Schedule of Benefits

Harvard Pilgrim Health Care, Inc.

The Harvard Pilgrim Independence Plan℠ POS
MASSACHUSETTS

Please Note: This Plan includes a In-Network tiered provider network. In this plan, Members pay different levels of Member Cost Sharing depending on the tier of the Provider delivering a Covered Benefit.

The Independence Plan Provider Directory includes Provider tiering information and is available online at site, **www.harvardpilgrim.org/GIC** or by calling the Member Services Department at **1-888-333-4742**. For TTY service, please call **711**.

This Schedule of Benefits states any Benefit Limits and Member Cost Sharing amounts you must pay for Covered Benefits. However, it is only a summary of your benefits. Please see your Benefit Handbook for details. Your Member Cost Sharing may include a Deductible, Coinsurance, and Copayments. Different Copayments apply depending on the type of Provider or the type of service. Please see the tables below for details.

You will find words in this Schedule of Benefits that have special meanings. When we use one of those words, we start it with a capital letter. Capitalized terms that are not defined in this Schedule of Benefits are defined in the Glossary in your Benefit Handbook.

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

In-Network coverage applies when Covered Benefits are provided or arranged by your Primary Care Provider (PCP) in the Service Area, or provided by a Plan Provider outside of the Service Area.

Out-of-Network coverage applies when Covered Benefits are provided by a Non-Plan Provider or provided by a Plan Provider without a Referral when a Referral is required. If a Non-Plan Provider charges any amount in excess of the Allowed Amount, you are responsible for the excess amount.

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

Prior Approval

Prior Approval is required for certain benefits. Before you receive services from a Non-Plan Provider or a Plan Provider outside the Service Area, please refer to our website, **www.harvardpilgrim.org** or contact the Member Services Department at **1-888-333-4742** for the complete listing of services that require Prior Approval.
To obtain Prior Approval please call:

- **1-800-708-4414** for medical services
- **1-844-387-1435** for Medical Drugs
- **1-888-777-4742** for mental health and substance use disorder treatment

More information about Prior Approval can be found on our website, **www.harvardpilgrim.org** and in your Benefit Handbook.

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 on our website at **www.harvardpilgrim.org** or by calling **1-888-888-4742**.

In-Network Tiered Providers

In-Network acute hospitals, PCPs, and medical specialists are placed into one of three benefit levels or "tiers." Member Cost Sharing for these Providers depends upon the tier in which a Provider is placed. Tier 1 is the lowest cost tier. Tier 2 is the medium cost tier. Tier 3 is the highest cost tier. Only acute care hospitals, PCPs, and medical specialists are assigned to one of three tiers. In some cases, a Provider may practice at more than one location and may have a different tier assigned to each location. Different out-of-pocket costs may apply to the same Provider based upon where you are treated by that Provider.

Certain Plan Providers in specialties such as cardiology, gastroenterology and obstetrics/gynecology may also be Providers in internal medicine, pediatrics or other primary care specialties. When these Providers bill us for their services as PCPs, the applicable tiered PCP Copayment will apply. When these Providers bill us for their services as specialists, the applicable tiered specialty Copayment will apply.

Some Plan Providers work from offices that are operated by a hospital. When services are rendered and billed from such an office or hospital outpatient department, a Tier 2 Specialist Copayment will be applied. However, please contact 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, nurse practitioner or a physician assistant in such an office to determine if you are subject to the PCP Copayment and which Tiered PCP Copayment will apply.

You can lower your out-of-pocket cost by selecting In-Network physicians and hospitals in the lower cost tiers. The tables below list the Member Cost Sharing for each type of tiered service. The Independence Plan Provider Directory lists all Plan Providers and their tier. You can access the Independence Plan Provider Directory at **www.harvardpilgrim.org/GIC.** You may also obtain a paper copy of the directory, free of charge, by calling our Member Services Department at **1–888–333–4742**.

Please note: When you choose a Provider, it is important to consider the tier of the hospital that your Provider uses. For example, a Tier 1 Provider may admit patients to a Tier 2 or to a Tier 3 hospital. If your Tier 1 PCP were to refer you to a Tier 3 hospital, you would pay the lowest out-of-pocket costs for physician services but the highest out-of-pocket costs for hospital care.

Non-Tiered Benefits

For certain Covered Benefits Member Cost Sharing is not tiered. These Covered Benefits include services provided by Plan Providers in the following specialties: behavioral health; early intervention; physical, speech and occupational therapy; chiropractic; audiology; and optometry. Your Member Cost Sharing for these Covered Benefits is listed in the tables below.

IMPORTANT POINTS TO REMEMBER

Under a Tiered Network Plan, your out-of-pocket costs will vary depending on whom you see and where you go for care. Please review and consider the following when seeking care under your Independence Plan:

- You can lower your out-of-pocket cost by selecting the Providers and hospitals in the lower cost tier.
- When you choose a PCP, it is important to consider the tier of the hospital that your PCP uses. For example, a Tier 1 PCP may admit patients to a Tier 2 or Tier 3 Hospital.
- A Provider may practice at more than one location and may have a different tier assigned to each location. Different out-of-pocket costs may apply to the same Provider based upon where you are treated by that Provider.

General Cost Sharing Features:	Member Cost Sharing:
Tiered Copayments	
	Tier 1 PCP Copayment: $10 per visit Tier 2 PCP Copayment: $20 per visit Tier 3 PCP Copayment: $40 per visit Tier 1 Specialist Copayment: $30 per visit Tier 2 Specialist Copayment: $60 per visit Tier 3 Specialist Copayment: $75 per visit
In-Network Inpatient Hospital Copayments	
Medical care	Hospital Tier 1 Inpatient Copayment: $275 per admission Hospital Tier 2 Inpatient Copayment: $500 per admission Hospital Tier 3 Inpatient Copayment: $1,500 per admission
Mental health care (Including the treatment of substance use disorders)	$275 Copayment per admission
Please Note: There is an Inpatient Hospital Copayment maximum of one Medical or Mental Health Care inpatient Copayment per Member during each Quarter in a Plan Year.	
If you are readmitted to a medical hospital or mental health care hospital in a new Quarter, but within 30 calendar days of a discharge, your second Inpatient Hospital 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 Plan Year basis. The bullets below list examples of when you can expect to pay a Inpatient Hospital Copayment and when you can expect that Copayment to be waived: • If you are admitted from March 2 until March 7, you are responsible for an Inpatient Hospital Copayment. If you are then readmitted from March 12 until March 15, the second Inpatient Hospital 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 Hospital 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 Hospital Copayment. The second admission occurred more than 30 days from the original discharge and it is a new Quarter. • If you are admitted June 2 until June 7, and then readmitted July 1 until July 4, you are responsible for the second Inpatient Hospital Copayment. Although the second admission occurred less than 30 days from the original discharge, it happened during a new Plan Year.	

General Cost Sharing Features:	Member Cost Sharing:
Surgical Day Care Copayment	
	$250 Copayment per visit, or $150 Copayment per visit for outpatient eye and gastrointestinal surgical procedures received in an ambulatory surgical center (ASC), up to a maximum of 4 Surgical Day Care Copayments per Member per Plan Year. See the benefit for Surgical Day Care below for details.
Other Copayments	
	See Covered Benefits below for details.
Deductibles – Medical	
In-Network Deductible	$500 per Member per Plan Year $1,000 per family per Plan Year
Out-of-Network Deductible	$500 per Member per Plan Year $1,000 per family per Plan Year
The In-Network Deductible for medical care is separate from the Out-of-Network Deductible.	
Coinsurance	
In-Network Coinsurance	20% Coinsurance for Skilled Nursing Facility care
Out-of-Network Coinsurance	20% Coinsurance
Out-of-Pocket Maximum	
Includes all In-Network Member Cost Sharing	$5,000 per Member per Plan Year $10,000 per family per Plan Year
Includes all Out-of-Network Member Cost Sharing except: • Copayments • Coinsurance for Skilled Nursing Facility care • Any charges above the Allowed Amount • Any penalty for failure to receive Prior Approval when using Non-Plan Providers	$5,000 per Member per Plan Year $10,000 per family per Plan Year
Out-of-Network Penalty Payment	
Does not count toward the Deductible or Out-of-Pocket Maximum.	$500 for medical care $200 for mental health care (including the treatment of substance use disorders)

Covered Benefits

Your Covered Benefits are administered on a Plan Year basis. The benefit table below is a summary of the services covered by your Plan. It also indicates your Member Cost Sharing, such as Copayment, Deductible or Coinsurance amounts. More detailed information about Covered Benefits can be found in your Benefit Handbook. Your Member Cost Sharing will depend upon the type of service provided and the location the service is provided in, as listed in this Schedule of Benefits. For example, for services provided in a physician's office, see "Physician and Other Professional Office Visits." For services provided in a hospital emergency room, see "Emergency Room Care," and for outpatient surgical procedures, please see "Surgical Day Care."

You have one set of Covered Benefits under the Plan. If a benefit limit applies (such as a day, visit or dollar limit), HPHC calculates your utilization for that benefit based on the Covered Benefits you have received from both In-Network Plan Providers and Out-of-Network Non-Plan Providers.

Benefit	In-Network Plan Providers with a proper Referral Member Cost Sharing	Out-of-Network Non-Plan Providers and Plan Providers without a Referral Member Cost Sharing
Ambulance Transport		
Emergency ambulance transport, including ground and/or air transportation	Deductible, then no charge	Same as In-Network
Non-emergency ambulance transport (ground only)	Deductible, then no charge	Deductible, then 20% Coinsurance
Autism Spectrum Disorders Treatment		
Applied behavior analysis	$10 Copayment per visit	Deductible, then 20% Coinsurance
Chemotherapy and Radiation Therapy		
	Deductible, then no charge	Deductible, then 20% Coinsurance
Chiropractic Care		
– Limited to 20 visits per Plan Year	$20 Copayment per visit	Deductible, then 20% Coinsurance
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 (received within 3 days of injury) Reduction of fractures and removal of cysts or tumors	Office Visits: $60 Copayment per visit Hospital Inpatient Services: Hospital Tier 1: $275 Copayment per admission, then Deductible Hospital Tier 2: $500 Copayment per admission, then Deductible Hospital Tier 3: $1,500 Copayment per admission, then Deductible Surgical Day Care: $250 Copayment per visit, then Deductible	Deductible, then 20% Coinsurance

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Benefit	In-Network Plan Providers with a proper Referral Member Cost Sharing	Out-of-Network Non-Plan Providers and Plan Providers without a Referral Member Cost Sharing
Dental Services (Continued)		
Please note: The Covered Benefits below are **only** provided when the Member has a serious medical condition that makes it essential that he or she be admitted to a 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. – 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	Hospital Inpatient Services: Hospital Tier 1: $275 Copayment per admission, then Deductible Hospital Tier 2: $500 Copayment per admission, then Deductible Hospital Tier 3: $1,500 Copayment per admission, then Deductible Surgical Day Care: $250 Copayment per visit, then Deductible	Deductible, then 20% Coinsurance
Diabetes Equipment and Supplies		
Diabetes equipment	Deductible, then no charge	Deductible, then 20% Coinsurance
Blood glucose monitors, insulin pumps and supplies and infusion devices	Deductible, then no charge	Deductible, then no charge
Diabetes equipment including needles and syringes for the administration of insulin are covered by this Plan. Insulin (other than insulin administered with an insulin pump) and other pharmacy supplies are covered under your outpatient prescription drug coverage, which is not administered by HPHC. Please see your **Express Scripts Prescription Drug Plan brochure** or call **Express Scripts** at **855–283–7679** for information on coverage of outpatient prescription drugs.		
Pharmacy supplies	See your **Express Scripts Prescription Drug Plan brochure** for cost sharing amounts.	
Dialysis		
Dialysis services	Deductible, then no charge	Deductible, then 20% Coinsurance
Installation of home equipment.	Deductible, then no charge	Deductible, then 20% Coinsurance
Durable Medical Equipment		
Durable medical equipment	Deductible, then no charge	Deductible, then 20% Coinsurance
Oxygen and respiratory equipment	Deductible, then no charge	Deductible, then 20% Coinsurance
Early Intervention Services		
	No charge	Deductible, then 20% Coinsurance
The Plan does not cover the family participation fee required by the Massachusetts Department of Public Health.		

Benefit	In-Network Plan Providers with a proper Referral Member Cost Sharing	Out-of-Network Non-Plan Providers and Plan Providers without a Referral Member Cost Sharing
Emergency Admission		
	Hospital Tier 1: $275 Copayment per admission, then Deductible Hospital Tier 2: $500 Copayment per admission, then Deductible Hospital Tier 3: $1,500 Copayment per admission, then Deductible **Please Note:** Emergency admission to a mental health facility is subject to a $275 Copayment per admission.	Same as In-Network
Emergency Room Care		
	$100 Copayment per visit, then the Deductible	Same as In-Network
This $100 Copayment is waived if the patient is admitted directly to the hospital from the emergency room.		
Hearing Aids		
Hearing Aids (for Members up to the age of 22) – $2,000 per hearing aid every 24 months, for each hearing impaired ear	No charge	Deductible, then 20% Coinsurance
Hearing aids - (for Member ages 22 and older) – $2,000 every 2 Plan Years	No charge for the first $500 20% Coinsurance on the remaining $1,500 (which equals $300). **Note:** The $2,000 benefit includes the $1,700 maximum paid by the Plan and the $300 Member Cost Sharing.	
Home Health Care Services		
	Deductible, then no charge No cost sharing applies to durable medical equipment, physical therapy or occupational therapy received as part of authorized home health care.	Deductible, then 20% Coinsurance
Hospice – Outpatient		
	Deductible, then no charge	Deductible, then 20% Coinsurance

Benefit	In-Network Plan Providers with a proper Referral Member Cost Sharing	Out-of-Network Non-Plan Providers and Plan Providers without a Referral Member Cost Sharing
Hospital – Inpatient Services		
Acute hospital care	Hospital Tier 1: $275 Copayment per admission, then Deductible Hospital Tier 2: $500 Copayment per admission, then Deductible Hospital Tier 3: $1,500 Copayment per admission, then Deductible	Deductible, then 20% Coinsurance
Inpatient maternity care Non-routine inpatient services for the newborn	Hospital Tier 1: $275 Copayment per admission, then Deductible Hospital Tier 2: $500 Copayment per admission, then Deductible Hospital Tier 3: $1,500 Copayment per admission, then Deductible	Deductible, then 20% Coinsurance
Inpatient routine nursery care	No charge	Deductible, then 20% Coinsurance
Inpatient rehabilitation	Deductible, then no charge	Deductible, then 20% Coinsurance
Skilled Nursing Facility limited to 45 days per Plan Year	Deductible, then 20% Coinsurance	Deductible, then 20% Coinsurance
Infertility Services and Treatments (see the Benefit Handbook for details)		
– Advanced reproductive technologies are limited to 5 cycles per lifetime	Tier 1 PCP Copayment: $10 per visit Tier 2 PCP Copayment: $20 per visit Tier 3 PCP Copayment: $40 per visit Tier 1 Specialist Copayment: $30 per visit Tier 2 Specialist Copayment: $60 per visit Tier 3 Specialist Copayment: $75 per visit	Deductible, then 20% Coinsurance
Laboratory, Radiology and Other Diagnostic Services		
Laboratory	Deductible, then no charge	Deductible, then 20% Coinsurance
Genetic testing	Deductible, then no charge	Deductible, then 20% Coinsurance

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Benefit	In-Network Plan Providers with a proper Referral Member Cost Sharing	Out-of-Network Non-Plan Providers and Plan Providers without a Referral Member Cost Sharing
Laboratory, Radiology and Other Diagnostic Services (Continued)		
Radiology	Deductible, then no charge	Deductible, then 20% Coinsurance
Advanced radiology, including CT scans, PET scans, MRI, MRA and nuclear medicine services	$100 Copayment per scan, then Deductible. There is a maximum of one Copayment per Member per day.	Deductible, then 20% Coinsurance
Other diagnostic services	Deductible, then no charge	Deductible, then 20% Coinsurance
Low Protein Foods		
	Deductible, then no charge	Deductible, then 20% Coinsurance
Maternity Care – Outpatient		
Routine outpatient prenatal and postpartum care	No charge	Deductible, then 20% Coinsurance
Non-routine outpatient prenatal and postpartum care	Deductible, then no charge	Deductible, then 20% Coinsurance
Medical Drugs (drugs that cannot be self-administered)		
Medical drugs received in a physician's office or other outpatient facility	Deductible, then no charge	Deductible, then 20% Coinsurance
Medical drugs received in the home	Deductible, then no charge	Deductible, then 20% Coinsurance
Some Medical Drugs may be supplied by a specialty pharmacy. When Medical Drugs are supplied by a specialty pharmacy, the Member Cost Sharing listed above will apply. Your outpatient prescription drug coverage is not administered by HPHC. Please see your **Express Scripts Prescription Drug Plan brochure** or call **Express Scripts** at **855–283–7679** for information on coverage of outpatient prescription drugs.		
Medical Formulas		
	Deductible, then no charge	Deductible, then 20% Coinsurance
Mental Health and Substance Use Disorder Treatment		
Inpatient services – Mental health services – Drug and Alcohol Rehabilitation Services – Detoxification	$275 Copayment per admission	Deductible, then 20% Coinsurance
Intermediate services – Acute residential treatment, including detoxification (long-term residential treatment is not covered), crisis stabilization, and in-home family stabilization	No charge	Deductible, then 20% Coinsurance

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Benefit	In-Network Plan Providers with a proper Referral Member Cost Sharing	Out-of-Network Non-Plan Providers and Plan Providers without a Referral Member Cost Sharing
Mental Health and Substance Use Disorder Treatment (Continued)		
– Intensive outpatient programs, partial hospitalization and day treatment programs, 24-hour intermediate care facilities, and therapeutic foster care		
Outpatient therapy services – Mental health services – Drug and alcohol rehabilitation services	Group therapy – $10 Copayment per visit Individual therapy – $10 Copayment per visit Telemedicine virtual visit – $10 Copayment per visit	Deductible, then 20% Coinsurance
Outpatient detoxification	No charge	Deductible, then 20% Coinsurance
Outpatient medication management	$10 Copayment per visit	Deductible, then 20% Coinsurance
Outpatient methadone maintenance	No charge	Deductible, then 20% Coinsurance
Outpatient psychological testing and neuropsychological assessment	No charge	Deductible, then 20% Coinsurance
Prior Approval is not required to obtain substance use disorder treatment from a Plan Provider. In addition, when services are obtained from a Plan Provider, the Plan will not deny coverage for the first 14 days of (1) Acute Treatment Services or (2) Clinical Stabilization Services for the treatment of substance use disorders so long as the Plan receives notice from the Plan Provider within 48 hours of admission. The terms "Acute Treatment Services" and "Clinical Stabilization Services" are defined in the Glossary at Section II of your Benefit Handbook. Services beyond the 14 day period may be subject to concurrent review as described in section J. Utilization Review Procedures of your Handbook.		
Observation Services		
	Deductible, then no charge	Deductible, then 20% Coinsurance
Ostomy Supplies		
	Deductible, then no charge	Deductible, then 20% Coinsurance
Outpatient Prescription Drug Coverage		
Your outpatient prescription drug coverage is not administered by HPHC. Please see your **Express Scripts Prescription Drug Plan brochure** or call **Express Scripts** at **855–283–7679** for information on coverage of outpatient prescription drugs. Regardless of whether the Express Scripts brochure is specifically noted in a handbook section, any reference to outpatient drugs found within this handbook is governed by the Express Scripts Prescription Drug Plan brochure.		
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	Deductible, then 20% Coinsurance

Benefit	In-Network Plan Providers with a proper Referral Member Cost Sharing	Out-of-Network Non-Plan Providers and Plan Providers without a Referral Member Cost Sharing
Physician and Other Professional Office Visits (This includes all covered Plan Providers unless otherwise listed in this Schedule of Benefits) (Continued)		
Not all services you receive during your routine exam are covered at no charge. Only preventive services designated under the Patient Protection and Affordable Care Act (PPACA) are covered at no charge. Other services not included under PPACA may be subject to additional cost sharing. For the current list of preventive services covered at no charge under PPACA, please see our website at **www.harvardpilgrim.org/GIC**. Please see "Laboratory, Radiology and Other Diagnostic Services" for the Member Cost Sharing that applies to diagnostic services not included on this list.		
Consultations, evaluations, sickness and injury care Nutritional counseling (limited to 3 visits for non-diabetes and non-eating disorder related conditions per Plan Year)	Tier 1 PCP Copayment: $10 per visit Tier 2 PCP Copayment: $20 per visit Tier 3 PCP Copayment: $40 per visit Tier 1 Specialist Copayment: $30 per visit Tier 2 Specialist Copayment: $60 per visit Tier 3 Specialist Copayment: $75 per visit	Deductible, then 20% Coinsurance
Administration of allergy injections Allergy tests and treatments Diagnostic screening and tests (including EKGs)	Deductible, then no charge	Deductible, then 20% Coinsurance
Preventive Services and Tests		
Preventive care services, including all FDA approved generic 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/GIC**. You may also get a copy of the Preventive Services Notice by calling the Member Services Department at **1–888–333–4742**.	No charge	Deductible, then 20% Coinsurance
Under applicable federal and state law, many preventive services and tests are covered with no Member Cost Sharing, including preventive colonoscopies, certain labs and x-rays, voluntary sterilization for women, and all FDA approved contraceptive devices. For a complete list of covered preventive services and tests go to HPHC's website at **www.harvardpilgrim.org/GIC**. You may also get a copy by calling the		

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Benefit	In-Network Plan Providers with a proper Referral Member Cost Sharing	Out-of-Network Non-Plan Providers and Plan Providers without a Referral Member Cost Sharing
Preventive Services and Tests (Continued)		
Member Services department at **1–888–333–4742**. HPHC will add or delete services from this benefit for preventive services and tests in accordance with federal and state guidance.		
Prosthetics		
	Deductible, then no charge	Deductible, then 20% Coinsurance
Reconstructive Surgery		
	Hospital Tier 1: $275 Copayment per admission, then Deductible Hospital Tier 2: $500 Copayment per admission, then Deductible Hospital Tier 3: $1,500 Copayment per admission, then Deductible	Deductible, then 20% Coinsurance
Rehabilitation and Habilitation Services - Outpatient		
Cardiac rehabilitation	Tier 1 PCP Copayment: $10 per visit Tier 2 PCP Copayment: $20 per visit Tier 3 PCP Copayment: $40 per visit Tier 1 Specialist Copayment: $30 per visit Tier 2 Specialist Copayment: $60 per visit Tier 3 Specialist Copayment: $75 per visit	Deductible, then 20% Coinsurance
Pulmonary rehabilitation therapy	$20 Copayment per visit	Deductible, then 20% Coinsurance
Speech-language and hearing services	No charge	Deductible, then 20% Coinsurance
Occupational therapy limited to 90 consecutive days per illness or injury Physical therapy limited to 90 consecutive days per illness or injury	$20 Copayment per visit	Deductible, then 20% Coinsurance
Outpatient physical and occupational therapy is not subject to the limit listed above and is covered to the extent Medically Necessary for: (1) children under the age of three and (2) the treatment of Autism Spectrum Disorders.		
Smoking Cessation		
Smoking Cessation (please see your Benefit Handbook for details on your coverage)	No charge	Deductible, then 20% Coinsurance

Benefit	In-Network Plan Providers with a proper Referral Member Cost Sharing	Out-of-Network Non-Plan Providers and Plan Providers without a Referral Member Cost Sharing
Surgical Day Care including Scopic Procedures		
Outpatient surgery, including outpatient scopic procedures (except for eye and gastrointestinal procedures)	$250 Copayment per visit, then Deductible	Deductible, then 20% Coinsurance
Outpatient eye surgical procedures and gastrointestinal surgical procedures, including but not limited to colonoscopy, endoscopy and sigmoidoscopy		
– In an ambulatory surgical center (ASC)	$150 Copayment per visit, then Deductible	Deductible, then 20% Coinsurance
– In a hospital	$250 Copayment per visit, then Deductible	
	There is a maximum of four Surgical Day Care Copayments per Member per Plan Year.	
For a list of covered ambulatory surgical centers (ASC) go to our website at **www.harvardpilgrim.org/GIC**, select your plan, Independence, then click "Provider Directory – effective July 1, 2019" under Quicklinks on the right side of the page.		
Telemedicine Virtual Visit Services		
Outpatient telemedicine virtual visit services: - Medical services	$15 Copayment per visit	Deductible, then 20% Coinsurance
- Mental health and substance use disorder services	$10 Copayment per visit	Deductible, then 20% Coinsurance
For inpatient hospital care, see "Hospital - Inpatient Services."		
Temporomandibular Joint Dysfunction Services		
	Tier 1 PCP Copayment: $10 per visit Tier 2 PCP Copayment: $20 per visit Tier 3 PCP Copayment: $40 per visit Tier 1 Specialist Copayment: $30 per visit Tier 2 Specialist Copayment: $60 per visit Tier 3 Specialist Copayment: $75 per visit	Deductible, then 20% Coinsurance
No Dental Care is covered for the treatment of Temporomandibular Joint Dysfunction (TMD).		

Benefit	In-Network Plan Providers with a proper Referral Member Cost Sharing	Out-of-Network Non-Plan Providers and Plan Providers without a Referral Member Cost Sharing
Transgender Health Services		
	Hospital Inpatient Services: Hospital Tier 1: $275 Copayment per admission, then Deductible Hospital Tier 2: $500 Copayment per admission, then Deductible Hospital Tier 3: $1,500 Copayment per admission, then Deductible Surgical Day Care: $250 Copayment per visit, then Deductible	Deductible, then 20% Coinsurance
Urgent Care Services		
Convenience care clinic	$10 Copayment per visit	Deductible, then 20% Coinsurance
Urgent care center (including hospital urgent care center)	$20 Copayment per visit	Deductible, then 20% Coinsurance
Additional Member Cost Sharing may apply. Please refer to the specific benefit in this Schedule of Benefits. For example, if you have an x-ray or have blood drawn, please refer to "Laboratory, Radiology and Other Diagnostic Services."		
Vision Services		
Routine eye examinations – limited to 1 exam every 24 months	Optometrist Copayment: $20 per visit Ophthalmologist Copayment: – Tier 1 Specialist Copayment: $30 per visit. – Tier 2 Specialist Copayment: $60 per visit. – Tier 3 Specialist Copayment: $75 per visit.	Deductible, then 20% Coinsurance
Vision hardware (such as eyeglasses or contact lenses) only for limited conditions (please see your Benefit Handbook for details and limits on your coverage)	Deductible, then no charge	Deductible, then 20% Coinsurance

Benefit	In-Network Plan Providers with a proper Referral Member Cost Sharing	Out-of-Network Non-Plan Providers and Plan Providers without a Referral Member Cost Sharing
Voluntary Sterilization		
	Office visits: Tier 1 Specialist Copayment: $30 per visit Tier 2 Specialist Copayment: $60 per visit Tier 3 Specialist Copayment: $75 per visit Surgical Day Care: $250 Copayment per visit, then Deductible	Deductible, then 20% Coinsurance
Voluntary Termination of Pregnancy		
	Office visits: Tier 1 Specialist Copayment: $30 per visit Tier 2 Specialist Copayment: $60 per visit Tier 3 Specialist Copayment: $75 per visit Surgical Day Care: $250 Copayment per visit, then Deductible	Deductible, then 20% Coinsurance
Wigs and Scalp Hair Prostheses		
When needed as a result of any form of cancer or leukemia, alopecia areata, alopecia totalis or permanent hair loss due to injury.	No charge	Deductible, then 20% Coinsurance