

## Option 1 RX 0/20/30

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](http://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

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General Cost Sharing Features:	Member Cost Sharing:
<b>Prior Carrier Credit</b>	
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
<b>Acupuncture Treatment for Injury or Illness</b>	
– Limited to 20 visits per Calendar Year	\$20 Copayment per visit
<b>Ambulance Transport</b>	
Emergency ambulance transport	No charge
Non-emergency ambulance transport	No charge
<b>Autism Spectrum Disorders Treatment</b>	
Applied behavior analysis	Not covered
<b>Chemotherapy and Radiation Therapy</b>	
Chemotherapy	No charge
Radiation therapy	No charge
<b>Chiropractic Care</b>	
– Limited to 12 visits per Calendar Year	\$20 Copayment per visit
<b>Dental Services</b>	
<b>Important Notice:</b> 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."
<b>Dialysis</b>	
	\$20 Copayment per visit
<b>Durable Medical Equipment</b>	
Durable medical equipment	20% Coinsurance
Blood glucose monitors, infusion devices and insulin pumps (including supplies)	No charge
Oxygen and respiratory equipment	No charge

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<b>Benefit</b>		<b>Member Cost Sharing</b>	
<b>Early Intervention</b>			
– Limited to \$3,200 per Member per Calendar Year, up to \$9,600 per lifetime		No charge	
<b>Emergency Room Care</b>			
		\$50 Copayment per visit	
This Copayment is waived if admitted to the hospital directly from the emergency room.			
<b>Hearing Aids</b>			
– Limited to \$1,500 per hearing aid every 60 months, for each hearing impaired ear		No charge	
<b>Home Health Care</b>			
		No charge	
If services include the administration of drugs, please see the benefit for “Medical Drugs” for Member Cost Sharing details.			
<b>Hospice - Outpatient</b>			
		No charge	
<b>Hospital – Inpatient Services</b>			
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	
<b>Infertility Services and Treatments</b>			
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	
<b>Laboratory and Radiology Services</b>			
Laboratory and x-rays		No charge	
Advanced radiology, including CT scans, PET scans, MRI, MRA and nuclear medicine services		No charge	
<b>Low Protein Foods</b>			
– Limited to \$1,800 per Member per Calendar Year		No charge	
<b>Maternity Care – Outpatient</b>			
Routine outpatient prenatal and postpartum care		No charge	

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<b>Benefit</b>		<b>Member Cost Sharing</b>
<b>Maternity Care – Outpatient (Continued)</b>		
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.”		
<b>Medical Drugs (drugs that cannot be self-administered)</b>		
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.		
<b>Medical Formulas</b>		
	No charge	
<b>Mental Health and Drug and Alcohol Rehabilitation Services</b>		
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	
<b>Ostomy Supplies</b>		
	20% Coinsurance	
<b>Physician and Other Professional Office Visits (This includes all covered Plan Providers unless otherwise listed in this Schedule of Benefits)</b>		
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 <a href="http://www.harvardpilgrim.org">www.harvardpilgrim.org</a> . 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	

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Benefit	Member Cost Sharing
<b>Preventive Services and Tests</b>	
	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 <a href="http://www.harvardpilgrim.org">www.harvardpilgrim.org</a> . You may also get a copy of the Preventive Services Notice by calling the Member Services Department at <b>1-888-333-4742</b> . Harvard Pilgrim will add or delete services from this benefit for preventive services and tests in accordance with Federal guidance.	
<b>Prosthetic Devices</b>	
	20% Coinsurance
<b>Rehabilitation and Habilitation Services – Outpatient</b>	
Cardiac rehabilitation	\$20 Copayment per visit
Pulmonary rehabilitation therapy	\$20 Copayment per visit
Occupational, physical and speech therapy – limited to 40 visits combined per Calendar Year	\$20 Copayment per visit
<b>Please Note:</b> Outpatient physical, occupational and speech therapies are covered without limits to the extent Medically Necessary for children under the age of three.	
<b>Scopic Procedures - Outpatient Diagnostic and Therapeutic</b>	
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
<b>Surgery – Outpatient</b>	
	No charge
<b>Telemedicine</b>	
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."
<b>Urgent Care Services</b>	
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."	
<b>Vision Services</b>	
Routine eye examinations – limited to 1 exam per Calendar Year	\$20 Copayment per visit
Vision hardware for special conditions	No charge
<b>Voluntary Sterilization – in a Physician's Office</b>	
	\$20 Copayment per visit

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Benefit	Member Cost Sharing
<b>Voluntary Termination of Pregnancy</b>	
	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."
<b>Wigs and Scalp Hair Protheses as required by law</b>	
See the Benefit Handbook for details	20% Coinsurance



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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](mailto: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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