductible, then 20% Coinsurance	Deductible, then 40% Coinsurance
Telemedicine Virtual Visit Services – Outpatient		
	Level 1: $30 Copayment per visit Level 2: $60 Copayment per visit	Deductible, then 40% Coinsurance
For inpatient hospital care, see "Hospital — Inpatient Services" for cost sharing details.		
Travel Reimbursement Benefit		
	Not covered	
Urgent Care Services		
Doctor On Demand	$30 Copayment per visit	
Important Note: Doctor On Demand is a specific network of providers contracted to provide virtual Urgent Care services. For more information on Doctor On Demand, including how to access them, please visit our website at **www.harvardpilgrim.org**.		
Convenience care clinic	$30 Copayment per visit	Deductible, then 40% Coinsurance
Urgent care center	$60 Copayment per visit	Deductible, then 40% Coinsurance
Hospital urgent care center	$60 Copayment per visit	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, Radiology and Other Diagnostic Services."		
Vision Services		
Routine eye examinations – limited to 1 exam per Calendar Year	$60 Copayment per visit	Deductible, then 40% Coinsurance
Vision hardware for special conditions	No charge	Deductible, then 40% Coinsurance
Voluntary Sterilization in a Physician's Office		
	Deductible, then 20% Coinsurance	Deductible, then 40% Coinsurance

Benefit	In-Network Plan Providers Member Cost Sharing	Out-of-Network Non-Plan Providers Member Cost Sharing
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		
– Limited to $350 per Calendar Year (see the Benefit Handbook for details)	No charge	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 اللُّغة العربية ، خدمات المساعدة اللُّغوية متوفرة لك مجانا. ً إتصل على **1 888-333-4742**
(TTY: 711)

ខ្មែរ (Cambodian) ប្រសិនជាអ្នកនិយាយភាសាខ្មែរ, បើអ្នកនិយាយភាសាខ្មែរ, បើសេវាកម្មបកប្រែ 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 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 (including pregnancy, sexual orientation, and gender identity). HPHC does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex (including pregnancy, sexual orientation, and gender identity).

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 (including pregnancy, sexual orientation, and gender identity), you can file a grievance with: Civil Rights Compliance Officer, 1 Wellness Way, Canton, MA 02021-1166, (866) 750-2074, TTY service: 711, Fax: (617) 509-3085, Email: civil_rights@point32health.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 New England and HPHC Insurance Company.

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