Schedule of Benefits

THE HARVARD PILGRIM BEST BUY HSA HMO MASSACHUSETTS

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

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

In a Medical Emergency, you should go to the nearest emergency facility or call 911 or other local emergency number. A Referral from your PCP is not needed. 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**.

COVERED BENEFITS

Your Covered Benefits are administered on a calendar year basis.

General Cost Sharing Features:	Member Cost Sharing:
Coinsurance and Copayments	
	See Covered Benefits below
Deductible	
– Applies to all services except where specifically noted below.	$1,500 for Individual Coverage per calendar year $3,000 for Family Coverage per calendar year
Important Notice: If you have Family Coverage, the Deductible may be met by any combination of covered family Members. The Individual Deductible does not apply. No Member in the family is eligible for benefits subject to the Deductible until the Family Coverage Deductible is met. Once a Deductible is met, coverage by the Plan is subject to any other Member Cost sharing that may apply.	
Deductible Rollover	
	None
Out-of-Pocket Maximum	
Includes all Member Cost Sharing	$2,500 for Individual Coverage per calendar year $5,000 for Family Coverage per calendar year

General Cost Sharing Features:	Member Cost Sharing:
Out-of-Pocket Maximum (Continued)	
Important Notice: If you have Family Coverage, the Out-of-Pocket Maximum may be met by any combination of covered family Members. The individual Out-of-Pocket Maximum does not apply. Once the Out-of-Pocket Maximum has been reached, no additional Member Cost Sharing will be applied for the remainder of the calendar 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	
– Applied behavior analysis	Deductible, then no charge
Chemotherapy and Radiation Therapy	
	Deductible, then no charge
Dental Services	
Important Notice: Coverage of Dental Care is very limited. Please see your Benefit Handbook for the details of your coverage.	
– Emergency Dental Care **Please Note:** Services must be received within 3 days of injury	Deductible, then no charge
– Extraction of teeth impacted in bone	Deductible, then no charge
– Preventive Dental Care for children (up to the age of 13) – limited to 2 preventive dental exams per calendar year, only the following services are included: – Cleaning – Fluoride treatment – Teaching plaque control – X-rays	No charge
Dialysis	
– Dialysis services	Deductible, then no charge
– Installation of home equipment is covered up to $300 in a Member's lifetime.	Deductible, then no charge
Durable Medical Equipment	
– Durable medical equipment	Deductible, then 20% Coinsurance
– Blood glucose monitors, infusion devices and insulin pumps (including supplies)	Deductible, then no charge
– Oxygen and respiratory equipment	Deductible, then 20% Coinsurance
Early Intervention Services	
	Deductible, then no charge **Please Note:** The Plan does not cover the family participation fee required by the Massachusetts Department of Public Health.

Benefit	Your Cost Sharing
Emergency Room Care	
	Deductible, then no charge
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	Deductible, then no charge
Home Health Care	
	Deductible, then no charge
Hospice – Outpatient Services	
	Deductible, then no charge
Hospital – Inpatient Services	
– Acute hospital care	Deductible, then no charge
– Inpatient maternity care	Deductible, then no charge
– Inpatient routine nursery care, including prophylactic medication to prevent gonorrhea	No charge
– Inpatient rehabilitation – limited to 60 days per calendar year	Deductible, then no charge
– Skilled nursing facility – limited to 100 days per calendar year	Deductible, then no charge
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)	
	Deductible, then no charge
Laboratory and Radiology Services	
– Laboratory and x-rays	Deductible, then no charge
Advanced radiology – CT scans – PET scans – MRI – MRA – Nuclear medicine services	Deductible, then no charge
Please Note: No Member Cost Sharing applies to certain preventive care services. For a list of covered preventive services, please see the Preventive Services notice at: **www.harvardpilgrim.org**.	

Benefit	Your Cost Sharing
Low Protein Foods	
– Limited to $5,000 per calendar year	Deductible, then no charge
Maternity Care - Outpatient	
– Routine outpatient prenatal and postpartum care	No charge The Deductible does not apply to prenatal and postpartum care provided in a physician's office. All other care is covered as stated in this Schedule of Benefits.
Please Note: Routine prenatal and postpartum care is usually received and billed from the same Provider as a single or bundled service. Different Member Cost Sharing may apply to any specialized or non-routine service that is billed separately from your routine outpatient prenatal and postpartum care. For example, for services provided by another physician or specialist, see "Physician and Other Professional Office Visits" for your applicable Member Cost Sharing. Please see your Benefit Handbook for more information on maternity care.	
Medical Formulas	
	Deductible, then no charge
Mental Health Care (Including the Treatment of Substance Abuse Disorders)	
Inpatient Mental Health Care Services	Deductible, then no charge
Intermediate Mental Health Care Services – Acute residential treatment (including detoxification), crisis stabilization and in-home family stabilization – Intensive outpatient programs, partial hospitalization and day treatment programs	Deductible, then no charge
– Outpatient mental health care services	**Group therapy** – Deductible, then no charge **Individual therapy** – Deductible, then no charge
– Detoxification	Deductible, then no charge
– Medication management	Deductible, then no charge
– Psychological testing and neuropsychological assessment	Deductible, then no charge
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, including immunizations	No charge
– Consultations, evaluations, sickness and injury care	Deductible, then no charge
– Administration of allergy injections	Deductible, then no charge

Benefit	Your Cost Sharing
Preventive Services and Tests	
– Preventive care services, including all FDA approved contraceptive devices. Under the federal health care reform law, many preventive services and tests are covered with no Member Cost Sharing. For a list of covered preventive services, please see the Preventive Services notice on our website at: **www.harvardpilgrim.org**. You may also get a copy of the Preventive Services notice by calling the Member Services Department at **1–888–333–4742**.	No charge
Under federal law the list of preventive services and tests may change periodically based on the recommendations of the following agencies: a. Grade "A" and "B" recommendations of the United States Preventive Services Task Force; b. With respect to immunizations, the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention; and c. With respect to services for women, infants, children and adolescents, the Health Resources and Services Administration. Information on the recommendations of these agencies may be found on the web site of the U.S. Department of Health and Human Services at: **https://www.healthcare.gov/what-are-my-preventive-care-benefits/#part=1**. Harvard Pilgrim will add or delete services from this benefit for preventive services and tests in accordance with changes in the recommendations of the agencies listed above. You can find a list of the current recommendations for preventive care on Harvard Pilgrim's web site at **www.harvardpilgrim.org**.	
Additional Preventive Services and Tests – Fetal ultrasound – Hepatitis C testing – Lead level testing – Prostate-specific antigen (PSA) screening – Routine hemoglobin tests – Routine urinalysis	No charge
Prosthetic Devices	
	Deductible, then 20% Coinsurance
Rehabilitation Therapy - Outpatient	
– Cardiac rehabilitation	Deductible, then no charge
– Pulmonary rehabilitation therapy	Deductible, then no charge
– Speech-language and hearing services	Deductible, then no charge

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Benefit	Your Cost Sharing
Rehabilitation Therapy - Outpatient (Continued)	
– Physical and occupational therapies – combined up to 20 visits per calendar 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	Deductible, then no charge
Please Note: No Member Cost Sharing applies to certain preventive care services. For a list of covered preventive services, please see the Preventive Services Notice at: **www.harvardpilgrim.org**.	
Spinal Manipulative Therapy (including care by a chiropractor)	
– Limited to 20 visits per calendar year	Deductible, then no charge
Surgery – Outpatient	
	Deductible, then no charge
Vision Services	
– 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)	Deductible, then no charge
Voluntary Sterilization	
	Deductible, then no charge
Please Note: No Member Cost Sharing applies to certain preventive care services. For a list of covered preventive services, please see the Preventive Services Notice at: **www.harvardpilgrim.org**.	
Voluntary Termination of Pregnancy	
	Deductible, then no charge
Wigs and Scalp Hair Prostheses as required by law	
– Limited to $350 per calendar year (see the Benefit Handbook for details)	Deductible, then 20% Coinsurance