Schedule of Benefits

Harvard Pilgrim Health Care, Inc.

THE HARVARD PILGRIM BEST BUY 500 HMO
MASSACHUSETTS

This Schedule of Benefits summarizes your Benefits under The Harvard Pilgrim Best Buy 500 HMO (the Plan) and states the Member Cost Sharing amounts that you must pay for Covered Benefits. However, it is only a summary of your benefits. Please see your Benefit Handbook and Prescription Drug Brochure (if you have the Plan's outpatient pharmacy coverage) for detailed information on benefits covered by the Plan and the terms and conditions of coverage.

Services are covered when Medically Necessary. Subject to the exceptions listed in the section of the Benefit Handbook titled, "How The Plan Works" all services must be (1) provided or arranged by your Primary Care Provider (PCP) and (2) provided by a Plan Provider. These requirements do not apply to care needed in a Medical Emergency.

In a Medical Emergency you should go to the nearest emergency facility or call 911 or other local emergency access number. A Referral from your PCP is not needed. Your emergency room Member Cost Sharing, including your Deductible if applicable, is listed in the tables below.

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 applicable to a service or procedure for which coverage is requested. Clinical review criteria may be obtained by calling **1-888-888-4742 ext. 38723**.

DEDUCTIBLE

A Deductible is a specific annual dollar amount that is payable by the Member for Covered Benefits received each Plan Year before any benefits subject to the Deductible are payable by the Plan. If a family Deductible applies, it is met when any combination of Members in a covered family incur expenses for services to which the Deductible applies.

Not all services under this Plan are subject to the Deductible. Deductible amounts are incurred on the date of service. Your Plan Deductible amounts are listed below.

Your Plan has both an individual Deductible and a family Deductible. However, please note that a Family Deductible only applies if you have Family coverage. Unless a family Deductible applies, you are responsible for the individual Deductible for Covered Benefits each Plan Year. If you are a Member with a family Deductible, your Deductible can be satisfied in one of two ways:

a. If a Member of a covered family meets the individual Deductible, then services for that Member that are subject to that Deductible are covered by the Plan for the remainder of the Plan Year.
b. If any number of Members in a covered family collectively meet the family Deductible, then all Members of the covered family receive coverage for services subject to that Deductible for the remainder of the Plan Year.

Once a Deductible is met, coverage by the Plan is subject to any other Member Cost Sharing that may apply.

Your Deductible applies to all services covered under the Plan except the following:

- Applied behavior analysis
- Blood glucose monitors, insulin pumps and infusion devices
- Early intervention services
- Examinations and consultations performed by physicians and podiatrists, including periodic routine exams for preventive care
- Family planning consultations and consultations concerning contraception
- Outpatient mental health care services (including the treatment of substance abuse disorders)
- Pediatric preventive Dental Care
- Preventive care and preventive services and tests, including all FDA approved contraceptive devices
- Routine prenatal and postpartum care in a physician's office
- Routine nursery charges for newborn care
- Well child care, including vision and auditory screenings

Please Note: (1) treatments and procedures by physicians and podiatrists and (2) psychological testing and neuropsychological assessment **are** subject to the Deductible.

PRESCRIPTION DRUG DEDUCTIBLE

If your Plan includes outpatient pharmacy coverage, your drug benefit may be subject to a separate Deductible. Payments made toward the prescription drug Deductible are not counted toward the Deductible amount(s) listed below. Please refer to your Prescription Drug Brochure for specific information on your prescription drug Deductible, if any.

DEDUCTIBLE AND OTHER COST SHARING

For certain services, both a Deductible and either a Copayment or Coinsurance may apply. In such cases, you must completely satisfy the Deductible before the Plan pays benefits on services subject to the Deductible. Once you have satisfied the annual Deductible, you are still responsible for any applicable Copayments or Coinsurance.

COPAYMENTS

A Copayment is a dollar amount that is payable by the Member for certain covered services. The Copayment is due at the time services are rendered or when billed by the provider. Different Copayments apply depending on the type of service, the specialty of the provider and the location of service. Your identification card contains the Copayment amounts that apply to the Plan's most frequently used services

COVERED BENEFITS

Your Covered Benefits are administered on a Plan Year basis. Your Plan Year begins on your Employer’s Anniversary Date. Please see your Benefit Handbook for more details. If you do not know your Employer’s Anniversary Date, please contact your Employer’s benefits office or call the Member Services Department at **1-888-333-4742**.

General Cost Sharing Features:	Member Cost Sharing:
Coinsurance and Copayments	
	See Covered Benefits below
Deductible	
– Applies to all services except where specifically noted below.	$500 per Member per Plan Year $1,000 per family per Plan Year
Deductible Rollover	
	None
Out-of-Pocket Maximum	
Includes all Member Cost Sharing	$6,600 per Member per Plan Year $13,200 per family per Plan Year

Benefit	Member Cost Sharing:
Acupuncture Treatment for Injury or Illness	
– Limited to 20 visits per Plan Year	$20 Copayment per visit
Ambulance Transport	
– Emergency ambulance transport	Deductible, then no charge
– Non-emergency ambulance transport	Deductible, then no charge
Autism Spectrum Disorders Treatment	
– Applied behavior analysis	$20 Copayment per visit
Chemotherapy and Radiation Therapy	
	Deductible, then no charge
Dental Services	
Important Notice: Coverage of Dental Care is very limited. Please see your Benefit Handbook for the details of your coverage.	
– Emergency Dental Care **Please Note:** Services must be received within 3 days of injury	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." For services provided in a hospital emergency room, see "Emergency Room Care."
– 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 Plan Year, only the following services are included: – Cleaning – Fluoride treatment – Teaching plaque control – X-rays	$20 Copayment per visit

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Benefit	Member Cost Sharing:
Dialysis	
– Dialysis services	Deductible, then no charge
– Installation of home equipment is covered up to $300 in a Member's lifetime.	Deductible, then no charge
Durable Medical Equipment	
– Durable medical equipment	Deductible, then no charge
– Blood glucose monitors, infusion devices and insulin pumps (including supplies)	No charge
– Oxygen and respiratory equipment	No charge
Early Intervention Services	
	No charge **Please Note:** The Plan does not cover the family participation fee required by the Massachusetts Department of Public Health.
Emergency Room Care	
	Deductible, then $100 Copayment per visit This Copayment is waived if admitted to the hospital directly from the emergency room.
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
Home Health Care	
	Deductible, then no charge
Hospice – Outpatient Services	
	Deductible, then no charge
Hospital – Inpatient Services	
– Acute hospital care	Deductible, then no charge
– Inpatient maternity care	Deductible, then no charge
– Inpatient routine nursery care, including prophylactic medication to prevent gonorrhea	No charge
– Inpatient rehabilitation – limited to 60 days per Plan Year	Deductible, then no charge
– Skilled nursing facility – limited to 100 days per Plan Year	Deductible, then no charge

Benefit	Member Cost Sharing:
Hypodermic Syringes and Needles	
	Subject to the applicable pharmacy Member Cost Sharing in your Outpatient Prescription Drug Schedule of Benefits and listed on your ID Card. If your Plan does not include coverage for outpatient prescription drugs, then coverage is subject to the lower of the pharmacy's retail price or a Copayment of $5 for Tier 1 drugs or supplies, $10 for Tier 2 drugs or supplies and $25 for Tier 3 drugs or supplies. All Copayments are based on a 30 day supply. For information on the drug tiers, please visit our website at **www.harvardpilgrim.org/members** and select **"pharmacy/drug tier look up"** or contact the Member Services Department at **1–888–333–4742**.
Infertility Services and Treatments (see the Benefit Handbook for details)	
	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."
Laboratory and Radiology Services	
– Laboratory and x-rays	Deductible, then no charge
Advanced radiology – CT scans – PET scans – MRI – MRA – Nuclear medicine services	Deductible, then no charge
Please Note: No Member Cost Sharing applies to certain preventive care services. For a list of covered preventive services, please see the Preventive Services notice at: **www.harvardpilgrim.org**.	
Low Protein Foods	
– Limited to $5,000 per Plan Year	Deductible, then no charge
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.
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, for services provided by another physician or specialist, see "Physician and Other Professional Office Visits" for your applicable Member Cost Sharing. Please see your Benefit Handbook for more information on maternity care.	
Medical Formulas	
	Deductible, then no charge

Benefit	Member Cost Sharing:
Mental Health Care (Including the Treatment of Substance Abuse Disorders)	
Inpatient Mental Health Care Services	Deductible, then no charge
Intermediate Mental Health Care Services – Acute residential treatment (including detoxification), crisis stabilization and in-home family stabilization – Intensive outpatient programs, partial hospitalization and day treatment programs	Deductible, then no charge
– Outpatient mental health care services	**Group therapy** – $10 Copayment per visit **Individual therapy** – $20 Copayment per visit
– Detoxification	$20 Copayment per visit
– Medication management	$20 Copayment per visit
– Psychological testing and neuropsychological assessment	Deductible, then no charge
Ostomy Supplies	
	Deductible, then no charge
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
– Consultations, evaluations, sickness and injury care	$20 Copayment per visit
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 – Surgical procedures	Deductible, then no charge
– Administration of allergy injections	Deductible, then no charge
Preventive Services and Tests	
Preventive care services, including all FDA approved contraceptive devices. Under the federal health care reform law, many preventive services and tests are covered with no Member Cost Sharing. For a 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**.	No charge

Benefit	Member Cost Sharing:
Preventive Services and Tests (Continued)	
Under federal law the list of preventive services and tests may change periodically based on the recommendations of the following agencies: a. Grade "A" and "B" recommendations of the United States Preventive Services Task Force; b. With respect to immunizations, the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention; and c. With respect to services for women, infants, children and adolescents, the Health Resources and Services Administration. Information on the recommendations of these agencies may be found on the web site of the U.S. Department of Health and Human Services at: **https://www.healthcare.gov/what-are-my-preventive-care-benefits/#part=1**. Harvard Pilgrim will add or delete services from this benefit for preventive services and tests in accordance with changes in the recommendations of the agencies listed above. You can find a list of the current recommendations for preventive care on Harvard Pilgrim's web site at **www.harvardpilgrim.org**.	
Additional Preventive Services and Tests – All lab handling and venipuncture charge – Alpha-fetoprotein (AFP) – Fetal ultrasound – Group B streptococcus (GBS) – Hepatitis C testing – Lead level testing – Prostate-specific antigen (PSA) screening – Routine hemoglobin tests – Routine urinalysis	No charge
Prosthetic Devices	
	Deductible, then no charge
Rehabilitation Therapy - Outpatient	
– Cardiac rehabilitation	Deductible, then no charge
– Pulmonary rehabilitation therapy	Deductible, then no charge
– Speech-language and hearing services	Deductible, then no charge
– Occupational therapy – limited to 60 visits per Plan Year – Physical therapy – limited to 60 visits per Plan Year **Please Note:** Outpatient physical and occupational therapy is covered to the extent Medically Necessary for: (1) children under the age of three and (2) the treatment of Autism Spectrum Disorders.	Deductible, then no charge

Benefit	Member Cost Sharing:
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
Please Note: No Member Cost Sharing applies to certain preventive care services. For a list of covered preventive services, please see the Preventive Services notice at: **www.harvardpilgrim.org**.	
Surgery – Outpatient	
	Deductible, then no charge
Vision Services	
– Routine eye examinations – limited to 1 exam per Plan Year	$20 Copayment per visit
– Vision hardware for special conditions (see the Benefit Handbook for details)	Deductible, then no charge
Voluntary Sterilization	
	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."
Please Note: No Member Cost Sharing applies to certain preventive care services. For a list of covered preventive services, please see the Preventive Services notice at: **www.harvardpilgrim.org**.	
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 "Physician and Other Professional Office Visits." For inpatient hospital care, see "Hospital – Inpatient Services."
Wigs and Scalp Hair Prostheses as required by law	
– Limited to $350 per Plan Year (see the Benefit Handbook for details)	Deductible, then no charge