Schedule of Benefits

The Harvard Pilgrim Primary Choice℠ Plan
Massachusetts

*Services listed are covered when medically necessary and provided by Harvard Pilgrim Health Care Primary Choice Providers. Please see your Benefit Handbook for details.*

**Important information about the Primary Choice Plan**

Your PCP will provide or arrange for all the health services you need—treating you when you’re sick and administering preventive screenings, routine check-ups and immunizations. Having a PCP makes health care easier for you. Your PCP is also the key to ensuring that you get high-quality specialty care if you need it.

If you need specialty care that your PCP does not provide, your PCP will refer you to another physician or appropriate medical professional. Referrals are not necessary for some services, such as routine eye exams. Please see your Benefit Handbook for information on services that do not require a Referral. **In either case, please make sure that you receive care from a specialist who participates in the Primary Choice network.**

Similarly, if you need to be admitted to a hospital, except in a medical emergency (see below), please make sure that you are referred to a Primary Choice hospital for your hospital care.

Except in a medical emergency (including but not limited to, heart attack, stroke, choking, loss of consciousness or seizures), care you receive from non-Primary Choice Providers is not covered.

For the most up to date information on participating Primary Choice providers, use the online directory at [www.harvardpilgrim.org/gic](http://www.harvardpilgrim.org/gic) or call Member Services at 1-888-333-4742.

Another important feature of The Primary Choice Plan is that it rewards members for choosing higher-quality and more cost-efficient providers, both physicians and hospitals. We tiered physicians in specialties that:

- Members use most often
- We had the most data to measure
- Show the widest variation in the ways that doctors treat similar conditions

Harvard Pilgrim worked with the analytical tools and statistical expertise of industry leaders to “profile” participating providers in thirteen high-volume specialties in Massachusetts. The goal of this work was to compare the relative quality and cost-efficiency of doctors who are in the same specialty in treating patients with similar conditions. Based on these comparisons, specialists were grouped into three levels, known as Tier 1 Providers (Excellent), Tier 2 Providers (Good) and Tier 3 Providers (Standard).

Quality of care was evaluated based on clinical guidelines for recommended care. Cost-efficiency was evaluated by comparing many resources each specialist used to treat patients with similar conditions, adjusting for price difference from one provider to another.
The text below describes how Participating Providers are placed into the three tiers.

The “Hospital Tiering” section on page 3 describes how Participating Hospitals are tiered and the applicable cost sharing for Tier 1 and Tier 2 hospitals.

**Member Cost**
Members are required to pay part of the cost of the benefits provided under the Plan. The following is a summary of the Member Cost amounts under your Plan.

Your Plan has different **Copayments** that apply depending on the type of Provider or the type of service. These Copayments are described below.

**Office Visit Copayment**
When you have an office visit with a Primary Choice Provider, your care will be covered after you pay an office visit Copayment. The amount of your Copayment will depend upon what type of service you receive and which Provider you see.

**Tiered Providers**
The Harvard Pilgrim Primary Choice Plan rewards members with lower office visit Copayments for using high-quality, cost-efficient Massachusetts specialists. Physicians in the following 13 specialties have been rated and placed into one of three categories or “tiers.” Tier 1 Copayments are the lowest and Tier 3 Copayments are the highest.

- Allergy/Immunology
- Cardiology (medical)†, ††
- Dermatology
- Endocrinology†
- Gastroenterology
- General Surgery
- Neurology†
- Obstetrics/Gynecology‡
- Ophthalmology
- Orthopedics
- Otolaryngology (ENT)†
- Pulmonology†
- Rheumatology†

† Both quality and cost-efficiency measures were used to tier physicians in these seven specialties; if individual physicians in these specialties had insufficient quality information to measure they were evaluated only on cost-efficiency. The other six specialties did not have adequate data available to evaluate quality. Physicians in those specialties were rated only on cost-efficiency.

†† There are two types of cardiologists:
- 'non-invasive' (also called, 'medical') Cardiologists
- 'invasive' (also called, 'interventional') Cardiologists.

Only 'non-invasive' (or 'medical') Cardiologists are tiered.

Specialists’ tiers are designated in the Primary Choice Provider Directory with asterisks. These mean:

- *** (Tier 1 – Excellent)
- ** (Tier 2 – Good)
- * (Tier 3 – Standard)
Non-tiered providers

“Non-tiered” providers include all Primary Choice providers who have not been rated for quality and/or cost-efficiency or assigned to a tier. These include:

- All Primary Choice providers (Massachusetts and other states) in: internal, adolescent and geriatric medicine; family and general practice; pediatrics; behavioral health; early intervention; physical, speech and occupational therapy; chiropractic care; audiology; optometry; midwives, nurse practitioners and physician assistants. These providers have been assigned a $20 Copayment and are marked in the Primary Choice Provider Directory with NT *.

The following are specialists who have been assigned the same Copayment as Tier 2 specialists and are marked in the Primary Choice Provider Directory with NT/ID (non-tiered/insufficient data):

- Massachusetts physicians in the 13 tiered specialties for whom there was insufficient data to measure their performance.
- Some providers work from offices that are operated by a hospital. When services are rendered and billed from such an office, a $35 Copayment will be applied. However, please contact Harvard Pilgrim Member Services if you received care from a physician who specializes in internal, adolescent or geriatric medicine; family and general practice; pediatrics; or a midwife, a nurse practitioner or a physician assistant to determine if you are subject to a $20 copayment.
- Non-Massachusetts physicians in the 13 tiered specialties.
- All other Primary Choice specialists (Massachusetts and other states) outside of the 13 tiered specialties.

* Important note about tiered and non-tiered providers: Some providers in tiered specialties such as cardiology, gastroenterology and obstetrics/gynecology may also be providers in internal medicine, pediatrics or other primary care specialties. For these providers, the Copayment for the tiered specialty will apply, regardless of the service they provide. For example, if you visit a Tier 2 gastroenterologist who also practices internal medicine, you will pay the Tier 2 level Copayment.

How we Tiered Hospitals

Harvard Pilgrim’s Primary Choice hospitals in Massachusetts, New Hampshire and Rhode Island are evaluated and assigned to one of two tiers, based upon cost and quality. You will pay a Tier 1 copayment (lowest) or Tier 2 copayment (highest) for each hospital admission. Please note that Tier 1 and Tier 2 hospital copayments are different than Tier 1 and Tier 2 specialist copayments. A Deductible applies to most hospital services. The “Hospital Inpatient Copayment” section below that describes the applicable cost sharing for Tier 1 and Tier 2 Hospitals.

When we ranked hospitals, we looked at quality data from the Centers for Medicare and Medicaid Services and The Leapfrog Group (a group that assesses and reports on hospital quality and safety; www.leapfroggroup.org), and at the average case-mix adjusted cost of an inpatient admission and outpatient treatment at each hospital.

- Hospitals that met the quality threshold and had lower costs were placed in Tier 1.
- Hospitals that had mid-range costs, regardless of whether they met the quality threshold, were placed in Tier 2.
- Hospitals that did not meet the quality threshold but had lower costs were placed in Tier 2.
- Hospitals that had higher costs, regardless of whether they met the quality threshold, were excluded from the Primary Choice network. Providers affiliated with these hospitals were excluded from the Primary Choice network as well.

* Please note that a Tier 2 copayment also applies to Harvard Pilgrim participating hospitals in Maine and Vermont, hospitals that had insufficient quality data for us to measure, as well as to certain specialty hospitals and hospitals that do not participate in the Harvard Pilgrim network.
IMPORTANT NOTICE: Some Primary Choice providers may be affiliated with hospitals that do not participate in the Primary Choice network. If a Primary Choice provider refers you to a hospital that is not in the Primary Choice network, coverage will not be provided under your Primary Choice plan.

Hospital Inpatient Copayment

**Medical Acute Hospital Services:** One Copayment per admission, then the Deductible, up to a maximum of one Medical or Mental Health and Substance Abuse Hospital Inpatient Copayment per Member during each Quarter in a calendar year. Depending on the hospital to which you are admitted, you will pay either a Tier 1 Copayment of $250 or a Tier 2 Copayment of $500.

**Mental Health and Substance Abuse Services:** $200 per admission up to a maximum of one Medical or Mental Health and Substance Abuse Hospital Inpatient Copayment per Member during each Quarter in a calendar year.

If you are readmitted to an acute care hospital or mental health hospital in a new Quarter, but within 30 calendar days of a discharge, your second Inpatient Copayment will be waived. Readmission does not have to be to the same hospital or for the same condition. This waiver is limited to a calendar year basis.

The bullets below list examples of when you can expect to pay an Inpatient Copayment and when you can expect an Inpatient Copayment to be waived:

- If you are admitted from March 2 until March 7, you are responsible for an Inpatient Copayment. If you are then readmitted from March 12 until March 15, the second Inpatient Copayment is waived because it is within the same Quarter as the first admission.
- If you are admitted March 2 until March 7, and then readmitted April 3 until April 8, the second Inpatient Copayment is waived even though it is a new Quarter because it is within 30 calendar days of the original discharge.
- If you are admitted March 2 until March 7, and then readmitted April 30 until May 2, you are responsible for the second Inpatient Copayment. The second admission occurred more than 30 days from the original discharge and it is a new Quarter.
- If you are admitted December 2 until December 7, and then readmitted January 1 until January 4, you are responsible for the second Inpatient Copayment. Although the second admission occurred less than 30 days from the original discharge, it is a new Quarter, and it is a new calendar year.

**Please note:** When you are billed for an Inpatient Copayment that should be waived, you must notify Harvard Pilgrim's Member Services Department at 1-888-333-4742 so that we may adjust your claim.
**Surgical Day Care Copayment**
$150 per admission, then the Deductible, up to a maximum of four Surgical Day Care Copayments per Member per calendar year.

**High Technology Radiology Copayment**
CT Scans, MRAs, MRIs, PET Scans and Nuclear Medicine: $100 Copayment per scan, then the Deductible, maximum of one Copayment per Member per day.

**Emergency Room Copayment**
$100 per visit, then the Deductible (the Emergency Room Copayment is waived if the Member is admitted directly to the hospital from the emergency room, however, in that case the Member owes the Hospital Inpatient Copayment).

**Deductible**
You have a Deductible for medical care of $250 per Member per calendar year or up to $750 per family per calendar year (maximum of $250 for any one family member).

Any Deductible amount incurred for services rendered during the last three months of a calendar year will be applied to the Deductible requirement for the next calendar year.

**Coinsurance**
You have Coinsurance of:
- 20% of the Allowed Amount for skilled nursing facility care; and
- 10% of the Allowed Amount for Coronary Artery Disease programs

**Out-of-Pocket Maximum**
You have an Out-of-Pocket Maximum for mental health and substance abuse services of $1,000 per Member and $2,000 per family per calendar year. The Out-of-Pocket Maximum includes Copayments for mental health and substance abuse services. Prescription Drug Copayments do not count towards the Out-of-Pocket Maximum.
This table is a summary of the services covered by your Plan. It also indicates the portion of the cost of the benefits that you are required to pay, such as Copayment, Deductible or Coinsurance amounts. More detailed information about the Covered Services under this Plan can be found in the Benefit Handbook.

<table>
<thead>
<tr>
<th>Service</th>
<th>Member Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Inpatient Acute Hospital Services</strong></td>
<td></td>
</tr>
<tr>
<td>All covered services including the following:</td>
<td>Subject to the Inpatient Acute Hospital Copayment, then the Deductible.</td>
</tr>
<tr>
<td>• Coronary care</td>
<td></td>
</tr>
<tr>
<td>• Hospital services</td>
<td></td>
</tr>
<tr>
<td>• Intensive care</td>
<td></td>
</tr>
<tr>
<td>• Physicians' and surgeons' services including consultations</td>
<td></td>
</tr>
<tr>
<td>• Private Duty Nursing</td>
<td></td>
</tr>
<tr>
<td>• Semi-private room and board (private room is covered when Medically Necessary)</td>
<td></td>
</tr>
<tr>
<td><strong>Surgical Day Care Services</strong></td>
<td>Subject to the Surgical Day Care Copayment, then the Deductible.</td>
</tr>
<tr>
<td>• Anesthesia Services</td>
<td></td>
</tr>
<tr>
<td>• Endoscopic procedures (unless performed in the Hospital Outpatient Department)</td>
<td></td>
</tr>
<tr>
<td>• Hospital services</td>
<td></td>
</tr>
<tr>
<td>• Physicians' and surgeons' services</td>
<td></td>
</tr>
<tr>
<td><strong>Hospital Outpatient Department Services</strong></td>
<td>Covered in full, after the Deductible has been met.</td>
</tr>
<tr>
<td>All covered services including the following:</td>
<td></td>
</tr>
<tr>
<td>• Anesthesia services</td>
<td>No cost sharing applies to certain preventive care services and tests. See “Physician Services” for details.</td>
</tr>
<tr>
<td>• Endoscopic procedures (unless performed as Surgical Day Care)</td>
<td></td>
</tr>
<tr>
<td>• Laboratory tests and x-rays</td>
<td></td>
</tr>
<tr>
<td>• Radiation therapy</td>
<td>Subject to the High Technology Radiology Copayment, then the Deductible.</td>
</tr>
<tr>
<td>• High technology radiology, including CT Scans, MRAs, MRIs, PET Scans and Nuclear Medicine</td>
<td></td>
</tr>
<tr>
<td><strong>Skilled Nursing Facility Care Services</strong></td>
<td>20% of the Allowed Amount, after the Deductible.</td>
</tr>
<tr>
<td>• Room and board, special services and physician services up to 45 days per calendar year</td>
<td></td>
</tr>
<tr>
<td><strong>Inpatient Rehabilitation Services</strong></td>
<td>Covered in full, after the Deductible has been met.</td>
</tr>
<tr>
<td>• Room and board, special services and physician services</td>
<td></td>
</tr>
</tbody>
</table>
### Maternity Services

- Prenatal and postpartum care, 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. **Covered in full.**

- All hospital services for mother **Subject to the Inpatient Acute Hospital Copayment, then the Deductible.**

- Routine nursery charges for newborn, including prophylactic medication to prevent gonorrhea and screenings for the following: hearing loss; congenital hypothyroidism; phenylketonuria (PKU); and sickle cell disease. **Covered in full.**

- Non-routine prenatal and postpartum care **Covered in full, after the Deductible has been met.**

- Non-routine hospital services for the newborn **Subject to the Inpatient Acute Hospital Copayment, then the Deductible.**

### Emergency Room Care Services

- Hospital emergency room treatment **$100 Copayment per visit, then the Deductible.**
  - You are always covered in a Medical Emergency. In a Medical Emergency, you should go to the nearest emergency facility or call 911 or other local emergency number. If you are hospitalized, admitted to the hospital from the emergency room, you must call Harvard Pilgrim within 48 hours or as soon as you can.

### Emergency Admission Services

- Inpatient hospital services which are required immediately following the rendering of emergency room treatment **Subject to the Inpatient Acute Hospital Copayment, then the Deductible.**
  - Please note that Emergency Admissions to Non-Primary Choice hospitals will take a tier 2 Copayment.
<table>
<thead>
<tr>
<th>Service</th>
<th>Member Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Physician Services</strong></td>
<td></td>
</tr>
<tr>
<td>All covered services including the following:</td>
<td>Tier 1 level Copayment: $20 per visit.</td>
</tr>
<tr>
<td>- Administration of injections</td>
<td>Tier 2 level Copayment: $35 per visit.</td>
</tr>
<tr>
<td>- Bi-annual routine eye exams – covered once every 24 months</td>
<td>Tier 3 level Copayment: $45 per visit.</td>
</tr>
<tr>
<td>- Changes and removal of casts, dressings or sutures</td>
<td></td>
</tr>
<tr>
<td>- Chemotherapy</td>
<td></td>
</tr>
<tr>
<td>- Diabetes self-management, including education and training</td>
<td></td>
</tr>
<tr>
<td>- Health education</td>
<td></td>
</tr>
<tr>
<td>- Infertility services</td>
<td></td>
</tr>
<tr>
<td>- Medical treatment of temporomandibular joint dysfunction (TMD)</td>
<td></td>
</tr>
<tr>
<td>- Nutritional counseling (limited to 3 visits for non-diabetes and non-eating disorder related conditions per calendar year)</td>
<td></td>
</tr>
<tr>
<td>- Sick visits</td>
<td></td>
</tr>
<tr>
<td>- Vision and hearing screening</td>
<td></td>
</tr>
<tr>
<td>- Administration of allergy injections</td>
<td>Covered in full, after the Deductible has been met.</td>
</tr>
<tr>
<td>- Allergy tests and treatments</td>
<td></td>
</tr>
<tr>
<td>- Most diagnostic screening and tests, including but not limited to blood tests, lead screenings and screenings mandated by state law</td>
<td></td>
</tr>
<tr>
<td>- Immunizations</td>
<td>Covered in full.</td>
</tr>
<tr>
<td>- Mammograms</td>
<td></td>
</tr>
<tr>
<td>- Consultations concerning contraception and hormone replacement therapy</td>
<td></td>
</tr>
<tr>
<td>- Family planning services</td>
<td></td>
</tr>
<tr>
<td>- Preventive care, including routine physical, gynecological, and well child examinations</td>
<td></td>
</tr>
</tbody>
</table>
The following preventive services and tests as defined by federal law:

- 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 (children of all ages; developmental surveillance, in primary care settings)
- Blood pressure screening (adults, without known hypertension)
- 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
- 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)
- Depression screening (adults, children ages 12-18, primary care visits only)
- Diabetes screenings
- Diet behavioral counseling (included as part of annual visit and intensive counseling by primary care clinicians or by nutritionists and dieticians)
- Dyslipidemia screening (for children at high risk for higher lipid levels)
- Folic acid supplements (women planning or capable of pregnancy only)
- Hemoglobin A1c testing
- Hepatitis B testing
- HIV screening and counseling
The Harvard Pilgrim Primary Choice℠ Plan
Massachusetts

**Physician Services (Continued)**

The following preventive services and tests as defined by federal law:

- 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 (children at risk)
- Microalbuminuria test
- Obesity screening (adults and children screening only, in primary care settings)
- Osteoporosis screening (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)
- Contraceptive methods approved by the FDA, sterilization procedures and contraceptive patient education and counseling
- Comprehensive lactation support, counseling, and costs of renting breastfeeding equipment

Under federal law the list of preventive care services covered under this benefit 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](http://www.healthcare.gov/center/regulations/prevention/recommendations.html)

Harvard Pilgrim will add or delete services from this benefit for preventive care 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](http://www.harvardpilgrim.org).
### Mental Health and Substance Abuse Services

- **Inpatient mental health services**
- **Inpatient substance abuse services**
- **Inpatient detoxification**
  
  Subject to the Mental Health Inpatient Hospital Copayment

- **Intermediate services**, including detoxification, acute residential treatment (long-term residential treatment is not covered), crisis stabilization, day/partial hospital programs, structured outpatient programs, 24-hour intermediate care facilities, and therapeutic foster care.
  
  Covered in full.

- **Outpatient mental health and substance abuse services**
  
  - **Group therapy**
    
    $15 Copayment per visit.
  
  - **Individual therapy**
    
    $20 Copayment per visit.

- **Psychopharmacological services**
  
  $15 Copayment per visit.

- **Psychological testing and neuropsychological assessment**
  
  Covered in full.

- **Please Note**: Educational services and testing are excluded from coverage under this benefit. 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.

### Autism Spectrum Disorders

**Professional Services**

Coverage for the treatment of Autism Spectrum Disorders is provided for all of the services otherwise covered under your Plan.

- **Applied Behavior Analysis**
  
  Tier 1 level Copayment: $20 per visit.

---

The Harvard Pilgrim Primary Choice℠ Plan
Massachusetts
<table>
<thead>
<tr>
<th>Service</th>
<th>Member Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Dental Services</strong></td>
<td></td>
</tr>
</tbody>
</table>
| • Initial emergency treatment (within 72 hours of injury)  
• Reduction of fractures and removal of cysts or tumors | $35 Copayment per office visit.  
If inpatient services are required, subject to the Inpatient Acute Hospital Copayment, then the Deductible.  
If Surgical Day Care Services are required, subject to the Surgical Day Care Copayment, then the Deductible. |
| • Removal of 7 or more permanent teeth, excision of radicular cysts involving the roots of three or more teeth, extraction of impacted teeth, and gingivectomies of two or more gum quadrants** | If inpatient services are required, subject to the Inpatient Acute Hospital Copayment, then the Deductible.  
If Surgical Day Care Services are required, subject to the Surgical Day Care Copayment, then the Deductible. |

** Benefits are provided for the dental services listed above only when the Member has a serious medical condition that makes it essential that he or she be admitted to a general hospital as an inpatient or to a surgical day care unit or ambulatory surgical facility as an outpatient in order for the dental care to be performed safely. Serious medical conditions include, but are not limited to, hemophilia and heart disease.
## Diabetes Equipment and Supplies

<table>
<thead>
<tr>
<th>Service</th>
<th>Member Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Therapeutic molded shoes and inserts, dosage gauges, injectors, lancet devices, voice synthesizers and visual magnifying aids</td>
<td>Covered in full, after the Deductible.</td>
</tr>
<tr>
<td>Blood glucose monitors, insulin pumps and supplies and infusion devices</td>
<td>Covered in full, after the Deductible.</td>
</tr>
</tbody>
</table>
| Insulin, insulin syringes, insulin pens with insulin, lancets, oral agents for controlling blood sugar, blood test strips, and glucose, ketone and urine test strips | 30-day supply at a retail pharmacy  
  - $10 Copayment for Tier 1 items  
  - $25 Copayment for Tier 2 items  
  - $50 Copayment for Tier 3 items  
  90-day supply through mail-order pharmacy  
  - $20 Copayment for Tier 1 items  
  - $50 Copayment for Tier 2 items  
  - $110 Copayment for Tier 3 items |

## Durable Medical and Prosthetic Equipment

Durable medical and prosthetic equipment coverage includes, but is not limited to:

<table>
<thead>
<tr>
<th>Service</th>
<th>Member Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Durable medical equipment</td>
<td>Covered in full, after the Deductible has been met.</td>
</tr>
<tr>
<td>Prosthetic devices</td>
<td></td>
</tr>
<tr>
<td>Breast prostheses, including replacements and mastectomy bras</td>
<td></td>
</tr>
<tr>
<td>Ostomy supplies</td>
<td></td>
</tr>
<tr>
<td>Oxygen and respiratory equipment</td>
<td></td>
</tr>
<tr>
<td>Wigs - up to a limit of $350 per calendar year when needed as a result of any form of cancer or leukemia, alopecia areata, alopecia totalis or permanent hair loss due to injury</td>
<td>Covered in full.</td>
</tr>
</tbody>
</table>

## Home Health Care Services

<table>
<thead>
<tr>
<th>Service</th>
<th>Member Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home care services</td>
<td>Covered in full, after the Deductible has been met.</td>
</tr>
<tr>
<td>Intermittent skilled nursing care</td>
<td></td>
</tr>
</tbody>
</table>

No cost sharing or benefit limit applies to durable medical equipment, physical therapy or occupational therapy received as part of authorized home health care.
<table>
<thead>
<tr>
<th>Service</th>
<th>Member Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Other Health Services</strong></td>
<td>Tier 1 level Copayment: $20 per visit.</td>
</tr>
<tr>
<td>· Cardiac rehabilitation</td>
<td>Tier 2 level Copayment: $35 per visit.</td>
</tr>
<tr>
<td>· Dialysis</td>
<td>Tier 3 level Copayment: $45 per visit.</td>
</tr>
<tr>
<td>· Ambulance services</td>
<td>Covered in full, after the Deductible has been met.</td>
</tr>
<tr>
<td>· Low protein foods ($5,000 per Member per calendar year)</td>
<td></td>
</tr>
<tr>
<td>· State mandated formulas</td>
<td></td>
</tr>
<tr>
<td>· Chiropractic services- up to 20 visits per calendar year</td>
<td></td>
</tr>
<tr>
<td>· Physical and occupational therapies – up to 90 consecutive days per illness or injury</td>
<td>Tier 1 level Copayment: $20 per visit.</td>
</tr>
<tr>
<td>Please note: Outpatient physical and occupational therapy is covered to the extent Medically Necessary for: (1) children under the age of three for Early Intervention Services up to the limit of that benefit and (2) the treatment of Autism Spectrum Disorders.</td>
<td></td>
</tr>
<tr>
<td>· Speech-language and hearing services, including therapy</td>
<td>Covered in full.</td>
</tr>
<tr>
<td>· Early intervention services - up to a maximum of $5,200 per Member per calendar year and a lifetime maximum of $15,600</td>
<td>Tier 1 level Copayment: $20 per visit.</td>
</tr>
<tr>
<td>· Voluntary sterilization **</td>
<td>Tier 2 level Copayment: $35 per visit.</td>
</tr>
<tr>
<td>· Voluntary termination of pregnancy **</td>
<td>Tier 3 level Copayment: $45 per visit.</td>
</tr>
<tr>
<td><strong>If a voluntary sterilization or voluntary termination of pregnancy is performed in a day surgery location, the day surgery cost sharing will apply.</strong></td>
<td>Tier 1 level Copayment: $20 per visit.</td>
</tr>
<tr>
<td>· Second Opinion</td>
<td>Tier 2 level Copayment: $35 per visit.</td>
</tr>
<tr>
<td></td>
<td>Tier 3 level Copayment: $45 per visit.</td>
</tr>
</tbody>
</table>
### Other Health Services (Continued)

<table>
<thead>
<tr>
<th>Service</th>
<th>Member Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hearing aids (for Members ages 22 and older)– every 2 calendar years</td>
<td>Covered in full for the first $500, 20% Coinsurance of the next $1,500, up to a maximum benefit of $1,700 every 2 calendar years.</td>
</tr>
<tr>
<td>· Hearing Aids (for Members up to the age of 22)</td>
<td>Covered in full.</td>
</tr>
<tr>
<td>– $2,000 per hearing aid every 36 months, for each hearing impaired ear</td>
<td></td>
</tr>
<tr>
<td>· House calls</td>
<td>Tier 1 level Copayment: $20 per visit.</td>
</tr>
<tr>
<td></td>
<td>Tier 2 level Copayment: $35 per visit.</td>
</tr>
<tr>
<td></td>
<td>Tier 3 level Copayment: $45 per visit.</td>
</tr>
<tr>
<td>· Hospice services</td>
<td>Covered in full, after the Deductible has been met.</td>
</tr>
<tr>
<td></td>
<td>If Inpatient Acute Hospital Services are required, subject to the Inpatient Acute Hospital Copayment, then the Deductible.</td>
</tr>
<tr>
<td>· Smoking Cessation (please see your Benefit Handbook for details on your coverage)</td>
<td>Covered in full.</td>
</tr>
<tr>
<td>· Vision hardware (such as eyeglasses or contact lenses) only for limited conditions (please see your Benefit Handbook for details on your coverage)</td>
<td>Covered in full, after the Deductible, up to the benefit limit.</td>
</tr>
</tbody>
</table>
| · Prescription Drug Coverage (Please see the Prescription Drug Brochure for more information on your prescription drug coverage.) | 30-day supply at a retail pharmacy  
   - $10 Copayment for Tier 1 items  
   - $25 Copayment for Tier 2 items  
   - $50 Copayment for Tier 3 items  
90-day supply through mail-order pharmacy  
   - $20 Copayment for Tier 1 items  
   - $50 Copayment for Tier 2 items  
   - $110 Copayment for Tier 3 items |
Membership Requirements

There are important requirements that you must meet in order to be covered by the Plan. (Please see your Benefit Handbook for a complete description).

- Members must live in the Harvard Pilgrim Primary Choice Enrollment Area of mainland Massachusetts (i.e. excluding Martha’s Vineyard, Nantucket, and Cape Cod) for at least nine months of the year. An exception is made for full-time student dependents and dependents enrolled under a Qualified Medical Child Support Order.

- All your medical and health care needs must be provided or arranged by your Primary Care Provider (PCP), except in a Medical Emergency, when you are temporarily outside the Harvard Pilgrim Primary Choice Enrollment Area or when you need one of the services which do not require a referral, for example chiropractic services (Please see your Benefit Handbook for information on services that do not require a Referral).

- All services, except in a medical emergency, must be provided by Primary Choice physicians and hospitals to be eligible for coverage.
Exclusions

- A provider's charge to file a claim or to transcribe or copy your medical records
- A service, supply or medication if there is a less intensive level of service, supply or medication or more cost-effective alternative which can be safely and effectively provided, or if the service, supply or medication can be safely and effectively provided to you in a less intensive setting
- Acupuncture, aromatherapy and alternative medicine
- All charges over the semi-private room rate, except when a private room is Medically Necessary
- Any home adaptations, including, but not limited to, home improvements and home adaptation equipment
- Any form of surrogacy
- Any services not specified in this Benefit Handbook and your Schedule of Benefits
- Any service or supply furnished along with a non-covered service
- Blood and blood products
- Care by a chiropractor that falls outside the scope of standard chiropractic practice, including, but not limited to, surgery, prescription or dispensing of drugs or medications, internal examinations, obstetrical practice, treatment of infectious disease, treatment with crystals, or diagnostic testing for chiropractic care other than an initial x-ray
- 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 service under your Handbook
- Charges for missed appointments
- Charges for services received after the date on which your membership ends
- Commercial diet plans or weight loss programs and any services in connection with such plans or programs
- Cosmetic procedures, including those for mental health reasons, except as described in your Benefit Handbook for post-mastectomy or reconstructive surgery
- Costs for services covered by workers’ compensation, third party liability, other insurance coverage or an employer under state or federal law
- Dental services, except the specific dental services listed in your Benefit Handbook. This exclusion includes, but is not limited to: (a) dental services for temporomandibular joint dysfunction (TMD); (b) restorative, periodontal, orthodontic, endodontic, prosthetic services; dental fillings; crowns; gum care, including gum surgery; braces; root canals; bridges and bonding are not covered except when Medically Necessary for the treatment of cleft lip or cleft palate; and (c) dentures.
- Devices or special equipment needed for sports or occupational purposes
- Devices or procedures intended to reduce snoring, including, but not limited to, laser-assisted uvulopalatoplasty, somnoplasty, and snore guards
- Any products or services, including, but not limited to, drugs, devices, treatments, procedures, and diagnostic tests, which are Experimental, Unproven, or Investigational
- Educational services and testing, including psychological testing and neuropsychological assessment related to educational services and testing. 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
- Electrolysis, routine foot care, biofeedback, hypnotherapy, psychoanalysis, pain management programs, massage therapy (including myotherapy), sports medicine clinics, services by a personal trainer, cognitive rehabilitation programs, and cognitive retraining programs
- Eyeglasses, contact lenses and fittings, except as listed in this Schedule of Benefits and your Benefit Handbook
- Gender reassignment surgery, including related drugs or procedures
- Any services or supplies furnished by, or covered as a benefit under, a program of any government or its subdivisions or agencies
except for the following: (a) a benefit plan established for its civilian employees, (b) Medicare (Title XVIII of the Social Security Act), (c) Medicaid (any state medical assistance program under Title XIX of the Social Security Act), or (d) a program of hospice care.

- Group diabetes training or educational programs or camps
- Hair removal or restoration, including, but not limited to, electrolysis, laser treatment, transplantation or drug therapy
- Health resorts, recreational programs, camps, wilderness programs, outdoor skills programs, relaxation or lifestyle programs, including any services provided in conjunction with, or as part of such types of programs
- Hearing aid batteries and any device used by individuals with hearing impairment to communicate over the telephone or internet, such as TTY or TDD
- Hospital charges after the date of service after your hospital discharge
- Infertility treatment for Members who are not medically infertile
- Mental health services that are (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
- Non-durable medical equipment, unless used as part of the treatment at a medical facility or as part of approved home health care services
- Personal comfort or convenience items (including telephone and television charges), exercise equipment, wigs (except as required by state law and specifically covered in this Schedule of Benefits), and repair or replacement of durable medical equipment or prosthetic devices as a result of loss, negligence, willful damage or theft
- Physical examinations for insurance, licensing or employment purposes which are not otherwise Medically Necessary
- Planned home births
- Preventive dental care
- Refractive eye surgery, including laser surgery and orthokeratology, for correction of myopia, hyperopia and astigmatism
- Rest or custodial care
- Reversal of voluntary sterilization (including procedures necessary for conception as a result of voluntary sterilization)
- Routine maternity (prenatal and postpartum) care when you are traveling outside of the Service Area
- Sclerotherapy for the treatment of spider veins
- Sensory integrative praxis tests
- 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
- Services for a newborn who has not been enrolled as a Member, other than nursery charges for routine services provided to a healthy for up to 30 days after the newborn’s birth
- Services not approved, arranged or provided by your PCP except: (1) in a Medical Emergency; (2) when you are outside of the Service Area; or (3) the special services that do not require a referral listed in your Benefit Handbook
- Services for cosmetic purposes, except as described in this Benefit Handbook for post-mastectomy services or reconstructive surgery
- Services for which no charge would be made in the absence of insurance
- Services for non-Members and after termination of membership
- Services for which you are legally entitled to treatment at government expense. This includes services for disabilities related to military service
- Services or supplies given to you by: (1) anyone related to you by blood, marriage or adoption or (2) anyone who ordinarily lives with you
- Services that are not Medically Necessary
- Taxes or assessments on services or supplies
- Any type of thermal therapy device
• Therapeutic molded shoes, and foot orthotics, except for the treatment of severe diabetic foot disease
• Transportation other than by ambulance
• Vocational rehabilitation or vocational evaluations on job adaptability, job placement, or therapy to restore function for a specific occupation
• Unless otherwise specified in the Schedule of Benefits or Benefit Handbook, the Plan does not cover food or nutritional supplements, including FDA-approved medical foods obtained by prescription
• 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.