Schedule of Benefits

Harvard Pilgrim Health Care, Inc.

The Harvard Pilgrim Primary Choice℠ Plan
MASSACHUSETTS

Please Note: This Plan includes a 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 Primary Choice Provider Directory includes provider tiering information and is available online at **www.harvardpilgrim.org/GIC** or by calling Member Services at **1-888-333-4742**. For TTY service, please call **711**.

This Schedule of Benefits states any Benefit Limits and Member Cost Sharing amounts that you must pay for Covered Benefits. However, it is only a summary of your Covered 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.

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 Primary Choice PCP is not needed. Your emergency room Member Cost Sharing is listed in the tables below.

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/GIC** or by calling **1-888-888-4742**.

Tiered Providers

Most hospitals and physicians covered by the Plan are placed into one of two benefit levels or "tiers." Member Cost Sharing for these Providers depends upon the tier in which a Provider is placed. Tier 1 is the lower cost tier and Tier 2 is the higher cost tier. Only acute care hospitals, Primary Care Providers (PCPs) and medical specialists are assigned to one of two 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 Primary Choice 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 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 the physicians and hospitals in the lower cost tier. The tables below list the Member Cost Sharing for each type of tiered service. The Primary Choice Provider Directory lists all Plan Providers and their tier. You can access the Primary Choice Provider Directory at **www.harvardpilgrim.org/GIC**. You may also obtain a paper copy of the directory, free of charge, by calling HPHC's Member Services Department at **1–888–333–4742**.

Please Note: 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 Hospital. If your Tier 1 PCP were to refer you to a Tier 2 hospital, you would pay the lower out-of-pocket costs for physician services but the higher 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 Primary Choice 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 Primary Choice 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 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.
- Some Primary Choice Providers have multiple offices and may be a Primary Choice Provider at one location, and not at another. You must check with HPHC to make sure the services you seek are covered under your Primary Choice Plan for that specific Provider at that specific location.
- 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.

General Cost Sharing Features:	Member Cost Sharing:
Tiered Copayments	
	Tier 1 PCP Copayment: $20 per visit. Tier 2 PCP Copayment: $20 per visit. Tier 1 Specialist Copayment: $30 per visit. Tier 2 Specialist Copayment: $60 per visit.
Inpatient Hospital Copayments	
Medical care	Hospital Tier 1 Inpatient Copayment: $275 per admission Hospital Tier 2 Inpatient Copayment: $500 per admission
Mental health care (including the treatment of substance use disorders)	$275 Copayment per admission

General Cost Sharing Features:	Member Cost Sharing:
Inpatient Hospital Copayments (Continued)	
Please Note: There is an Inpatient 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.	
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.
Deductible – Medical	
	$400 per Member per Plan Year $800 per family per Plan Year
Coinsurance	
	20% Coinsurance for Skilled Nursing Facility care
Out-of-Pocket Maximum	
Includes all Member Cost Sharing	$5,000 per Member per Plan Year $10,000 per family per Plan Year

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."

Benefit	Member Cost Sharing
Ambulance Transport	
Emergency ambulance transport, including ground and/or air transportation	Deductible, then no charge
Non-emergency ambulance transport (ground only)	Deductible, then no charge
Autism Spectrum Disorders Treatment	
Applied behavior analysis	$20 Copayment per visit
Chemotherapy and Radiation Therapy	
	Deductible, then no charge
Chiropractic Care	
– Limited to 20 visits per Plan Year	$20 Copayment per visit
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 Surgical Day Care: $250 Copayment per visit, then Deductible
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	Hospital Inpatient Services: Hospital Tier 1: $275 Copayment per admission, then Deductible Hospital Tier 2: $500 Copayment per admission, then Deductible Surgical Day Care:

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Benefit	Member Cost Sharing
Dental Services (Continued)	
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	$250 Copayment per visit, then Deductible
Diabetes Equipment and Supplies	
Diabetes equipment	Deductible, then no charge
Blood glucose monitors, insulin pumps and supplies and infusion devices	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
Installation of home equipment.	Deductible, then no charge
Durable Medical Equipment	
Durable medical equipment	Deductible, then no charge
Oxygen and respiratory equipment	Deductible, then no charge
Early Intervention Services	
	No charge
The Plan does not cover the family participation fee required by the Massachusetts Department of Public Health.	
Emergency Admission	
	Hospital Tier 1: $275 Copayment per admission, then Deductible Hospital Tier 2: $500 Copayment per admission, then Deductible **Please Note:** Emergency admission to a mental health facility is subject to a $275 Copayment per admission
Emergency Room Care	
	$100 Copayment per visit, then the Deductible
This $100 Copayment is waived if the patient is admitted directly to the hospital from the emergency room.	

Benefit	Member Cost Sharing
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
Hearing aids – (for Members 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 or benefit limit applies to durable medical equipment, physical therapy or occupational therapy received as part of authorized home health care.
Hospice – Outpatient	
	Deductible, then no charge
Hospital – Inpatient Services	
Acute hospital care	Hospital Tier 1: $275 Copayment per admission, then Deductible Hospital Tier 2: $500 Copayment per admission, then Deductible
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
Inpatient routine nursery care	No charge
Inpatient rehabilitation	Deductible, then no charge
Skilled Nursing Facility limited to 45 days per Plan Year	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: $20 per visit Tier 2 PCP Copayment: $20 per visit. Tier 1 Specialist Copayment: $30 per visit Tier 2 Specialist Copayment: $60 per visit
Laboratory, Radiology and Other Diagnostic Services	
Laboratory	Deductible, then no charge
Genetic testing	Deductible, then no charge
Radiology	Deductible, then no charge
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.
Other diagnostic services	Deductible, then no charge

Benefit	Member Cost Sharing
Low Protein Foods	
	Deductible, then no charge
Maternity Care - Outpatient	
Routine outpatient prenatal and postpartum care	No charge
Non-routine outpatient prenatal and postpartum car	Deductible, then no charge
Medical Drugs (drugs that cannot be self-administered)	
Medical drugs received in a physician's office or other outpatient facility	Deductible, then no charge
Medical drugs received in the home	Deductible, then no charge
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
Mental Health and Substance Use Disorder Treatment	
Inpatient services – Mental health services – Drug and Alcohol Rehabilitation Services – Detoxification	$275 Copayment per admission
Intermediate services – Acute residential treatment, including detoxification (long-term residential treatment is not covered), crisis stabilization, and in home family stabilization – Intensive outpatient programs, partial hospitalization and day treatment programs, 24-hour intermediate care facilities, and therapeutic foster care	No charge
Outpatient therapy services – Mental health services – Drug and alcohol rehabilitation services	Group therapy – $15 Copayment per visit Individual therapy – $20 Copayment per visit Telemedicine virtual visit – $15 Copayment per visit
Outpatient detoxification	No charge
Outpatient medication management	$15 Copayment per visit
Outpatient methadone maintenance	No charge
Outpatient psychological testing and neuropsychological assessment	No charge

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Benefit	Member Cost Sharing
Mental Health and Substance Use Disorder Treatment (Continued)	
Prior Approval is not required to obtain substance use disorders treatment from a Primary Choice Provider. In addition, when services are obtained from a Primary Choice 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 Primary Choice Provider within 48 hours of admission. The terms "Acute Treatment Services" and "Clinical Stabilization Services" are defined in the Glossary 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
Ostomy Supplies	
	Deductible, then no charge
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 Primary Choice Providers unless otherwise listed in this Schedule of Benefits.)	
Routine examinations for preventive care, including immunizations	No charge
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: $20 per visit Tier 2 PCP Copayment: $20 per visit. Tier 1 Specialist Copayment: $30 per visit Tier 2 Specialist Copayment: $60 per visit
Administration of allergy injections Allergy tests and treatments Diagnostic screening and tests (including EKGs)	Deductible, then no charge

Benefit	Member Cost Sharing
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 complete 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
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 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
Reconstructive Surgery	
	Hospital Tier 1: $275 Copayment per admission, then Deductible Hospital Tier 2: $500 Copayment per admission, then Deductible
Rehabilitation and Habilitation Services - Outpatient	
Cardiac rehabilitation	Tier 1 PCP Copayment: $20 per visit Tier 2 PCP Copayment: $20 per visit. Tier 1 Specialist Copayment: $30 per visit Tier 2 Specialist Copayment: $60 per visit
Pulmonary rehabilitation therapy	$20 Copayment per visit
Speech-language and hearing services	No charge
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
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

Benefit	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
Outpatient eye and gastrointestinal surgical procedures, including but not limited to colonoscopy, endoscopy and sigmoidoscopy – In an ambulatory surgical center (ASC) – In a hospital	 $150 Copayment per visit, then Deductible $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, Primary Choice, 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
- Mental health and substance use disorder services	$15 Copayment per visit
For inpatient hospital care, see "Hospital - Inpatient Services."	
Temporomandibular Joint Dysfunction Services	
	Tier 1 PCP Copayment: $20 per visit Tier 2 PCP Copayment: $20 per visit. Tier 1 Specialist Copayment: $30 per visit Tier 2 Specialist Copayment: $60 per visit
No Dental Care is covered for the treatment of Temporomandibular Joint Dysfunction (TMD).	
Transgender Health Services	
	Hospital Inpatient Services: Hospital Tier 1: $275 Copayment per admission, then Deductible Hospital Tier 2: $500 Copayment per admission, then Deductible Surgical Day Care: $250 Copayment per visit, then Deductible
Urgent Care Services	
Convenience care clinic	$20 Copayment per visit
Urgent care center (including hospital urgent care center)	$20 Copayment per visit

Benefit	Member Cost Sharing
Urgent Care Services (Continued)	
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.
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
Voluntary Sterilization	
	Office visits: Tier 1 Specialist Copayment: $30 per visit Tier 2 Specialist Copayment: $60 per visit Surgical Day Care: $250 Copayment per visit, then Deductible
Voluntary Termination of Pregnancy	
	Office visits: Tier 1 Specialist Copayment: $30 per visit Tier 2 Specialist Copayment: $60 per visit Surgical Day Care: $250 Copayment per visit, then Deductible
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