Harvard Pilgrim Health Care

Massachusetts

Harvard Pilgrim Health Care, Inc.
The Harvard Pilgrim Best Buy HMO

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 2012-2013

Coverage for: Individual + Family | **Plan Type:** HMO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at **www.harvardpilgrim.org** or by calling **1-888-333-4742**.

Important Questions	Answers	Why this matters:
What is the overall deductible?	$2,000 per member per Plan Year / $4,000 per family per Plan Year The **deductible** applies to benefits cited in the chart starting on Page 2, for other benefits see your Plan document.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	Yes. **Prescription Drug Deductible:** $250 per member per Plan Year / $500 per family per Plan Year	You must pay all of the costs for these services up to the specific **deductible** amount before this **plan** begins to pay for these services.
Is there an out–of–pocket limit on my expenses?	Yes. $4,000 per member per Plan Year / $8,000 per family per Plan Year	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Please see your Schedule of Benefits for out-of-pocket maximum exclusions for your plan.	Even though you pay these expenses, they don't count toward the **out–of–pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the **plan** will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of preferred **providers**, see **www.harvardpilgrim.org** or call **1-888-333-4742**.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	Yes, some exceptions apply.	This plan will pay some or all of the costs to see a **specialist** for covered services but only if you have the plan's permission before you see the **specialist**.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

Questions: Call 1-888-333-4742 or visit us at **www.harvardpilgrim.org**. If you are not clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at **www.harvardpilgrim.org/fhcr** or call **1-888-333-4742** to request a copy.

- Co-payments are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- Co-insurance is your share of the costs of a covered service, calculated as a percent of the allowed amount for the service. For example, if the plan's allowed amount for an overnight hospital stay is $1,000, your co-insurance payment of 20% would be $200. This may change if you haven't met your deductible.
- The amount the plan pays for covered services is based on the allowed amount. If an out-of-network provider charges more than the allowed amount, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the allowed amount is $1,000, you may have to pay the $500 difference. (This is called balance billing.)
- This plan may encourage you to use participating providers by charging you lower deductibles, co-payments and co-insurance amounts.

Common Medical Event	Services You May Need	Participating Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 Copayment per visit	None
	Specialist visit	$20 Copayment per visit	None
	Other practitioner office visit	Deductible, then no charge	– Chiropractic Care is limited. Cost sharing may vary for certain practitioners.
	Preventive care/ screening/ immunization	No charge	None
If you have a test	Diagnostic test (x-ray, blood work)	Deductible, then no charge	None
	Imaging (CT/PET scans, MRIs)	Deductible, then no charge	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at **www.harvardpilgrim.org**.	Most generic drugs	**Retail Pharmacy Tier 1:** $5 Copayment **Retail Pharmacy Tier 2:** $20 Copayment	– Retail Pharmacy – limited to 30 day supply per refill – Mail Order Pharmacy – limited to 90 day supply per refill
	Preferred brand drugs	**Retail Pharmacy Tier 3:** Deductible, then 50% Coinsurance	Same as above.
	Non-preferred brand drugs	**Retail Pharmacy Tier 4:** Deductible, then 50% Coinsurance	Some generic drugs are in this tier. Same as above.
	Specialty drugs	All drugs are covered in Retail and Mail Order Pharmacy Tiers 1 — 4	Must be obtained through a Specialty Pharmacy.

Common Medical Event	Services You May Need	Participating Provider	Limitations & Exceptions
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Deductible, then no charge	None
	Physician/surgeon fees	Deductible, then no charge	None
If you need immediate medical attention	Emergency Room Services	Deductible, then $100 Copayment per visit This Copayment is waived if admitted to the hospital directly from the emergency room.	None
	Emergency Medical Transportation	Deductible, then no charge	None
	Urgent Care	$20 Copayment per visit	None
If you have a hospital stay	Facility fee (e.g., hospital room)	Deductible, then no charge	None
	Physician/surgeon fee	Deductible, then no charge	None
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	**Group Therapy:** $10 Copayment per visit **Individual Therapy:** $20 Copayment per visit	– In some cases, coverage may be limited to 24 visits per Plan Year for individual therapy and up to 25 visits per Plan Year for group therapy.
	Mental/Behavioral health inpatient services	Deductible, then no charge	– In some cases, coverage may be limited to 60 days per Plan Year.
	Substance use disorder outpatient services	**Group Therapy:** $10 Copayment per visit **Individual Therapy:** $20 Copayment per visit	None
	Substance use disorder inpatient services	Deductible, then no charge	None
If you are pregnant	Prenatal and postnatal care	No charge	None
	Delivery and all inpatient services	Deductible, then no charge	None

Common Medical Event	Services You May Need	Participating Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	Deductible, then no charge	None
	Rehabilitation services (Inpatient)	Deductible, then no charge	– Limited to 60 days per Plan Year
	Habilitation services (Outpatient)	Deductible, then no charge	– Physical Therapy – limited to 20 visits per Plan Year – Occupational Therapy – limited to 20 visits per Plan Year
	Skilled nursing care	Deductible, then no charge	– Limited to 100 days per Plan Year
	Durable medical equipment	Deductible, then 20% Coinsurance	– Wigs – limited to $350 per Plan Year
	Hospice service	Deductible, then no charge	If inpatient services are required, please see "If you have a hospital stay".
If your child needs dental or eye care	Eye exam	$20 Copayment per visit	– Limited to 1 exam per Plan Year You may have other coverage under a Vision Rider.
	Glasses	Not covered	You may have other coverage under a Vision Rider.
	Dental check-up – Up to the age of 13	$20 Copayment per visit	– Limited to 2 exams per Plan Year You may have other coverage under a Dental Rider.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)
• Acupuncture • Hearing Aids • Long-Term (Custodial) Care • Most Cosmetic Surgery • Most Dental Care (Adult) • Non-emergency care when traveling outside the U.S. • Private-duty nursing • Routine foot care • Weight Loss Programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)
• Bariatric Surgery • Chiropractic Care • Infertility Treatments • Routine eye care (Adult)

Your Rights to Continue Coverage:

Individual health insurance sample-

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your **premium**. There are exceptions, however, such as if:

- You commit fraud
- The insurer stops offering services in the State
- You move outside the coverage area

For more information on your rights to continue coverage, contact the insurer at **1–800–333–4742**. You may also contact your state insurance department at:
Massachusetts Division of Insurance
1000 Washington Street, Suite 810
Boston, MA 02118–6200
1-617-521-7794

OR

Group health coverage sample-

If you lose coverage under the **plan**, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the **premium** you pay while covered under the **plan**. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the **plan** at **1–800–333–4742**. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or **www.dol.gov/ebsa**, or the U.S. Department of Health and Human Services at **1-877-267-2323 x61565** or **www.cciio.cms.gov**

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your **plan**, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact:

HPHC Member Appeals Member Services Department Harvard Pilgrim Health Care, Inc.
1600 Crown Colony Drive
Quincy, MA 02169
Telephone: 1-888-333-4742
Fax: 1-617-509-3085

Department of Labor's Employee Benefits Security Administration
1-866-444-3272
www.dol.gov/ebsa/healthreform

Health Care for All
30 Winter Street, Suite 1004
Boston, MA 02108
1-800-272-4232
http://www.hcfama.org/helpline

Massachusetts Division of Insurance
1000 Washington Street, Suite 810
Boston, MA 02118–6200
1-617-521-7794

Para obtener asistencia en Español, llame al 1-888-333-4742.

如果需要中文的帮助，请拨打这个号码 1-888-333-4742.

De assistência em Português, por favor ligue 1-888-333-4742.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers: $7,540**
- **Plan pays: $5,380**
- **Patient pays: $2,160**

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$2,000
Co-pays	$10
Co-insurance	$0
Limits or exclusions	$150
Total	**$2,160**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers: $5,400**
- **Plan pays: $3,780**
- **Patient pays: $1,620**

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$140
Co-pays	$1,400
Co-insurance	$0
Limits or exclusions	$80
Total	**$1,620**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health **plan**.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any **member** covered under this **plan**.
- **Out-of-pocket** expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co-payments**, and **co-insurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✗ **No**. Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✗ **No**. Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health **plan** allows.

Can I use Coverage Examples to compare plans?

✓ **Yes**. When you look at the Summary of Benefits and Coverage for other **plans**, you'll find the same Coverage Examples. When you compare **plans**, check the "Patient Pays" box in each example. The smaller that number, the more coverage the **plan** provides.

Are there other costs I should consider when comparing plans?

✓ **Yes**. An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in **out-of-pocket** costs, such as **co-payments**, **deductibles**, and **co-insurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay **out-of-pocket** expenses.

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CODE: RW-X

Schedule of Benefits

Harvard Pilgrim Health Care, Inc.

THE HARVARD PILGRIM BEST BUY HMO 2000
MASSACHUSETTS

This Schedule of Benefits summarizes your Benefits under The Harvard Pilgrim Best Buy HMO 2000 (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.

You always have coverage for care in a Medical Emergency. A Referral from your PCP is not needed. In a Medical Emergency, you should go to the nearest emergency facility or call 911 or other local emergency number. Your emergency room Member Cost Sharing is listed below under the heading "Emergency Room Care."

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**.

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**.

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:

- Examinations and consultations performed by physicians and podiatrists, including periodic exams for adults and children
- Well child care, including vision and auditory screenings
- Family planning consultations and consultations concerning contraception
- The Preventive Care and Services as listed in the "Physician and Other Professional Office Visits" and "Preventive Services and Tests" Sections of this Schedule of Benefits
- Prenatal and postpartum care in a physician's office
- Routine nursery charges for newborn care
- Outpatient mental health care (including the treatment of substance abuse disorders)
- Pediatric preventive dental care
- Blood glucose monitors, insulin pumps and infusion devices
- Applied behavior analysis
- Spinal Manipulative Therapy (including care by a chiropractor)

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 a Copayment 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.

General Cost Sharing Features:	Member Cost Sharing:
Coinsurance and Copayments	
	See Covered Benefits below
Deductible	
The Deductible applies to all services except where specifically noted below.	$2,000 per Member per Plan Year $4,000 per family per Plan Year

General Cost Sharing Features:	Member Cost Sharing:
Out-of-Pocket Maximum	
– Includes all Member Cost Sharing except charges for prescription drugs.	$4,000 per Member per Plan Year $8,000 per family per Plan Year

Benefit	Your Cost Sharing
Ambulance Transport	
– Emergency ambulance transport	Deductible, then no charge
– Non-emergency ambulance transport	Deductible, then no charge
Autism Spectrum Disorders Treatment	
Professional Services – Coverage for the treatment of Autism Spectrum Disorders is provided for all of the services otherwise covered under your Plan. However, no benefit limit applies to services for the treatment of Autism Spectrum Disorders.	Your Member cost sharing depends upon the type of service provided, as listed in this Schedule of Benefits. For example: For services provided by a physician see "Physician and Other Professional Office Visits." For services by a Licensed Mental Health Professional see "Mental Health Care (Including the Treatment of Substance Abuse Disorders)." For services by a physical therapist and occupational therapist, see "Rehabilitation Therapy - Outpatient."
Applied Behavior Analysis – No benefit limit applies to this service.	$20 Copayment per visit The Deductible does not apply to these services.
Cardiac Rehabilitation	
	Deductible, then no charge
Chemotherapy and Radiation Therapy — Outpatient	
– Chemotherapy – Radiation therapy	Deductible, then no charge
Clinical Trials for the Treatment of Cancer	
	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."
Dental Services	
– Emergency 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 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)	$20 Copayment per visit The Deductible does not apply to pediatric preventive dental care.
Important Notice: Coverage of Dental Care is very limited. Please see your Benefit Handbook for the details of your coverage.	

Benefit	Your Cost Sharing
Diabetes Services and Supplies	
– Self management and training/diabetic eye examinations/foot care	$20 Copayment per visit The Deductible does not apply to health education, including medical nutrition therapy and diabetes education and training.
– Diabetes equipment	Deductible, then no charge Member Cost Sharing, including the Deductible, does not apply to blood glucose monitors or insulin pumps (including supplies) and infusion devices.
– Pharmacy supplies	Subject to the applicable pharmacy Member Cost Sharing listed in your Outpatient Prescription Drug Schedule of Benefits and 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**.
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	
	Deductible, then 20% Coinsurance Member Cost Sharing does not apply to the following: – Respiratory equipment – Oxygen and oxygen equipment
Early Intervention Services	
	No charge
Emergency Room Care	
	Deductible, then $100 Copayment per visit This Copayment is waived if admitted to the hospital directly from the emergency room.
Family Planning Services	
	$20 Copayment per visit The Deductible does not apply to family planning consultations and consultations concerning contraception.
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

Benefit	Your Cost Sharing
Hospice Services	
	Deductible, then no charge for outpatient services. If inpatient services are required please see "Hospital - Inpatient Services" or "Skilled Nursing Facility Care" for Member Cost Sharing details.
Hospital – Inpatient Services	
	Deductible, then no charge
House Calls	
	Deductible, then no charge
Human Organ Transplant 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."
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
High end radiology – CT scans – PET scans – MRI – MRA – Nuclear medicine services	Deductible, then no charge
No Member Cost Sharing applies to certain preventive care services. See "Preventive Services and Tests," below.	
Low Protein Foods	
– Limited to $5,000 per Plan Year	Deductible, then no charge

Benefit	Your Cost Sharing
Maternity Care	
– 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.
– Preventive services and screenings including: counseling about alcohol and tobacco use, services to promote breastfeeding, routine urinalysis and screenings for the following: asymptomatic bacteriuria; hepatitis B infection; HIV and screenings for STDs (chlamydia, gonorrhea and syphilis); iron deficiency anemia; and Rh (D) incompatibility.	No charge
Please see "Preventive Services and Tests," below, for additional services and tests covered with no Member Cost Sharing.	
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.	
– Routine nursery care for the newborn, including prophylactic medication to prevent gonorrhea and screenings for the following: hearing loss; congenital hypothyroidism; phenylketonuria (PKU); and sickle cell disease.	No charge
– Hospital inpatient services	Deductible, then no charge
Medical Formulas	
	Deductible, then no charge
Mental Health Care (Including the Treatment of Substance Abuse Disorders)	
Please Note: Your Plan is not subject to the Federal Mental Health Parity Act.	
Inpatient Mental Health Care Services – In a licensed general hospital – unlimited – In a psychiatric hospital – up to 60 days per Plan Year	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 – Up to 24 visits per Plan Year for individual therapy and up to 25	Group therapy — $10 Copayment per visit Individual therapy — $20 Copayment per visit

Benefit	Your Cost Sharing
Mental Health Care (Including the Treatment of Substance Abuse Disorders) (Continued)	
visits per Plan Year for group therapy, not to exceed a combined maximum of 25 individual and group therapy visits per Plan Year	The Deductible does not apply to these services.
– Detoxification	$20 Copayment per visit The Deductible does not apply to these services.
– Medication management	$20 Copayment per visit The Deductible does not apply to these services.
– Psychological testing and neuropsychological assessment	Deductible, then no charge
Important Notice: No day or visit limits apply to mental health care services for biologically-based mental disorders (including substance abuse disorders), rape-related mental or emotional disorders, and non-biologically-based mental, behavioral or emotional disorders for children and adolescents. (Please see your Benefit Handbook for details.)	
Ostomy Supplies	
	Deductible, then 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 – Routine physical examinations, annual gynecological examinations, school, camp, sports and premarital examinations	No charge The Deductible does not apply to these services.
No Member Cost Sharing applies to certain preventive care services. See "Preventive Services and Tests," below.	
Consultations, evaluations, sickness and injury care – Examinations for illness or injury – Medication management – Consultations and evaluations with specialists – Nutritional counseling – Consultations concerning hormone replacement therapy	$20 Copayment per visit The Deductible does not apply to these services.
Treatments and procedures, including but not limited to: – Administration of injections – Allergy treatments – Casting, suturing and the application of dressings – Pregnancy testing – Genetic counseling – Surgical procedure – Non-routine foot care	Deductible, then no charge
– Administration of allergy injections	Deductible, then no charge

<table>
<tr><th>Benefit</th><th colspan="3">Your Cost Sharing</th></tr>
<tr><td colspan="4">Preventive Services and Tests</td></tr>
<tr><td>Limited to the following select preventive laboratory and pathology tests and screenings as defined by federal law:</td><td colspan="3">No charge
The Deductible does not apply to these services.</td></tr>
<tr><td>– Abdominal aortic aneurysm screening (for males 65-75 one time only, if ever smoked)
– Alcohol misuse screening and counseling (primary care visits only)
– Aspirin for the prevention of heart disease (primary care counseling only)
– Autism screening (for children at 18 and 24 months of age – primary care visits only)
– Behavioral assessments (developmental surveillance, for children of all ages – primary care visits only)
– Blood pressure screening
– Breast cancer chemoprevention counseling (only for women at high risk for Breast Cancer and low risk for adverse effects of chemoprevention)
– Breast cancer screening, including mammograms and counseling for genetic susceptibility screening</td><td>– Cervical cancer screening, including pap smears
– Cholesterol screening (for adults only)
– Colorectal cancer screening, including colonoscopy, sigmoidoscopy and fecal occult blood test
– Dental caries prevention - oral fluoride (for children to age 5 only)
Note: Coverage for fluoride is only provided if your Plan includes outpatient pharmacy coverage.
– Depression screening (primary care visits only)
– Diabetes screenings
– Diet counseling
– Dyslipidemia screening (for children at high risk for higher lipid levels)
– Folic acid supplements (women planning or capable of pregnancy only)
Note: Coverage for folic acid is only provided if your Plan includes outpatient pharmacy coverage.
– Hemoglobin A1c
– Hepatitis B testing</td><td colspan="2">– HIV screening
– Immunizations, including flu shots (for children and adults as appropriate)
– Iron deficiency prevention (primary care counseling for children age 6 to 12 months only)
– Lead screening (for children at risk)
– Microalbuminuria test
– Obesity screening
– Osteoporosis screening (to begin at age 60 for women at increased risk)
– Ovarian cancer susceptibility screening
– Sexually transmitted diseases (STDs) – screenings and counseling
– Tobacco use counseling (primary care visits only)
– Total cholesterol tests
– Tuberculosis skin testing
– Vision screening (children to age 5 only)
Please see the Maternity Care benefit for additional services and tests covered with no Member Cost Sharing.</td></tr>
<tr><td colspan="4">Under federal law the list of preventive services and tests covered above 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 US Department of Health and Human Services at: http://www.healthcare.gov/center/regulations/prevention/recommendations.html.
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.</td></tr>
<tr><td>Additional Preventive Services and Tests
– All lab handling and venipuncture charge
– Alpha-Fetoprotein (AFP)
– Fetal ultrasound</td><td colspan="3">No charge
The Deductible does not apply to these services.</td></tr>
</table>

Benefit	Your Cost Sharing
Preventive Services and Tests (Continued)	
– Group B - Streptococcus (GBS) test – Hepatitis C testing – Lead level testing – Prostate-specific antigen (PSA) screening – Routine hemoglobin tests – Routine urinalysis	
Prosthetic Devices	
	Deductible, then 20% Coinsurance
Reconstructive Surgery	
	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."
Rehabilitation Hospital Care	
– Limited to 60 days per Plan Year	Deductible, then no charge
Rehabilitation Therapy - Outpatient	
– Pulmonary rehabilitation therapy	Deductible, then no charge
– Occupational therapy — limited to 20 visits per Plan Year – Physical therapy — limited to 20 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
Scopic Procedures - Outpatient Diagnostic and Therapeutic	
– Colonoscopy, 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."
Skilled Nursing Facility Care	
– Limited to 100 days per Plan Year	Deductible, then no charge
Speech-Language and Hearing Services	
	Deductible, then no charge
Spinal Manipulative Therapy (including care by a chiropractor)	
– Limited to 12 visits per Plan Year	$20 Copayment per visit The Deductible does not apply to spinal manipulative therapy.
Surgery — Outpatient	
	Deductible, then no charge

Benefit	Your Cost Sharing
Temporomandibular Joint Dysfunction Services (medical treatment only)	
	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."
Vision Services	
– Routine eye examinations — limited to 1 per Plan Year	$20 Copayment per visit The Deductible does not apply to routine eye examinations.
– 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."
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)	
When needed as a result of any form of cancer or leukemia, alopecia areata, alopecia totalis or permanent hair loss due to injury. – Limited to $350 per Plan Year (see the Benefit Handbook for details)	Deductible, then 20% Coinsurance

Harvard Pilgrim Health Care, Inc.
MASSACHUSETTS HMO
General List of Exclusions

The following list identifies services that are generally excluded from Harvard Pilgrim HMO Plans. Additional services may be excluded related to access or product design. For a complete list of exclusions please refer to the specific plan's Benefit Handbook.

Exclusion	Description
Alternative Treatments	
	1. Acupuncture services, except when specifically listed as a Covered Benefit. 2. Acupuncture services that are outside the scope of standard acupuncture treatment, except when specifically listed as a Covered Benefit, including services for preventive, maintenance, or wellness care, thermography, hair analysis, heavy metal screening or mineral studies, massage or soft-tissue techniques, diagnostic services, x-rays or services related to menstrual cramps. 3. Alternative, holistic or naturopathic services and all procedures, laboratories and nutritional supplements associated with such treatments. 4. Aromatherapy, treatment with crystals and alternative medicine. 5. Health resorts, spas, recreational programs, camps, wilderness programs (therapeutic outdoor programs), outdoor skills programs, relaxation or lifestyle programs, including any services provided in conjunction with, or as part of such types of programs. 6. Massage therapy. 7. Myotherapy.
Dental Services	
	1. Dental Care, except the specific dental services listed as Covered Benefits in the Plan's Benefit Handbook and Schedule of Benefits. 2. All services of a dentist for Temporomandibular Joint Dysfunction (TMD). 3. Extraction of teeth, except when specifically listed as a Covered Benefit. 4. Preventive dental care for children, except when specifically listed as a Covered Benefit. 5. Dentures.
Durable Medical Equipment and Prosthetic Devices	
	1. Any devices or special equipment needed for sports or occupational purposes. 2. Any home adaptations, including, but not limited to home improvements and home adaptation equipment. 3. Myoelectric and bionic arms and leg, except when specifically listed as a Covered Benefit. 4. Non-durable medical equipment, unless used as part of the treatment at a medical facility or as part of approved home health care services. 5. Repair or replacement of durable medical equipment or prosthetic devices as a result of loss, negligence, willful damage, or theft.

Exclusion	Description
Experimental, Unproven or Investigational Services	
	1. Any products or services, including, but not limited to, drugs, devices, treatments, procedures, and diagnostic tests that are Experimental, Unproven, or Investigational.
Foot Care	
	1. Foot orthotics, except for the treatment of severe diabetic foot disease or when specifically listed as a Covered Benefit. 2. Routine foot care. Examples include nail trimming, cutting or debriding and the cutting or removal of corns and calluses. This exclusion does not apply to preventive foot care for Members with diabetes.
Maternity Services	
	1. Delivery outside the Service Area after the 37th week of pregnancy, or after you have been told that you are at risk for early delivery. 2. Planned home births. 3. Routine pre-natal and post-partum care when you are traveling outside the Service Area.
Mental Health Care	
	1. Biofeedback. 2. Educational services or testing, except services covered under the benefit for Early Intervention Services. No benefits are provided: (1) for educational services intended to enhance educational achievement; (2) to resolve problems of school performance; or (3) to treat learning disabilities. 3. Methadone maintenance. 4. Sensory integrative praxis tests. 5. Services for any condition with only a "V Code" designation in the Diagnostic and Statistical Manual of Mental Disorders, which means that the condition is not attributable to a mental disorder. 6. Mental health care that is (1) provided to Members who are confined or committed to a jail, house of correction, prison, or custodial facility of the Department of Youth Services; or (2) provided by the Department of Mental Health. 7. Services or supplies for the diagnosis or treatment of mental health and substance abuse disorders that, in the reasonable judgment of the Behavioral Health Access Center, are any of the following: • Not consistent with prevailing national standards of clinical practice for the treatment of such conditions. • Not consistent with prevailing professional research demonstrating that the services or supplies will have a measurable and beneficial health outcome. • Typically do not result in outcomes demonstrably better than other available treatment alternatives that are less intensive or more cost effective. 8. Services related to autism spectrum disorders provided under an individualized education program (IEP), including any services provided under an IEP that are delivered by school personnel or any services provided under an IEP purchased from a contractor or vendor.

Exclusion	Description
Physical Appearance	
	1. Cosmetic Services, including drugs, devices, treatments and procedures, except for (1) Cosmetic Services that are incidental to the correction of a Physical Functional Impairment, (2) restorative surgery to repair or restore appearance damaged by an accidental injury, and (3) post-mastectomy care. 2. Hair removal or restoration, including, but not limited to, electrolysis, laser treatment, transplantation or drug therapy. 3. Liposuction or removal of fat deposits considered undesirable. 4. Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures). 5. Skin abrasion procedures performed as a treatment for acne. 6. Treatment for skin wrinkles or any treatment to improve the appearance of the skin. 7. Treatment for spider veins.
Procedures and Treatments	
	1. Care by a chiropractor outside the scope of standard chiropractic practice, including but not limited to, surgery, prescription or dispensing of drugs or medications, internal examinations, obstetrical practice, or treatment of infections and diagnostic testing for chiropractic care other than an initial X-ray. 2. Spinal manipulative therapy (including care by a chiropractor), except when specifically listed as a Covered Benefit. 3. Commercial diet plans, weight loss programs and any services in connection with such plans or programs. 4. Gender reassignment surgery and all related drugs and procedures. 5. If a service is listed as requiring that it be provided at a Center of Excellence, no coverage will be provided if that service is received from a Provider that has not been designated as a Center of Excellence. 6. Nutritional or cosmetic therapy using vitamins, minerals or elements, and other nutrition-based therapy. Examples include supplements, electrolytes, and foods of any kind (including high protein foods and low carbohydrate foods). 7. Physical examinations and testing for insurance, licensing or employment. 8. Services for Members who are donors for non-members, except as described under Human Organ Transplant Services. 9. Testing for central auditory processing. 10. Group diabetes training, educational programs or camps.

Exclusion	Description
Providers	
	1. Charges for services which were provided after the date on which your membership ends. 2. Charges for any products or services, including, but not limited to, professional fees, medical equipment, drugs, and hospital or other facility charges, that are related to any care that is not a Covered Benefit. 3. Charges for missed appointments. 4. Concierge service fees. (See the Plan's *Benefit Handbook* for more information.) 5. Follow-up care after an emergency room visit, unless provided or arranged by your PCP. 6. Inpatient charges after your hospital discharge. 7. Provider's charge to file a claim or to transcribe or copy your medical records. 8. Services or supplies provided by: (1) anyone related to you by blood, marriage or adoption, or (2) anyone who ordinarily lives with you.
Reproduction	
	1. Any form of Surrogacy or services for a gestational carrier. 2. Infertility drugs if a member is not in a Plan authorized cycle of infertility treatment. 3. Infertility drugs, if infertility services are not a Covered Benefit. 4. Infertility drugs that must be purchased at an outpatient pharmacy, unless your Plan includes outpatient pharmacy coverage. 5. Infertility treatment for Members who are not medically infertile. 6. Infertility treatment and birth control drugs, implants and devices. 7. Reversal of voluntary sterilization (including any services for infertility related to voluntary sterilization or its reversal). 8. Sperm collection, freezing and storage except as described in the Plan's *Benefit Handbook*. 9. Sperm identification when not Medically Necessary (e.g., gender identification). 10. The following fees: wait list fees, non-medical costs, shipping and handling charges etc. 11. Voluntary sterilization, including tubal ligation and vasectomy, except when specifically listed as a Covered Benefit. 12. Voluntary termination of pregnancy, unless the life of the mother is in danger or unless specifically listed as a Covered Benefit.
Services Provided Under Another Plan	
	1. Costs for any services for which you are entitled to treatment at government expense, including military service connected disabilities. 2. Costs for services for which payment is required to be made by a Workers' Compensation plan or an Employer under state or federal law.

Exclusion	Description
Types of Care	
	1. Custodial Care. 2. Rest or domiciliary care 3. All institutional charges over the semi-private room rate, except when a private room is Medically Necessary. 4. Home health care services that extend beyond care on a short-term intermittent basis. 5. Pain management programs or clinics. 6. Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, and diversion or general motivation. 7. Private duty nursing. 8. Sports medicine clinics. 9. Vocational rehabilitation, or vocational evaluations on job adaptability, job placement, or therapy to restore function for a specific occupation.
Vision and Hearing	
	1. Eyeglasses, contact lenses and fittings, except as listed in the Plan's Benefit Handbook. 2. Hearing aids for self-insured groups, except when specifically listed as a Covered Benefit. 3. Refractive eye surgery, including, but not limited to, lasik surgery, orthokeratology and lens implantation for the correction of myopia, hyperopia and astigmatism. 4. Routine eye examinations except when specifically listed as a Covered Benefit.
All Other Exclusions	
	1. Any service or supply furnished in connection with a non-Covered Benefit. 2. Beauty or barber service. 3. Any drug or other product obtained at an outpatient pharmacy, except for pharmacy supplies covered under the benefit for diabetes services and hypodermic syringes and needles, as required by law, unless your Plan includes outpatient pharmacy coverage. 4. Food or nutritional supplements, including, but not limited to, FDA-approved medical foods obtained by prescription, except as required by law. 5. Guest services. 6. Services for non-Members. 7. Services for which no charge would be made in the absence of insurance. 8. Services for which no coverage is provided in the Plan's Benefit Handbook, Schedule of Benefits or Prescription Drug Brochure. 9. Services that are not Medically Necessary. 10. Services your PCP or a Plan Provider has not provided, arranged or approved except as described in the Plan's *Benefit Handbook.*

Exclusion	Description
All Other Exclusions (Continued)	
	11. Taxes or governmental assessments on services or supplies. 12. Transportation other than by ambulance. 13. The following products and services: • Air conditioners, air purifiers and filters, dehumidifiers and humidifiers. • Car seats. • Chairs, bath chairs, feeding chairs, toddler chairs, chair lifts, recliners. • Electric scooters. • Exercise equipment. • Home modifications including but not limited to elevators, handrails and ramps. • Hot tubs, jacuzzis, saunas or whirlpools. • Mattresses. • Medical alert systems. • Motorized beds. • Pillows. • Power-operated vehicles. • Stair lifts and stair glides. • Strollers. • Safety equipment. • Vehicle modifications including but not limited to van lifts. • Telephone. • Television.