

# Schedule of Benefits

## Harvard Pilgrim Health Care, Inc.

### THE HARVARD PILGRIM IN-NETWORK POS MASSACHUSETTS

This Schedule of Benefits summarizes your Covered Benefits under The Harvard Pilgrim In-Network POS (the Plan). It also states the Member Cost Sharing amounts you must pay for In-Network Covered Benefits. However, the Schedule of Benefits 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 your Covered Benefits and the terms and conditions of coverage.

#### **There are two levels of coverage: In-Network and Out-of-Network**

##### **In-Network Coverage**

You pay lower out-of-pocket cost when you receive in-Network benefits under your POS Plan. With very limited exceptions summarized below, you must obtain services from Plan Providers to obtain In-Network benefits. However, different rules apply depending on whether care is received inside or outside the Plan Service Area.

Care Inside the Service Area. The Plan Service Area is the states of Massachusetts, New Hampshire, Maine, Rhode Island and Vermont. To obtain In-Network coverage in the Service Area, most covered medical services must be either provided by, or upon referral from, your Primary Care Provider (PCP). However, certain services may be obtained from Plan Providers without a referral from your PCP. They include a variety of family planning, maternity and gynecological care. Please see Benefit Handbook Section I.D.8, titled "Services that Do Not Require a Referral," for a list of these services.

Care Outside the Service Area. To obtain In-Network coverage outside the Service Area, you must receive Covered Benefits from a Plan Provider in the Plan's national provider network. To find a Plan Provider, please see the Plan Provider Directory. The Provider Directory is available online at [www.harvardpilgrim.org](http://www.harvardpilgrim.org) or by calling the Member Services Department at **1-888-333-4742**. When you are outside of the Plan Service Area you do not need a referral from your PCP.

##### **Out-of-Network Coverage**

You receive Out-of-Network coverage when Covered Benefits are provided by Non-Plan Providers or Plan Providers without a referral when a referral is required. Although your Member Cost Sharing is generally higher for Out-of-Network benefits, you may obtain Covered Benefits from the licensed provider of your choice. Please review your separate HPHC Insurance Company, Insurance Contract and Schedule of Benefits for information on your Out-of-Network Benefits.

**Emergency Care** In a Medical Emergency, including a mental health emergency, you should promptly go to the nearest emergency facility or call 911 or other local emergency number. You always receive In-Network coverage for emergency ambulance transportation, and care at a hospital emergency room and an emergency admission immediately following emergency room treatment.

**Mental Health Care** When you need mental health services, including the treatment of substance abuse disorders, you must call the Behavioral Health Access Center at **1-888-777-4742**. (The only exception is for care required in a Medical Emergency.) The Behavioral Health Access

**THE HARVARD PILGRIM IN-NETWORK POS - MASSACHUSETTS**

Center phone line is staffed by licensed mental health clinicians. A clinician will assist you in determining the type of care you need, finding an appropriate Plan Provider, and arranging the services you require.

**Clinical Review Criteria** We use clinical review criteria to evaluate whether certain services or procedures are Medically Necessary for a Member’s care. Members or their Providers, 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**.

**Covered Benefits** Your Covered Benefits are administered on a calendar year basis.

**Schedule of In-Network Benefits and Member Cost Sharing:**

<b>General Cost Sharing Features:</b>	<b>Member Cost Sharing:</b>
<b>Coinsurance and Copayments</b>	
	See Covered Benefits below
<b>In-Network Deductible</b>	
	None
<b>In-Network Out-of-Pocket Maximum</b>	
Includes all In-Network Member Cost Sharing	\$2,000 per Member per calendar year \$4,000 per family per calendar year

<b>Benefit</b>	<b>In-Network (Plan Providers with a referral when required) Member Cost Sharing:</b>
<b>Acupuncture Treatment for Injury or Illness</b>	
– Limited to 20 visits per calendar year	\$25 Copayment per visit
<b>Ambulance Transport</b>	
– Emergency ambulance transport	No charge
– Non-emergency ambulance transport	No charge
<b>Autism Spectrum Disorders Treatment</b>	
– Applied behavior analysis	\$25 Copayment per visit
<b>Chemotherapy and Radiation Therapy</b>	
	No charge
<b>Dental Services</b>	
<b>Important Notice:</b> Coverage of Dental Care is very limited. Please see your Benefit Handbook for the details of your coverage.	

(Continued on next page)

**THE HARVARD PILGRIM IN-NETWORK POS - MASSACHUSETTS**

<b>Benefit</b>	<b>In-Network (Plan Providers with a referral when required) Member Cost Sharing:</b>
<b>Dental Services (Continued)</b>	
– Emergency dental care <b>Please Note:</b> Services must be received within 3 days of injury.	Your Member Cost Sharing will depend upon the types of services provided, as listed in this Schedule of Benefits. For example, for services provided in a dentist’s office, see “Physician and Other Professional Office Visits.” For services provided in a hospital emergency room, see “Emergency Room Care.”
– Extraction of teeth impacted in bone	Your Member Cost Sharing will depend upon the types of services provided, as listed in this Schedule of Benefits. For example, for services provided in a dentist’s office, see “Physician and Other Professional Office Visits.”
– Preventive Dental Care for children (up to the age of 13)	No charge
<b>Dialysis</b>	
– Dialysis services	\$25 Copayment per visit
– Installation of home equipment is covered up to \$300 in a Member’s lifetime.	No charge
<b>Durable Medical Equipment</b>	
– Durable medical equipment	20% Coinsurance
– Blood glucose monitors, infusion devices and insulin pumps (including supplies)	No charge
– Oxygen and respiratory equipment	No charge
<b>Early Intervention Services</b>	
	No charge <b>Please Note:</b> The Plan does not cover the family participation fee required by the Massachusetts Department of Public Health.
<b>Emergency Admission</b>	
	No charge
<b>Emergency Room Care</b>	
	\$150 Copayment per visit This Copayment is waived if you are admitted directly to the hospital from the emergency room.
<b>Hearing Aids (for Members up to the age of 22)</b>	
– Limited to \$2,000 per hearing aid every 36 months, for each hearing impaired ear	No charge
<b>Home Health Care</b>	
	No charge No cost sharing or benefit limit applies to durable medical equipment, physical therapy or occupational therapy received as part of authorized home health care.
<b>Hospice – Outpatient Services</b>	
	No charge

**THE HARVARD PILGRIM IN-NETWORK POS - MASSACHUSETTS**

<b>Benefit</b>	<b>In-Network (Plan Providers with a referral when required) Member Cost Sharing:</b>
<b>Hospital – Inpatient Services</b>	
– Acute hospital care	No charge
– Inpatient maternity care	No charge
– Inpatient routine nursery care, including prophylactic medication to prevent gonorrhea	No charge
– Inpatient rehabilitation– limited to 60 days per calendar year	No charge
– Skilled nursing facility – limited to 100 days per calendar year	No charge
<b>Infertility Services and Treatments (see the Benefit Handbook for details)</b>	
	Your Member Cost Sharing will depend upon the types of services provided, as listed in this Schedule of Benefits. For example, for services provided by a physician, see “Physician and Other Professional Office Visits.” For inpatient hospital care, see “Hospital – Inpatient Services.”
<b>Laboratory and Radiology Services</b>	
– Laboratory and x-rays	No charge
<b>Advanced radiology</b> – CT scans – PET scans – MRI – MRA – Nuclear medicine	No charge
<b>Please Note:</b> No Member Cost Sharing applies to certain preventive care services. For a list of covered preventive services, please see the Preventive Services notice at: <a href="http://www.harvardpilgrim.org">www.harvardpilgrim.org</a> .	
<b>Low Protein Foods</b>	
– Limited to \$5,000 per calendar year	No charge
<b>Maternity Care - Outpatient</b>	
– 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.
<b>Please Note:</b> Routine prenatal and postpartum care is usually received and billed from the same Provider as a single or bundled service. Different Member Cost Sharing may apply to any specialized or non-routine service that is billed separately from your routine outpatient prenatal and postpartum care. For example, 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.	
<b>Medical Formulas</b>	
	No charge

**THE HARVARD PILGRIM IN-NETWORK POS - MASSACHUSETTS**

<b>Benefit</b>	<b>In-Network (Plan Providers with a referral when required) Member Cost Sharing:</b>
<b>Mental Health Care (Including the Treatment of Substance Abuse Disorders)</b>	
<b>Inpatient Mental Health Care Services</b>	No charge
<b>Intermediate Mental Health Care Services</b> – Acute residential treatment (including detoxification), crisis stabilization and in-home family stabilization – Intensive outpatient programs, partial hospitalization and day treatment programs	No charge
<b>Outpatient Mental Health Care Services</b>	<b>Group therapy</b> – \$10 Copayment per visit <b>Individual therapy</b> – \$25 Copayment per visit
– Detoxification	\$25 Copayment per visit
– Medication management	\$25 Copayment per visit
– Psychological testing and neuropsychological assessment	\$25 Copayment per visit
<b>Ostomy Supplies</b>	
	20% Coinsurance
<b>Physician and Other Professional Office Visits (This includes all covered Plan Providers unless otherwise listed in this Schedule of Benefits.)</b>	
– Routine examinations for preventive care, including immunizations	No charge
– Consultations, evaluations, sickness and injury care	\$25 Copayment per visit
– Administration of allergy injections	\$5 Copayment per visit
<b>Preventive Services and Tests</b>	
– Preventive care services, including FDA approved contraceptive devices. Under the federal health care reform law, many preventive services and tests are covered with no member cost sharing. For a complete list of covered preventive services, go to <b>www.harvardpilgrim.org</b> – For a complete list of covered preventive services, please see the Preventive Services notice on our website at <b>www.harvardpilgrim.org</b> . You may also get a copy of the Preventive Services notice by calling the Member Services Department at <b>1-888-333-4742</b>	No charge
Under federal law the list of preventive services and tests may change periodically based on the recommendations of the following agencies: a. Grade "A" and "B" recommendations of the United States Preventive Services Task Force;	

(Continued on next page)

Benefit	In-Network (Plan Providers with a referral when required) Member Cost Sharing:
---------	---

<b>Preventive Services and Tests (Continued)</b>	
<p>b. With respect to immunizations, the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention; and</p> <p>c. With respect to services for women, infants, children and adolescents, the Health Resources and Services Administration.</p> <p>Information on the recommendations of these agencies may be found on the web site of the U.S. Department of Health and Human Services at: <a href="https://www.healthcare.gov/what-are-my-preventive-care-benefits/#part=1">https://www.healthcare.gov/what-are-my-preventive-care-benefits/#part=1</a>.</p> <p>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 <a href="http://www.harvardpilgrim.org">www.harvardpilgrim.org</a>.</p>	
<b>Prosthetic Devices</b>	
	20% Coinsurance
<b>Rehabilitation Therapy - Outpatient</b>	
– Cardiac rehabilitation	\$25 Copayment per visit
– Pulmonary rehabilitation therapy	\$25 Copayment per visit
– Speech-language and hearing services	\$25 Copayment per visit
– Occupational therapy – limited to 30 visits per calendar year	\$25 Copayment per visit
– Physical therapy – limited to 30 visits per calendar year	
<p><b>Please Note:</b> 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.</p>	
<b>Scopic Procedures - Outpatient Diagnostic and Therapeutic</b>	
– Endoscopy and sigmoidoscopy	
– Colonoscopy	No charge
<p><b>Please Note:</b> No Member Cost Sharing applies to certain preventive care services. For a list of covered preventive services, please see the Preventive Services notice at: <a href="http://www.harvardpilgrim.org">www.harvardpilgrim.org</a>.</p>	
<b>Spinal Manipulative Therapy (including care by a chiropractor)</b>	
– Limited to \$500 per calendar year	\$25 Copayment per visit
<b>Surgery – Outpatient</b>	
	No charge
<b>Vision Services</b>	
– Routine eye examinations – limited to 1 exam per calendar year	\$25 Copayment per visit
– Vision hardware for special conditions (see the Benefit Handbook for details)	No charge

<b>Benefit</b>	<b>In-Network (Plan Providers with a referral when required) Member Cost Sharing:</b>
<b>Voluntary Sterilization</b>	
	Your Member Cost Sharing will depend upon where the service is provided as listed in this Schedule of Benefits. For example, for a service provided in an outpatient surgical center, see "Surgery– Outpatient." For services provided in a physician's office, see "Physician and Other Professional Office Visits." For inpatient hospital care, see "Hospital – Inpatient Services."
<b>Please Note:</b> No Member Cost Sharing applies to certain preventive care services. For a list of covered preventive services, please see the "Preventive Services" notice at: <a href="http://www.harvardpilgrim.org">www.harvardpilgrim.org</a> .	
<b>Voluntary Termination of Pregnancy</b>	
	Your Member Cost Sharing will depend upon where the service is provided as listed in this Schedule of Benefits. For example, for a service provided in an outpatient surgical center, see "Surgery– Outpatient." For services provided in a physician's office, see "Physician and Other Professional Office Visits." For inpatient hospital care, see "Hospital – Inpatient Services."
<b>Wigs and Scalp Hair Protheses (as required by law)</b>	
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 calendar year (see the Benefit Handbook for details)	20% Coinsurance

**THIS PAGE INTENTIONALLY LEFT BLANK.**

# Schedule of Benefits

Harvard Pilgrim Health Care, Inc.

THE HPHC INSURANCE COMPANY OUT-OF-NETWORK POS  
MASSACHUSETTS

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

**There are two levels of coverage: In-Network and Out-of-Network**

## In-Network Coverage

You pay lower out-of-pocket cost when you receive in-Network benefits under your POS Plan. With very limited exceptions, you must obtain services from Plan Providers to obtain In-Network benefits. Your In-Network coverage is underwritten by Harvard Pilgrim Health Care and is described in your In-Network Benefit Handbook and In-Network Schedule of Benefits.

In a Medical Emergency, including a mental health emergency, you should promptly go to the nearest emergency facility or call 911 or other local emergency number. You always receive In-Network coverage for emergency ambulance transportation, and care at a hospital emergency room and an emergency admission immediately following emergency room treatment.

## Out-of-Network Coverage

Your Out-of-Network coverage applies when you use a Non-Plan Provider or a Plan Provider without a referral when a referral is required for Covered Benefits. When using Non-Plan Providers, we pay a percentage of the cost of care you receive, up to the Allowed Amount for Covered Benefits. If a Non-Plan Provider charges any amount in excess of the Allowed Amount, you are responsible for the excess amount. Please refer to your Out-of-Network Benefit Handbook for additional information about Out-of-Network Charges in excess of the Allowed Amount.

## Member Responsibility for Notification and Prior Approval

Members must contact HPHC for coverage of a number of services. These are listed below.

**Mental Health Care (Including the Treatment of Substance Abuse Disorders)** Prior Approval must be obtained before receiving certain mental health care (including the treatment of substance abuse disorders). Please refer to our internet site, [www.harvardpilgrim.org](http://www.harvardpilgrim.org), or contact the Member Services Department at **1-888-333-4742** for a list of services. To obtain Prior Approval for mental health care (including the treatment of substance abuse disorders), please call the Behavioral Health Access Center at **1-888-777-4742**.

**Medical Services** Members are required to notify HPHC before the start of any planned inpatient admission to a Non-Plan medical facility. Members are also required to obtain Prior Approval from HPHC for certain services. Before you receive services from a Non-Plan Provider, please refer to our Internet site, [www.harvardpilgrim.org](http://www.harvardpilgrim.org), or contact the Member Services Department at **1-888-333-4742** for a list of Out-of-Network services that require Prior Approval. If you do not provide Notification or obtain Prior Approval when required, you will be responsible for paying the Out-of-Network Penalty amount stated in this Schedule of Benefits in addition to

EFFECTIVE DATE: 07/01/2015

FORM #1129\_03

SCHEDULE OF BENEFITS | 9

any applicable Member Cost Sharing. No coverage will be provided if HPHC determines that the service is not Medically Necessary, and you will be responsible for the entire cost of the service.

**Emergency Care** You do not need to contact HPHC before receiving care in a Medical Emergency. In the event of an emergency hospital admission to a Non-Plan Provider, you must notify HPHC within 48 hours of the admission, unless Notification is not possible because of your condition. If notice is given to HPHC by an attending emergency physician, no further Notification is required. However, if Notification is not received when the Member's condition permits it, the Member is responsible for the Out-of-Network Penalty amount stated in this Schedule of Benefits. Please call **1-800-708-4414** to notify us of an emergency admission to a Non-Plan facility.

**Clinical Review Criteria**

We use clinical review criteria to evaluate whether certain services or procedures are Medically Necessary for a Member's care. Members or their practitioners may obtain a copy of our clinical review criteria 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**.

**Covered Benefits** Your Covered Benefits are administered on a calendar year basis.

**Schedule of Out-of-Network Benefits and Member Cost Sharing:**

General Cost Sharing Features:	Member Cost Sharing:
<b>Copayments</b>	See Covered Benefits below
<b>Coinsurance</b>	See Covered Benefits below
<b>Out-of-Network Deductible</b>	\$250 per Member per calendar year \$500 per family per calendar year
<b>Out-of-Network Out-of-Pocket Maximum</b>	\$2,000 per Member per calendar year \$4,000 per family per calendar year
Includes all Out-of-Network Member Cost Sharing except: – Any charges above the Allowed Amount and any penalty for failure to receive Prior Approval when using Non-Plan Providers	
<b>Out-of-Network Penalty Payment</b>	\$500
– Does not count toward the Out-of-Network Deductible or Out-of-Pocket Maximum.	
<b>Deductible Rollover</b>	– Your Plan has a Deductible Rollover that applies to any Deductible amount that is incurred for services during the last 3 months of the calendar year and is applied toward the Deductible requirement for the next calendar year.

Benefit	Out-of-Network (Non-Plan Providers and Plan Providers without a referral when a referral is required) Member Cost Sharing
<b>Acupuncture Treatment for Injury or Illness</b>	
– Limited to 20 visits per calendar year	Deductible, then 20% Coinsurance
<b>Ambulance Transport</b>	
– Emergency ambulance transport	No charge
– Non-emergency ambulance transport	No charge
<b>Autism Spectrum Disorders Treatment</b>	
– Applied behavior analysis	Deductible, then 20% Coinsurance
<b>Chemotherapy and Radiation Therapy</b>	
	Deductible, then 20% Coinsurance
<b>Dental Services</b>	
<b>Important Notice:</b> Coverage of Dental Care is very limited. Please see your Benefit Handbook for the details of your coverage.	
– 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.” For services provided in a hospital emergency room, see “Emergency Room Care.”
– Preventive dental care for children (up to the age of 13)	Deductible, then 20% Coinsurance
<b>Dialysis</b>	
– Dialysis services	Deductible, then 20% Coinsurance
– Installation of home equipment is covered up to \$300 in a Member’s lifetime.	Deductible, then 20% Coinsurance
<b>Durable Medical Equipment</b>	
– Durable medical equipment	Deductible, then 20% Coinsurance
– Blood glucose monitors, infusion devices and insulin pumps (including supplies)	No charge
– Oxygen and respiratory equipment	Deductible, then 20% Coinsurance
<b>Early Intervention Services</b>	
	No charge  <b>Please Note:</b> The Plan does not cover the family participation fee required by the Massachusetts Department of Public Health.

<b>Benefit</b>		<b>Out-of-Network (Non-Plan Providers and Plan Providers without a referral when a referral is required) Member Cost Sharing</b>
<b>Emergency Admission</b>		
		No charge
<b>Emergency Room Care</b>		
		\$150 Copayment per visit This Copayment is waived if you are admitted directly from a hospital emergency room.
<b>Hearing Aids (for Members up to the age of 22)</b>		
– Limited to \$2,000 per hearing aid every 36 months, for each hearing impaired ear		Deductible, then 20% Coinsurance
<b>Home Health Care</b>		
		Deductible, then 20% Coinsurance
<b>Hospice - Outpatient Services</b>		
		Deductible, then 20% Coinsurance
<b>Hospital – Inpatient Services</b>		
– Acute hospital care		Deductible, then 20% Coinsurance
– Inpatient maternity care		Deductible, then 20% Coinsurance
– Inpatient rehabilitation– limited to 60 days per calendar year		Deductible, then 20% Coinsurance
– Skilled nursing facility – limited to 100 days per calendar year		Deductible, then 20% Coinsurance
<b>Infertility Services and Treatments (see the Benefit Handbook for details)</b>		
		Your Member Cost Sharing will depend upon the types of services provided, as listed in this Schedule of Benefits. For example, for services provided by a physician, see “Physician and Other Professional Office Visits.” For inpatient hospital care, see “Hospital – Inpatient Services.”
<b>Laboratory and Radiology Services</b>		
– Laboratory and x-rays		Deductible, then 20% Coinsurance
<b>Advanced radiology</b> – CT scans – PET scans – MRI – MRA – Nuclear medicine		Deductible, then 20% Coinsurance
<b>Please Note:</b> Certain laboratory and radiology services, including mammograms, may be available with no Member Cost Sharing if received from a Plan Provider. Please see your In-Network Schedule of Benefits for information on your In-Network coverage.		
<b>Low Protein Foods</b>		
– Limited to \$5,000 per calendar year		No charge

Benefit	Out-of-Network (Non-Plan Providers and Plan Providers without a referral when a referral is required) Member Cost Sharing
<b>Maternity Care - Outpatient</b>	
– Routine outpatient prenatal and postpartum care	Deductible, then 20% Coinsurance
<p><b>Please Note:</b> Routine prenatal and postpartum care is usually received and billed from the same Provider as a single or bundled service. Different Member Cost Sharing may apply to any specialized or non-routine service that is billed separately from your routine outpatient prenatal and postpartum care. For example, for services provided by another physician or specialist, see “Physician and Other Professional Services” for your applicable Member Cost Sharing. Please see your Benefit Handbook for more information on maternity care.</p>	
<b>Medical Formulas</b>	
	No charge
<b>Mental Health Care (Including the Treatment of Substance Abuse Disorders)</b>	
<b>Inpatient Mental Health Care Services</b>	Deductible, then 20% Coinsurance
<b>Intermediate Mental Health Care Services</b> – Acute residential treatment (including detoxification), crisis stabilization and in-home family stabilization – Intensive outpatient programs, partial hospitalization and day treatment programs	Deductible, then 20% Coinsurance
<b>Outpatient Mental Health Care Services</b>	<b>Group therapy</b> – Deductible, then 20% Coinsurance <b>Individual therapy</b> – Deductible, then 20% Coinsurance
– Detoxification	Deductible, then 20% Coinsurance
– Medication management	Deductible, then 20% Coinsurance
– Psychological testing and neuropsychological assessment	Deductible, then 20% Coinsurance
<b>Ostomy Supplies</b>	
	Deductible, then 20% Coinsurance
<b>Physician and Other Professional Office Visits (This includes all covered Providers unless otherwise listed in this Schedule of Benefits.)</b>	
– Routine examinations for preventive care, including immunizations	Deductible, then 20% Coinsurance
– Consultations, evaluations and sickness and injury care	Deductible, then 20% Coinsurance
– Administration of allergy injections	Deductible, then 20% Coinsurance
<b>Preventive Services and Tests</b>	
– Preventive care services, including all FDA approved contraceptive devices.	Deductible, then 20% Coinsurance

(Continued on next page)

Benefit	Out-of-Network (Non-Plan Providers and Plan Providers without a referral when a referral is required) Member Cost Sharing
<b>Preventive Services and Tests (Continued)</b>	
<b>Please Note:</b> Certain preventive services and tests may be available with no Member Cost Sharing if received from a Plan Provider. Please see your In-Network Schedule of Benefits for information on your In-Network coverage.	
Under federal law the list of preventive services and tests may change periodically based on the recommendations of the following agencies:	
<ul style="list-style-type: none"> <li>a. Grade "A" and "B" recommendations of the United States Preventive Services Task Force;</li> <li>b. With respect to immunizations, the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention; and</li> <li>c. With respect to services for women, infants, children and adolescents, the Health Resources and Services Administration.</li> </ul>	
Information on the recommendations of these agencies may be found on the web site of the U.S. Department of Health and Human Services at: <a href="https://www.healthcare.gov/what-are-my-preventive-care-benefits/#part=1">https://www.healthcare.gov/what-are-my-preventive-care-benefits/#part=1</a> .	
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 <a href="http://www.harvardpilgrim.org">www.harvardpilgrim.org</a> .	
<b>Prosthetic Devices</b>	
	Deductible, then 20% Coinsurance
<b>Rehabilitation Therapy - Outpatient</b>	
– Cardiac rehabilitation	Deductible, then 20% Coinsurance
– Pulmonary rehabilitation therapy	Deductible, then 20% Coinsurance
– Speech-language and hearing services	Deductible, then 20% Coinsurance
– Occupational therapy – limited to 30 visits per calendar year	Deductible, then 20% Coinsurance
– Physical therapy – limited to 30 visits per calendar year	
<b>Please Note:</b> 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.	
<b>Scopic Procedures - Outpatient Diagnostic and Therapeutic</b>	
– Endoscopy and sigmoidoscopy	[Your Member Cost Sharing will depend upon where the service is provided as listed in this Schedule of Benefits. For example, for a service provided in an outpatient surgical center, see "Surgery– Outpatient." For services provided in a physician's office, see "Physician and Other Professional Services." For inpatient hospital care, see "Hospital – Inpatient Services."
– Colonoscopy	Deductible, then 20% Coinsurance
<b>Please Note:</b> No Member Cost Sharing applies to certain preventive care services if received from a Plan Provider. Please see your In-Network Schedule of Benefits for information on your In-Network coverage.	
<b>Spinal Manipulative Therapy (including care by a chiropractor)</b>	
– Limited to \$500 per calendar year	Deductible, then 20% Coinsurance

<b>Benefit</b>		<b>Out-of-Network (Non-Plan Providers and Plan Providers without a referral when a referral is required) Member Cost Sharing</b>
<b>Surgery – Outpatient</b>		
		Deductible, then 20% Coinsurance
<b>Vision Services</b>		
– Routine eye examinations – limited to 1 exam per calendar year		Deductible, then 20% Coinsurance
– Vision hardware for special conditions (see the Benefit Handbook for details)		Deductible, then 20% Coinsurance
<b>Voluntary Sterilization</b>		
	Your Member Cost Sharing will depend upon where the service is provided as listed in this Schedule of Benefits. For example, for a service provided in an outpatient surgical center, see “Surgery– Outpatient.” For services provided in a physician’s office, see “Physician and Other Professional Office Visits.” For inpatient hospital care, see “Hospital – Inpatient Services.”	
<b>Please Note:</b> No Member Cost Sharing applies to certain preventive care services if received from a Plan Provider. Please see your In-Network Schedule of Benefits for information on your In-Network coverage.		
<b>Voluntary Termination of Pregnancy</b>		
	Your Member Cost Sharing will depend upon where the service is provided as listed in this Schedule of Benefits. For example, for a service provided in an outpatient surgical center, see “Surgery– Outpatient.” For services provided in a physician’s office, see “Physician and Other Professional Office Visits.” For inpatient hospital care, see “Hospital – Inpatient Services.”	
<b>Wigs and Scalp Hair Protheses (as required by law)</b>		
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 calendar year (see the Benefit Handbook for details)		Deductible, then 20% Coinsurance