City's Plan RX 0/25/40

ID: MD0000016994_A5
HMO

Schedule of Benefits

THE HARVARD PILGRIM HMO
NEW HAMPSHIRE

Coverage under this Plan is under the jurisdiction of the New Hampshire Insurance Commissioner.

IMPORTANT INFORMATION: This policy reflects the known requirements for compliance under The Affordable Care Act as passed on March 23, 2010. As additional guidance is forthcoming from the U.S. Department of Health and Human Services, and the New Hampshire Insurance Department, those changes will be incorporated into your health insurance policy.

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.

In a Medical Emergency you should go to the nearest emergency facility or call 911 or other local emergency 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 ext. 38723**.

Covered Benefits

Your Covered Benefits are administered on a Calendar Year basis. Your Member Cost Sharing will depend upon the type of service provided and the location the service is provided in, as listed in this Schedule of Benefits. For example, for services provided in a doctor's office, see "Physician and Other Professional Office Visits." For services provided in a hospital emergency room, see "Emergency Room Care," and for outpatient surgical procedures, please see "Surgery – Outpatient."

General Cost Sharing Features:	Member Cost Sharing:
Coinsurance and Copayments	
	See the benefits table below
Deductible	
	None
Deductible Rollover	
None	
Durable Medical Equipment and Prosthetic Devices Deductible	
	None
Out-of-Pocket Maximum	
Includes all Member Cost Sharing	$6,000 per Member per Calendar Year $12,000 per family per Calendar Year

EFFECTIVE DATE: 04/01/2017

General Cost Sharing Features:	Member Cost Sharing:
Prior Carrier Credit	
Your Plan has a Prior Carrier Credit for the first year of coverage toward the Deductible and Coinsurance that applies to your Out-of-Pocket Maximum. See Prior Carrier Credit in your Benefit Handbook for details.	

Benefit	Member Cost Sharing
Acupuncture Treatment for Injury or Illness	
– Limited to 20 visits per Calendar Year	$20 Copayment per visit
Ambulance Transport	
Emergency ambulance transport	No charge
Non-emergency ambulance transport	No charge
Autism Spectrum Disorders Treatment	
Applied behavior analysis	Not covered
Chemotherapy and Radiation Therapy	
Chemotherapy	No charge
Radiation therapy	No charge
Chiropractic Care	
– Limited to 12 visits per Calendar Year	$20 Copayment per visit
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	Your Member Cost Sharing will depend upon the types of services 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."
Preventive dental care for children up to the age of 13 – limited to 2 preventive dental exams per Calendar Year, only the following services are included: cleaning, fluoride treatment, teaching plaque control and x-rays	No charge
Outpatient surgery expenses for dental care	Your Member Cost Sharing will depend upon the types of services provided, as listed in this Schedule of Benefits. For example, for services provided by a physician, see "Physician and Other Professional Office Visits." For day surgery, see "Surgery – Outpatient."
Dialysis	
	$20 Copayment per visit
Durable Medical Equipment	
Durable medical equipment	20% Coinsurance
Blood glucose monitors, infusion devices and insulin pumps (including supplies)	No charge
Oxygen and respiratory equipment	No charge

Benefit	Member Cost Sharing
Early Intervention	
– Limited to $3,200 per Member per Calendar Year, up to $9,600 per lifetime	No charge
Emergency Room Care	
	$50 Copayment per visit
This Copayment is waived if admitted to the hospital directly from the emergency room.	
Hearing Aids	
– Limited to $1,500 per hearing aid every 60 months, for each hearing impaired ear	No charge
Home Health Care	
	No charge
If services include the administration of drugs, please see the benefit for "Medical Drugs" for Member Cost Sharing details.	
Hospice - Outpatient	
	No charge
Hospital – Inpatient Services	
Acute hospital care	No charge
Inpatient maternity care	No charge
Inpatient routine nursery care	No charge
Inpatient rehabilitation – limited to 60 days per Calendar Year	No charge
Skilled nursing facility – limited to 100 days per Calendar Year	No charge
Infertility Services and Treatments	
Diagnostic services for infertility including: consultation, evaluation and laboratory tests	Your Member Cost Sharing will depend upon the types of services provided, as listed in this Schedule of Benefits. For example, for services provided by a physician, see "Physician and Other Professional Office Visits.
Infertility treatment (see the Benefit Handbook for details)	Not covered
Laboratory and Radiology Services	
Laboratory and x-rays	No charge
Advanced radiology, including CT scans, PET scans, MRI, MRA and nuclear medicine services	No charge
Low Protein Foods	
– Limited to $1,800 per Member per Calendar Year	No charge
Maternity Care – Outpatient	
Routine outpatient prenatal and postpartum care	No charge

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Benefit	Member Cost Sharing
Maternity Care – Outpatient (Continued)	
Routine prenatal and postpartum care is usually received and billed from the same Provider as a single or bundled service. Different Member Cost Sharing may apply to any specialized or non-routine service that is billed separately from your routine outpatient prenatal and postpartum care. For example, Member Cost Sharing for services provided by a specialist is listed under "Physician and Other Professional Office Visits" and Member Cost Sharing for an ultrasound billed as a specialized or non-routine service is listed under "Laboratory and Radiology Services."	
Medical Drugs (drugs that cannot be self-administered)	
Medical drugs received in a doctor's office or other outpatient facility	No charge
Medical drugs received in the home	No charge
Some medical drugs received in a physician's office or outpatient facility may be provided by the Specialty Pharmacy Program under your outpatient prescription drug benefit. If you have outpatient prescription drug coverage, your Member Cost Sharing will be listed on your ID Card. Please see the Prescription Drug Brochure for a detailed explanation of your benefits.	
Medical Formulas	
	No charge
Mental Health and Drug and Alcohol Rehabilitation Services	
Inpatient services	No charge
Partial hospitalization services	No charge
Outpatient group therapy	$10 Copayment per visit
Outpatient treatment including individual therapy, detoxification, and medication management	$20 Copayment per visit
Outpatient methadone maintenance	$20 Copayment per week
Outpatient psychological testing	$20 Copayment per visit
eVisits	No charge
Ostomy Supplies	
	20% 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
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 and Radiology Services" for the Member Cost Sharing that applies to diagnostic services not included on this list.	
Consultations, evaluations, sickness and injury care	$20 Copayment per visit
Office based treatment and procedures including but not limited to: casting, suturing and the application of dressings, non-routine foot care, and surgical procedures	No charge
Administration of allergy injections	$5 Copayment per visit
eVisits	No charge

Benefit	Member Cost Sharing
Preventive Services and Tests	
	No charge
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	
	20% Coinsurance
Rehabilitation and Habilitation Services – Outpatient	
Cardiac rehabilitation Pulmonary rehabilitation therapy	$20 Copayment per visit
Occupational, physical and speech therapy – limited to 40 visits combined per Calendar Year	$20 Copayment per visit
Please Note: Outpatient physical, occupational and speech therapies are covered without limits to the extent Medically Necessary for children under the age of three.	
Scopic Procedures - Outpatient Diagnostic and Therapeutic	
Endoscopy and sigmoidoscopy	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 "Physician and Other Professional Office Visits." For inpatient hospital care, see "Hospital – Inpatient Services."
Colonoscopy	No charge
Surgery – Outpatient	
	No charge
Telemedicine	
Outpatient and inpatient telemedicine services	Your Member Cost Sharing will depend upon the types of services provided, as listed in this Schedule of Benefits. For example, for services provided by a physician, see "Physician and Other Professional Office Visits." For inpatient hospital care, see "Hospital – Inpatient Services."
Urgent Care Services	
Convenience care clinic	$20 Copayment per visit
Urgent care clinic	$20 Copayment per visit
Hospital urgent care clinic	$25 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 and Radiology Services."	
Vision Services	
Routine eye examinations – limited to 1 exam per Calendar Year	$20 Copayment per visit
Vision hardware for special conditions	No charge
Voluntary Sterilization – in a Physician's Office	
	$20 Copayment per visit

Benefit	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 as required by law	
See the Benefit Handbook for details	20% 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)
انتباه: إذا كنت تتكلم اللغة العربية، خدمات المساعدة اللغوية متوفرة لك مجانًا. اتصل على 1-888-333-4742
(TTY: 711)

ខ្មែរ (Cambodian) ប្រសិនបើអ្នកនិយាយភាសាខ្មែរ, សេវាកម្មបកប្រែ ជូនលោកអ្នកដោយ គិតឥតគិតថ្លៃ។ ចូរ ទូរស័ព្ទ 1-888-333-4742 (TTY: 711)។

Français (French) ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-888-333-4742 (ATS: 711).

Italiano (Italian) ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-888-333-4742 (TTY: 711).

한국어 (Korean) '알림': 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-888-333-4742 (TTY: 711) 번으로 전화해 주십시오.

ελληνικά (Greek) ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, υπάρχουν στη διάθεσή σας δωρεάν υπηρεσίες γλωσσικής υποστήριξης. Καλέστε 1-888-333-4742 (TTY: 711).

Polski (Polish) UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-888-333-4742 (TTY: 711).

हिंदी (Hindi) ध्यान दीजिए: अगर आप हिंदी बोलते हैं तो आपके लिये भाषाकी सहायता मुफ्त में उपलब्ध है. जानकारी के लिये फोन करे. 1-888-333-4742 (TTY: 711)

ગુજરાતી (Gujarati) ધ્યાન આપો : જો તમે ગુજરાતી બોલતા હો તો આપને માટે ભાષાકીય સહાય તદ્દન મફત ઉપલબ્ધ છે. વિશેષ માહિતી માટે ફોન કરો. 1-888-333-4742 (TTY: 711)

ພາສາລາວ (Lao) ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທ 1-888-333-4742 (TTY: 711).

ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call 1-888-333-4742 (TTY: 711).

Harvard Pilgrim Health Care includes Harvard Pilgrim Health Care, Harvard Pilgrim Health Care of Connecticut, Harvard Pilgrim Health Care of New England and HPHC Insurance Company.

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General Notice About Nondiscrimination and Accessibility Requirements

Harvard Pilgrim Health Care and its affiliates as noted below ("HPHC") comply with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. HPHC does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

HPHC:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, audio, other formats)
- Provides free language services to people whose primary language is not English, such as qualified interpreters.

If you need these services, contact our Civil Rights Compliance Officer.

If you believe that HPHC has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with: Civil Rights Compliance Officer, 93 Worcester St, Wellesley, MA 02481, (866) 750-2074, TTY service: 711, Fax: (617) 509-3085, Email: civil_rights@harvardpilgrim.org. You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, the Civil Rights Compliance Officer is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
(800) 368-1019, (800) 537-7697 (TTY)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

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