Schedule of Benefits

The Harvard Pilgrim Tiered POS
MASSACHUSETTS

Please Note: This plan includes a tiered provider network called the **Tiered POS** network. In this plan, Members pay different levels of Deductibles, Copayments, or Coinsurance depending on the tier of the provider delivering a covered service or supply. This plan may make changes to a Provider's benefit tier annually on January 1. Please consult the **BILH Tiered POS** Provider Directory or visit the provider search tool at **www.harvardpilgrim.org/bilh** to determine the tier of Providers in the **Tiered POS** Network.

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.

This plan does not provide coverage for outpatient prescription drugs. Your coverage for prescription drugs is administered by a third party named Caremark. If you have questions regarding your pharmacy coverage, Caremark can be reached at **1–855–303–3980**.

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.

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 Physician (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.

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
- **1–888–333–4742** 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 at **www.harvardpilgrim.org** and in your Benefit Handbook.

TIERED PROVIDERS – IN–NETWORK

In-Network acute hospitals, Primary Care Providers (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 lower cost tier. Tier 2 is the medium cost tier. Tier 3 is the higher cost tier. Only acute care hospitals, Primary Care Physicians (PCPs) and medical specialists are assigned to one of three tiers. All other covered providers are assigned to Tier 2. In some cases, a provider may practice at more than one location and may have a different tier

assigned to each location. Keep in mind that different out-of-pocket costs may apply to the same provider based upon where you are treated by that provider.

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

Because Member Cost Sharing is dependent upon the tier placement of a doctor or hospital, you will have lower out-of-pocket costs when you select providers from the lower tier. You should consider a provider's tier and where the provider has hospital admitting privileges before selecting a provider. For example, if you require hospital care with a Tier 1 physician who performs your service at a Tier 1 hospital, you will pay the Tier 1 out-of-pocket costs for both your physician and hospital care. However, if you require hospital care with a Tier 1 physician who performs your service at a Tier 2 or Tier 3 hospital, you will pay the lower Tier 1 out-of-pocket costs for the physician services but the higher Tier 2 or Tier 3 out-of-pocket costs for hospital care.

Medical Necessity Guidelines

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 Medical Necessity Guidelines on our website at **www.harvardpilgrim.org** or by calling the Member Services Department at **1-888-333-4742**.

Covered Benefits

Your Covered Benefits are administered on a Calendar Year basis. 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 "Surgery – Outpatient."

When you receive a service at your home (other than home health care), your Member Cost Sharing will be the same as when the service is provided in an office or facility. For example, if you have a physician visit in your home, see "Physician and Other Professional Office Visits." If you have blood drawn at home, see "Laboratory, Radiology and Other Diagnostic Services."

General Cost Sharing Features:	In-Network Tier 1 Member Cost Sharing:	In-Network Tier 2 Member Cost Sharing:	In-Network Tier 3 Member Cost Sharing:	Out-of-Network Member Cost Sharing:
Coinsurance and Copayments				
	See the benefits table below			
Deductibles				
	None	$500 per Member per Calendar Year $1,000 per family per Calendar Year	$2,000 per Member per Calendar Year $4,000 per family per Calendar Year	$2,000 per Member per Calendar Year $4,000 per family per Calendar Year

General Cost Sharing Features:	In-Network Tier 1 Member Cost Sharing:	In-Network Tier 2 Member Cost Sharing:	In-Network Tier 3 Member Cost Sharing:	Out-of-Network Member Cost Sharing:
Deductibles (Continued)				
Please Note: The maximum amount you will pay for an In-Network Deductible in a Calendar Year will not exceed the Out-of-Network Deductible amounts. For Example, if you have satisfied your Tier 3 Member Deductible of $1,000 and then receive Covered Benefits from an Out-of-Network Provider that apply toward your Tier 3 Deductible, you will not be required to pay the full $2,000 Out–of–Network Deductible. $1,000 has already been satisfied when the Tier 3 Deductible was met.				
Deductible Rollover				
	None			
Out-of-Pocket Maximum				
Includes all In-Network and Out-of-Network Member Cost Sharing except: – Charges for prescription drugs. – Any charges above the Allowed Amount and any penalty for failure to receive Prior Approval when using Non-Plan Providers	$3,000 per Member per Calendar Year $6,000 per family per Calendar Year			
Out-of-Network Penalty Payment				
Applies when the Member fails to obtain required Prior Approval for services from a Non-Plan Provider. Does not count toward the Deductible or Out-of-Pocket Maximum.	$500			

Benefit	Tier 1 Member Cost Sharing	Tier 2 Member Cost Sharing:	Tier 3 Member Cost Sharing:	Out-of-Network Cost Sharing:
Acupuncture Treatment for Injury or Illness				
– Limited to 20 visits per Calendar Year	**Adults:** $30 Copayment per visit **Pediatrics (up to age 19):** $30 Copayment per visit			Deductible, then 30% Coinsurance
Ambulance and Medical Transport				
Emergency ambulance transport	No charge			Same as In-Network
Non-emergency medical transport	No charge			Deductible, then 30% Coinsurance
Autism Spectrum Disorders Treatment				
Applied behavior analysis	**Adults:** $20 Copayment per visit **Pediatrics (up to age 19):** $20 Copayment per visit			Deductible, then 30% Coinsurance

Benefit	Tier 1 Member Cost Sharing	Tier 2 Member Cost Sharing:	Tier 3 Member Cost Sharing:	Out-of-Network Cost Sharing:
Chemotherapy and Radiation Therapy				
	No charge	**Adults:** Deductible, then 10% Coinsurance **Pediatrics (up to age 19):** No charge	**Adults:** Deductible, then 20% Coinsurance **Pediatrics (up to age 19):** Deductible, then 20% Coinsurance	Deductible, then 30% Coinsurance
Dental Services				
Extraction of teeth impacted in bone (performed in a physician's office)	**Adults:** $20 Copayment per visit **Pediatrics (up to age 19):** $20 Copayment per visit			Deductible, then 30% Coinsurance
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 and bitewing x-rays.	$20 Copayment per visit			Deductible, then 30% Coinsurance
Important Notice: Coverage of Dental Care is very limited. Please see your Benefit Handbook for the details of your coverage.				
Dialysis				
	No charge		**Adults:** Deductible, then 20% Coinsurance **Pediatrics (up to age 19):** Deductible, then 20% Coinsurance	Deductible, then 30% Coinsurance
Durable Medical Equipment				
Durable medical equipment	No charge			Deductible, then 30% Coinsurance
Blood glucose monitors, infusion devices and insulin pumps (including supplies)	No charge			Deductible, then 30% Coinsurance
Oxygen and respiratory equipment	No charge			Deductible, then 30% Coinsurance
Early Intervention Services				
	$20 Copayment per visit			Deductible, then 30% Coinsurance

Benefit	Tier 1 Member Cost Sharing	Tier 2 Member Cost Sharing:	Tier 3 Member Cost Sharing:	Out-of-Network Cost Sharing:
Early Intervention Services (Continued)				
The Plan does not cover the family participation fee required by the Massachusetts Department of Public Health.				
Emergency Admission				
	No charge			Same as In-Network
Emergency Room Care				
	$150 Copayment per visit			Same as In-Network
This Copayment is waived if (1) transferred to either Observation Services or Outpatient Surgery or (2) admitted to the hospital directly from the emergency room. Please see "Hospital - Inpatient Services," "Observation Services," or "Surgery – Outpatient" for the Member Cost Sharing that applies to these benefits.				
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	No charge			Deductible, then 30% Coinsurance
Home Health Care				
	No charge			Deductible, then 30% Coinsurance
If services include the administration of drugs, please see the benefit for "Medical Drugs" for Member Cost Sharing details.				
Hospice – Outpatient				
	No charge			Deductible, then 30% Coinsurance
Hospital – Inpatient Services				
Acute hospital care	No charge	**Adults:** Deductible, then 10% Coinsurance **Pediatrics (up to age 19):** No charge	**Adults:** Deductible, then 20% Coinsurance **Pediatrics (up to age 19):** Deductible, then 20% Coinsurance	Deductible, then 30% Coinsurance
Inpatient maternity care	No charge	**Adults:** Deductible, then 10% Coinsurance **Pediatrics (up to age 19):** No charge	**Adults:** Deductible, then 20% Coinsurance **Pediatrics (up to age 19):** Deductible, then 20% Coinsurance	Deductible, then 30% Coinsurance

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Benefit	Tier 1 Member Cost Sharing	Tier 2 Member Cost Sharing:	Tier 3 Member Cost Sharing:	Out-of-Network Cost Sharing:
Hospital – Inpatient Services (Continued)				
Inpatient routine nursery care	No charge			Deductible, then 30% Coinsurance
Inpatient rehabilitation – limited to 60 days per Calendar Year	No charge			Deductible, then 30% Coinsurance
Skilled nursing facility – limited to 100 days per Calendar Year	No charge			Deductible, then 30% Coinsurance
Infertility Services and Treatments (see the Benefit Handbook for details)				
Consultations, Evaluations and Laboratory Tests	Your Member Cost Sharing will depend upon the types of services provided and the tier placement of the provider rendering services, as listed in this Schedule of Benefits. For example, for services provided by a physician, see "Physician and Other Professional Office Visits."			Deductible, then 30% Coinsurance
Infertility Treatment (as outlined in your Benefit Handbook)	No charge	Deductible, then 10% Coinsurance	Deductible, then 20% Coinsurance	Deductible, then 30% Coinsurance
Laboratory, Radiology and Other Diagnostic Services				
Laboratory, radiology, genetic testing, and other diagnostic services – In a physician's office or non-hospital affiliated facility	No charge	**Adults:** $75 Copayment per visit **Pediatrics (up to age 19):** No charge	**Adults:** $75 Copayment per visit **Pediatrics (up to age 19):** $75 Copayment per visit	Deductible, then 30% Coinsurance
Laboratory, radiology, genetic testing, and other diagnostic services – In a hospital or hospital affiliated facility	No charge	**Adults:** Deductible, then 10% Coinsurance **Pediatrics (up to age 19):** No charge	**Adults:** Deductible, then 20% Coinsurance **Pediatrics (up to age 19):** Deductible, then 20% Coinsurance	Deductible, then 30% Coinsurance
Advanced radiology, including CT scans, PET scans, MRI, MRA and nuclear medicine services – In a physician's office or non-hospital affiliated facility	No charge	**Adults:** $75 Copayment per visit **Pediatrics (up to age 19):** No charge	**Adults:** $75 Copayment per visit **Pediatrics (up to age 19):** $75	Deductible, then 30% Coinsurance

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Benefit	Tier 1 Member Cost Sharing	Tier 2 Member Cost Sharing:	Tier 3 Member Cost Sharing:	Out-of-Network Cost Sharing:
Laboratory, Radiology and Other Diagnostic Services (Continued)				
			Copayment per visit	
Advanced radiology, including CT scans, PET scans, MRI, MRA and nuclear medicine services – In a hospital or hospital affiliated facility	No charge	**Adults:** Deductible, then 10% Coinsurance **Pediatrics (up to age 19):** No charge	**Adults:** Deductible, then 20% Coinsurance **Pediatrics (up to age 19):** Deductible, then 20% Coinsurance	Deductible, then 30% Coinsurance
Low Protein Foods				
– Limited to $5,000 per Calendar Year	No charge			Deductible, then 30% Coinsurance
Maternity Care - Outpatient				
Childbirth classes	Harvard Pilgrim will reimburse you up to $150 annually for a childbirth class taken at any Harvard Pilgrim Health Care affiliated provider. Just send a copy of your receipt and completion certificate to: Harvard Pilgrim Health Care P.O. Box 699183 Quincy, MA 02269–9183			
Routine outpatient prenatal and postpartum care	No charge			Deductible, then 30% Coinsurance
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, Member Cost Sharing for services provided by a specialist is listed under "Physician and Other Professional Office Visits" and Member Cost Sharing for an ultrasound billed as a specialized or non-routine service is listed under "Laboratory, Radiology and Other Diagnostic Services."				
Medical Drugs (drugs that cannot be self-administered)				
Medical drugs received in a physician's office or other outpatient facility	No charge			Deductible, then 30% Coinsurance
Medical drugs received in the home	No charge			Deductible, then 30% Coinsurance
Please Note: Your Employer Group also provides outpatient prescription drug coverage through a third party called Caremark. Caremark provides coverage for most prescription drugs purchased at an outpatient pharmacy. Some Medical Drugs received in a physician's office or outpatient facility may be covered under your outpatient prescription drug benefit. Please contact Caremark at **1–855–303–3980** for information on outpatient prescription drugs.				

Benefit	Tier 1 Member Cost Sharing	Tier 2 Member Cost Sharing:	Tier 3 Member Cost Sharing:	Out-of-Network Cost Sharing:
Medical Formulas				
	No charge			Deductible, then 30% Coinsurance
Mental Health and Substance Use Disorder Treatment				
Inpatient services	No charge			Deductible, then 30% Coinsurance
Intermediate services – Acute residential treatment (including detoxification), crisis stabilization and in-home family stabilization – Intensive outpatient programs, partial hospitalization and day treatment programs	No charge			Deductible, then 30% Coinsurance
Outpatient group therapy	**Adults:** Tier 1 Primary Care Copayment: $20 per visit **Pediatrics (up to age 19):** Tier 1 Primary Care Copayment: $20 per visit			Deductible, then 30% Coinsurance
Outpatient treatment, including individual therapy, detoxification and medication management	**Adults:** Tier 1 Primary Care Copayment: $20 per visit **Pediatrics (up to age 19):** Tier 1 Primary Care Copayment: $20 per visit			Deductible, then 30% Coinsurance
Outpatient methadone maintenance	No charge			Deductible, then 30% Coinsurance
Outpatient psychological testing and neuropsychological assessment – Performed by a Licensed Mental Health Professional	**Adults:** Tier 1 Primary Care Copayment: $20 per visit **Pediatrics (up to age 19):** Tier 1 Primary Care Copayment: $20 per visit			Deductible, then 30% Coinsurance
– Performed by a Neurologist or other medical specialist	**Adults:** $30 Copayment per visit **Pediatrics (up to age 19):** $30 Copayment per visit	**Adults:** $45 Copayment per visit **Pediatrics (up to age 19):** $30 Copayment per visit	**Adults:** $100 Copayment per visit **Pediatrics (up to age 19):** $100 Copayment per visit	Deductible, then 30% Coinsurance
Outpatient telemedicine virtual visit services	**Adults:** Tier 1 Primary Care Copayment: $20 per visit **Pediatrics (up to age 19):** Tier 1 Primary Care Copayment: $20 per visit			Deductible, then 30% Coinsurance
Observation Services				
	No charge			Deductible, then 30% Coinsurance

Benefit	Tier 1 Member Cost Sharing	Tier 2 Member Cost Sharing:	Tier 3 Member Cost Sharing:	Out-of-Network Cost Sharing:
Ostomy Supplies				
	No charge			Deductible, then 30% 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			Deductible, then 30% Coinsurance
Not all In-Network 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 the Preventive Services notice on our website at **www.harvardpilgrim.org.** 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 – Primary Care Copayments	**Adults:** $20 Copayment per visit **Pediatrics (up to age 19):** $20 Copayment per visit	**Adults:** $30 Copayment per visit **Pediatrics (up to age 19):** $20 Copayment per visit	**Adults:** $75 Copayment per visit **Pediatrics (up to age 19):** $75 Copayment per visit	Deductible, then 30% Coinsurance
– Specialty and Hospital Based Care Copayments	**Adults:** $30 Copayment per visit **Pediatrics (up to age 19):** $30 Copayment per visit	**Adults:** $45 Copayment per visit **Pediatrics (up to age 19):** $30 Copayment per visit	**Adults:** $100 Copayment per visit **Pediatrics (up to age 19):** $100 Copayment per visit	Deductible, then 30% Coinsurance
Additional Member Cost Sharing may apply. Please refer to the specific benefit in this Schedule of Benefits. For example, if you need sutures, please refer to office based treatments and procedures below. If you need an x-ray or have blood drawn, please refer to "Laboratory, Radiology and Other Diagnostic Services."				

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Benefit	Tier 1 Member Cost Sharing	Tier 2 Member Cost Sharing:	Tier 3 Member Cost Sharing:	Out-of-Network Cost Sharing:
Physician and Other Professional Office Visits (This includes all covered Plan Providers unless otherwise listed in this Schedule of Benefits.) (Continued)				
Office based treatments and procedures, including but not limited to: administration of injections, casting, suturing and the application of dressings, genetic counseling, non-routine foot care, and surgical procedures	No charge	**Adults:** Deductible, then 10% Coinsurance **Pediatrics (up to age 19):** No charge	**Adults:** Deductible, then 20% Coinsurance **Pediatrics (up to age 19):** Deductible, then 20% Coinsurance	Deductible, then 30% Coinsurance
Administration of allergy injections	$15 Copayment per visit			Deductible, then 30% Coinsurance
Preventive Services and Tests				
	No charge			Deductible, then 30% Coinsurance
Under federal 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, 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.** Harvard Pilgrim will add or delete services from this benefit for preventive services and tests in accordance with Federal guidance.				
Prosthetic Devices				
	No charge			Deductible, then 30% Coinsurance
Rehabilitation and Habilitation Services - Outpatient				
Cardiac rehabilitation Pulmonary rehabilitation therapy Speech-Language and Hearing Services	**Adults:** $30 Copayment per visit **Pediatrics (up to age 19):** $30 Copayment per visit	**Adults:** $45 Copayment per visit **Pediatrics (up to age 19):** $30 Copayment per visit	**Adults:** $45 Copayment per visit **Pediatrics (up to age 19):** $30 Copayment per visit	Deductible, then 30% Coinsurance

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Benefit	Tier 1 Member Cost Sharing	Tier 2 Member Cost Sharing:	Tier 3 Member Cost Sharing:	Out-of-Network Cost Sharing:
Rehabilitation and Habilitation Services - Outpatient (Continued)				
Physical and occupational therapies – combined up to 72 visits per Calendar Year	**Adults:** $30 Copayment per visit **Pediatrics (up to age 19):** $30 Copayment per visit	**Adults:** $45 Copayment per visit **Pediatrics (up to age 19):** $30 Copayment per visit	**Adults:** $45 Copayment per visit **Pediatrics (up to age 19):** $30 Copayment per visit	Deductible, then 30% 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 up to the age of three, and (2) the treatment of Autism Spectrum Disorders.				
Scopic Procedures - Outpatient Diagnostic and Therapeutic				
Colonoscopy, endoscopy and sigmoidoscopy	No charge	**Adults:** Deductible, then 10% Coinsurance **Pediatrics (up to age 19):** No charge	**Adults:** Deductible, then 20% Coinsurance **Pediatrics (up to age 19):** Deductible, then 20% Coinsurance	Deductible, then 30% Coinsurance
Spinal Manipulative Therapy (including care by a chiropractor)				
– Limited to 12 visits per Calendar Year	$30 Copayment per visit	$30 Copayment per visit	$45 Copayment per visit	Deductible, then 30% Coinsurance
Surgery – Outpatient				
	No charge	**Adults:** Deductible, then 10% Coinsurance **Pediatrics (up to age 19):** No charge	**Adults:** Deductible, then 20% Coinsurance **Pediatrics (up to age 19):** Deductible, then 20% Coinsurance	Deductible, then 30% Coinsurance

Benefit	Tier 1 Member Cost Sharing	Tier 2 Member Cost Sharing:	Tier 3 Member Cost Sharing:	Out-of-Network Cost Sharing:
Telemedicine Virtual Visit Services – Outpatient				
Consultations, evaluations, sickness and injury care – Primary Care Copayments	**Adults:** $20 Copayment per visit **Pediatrics (up to age 19):** $20 Copayment per visit	**Adults:** $30 Copayment per visit **Pediatrics (up to age 19):** $20 Copayment per visit	**Adults:** $75 Copayment per visit **Pediatrics (up to age 19):** $75 Copayment per visit	Deductible, then 30% Coinsurance
– Specialty and Hospital Based Care Copayments	**Adults:** $30 Copayment per visit **Pediatrics (up to age 19):** $30 Copayment per visit	**Adults:** $45 Copayment per visit **Pediatrics (up to age 19):** $30 Copayment per visit	**Adults:** $100 Copayment per visit **Pediatrics (up to age 19):** $100 Copayment per visit	Deductible, then 30% Coinsurance
Urgent Care Services				
Doctor On Demand	**Adults:** Tier 1 Primary Care Copayment: $20 per visit **Pediatrics (up to age 19):** Tier 1 Primary Care Copayment: $20 per visit			
Important Note: Doctor On Demand is a specific network of providers contracted to provide virtual Urgent Care services. For more information on Doctor On Demand, including how to access them, please visit our website at **www.harvardpilgrim.org**..				
Convenience care clinic	**Adults:** $20 Copayment per visit **Pediatrics (up to age 19):** $20 Copayment per visit			Deductible, then 30% Coinsurance
Urgent care center	$30 Copayment per visit	**Adults:** $70 Copayment per visit **Pediatrics (up to age 19):** $30 Copayment per visit	$110 Copayment per visit	Deductible, then 30% Coinsurance
Please Note: These urgent care copays only apply to urgent care centers identified in the Plan's Provider Directory. You can access the Provider Directory at **www.harvardpilgrim.org/bilh** and search for providers under the "Urgent Care Center" specialty to find a participating urgent care center near you. Also, additional Member Cost Sharing may apply at urgent care centers. For example, if you have an x-ray or have blood drawn additional cost sharing may apply; please refer to "Laboratory, Radiology and Other Diagnostic Services" in this Schedule of Benefit. Urgent care locations that are not specifically noted in the Provider Directory under the "Urgent Care Center" specialty may have *different* cost sharing.				

Benefit	Tier 1 Member Cost Sharing	Tier 2 Member Cost Sharing:	Tier 3 Member Cost Sharing:	Out-of-Network Cost Sharing:
Vision Services				
Routine eye examinations – limited to 1 per Calendar Year	**Adults:** $30 Copayment per visit **Pediatrics (up to age 19):** $30 Copayment per visit	**Adults:** $45 Copayment per visit **Pediatrics (up to age 19):** $30 Copayment per visit	**Adults:** $100 Copayment per visit **Pediatrics (up to age 19):** $30 Copayment per visit	Deductible, then 30% Coinsurance
Vision hardware for special conditions	No charge			Deductible, then 30% Coinsurance
Voluntary Sterilization – in a Physician's office				
	No charge	Deductible, then 10% Coinsurance	Deductible, then 20% Coinsurance	Deductible, then 30% Coinsurance
Voluntary Termination of Pregnancy				
	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 "Office based treatments and procedures." For inpatient hospital care, see "Hospital – Inpatient Services."			Deductible, then 30% Coinsurance
Wigs and Scalp Hair Prostheses				
Limited to $350 per Calendar Year (see the Benefit Handbook for details)	No charge			Deductible, then 30% Coinsurance

Language Assistance Services

Español (Spanish) ATENCIÓN: Si usted habla español, servicios de asistencia lingüística, de forma gratuita, están a su disposición. Llame al 1-888-333-4742 (TTY: 711).

Português (Portuguese) ATENÇÃO: Se você fala português, encontram-se disponíveis serviços linguísticos gratuitos. Ligue para 1-888-333-4742 (TTY: 711).

Kreyòl Ayisyen (French Creole) ATANSYON: Si nou palé Kreyòl Ayisyen, gen asistans pou sèvis ki disponib nan lang nou pou gratis. Rele 1-888-333-4742 (TTY: 711).

繁體中文 (Traditional Chinese) 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-888-333-4742（TTY：711）。

Tiếng Việt (Vietnamese) CHÚ Ý: Nếu quí vị nói Tiếng Việt, dịch vụ thông dịch của chúng tôi sẵn sàng phục vụ quí vị miễn phí. Gọi số 1-888-333-4742 (TTY: 711).

Русский (Russian) ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-888-333-4742 (телетайп: 711).

العربية (Arabic)
إنتباه: إذا أنت تتكلم اللغة العربية ، خدمات المساعدة اللغوية متوفرة لك مجانا. إتصل على **1 888-333-4742**
(TTY: 711)

ខ្មែរ (Cambodian) ប្រសិនជាអ្នកនិយាយភាសាខ្មែរ, បើអ្នកនិយាយភាសាខ្មែរ, យើងមានសេវាកម្មបកប្រែ ជូនលោកអ្នកដោយឥតគិតថ្លៃ។ ចូរ ទូរស័ព្ទ 1-888-333-4742 (TTY: 711)។

Français (French) ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-888-333-4742 (ATS: 711).

Italiano (Italian) ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-888-333-4742 (TTY: 711).

한국어 (Korean) '알림': 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-888-333-4742 (TTY: 711) 번으로 전화해 주십시오.

Ελληνικά (Greek) ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, υπάρχουν στη διάθεσή σας δωρεάν υπηρεσίες γλωσσικής υποστήριξης. Καλέστε 1-888-333-4742 (TTY: 711).

Polski (Polish) UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-888-333-4742 (TTY: 711).

हिंदी (Hindi) ध्यान दीजिए: अगर आप हिंदी बोलते हैं तो आपके लिये भाषाकी सहायता मुफ्त में उपलब्ध है. जानकारी के लिये फोन करे. 1-888-333-4742 (TTY: 711)

ગુજરાતી (Gujarati) ધ્યાન આપો : જો તમે ગુજરાતી બોલતા હો તો આપને માટે ભાષાકીય સહાય તદ્દન મફત ઉપલબ્ધ છે. વિશેષ માહિતી માટે ફોન કરો. 1-888-333-4742 (TTY: 711)

ພາສາລາວ (Lao) ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ສັ້ງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-888-333-4742 (TTY: 711).

ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call 1-888-333-4742 (TTY: 711).

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HPHC:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, audio, other formats)
- Provides free language services to people whose primary language is not English, such as qualified interpreters.

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U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
(800) 368-1019, (800) 537-7697 (TTY)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

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