Schedule of Benefits

THE HARVARD PILGRIM TIERED COPAYMENT HMO CITY OF BOSTON MASSACHUSETTS

This Schedule of Benefits summarizes your Benefits under The Harvard Pilgrim Tiered Copayment HMO CITY OF BOSTON (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 access number. A Referral from your PCP is not needed. Your emergency room Member Cost Sharing, including your Deductible if applicable, is listed in the tables below.

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**.

COINSURANCE

Coinsurance is a percentage of the cost for certain covered services that is payable by the Member. Please see the tables below for the Coinsurance amounts that apply to your Plan.

COPAYMENTS

A Copayment is a dollar amount that is payable by the Member for certain covered services. The Copayment is due at the time services are rendered or when billed by the provider. Different Copayments apply depending on the type of service, the specialty of the provider and the location of service. Your identification card contains the Copayment amounts that apply to the Plan's most frequently used services

There are two types of outpatient Copayments that apply to your Plan. A lower Copayment, known as "Copayment Level 1," applies to some outpatient services, including most primary care, obstetrical care, gynecological care, and mental health care (including the treatment of substance abuse disorders). Most outpatient specialty care requires payment of a higher Copayment, known as "Copayment Level 2." The Level 1 and Level 2 Copayments that apply to your Plan are listed below.

With the exception of certain preventive services, which are never subject to Member Cost Sharing, the following Copayments apply to the outpatient services covered by your Plan:

COPAYMENT LEVEL 1

Copayment Level 1 always applies to the following outpatient services regardless of the provider or location of service:

- Applied behavior analysis
- Infertility services and treatments
- Mental health care (including the treatment of substance abuse disorders)
- Physical and occupational therapy
- Pulmonary rehabilitation therapy
- Routine eye examinations
- Speech-language and hearing services

In addition to the Level 1 Services listed above, Copayment Level 1 applies to covered outpatient professional services, other than services received at a professional office operated by a hospital, from the following types of providers:

- All Primary Care Providers. The term "Primary Care Provider" (PCP) includes physicians, physician assistants and nurse practitioners in the following specialties: internal medicine, family practice, general practice and pediatrics
- Obstetricians and gynecologists
- Certified nurse midwives
- Nurse practitioners who bill independently

COPAYMENT LEVEL 2

Copayment Level 2 applies to the following outpatient professional services:

- Any covered **service** or **provider** that is not listed under Copayment Level 1 or
- Any **service** provided in a hospital operated doctor's office, except the specific services listed under Copayment Level 1 above.

If a provider is categorized as both a Copayment Level 1 provider and a Copayment Level 2 provider, Copayment Level 1 applies. For example, if a provider is both a PCP and a cardiologist, you will be responsible for Copayment Level 1.

A Copayment applies to all services except where specifically stated in the tables below.

Please Note: Occasionally the Copayment may exceed the contract rate payable by the Plan for a service. If the Copayment is greater than the contract rate, you are responsible for the full Copayment, and the provider keeps the entire Copayment.

COVERED BENEFITS

Your Covered Benefits are administered on a calendar year basis.

General Cost Sharing Features:	Member Cost Sharing:
Tiered Copayments	
	Copayment Level 1: Your Plan has a $20 Copayment per visit **Copayment Level 2:** Your Plan has a $30 Copayment per visit

General Cost Sharing Features:	Member Cost Sharing:
Tiered Copayments (Continued)	
Please see the "Copayments" section for an explanation of your Level 1 and your Level 2 Copayments.	
Coinsurance and Other Copayments	
	See Covered Benefits below
Out-of-Pocket Maximum	
Includes all Member Cost Sharing	$4,500 per Member per calendar year $9,000 per family per calendar year

Benefit	Member Cost Sharing:
Ambulance Transport	
– Emergency ambulance transport	No charge
– Non-emergency ambulance transport	No charge
Autism Spectrum Disorders Treatment	
– Applied behavior analysis	Copayment Level 1: $20 Copayment per visit
Chemotherapy and Radiation Therapy	
	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	Your Member Cost Sharing will depend upon the types of services provided, as listed in this Schedule of Benefits. For example, for services provided in a dentist's office, see "Physician and Other Professional Office Visits." For services provided in a hospital emergency room, see "Emergency Room Care."
– Extraction of teeth impacted in bone	Your Member Cost Sharing will depend upon the types of services provided, as listed in this Schedule of Benefits. For example, for services provided in a dentist's office, see "Physician and Other Professional Office Visits."
– Preventive Dental Care for children (up to the age of 13) – 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	No charge
– Installation of home equipment is covered up to $300 in a Member's lifetime.	No charge

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Benefit	Member Cost Sharing:
Durable Medical Equipment	
– Durable medical equipment	No charge
– Blood glucose monitors, infusion devices and insulin pumps (including supplies)	No charge
– Oxygen and respiratory equipment	No charge
Early Intervention Services	
	No charge **Please Note:** The Plan does not cover the family participation fee required by the Massachusetts Department of Public Health.
Emergency Room Care	
	$100 Copayment per visit This Copayment is waived if admitted to the hospital directly from the emergency room.
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
Home Health Care	
	No charge
Hospice – Outpatient Services	
	No charge
Hospital – Inpatient Services	
– Acute hospital care	No charge
– Inpatient maternity care	No charge
– Inpatient routine nursery care, including prophylactic medication to prevent gonorrhea	No charge
– Inpatient rehabilitation – limited to 60 days per calendar year	No charge
– Skilled nursing facility – limited to 100 days per calendar year	No charge
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**.

Benefit	Member Cost Sharing:
Infertility Services and Treatments (see the Benefit Handbook for details)	
	Your Member Cost Sharing will depend upon the types of services provided, as listed in this Schedule of Benefits. For example, for services provided by a physician, see "Physician and Other Professional Office Visits."
Laboratory and Radiology Services	
– Laboratory and x-rays	No charge
Advanced radiology – CT scans – PET scans – MRI – MRA – Nuclear medicine services	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**.	
Low Protein Foods	
– Limited to $5,000 per calendar year	No charge
Maternity Care - Outpatient	
– Routine outpatient prenatal and postpartum care	No charge
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	
	No charge
Mental Health Care (Including the Treatment of Substance Abuse Disorders)	
Inpatient Mental Health Care Services	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	No charge
– Outpatient mental health care services	**Group therapy** – $10 Copayment per visit **Individual therapy** – Copayment Level 1: $20 Copayment per visit
– Detoxification	Copayment Level 1: $20 Copayment per visit
– Medication management	Copayment Level 1: $20 Copayment per visit
– Psychological testing and neuropsychological assessment	Copayment Level 1: $20 Copayment per visit
Ostomy Supplies	
	No charge

Benefit	Member Cost Sharing:
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	Copayment Level 1: $20 Copayment per visit Copayment Level 2: $30 Copayment per visit
– Administration of allergy injections	$5 Copayment per visit
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**.	
Prosthetic Devices	
	No charge
Rehabilitation Therapy - Outpatient	
– Cardiac rehabilitation	Copayment Level 2: $30 Copayment per visit
– Pulmonary rehabilitation therapy	Copayment Level 1: $20 Copayment per visit
– Speech-language and hearing services	Copayment Level 1: $20 Copayment per visit

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Benefit	Member Cost Sharing:
Rehabilitation Therapy - Outpatient (Continued)	
– Occupational therapy – limited to 60 visits per calendar year – Physical therapy – limited to 60 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.	Copayment Level 1: $20 Copayment per visit
Scopic Procedures - Outpatient Diagnostic and Therapeutic	
– Endoscopy and sigmoidoscopy	Your Member Cost Sharing will depend upon where the service is provided as listed in this Schedule of Benefits. For example, for a service provided in an outpatient surgical center, see "Surgery – Outpatient." For services provided in a physician's office, see "Physician and Other Professional Office Visits." For inpatient hospital care, see "Hospital – Inpatient Services."
– Colonoscopy	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**.	
Surgery – Outpatient	
	No charge
Vision Services	
– Routine eye examinations – limited to 1 exam per calendar year	Copayment Level 1: $20 Copayment per visit
– Vision hardware for special conditions (see the Benefit Handbook for details)	No charge
Voluntary Sterilization	
	Your Member Cost Sharing will depend upon where the service is provided as listed in this Schedule of Benefits. For example, for a service provided in an outpatient surgical center, see "Surgery – Outpatient." For services provided in a physician's office, see "Physician and Other Professional Office Visits." For inpatient hospital care, see "Hospital – Inpatient Services."
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	
	Your Member Cost Sharing will depend upon where the service is provided as listed in this Schedule of Benefits. For example, for a service provided in an outpatient surgical center, see "Surgery – Outpatient." For services provided in a physician's office, see "Physician and Other Professional Office Visits." For inpatient hospital care, see "Hospital – Inpatient Services."
Wigs and Scalp Hair Prostheses as required by law	
	20% Coinsurance