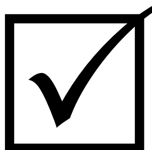
Schedule of Benefits

Complete HMO HSA 2500

For Individuals and Small Group Employers



This health plan meets Minimum Creditable Coverage standards and will satisfy the individual mandate that you have health insurance. Please see the last page for additional information.

Schedule of Benefits

This Schedule of Benefits is a general description of your coverage as a member of AllWays Health Partners. For more information about your benefits, log into www.allwaysmember.org to see your plan documents and get personalized information about your plan or call AllWays Health Partners Customer Service at 866-414-5533 (TTY 711).

All covered services must be medically necessary and some may require prior authorization. Please check with your PCP or treating provider to determine if a prior authorization is necessary. The AllWays Health Partners Member Handbook may include additional coverage and/or exclusions not listed on the Schedule of Benefits.

DEDUCTIBLE AND OUT-OF-POCKET MAXIMUM

Deductible per benefit period	**Medical/Dental/Vision/Behavioral Health/Prescription Drug (Combined): $2,500 Individual/$5,000 Family**

With family coverage, the individual deductible does not apply. The entire family deductible must be met before benefits are payable for anyone in the family. Deductible doesn't apply to preventive services.

Out-of-Pocket Maximum per benefit period	**Medical/Dental/Vision/Behavioral Health/Prescription Drug (Combined): $6,750 Individual/$13,500 Family**

With family coverage, the family out-of-pocket maximum is satisfied by combining the deductibles, coinsurance, and copayment amounts paid by covered family members. A covered member will not exceed the Individual maximum out-of-pocket amount.

The Deductible, Coinsurance and Copayments for Medical, Dental, Vision, Behavioral Health, and Prescription Drugs apply to the annual Out-of-Pocket Maximum. This Schedule of Benefits and the AllWays Health Partners Member Handbook comprise the Evidence of Coverage for AllWays Health Partners members covered on this health plan.

OUTPATIENT MEDICAL CARE

Preventive Services

Annual Physical Exams[1]	No Member Cost-Sharing
Annual Gynecological Exams[1]	No Member Cost-Sharing
Family Planning Services	No Member Cost-Sharing
Immunizations & Vaccinations	No Member Cost-Sharing
Preventive Laboratory Tests	No Member Cost-Sharing
Screening Colonoscopy	No Member Cost-Sharing
Screening Mammography	No Member Cost-Sharing
Well Child Visits	No Member Cost-Sharing

[1] Services for specific conditions during an annual exam may be subject to cost sharing.

Other Primary & Specialty Care Office Visits

Office Visits for Other Primary Care	Subject to deductible, then $30 copayment
Office Visits for Other Specialty Care	Subject to deductible, then $45 copayment
Allergy Shots	Subject to deductible
Cardiac Rehabilitation Service	Subject to deductible, then $45 copayment
Chiropractic Care	Subject to deductible, then $30 copayment

Other Primary & Specialty Care Office Visits **(cont.)**

Routine Adult Eye Exam (one visit per member age 19 and over, every 12 months)	Subject to deductible, then $45 copayment
Hearing Exams	Subject to deductible, then $45 copayment
Infertility Services	Subject to deductible, then $45 copayment
Physical Therapy/Occupational Therapy (up to 120 combined visits per benefit period)[2]	Subject to deductible, then $45 copayment
Speech Therapy	Subject to deductible, then $45 copayment
Routine Prenatal and Postnatal Care	Subject to deductible

[2] No benefit limit when covered services are furnished to treat autism spectrum disorders.

Other Outpatient Services

Diagnostic, Imaging and X-ray	Subject to deductible
Laboratory	Subject to deductible
High-tech Radiology (MRI, CT, PET Scan, Nuclear Cardiac Imaging)	Subject to deductible
Outpatient Surgery—Facility Fee	Subject to deductible, then $250 copayment
Outpatient Surgery—Professional Fee	Subject to deductible

INPATIENT MEDICAL CARE

Inpatient Medical Services (Including Maternity)—Facility Fee	Subject to deductible, then $500 copayment per admission
Inpatient Medical Services—Professional Fee	Subject to deductible
Inpatient Care in a Skilled Nursing Facility (for up to 100 days per benefit period) —Facility Fee	Subject to deductible, then $500 copayment per admission
Inpatient Care in a Skilled Nursing Facility—Professional Fee	Subject to deductible
Inpatient Care in a Rehabilitation Facility (for up to 60 days per benefit period) —Facility Fee	Subject to deductible, then $500 copayment per admission
Inpatient Care in a Rehabilitation Facility—Professional Fee	Subject to deductible
Routine Nursery and Newborn Care	No Member Cost-Sharing

BEHAVIORAL HEALTH—OUTPATIENT

Mental Health Care or Substance Use Care	Subject to deductible, then $30 copayment

BEHAVIORAL HEALTH—INPATIENT

Mental Health Care—Facility Fee	Subject to deductible, then $500 copayment per admission
Mental Health Care—Professional Fee	Subject to deductible
Substance Use Detoxification or Rehabilitation—Facility Fee	Subject to deductible, then $500 copayment per admission
Substance Use Detoxification or Rehabilitation—Professional Fee	Subject to deductible

URGENT CARE

Care for an illness, injury, or condition serious enough that a person would seek immediate care, but not so severe as to require Emergency room care.

Urgent Care	Subject to deductible, then $45 copayment

EMERGENCY CARE

If you require emergency medical care, go to the nearest emergency room or call 911. You or a family member should notify your PCP within 48 hours of an emergency visit.

Care you receive in an emergency room, in or out of AllWays Health Partners Service Area	Subject to deductible, then $250 copayment (copayment waived if admitted to hospital for inpatient care)
Ambulance Services (emergency transport only)	Subject to deductible
Emergency Dental Care (within 72 hours of accident or injury)	Subject to deductible, then $250 copayment (copayment waived if admitted to hospital for inpatient care)

PEDIATRIC DENTAL and VISION CARE BENEFITS[3]

Dental

Preventive and Diagnostic (oral exams, X-rays, cleanings)	Subject to deductible
Basic Restorative (fillings, root canal, treatment)	Subject to deductible, then 25% coinsurance
Major Restorative (dentures, crowns)	Subject to deductible, then 50% coinsurance
Orthodontic Services (medically necessary)	Subject to deductible, then 50% coinsurance

Vision

Routine Eye Exams (once every 12 months)	Subject to deductible
Frames and Lenses (provider designated frames and lenses)	Subject to deductible

[3] This policy does include coverage of pediatric dental and vision services for children up to age 19 as required under the Federal Patient Protection and Affordable Care Act. Please see the sections later in this Schedule of Benefits for additional coverage information.

PRESCRIPTION DRUGS (6-Tier)

With a valid prescription and purchased at a participating pharmacy for up to a 30-day supply	Low-Cost Generic: Subject to deductible, then $5 copayment Generic: Subject to deductible, then $30 copayment Preferred brand-name: Subject to deductible, then $60 copayment Non-preferred brand-name: Subject to deductible, then $100 copayment Preferred Specialty: Subject to deductible, then $125 copayment Non-preferred Specialty: Subject to deductible, then $175 copayment
Access90: With a valid prescription for a 90-day supply of a maintenance medication and purchased through the mail or at a participating pharmacy	Low-Cost Generic: Subject to deductible, then $10 copayment Generic: Subject to deductible, then $60 copayment Preferred brand-name: Subject to deductible, then $120 copayment Non-preferred brand-name: Subject to deductible, then $300 copayment

OVER-THE-COUNTER DRUGS

For a complete list of over-the-counter drugs, visit www.allwayshealthpartners.org or call AllWays Health Partners Customer Service at 1-866-414-5533 (TTY 711).

Select over-the-counter medicines and products with a valid prescription and purchased at a participating pharmacy.	$0- Subject to deductible, then $60 copayment (depending on drug prescribed)

ADDITIONAL SERVICES

Diabetic Supplies	Subject to deductible
Disposable Medical Supplies	Subject to deductible
Durable Medical Equipment	Subject to deductible, then 20% coinsurance
Early Intervention (from birth up to age three)	Subject to deductible
Fitness Program Benefit	Coverage for one month of membership fees (minimum of $150) per calendar year at a qualified health club for either a covered Subscriber or one covered Dependent (see www.allwayshealthpartners.org for qualifications)
Hearing Aids (age 21 and under)	Subject to deductible, then covered up to $2,000 for each affected ear every 36 months
Home Health Care	Subject to deductible
Hospice Care	Subject to deductible
Oxygen Supplies and Therapy	Subject to deductible
Routine Foot Care (covered for diabetes and some circulatory diseases)	Subject to deductible, then $45 copayment
Weight Loss Program Benefit	Coverage for six months of membership fees per calendar year in a Jenny Craig or Weight Watchers program for either a covered Subscriber or one covered Dependent (see www.allwayshealthpartners.org for qualifications)
Wigs (when medically necessary for hair loss due to cancer treatment or other conditions)	Subject to deductible, then 20% coinsurance

ABOUT YOUR ALLWAYS HEALTH PARTNERS MEMBERSHIP

For questions or concerns about your AllWays Health Partners coverage, call AllWays Health Partners Customer Service at 1-866-414-5533 (TTY 711). Representatives are available Monday through Friday, 8:00 a.m.–6:00 p.m. (Thursday 8:00 a.m.–8:00 p.m.)

Benefit Period

If you have non-group coverage, your benefit period resets on January 1. If you are enrolled through employer sponsored group coverage, your benefit period resets on your employer's anniversary date.

Copayments, Coinsurance, or Deductibles Required for Certain Services

Before coverage begins for certain services, you pay a deductible each benefit period. Your plan deductible is an amount you pay for certain services each year before AllWays Health Partners starts to pay for those certain covered services.

Your Health Savings Account (HSA) Compatible plan uses an Aggregate Deductible and Embedded Out-of- Pocket Maximum.

If you have individual coverage, you only need to satisfy the individual deductible and out-of-pocket maximum amounts. Family amounts do not apply to you. If you have family coverage, the individual deductible does not apply. Your entire family deductible must be met before benefits are payable for anyone in the family. With family coverage, the family out-of-pocket maximum is satisfied by combining the deductibles, coinsurance, and copayment amounts paid by covered family members.

A covered member will not exceed the Individual out-of-pocket maximum before the plan starts to pay 100% for covered services.

As a reminder, under HSA-compatible plans, all covered services except covered preventive services apply toward satisfaction of the deductible.

Your Primary Care Provider (PCP)

Your PCP arranges your health care and is the first person you call when you need medical care. Be sure to check with your PCP to find out office hours and whether urgent care is offered.

AllWays Health Partners requires the designation of a PCP. You have the right to designate any PCP who participates in our network and who is available to accept you or your family members. For children, you may designate a pediatrician as the PCP.

For information on how to select a PCP, or a list of the most up-to date provider information, or a list of participating health care professionals who specialize in obstetrics or gynecology, visit www.allwayshealthpartners.org or call AllWays Health Partners Customer Service.

Preventive Care Services

AllWays Health Partners covers eligible preventive services for adults, women (including pregnant women) and children, which includes coverage for annual physical exams, immunizations, well child visits and annual gynecological exams. For a complete list of eligible preventive care services, please visit www.allwayshealthpartners.org or call AllWays Health Partners Customer Service.

Primary Care Provider (PCP) and Obstetrical Rights

You do not need prior authorization from AllWays Health Partners or from any other person (including a PCP) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. However, the health care professional may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals.

Urgent Care

If you need urgent care, call your PCP to arrange where you will receive treatment. Examples of conditions requiring urgent care include, but are not limited to, fever, sore throat or an earache.

Emergency Care

In an emergency, go to the nearest emergency facility, or call 911. Please refer to this Schedule of Benefits for your cost sharing amount. All follow-up care must be arranged by your PCP.

Referrals
AllWays Health Partners requires referral for specialist services provided by in-network AllWays Health Partners Providers, except the following: Gynecologist or Obstetrician for routine, preventive or urgent care; Family Planning services; Outpatient and Diversionary Behavioral Health Services; Physical Therapy; Occupational Therapy; Speech Therapy; Routine Eye exam; and Emergency Services.

Utilization Review Program
The Utilization Review standards AllWays Health Partners uses were created to assure our members consistently receive high quality, appropriate medical care. To determine coverage, specific criteria are used to make Utilization Review decisions. These criteria are developed by physicians and meet the standards of national accreditation organizations. As new treatments and technologies become available, we update our Utilization Review standards annually.

To make utilization decisions AllWays Health Partners conducts prospective, concurrent, and retrospective reviews of the health care services our members use.

Initial Determination *(Prospective Review or Prior Authorization)*
Determines in advance if a procedure or treatment either you or your doctor is requesting is both medically appropriate and medically necessary.

Concurrent Review
During the course of treatment, such as hospitalization, concurrent review monitors the progress of treatment and determines for how long it will be deemed medically necessary.

Retrospective Review
After care has been provided, AllWays Health Partners reviews treatment outcomes to ensure that the health care services provided to you met certain quality standards.

Care Management
When members have a severe or chronic illness or condition, they may qualify for Care Management. AllWays Health Partners' care managers work one-on-one with members and their providers to find the most appropriate and cost-effective ways to manage a condition. Together, a treatment plan that best meets the member's needs is developed with the goal of promoting patient education, self-care, and providing access to the right kinds of health care services and options.

To learn more about Utilization Review or Care Management at AllWays Health Partners, please refer to your AllWays Health Partners Member Handbook or call AllWays Health Partners Customer Service.

Benefit Exclusions
Services or supplies that AllWays Health Partners does not cover include: Acupuncture; Benefits from other sources; Diet foods; Educational testing and evaluations; Massage therapy; Out-of-network providers; Non-emergency care when traveling outside the U.S.

Additional benefit exclusions apply, for a complete list please refer to your plan's Benefit Handbook.

Pediatric Dental Care Benefits

Members up to age 19 (through the end of the month the member turns 19 years of age) are eligible for the coverage below, when provided by an in-network Dental Provider. You must always verify the participation status of a Dental Provider prior to seeking services.

How to find a Dental Care Provider:

To find a participating provider, go to www.allwayshealthpartners.org or call Delta Dental Customer Services at 1-855-264-7898 (TTY 711).

Preventive and Diagnostic (oral exams, X-rays, cleanings)	
Topical fluoride treatment (one per 90 days)	Subject to deductible
Periodic oral exams (2 per benefit period)	Subject to deductible
Routine cleanings (2 per benefit period)	Subject to deductible
Bitewing x-rays (2 per benefit period)	Subject to deductible
Panoramic x-rays (1 every 3 years)	Subject to deductible
Sealants (1 every 3 years)	Subject to deductible
Space maintainers	Subject to deductible
Basic Restorative (fillings, root canal treatment)	
Fillings (one per 12 months)	Subject to deductible, then 25% coinsurance
Simple tooth extractions (once per tooth)	Subject to deductible, then 25% coinsurance
Surgical extractions	Subject to deductible, then 25% coinsurance
General Anesthesia or Minor treatment for pain relief	Subject to deductible, then 25% coinsurance
Root canals (once per permanent tooth)	Subject to deductible, then 25% coinsurance
Periodontal services (limits vary)	Subject to deductible, then 25% coinsurance
Endodontic services (limits vary)	Subject to deductible, then 25% coinsurance
Repair of crowns (limits vary)	Subject to deductible, then 25% coinsurance
Palliative treatment of dental pain (limits vary)	Subject to deductible, then 25% coinsurance
Adjustment of dentures (limits vary)	Subject to deductible, then 25% coinsurance
Major Restorative (dentures, crowns)	
Dentures (one per 84 months)	Subject to deductible, then 50% coinsurance
Crowns (one per 60 months)	Subject to deductible, then 50% coinsurance
Orthodontic Services - All Orthodontic Treatment Requires Preauthorization	
Only medically necessary orthodontic treatment is covered	Subject to deductible, then 50% coinsurance

Pediatric Vision Care Benefits

Members up to age 19 (through the end of the month the member turns 19 years of age) are eligible for the coverage below, when provided by an in-network vision provider.

How to find a Vision Care Provider:

To find a participating provider, go to www.allwayshealthpartners.org or call EyeMed Customer Services at 1-844-201-3993 (TTY 711).

Frequency	
Examinations	Once every 12 months
Frames	Once every 12 months
Lenses or Contact Lenses	Once every 12 months
Exams	
Routine Eye Exam, with dilation as necessary	Subject to deductible
Frames	
Collection (provider designated frames)	Subject to deductible
Lenses ***Standard Plastic Lenses***	
Single Vision	Subject to deductible
Conventional (Lined) Bifocal	Subject to deductible
Conventional (Lined) Trifocal	Subject to deductible
Lenticular	Subject to deductible
Standard Progressive Lens	Subject to deductible
Additional Lens Options	
UV Treatment	Subject to deductible
Tint (Solid and Gradient)	Subject to deductible
Standard Plastic Scratch Coating	Subject to deductible
Photochromatic/ Transitions Lens	Subject to deductible
Contact Lenses	
Contact lenses (provider designated lenses)	Subject to deductible
Extended Wear Disposables	Up to 6-month supply of monthly or 2-week disposable, single vision spherical or toric contact lenses
Daily Wear/ Disposables	Up to 3-month supply of daily disposable, single vision spherical contact lenses
Conventional	1 pair from selection of provider designated contact lenses

MASSACHUSETTS REQUIREMENT TO PURCHASE HEALTH INSURANCE:

As of January 1, 2009, the Massachusetts Health Care Reform Law requires that Massachusetts residents, eighteen (18) years of age and older, must have health coverage that meets the Minimum Creditable Coverage standards set by the Commonwealth Health Insurance Connector, unless waived from the health insurance requirement based on affordability or individual hardship. For more information call the Connector at 1-877-MA-ENROLL or visit the Connector website (www.mahealthconnector.org).

This health plan meets Minimum Creditable Coverage standards that are effective January 1, 2019 as part of the Massachusetts Health Care Reform Law. If you purchase this plan, you will satisfy the statutory requirement that you have health insurance meeting these standards.

This disclosure is for minimum creditable coverage standards that are effective January 1, 2019. Because these standards may change, review your health plan material each year to determine whether your plan meets the latest standards.

If you have questions about this notice, you may contact the Division of Insurance by calling 617-521-7794 or visiting its website at www.mass.gov/doi.

This plan is underwritten by AllWays Health Partners, Inc.