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 which rewards members with lower office visits Copayments for using high-quality, cost-efficient providers, both physician and hospitals. 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**. or by calling the Member Services Department at **1-888-333-4742**. For TTY service, please call **711**.

This Schedule of Benefits summarizes your benefits under the The Harvard Pilgrim Independence Plan℠ POS (the Plan). It also states the Member Cost Sharing amounts you must pay for Covered Benefits. However, it is only a summary of your benefits. Please see your Benefit Handbook and Prescription Drug Brochure for detailed information on benefits covered by the Plan and the terms and conditions of coverage.

Services listed below are covered when Medically Necessary. Please see your Benefit Handbook for details.

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

In-Network Coverage

You pay lower out-of-pocket cost when you receive In-Network benefits under your POS Plan. With very limited exceptions summarized below, you must obtain services from Plan Providers to obtain In-Network benefits. However, different rules apply depending on whether care is received inside or outside the Service Area.

Care Inside the Service Area. The Service Area is the states of Massachusetts, New Hampshire, Maine, Rhode Island, Connecticut and Vermont. To obtain In-Network coverage in the Service Area, most Covered Benefits must be either provided by, or upon Referral from, your Primary Care Provider (PCP). However, certain services may be obtained from Plan Providers without a Referral from your PCP. They include a variety of family planning, maternity and gynecological care. Please see the Benefit Handbook section titled "Services that Do Not Require a Referral," for a list of these services.

Care Outside the Service Area. To obtain In-Network coverage outside the Service Area, you must receive Covered Benefits from a Plan Provider in the Plan's national provider network. To find a Plan Provider, please see the Independence Plan Provider Directory. When you are outside of the Service Area you do not need a Referral from your PCP.

Out-of-Network Coverage

You receive Out-of-Network coverage when Covered Benefits are provided by Non-Plan Providers or Plan Providers without a referral when a referral is required. Although your Member Cost Sharing is generally higher for Out-of-Network coverage, you may obtain Covered Benefits from the licensed provider of your choice.

Please refer to your Benefit Handbook for further information about how your In-Network and Out-of-Network coverage works.

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.

Member Responsibility for Notification and Prior Approval

Members must contact HPHC for coverage of a number of services. These are listed below.

Mental Health Care (Including the Treatment of Substance Abuse Disorders). Notification must be provided before the start of any planned inpatient admission to a Non-Plan mental health or drug and alcohol rehabilitation facility. Prior Approval must be obtained before receiving certain mental health services from Non-Plan Providers. This requirement also applies to the treatment of substance abuse disorders. For a list of such services, please refer to our internet site,**www.harvardpilgrim.org**. You may contact the Member Services Department at **1-888-333-4742**. To provide Notification or obtain Prior Approval for mental health or substance abuse services, please call the Behavioral Health Access Center at **1-888-777-4742**.

Medical Services. Members are required to notify HPHC before the start of any planned inpatient admission to a Non-Plan medical facility. Members are also required to obtain Prior Approval from HPHC for certain services. Before you receive services from a Non-Plan Provider, please refer to our Internet site, **www.harvardpilgrim.org**. You may also contact the Member Services Department at **1-888-333-4742** for a list of Out-of-Network services that require Prior Approval.

If you do not provide Notification or obtain Prior Approval when required, you will be responsible for paying the Penalty amount stated in this Schedule of Benefits in addition to any applicable Member Cost Sharing. No coverage will be provided if HPHC determines that the service is not Medically Necessary. In that case, and you will be responsible for the entire cost of the service.

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 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**.

MEMBER COST SHARING

Members are required to pay part of the cost of the Covered Benefits provided under the Plan. Your Member Cost Sharing responsibilities are described below.

Copayments

Your Plan has different Copayments that apply depending on the type of Provider or the type of service.

Please see the General Cost Sharing and Benefit Tables below for cost Member Cost Sharing details.

In-Network Tiered Provider Specialist

The Plan rewards Members with lower office visit Copayments for choosing high-quality, cost-efficient Massachusetts specialists. Physicians in the following 13 specialties have been rated and placed into one of three categories or "tiers" (Tier 1 Copayments are the lowest and Tier 3 Copayments are the highest):

- Allergy/Immunology
- Cardiology (medical) †, ††
- Dermatology
- Endocrinology †
- Gastroenterology
- General Surgery
- Neurology †
- Obstetrics/Gynecology †
- Ophthalmology
- Orthopedics
- Otolaryngology (ENT) †
- Pulmonology †
- Rheumatology †

† Both quality and cost-efficiency measures were used to tier physicians in these seven specialties. If individual physicians in these specialties had insufficient quality information to measure they were evaluated only on cost-efficiency. The other six specialties did not have adequate data available to evaluate quality. Physicians in those specialties were rated only on cost-efficiency.

†† There are two types of cardiologists:

- 'non-invasive' (also called, 'medical') Cardiologists
- 'invasive' (also called, 'interventional') Cardiologists

Only 'non-invasive' (or 'medical') Cardiologists are tiered.

Specialists' tiers are designated in the Independence Plan Provider Directory with asterisks as follows:

- *** (Tier 1 – Excellent)
- ** (Tier 2 – Good)
- * (Tier 3 – Standard)

In-Network Non-Tiered Plan Providers

"Non-Tiered" Providers are Plan Providers who have not been rated for quality and/or cost-efficiency or assigned to a tier. These include:

- All Plan Providers (Massachusetts and other states) in: internal, adolescent and geriatric medicine; family and general practice; pediatrics; behavioral health; early intervention; physical, speech and occupational therapy; chiropractic; audiology; optometry; midwives, nurse practitioners and physician assistants. These Providers have been assigned the PCP Copayment and are marked in the Independence Plan Provider Directory with NT*.
- The following Plan Providers have been assigned a Tier 2 Specialist Copayment and are marked in the Independence Plan Provider Directory with NT/ID: Massachusetts Independence Plan Providers in the 13 tiered specialties for whom there was insufficient data to measure their performance; non-Massachusetts physicians in the 13 tiered specialties; and all other Independence Plan specialists (Massachusetts and other states) outside of the 13 tiered specialties.
- Some Providers work from offices that are operated by a hospital. When services are rendered and billed from such an office, 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.

Important note about Tiered and Non-Tiered Providers: Some Plan Providers in tiered specialties such as cardiology, gastroenterology, and obstetrics/gynecology may also be Providers in internal medicine, pediatrics or other primary care specialties that are not tiered. For these Providers, the Copayment for the tiered specialty applies when these Providers bill us for their

services as specialists. When these Providers bill us for their services as primary care providers, the PCP Copayment will apply.

In-Network Hospital Tiering

We evaluated participating hospitals in Massachusetts, New Hampshire and Rhode Island on quality and cost. Based on these comparisons, hospitals were grouped into three levels, known as Tier 1 hospitals, Tier 2 hospitals and Tier 3 hospitals. Tier 1 Copayments are the lowest and Tier 3 Copayments are the highest. When we tiered hospitals, we looked at quality data from the Centers for Medicare and Medicaid Services and The Leapfrog Group (a group that assesses and reports on hospital quality and safety; www.leapfroggroup.org), and at the average case-mix adjusted cost of an inpatient admission and outpatient treatment at each hospital.

- Hospitals that met the quality threshold and had lower costs were placed in Tier 1.
- Higher cost hospitals, regardless of whether they met the quality threshold, were placed in Tier 3.
- All other hospitals, including participating hospitals in Maine and Vermont, hospitals that had insufficient quality data for us to measure, certain specialty hospitals, and hospitals that do not participate in the network, were placed in Tier 2.

General Cost Sharing Features:	Member Cost Sharing:
Tiered Copayments	
	PCP Copayment: $20 per visit Tier 1 Specialist Copayment: $30 per visit Tier 2 Specialist Copayment: $60 per visit Tier 3 Specialist Copayment: $90 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 substance abuse 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, up to a maximum of 4 Surgical Day Care Copayments per Member per Plan Year.
Other Copayments	
	See Covered Benefits below for details.
Deductibles	
– In-Network Deductible	$300 per Member per Plan Year $900 per family per Plan Year
– Out-of-Network Deductible	$450 per Member per Plan Year $900 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 abuse disorders)

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.

You have one set of Covered Benefits under the Plan. If a benefit limit applies (such as a day, visit or dollar limit), Harvard Pilgrim 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	$20 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 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
– Pharmacy supplies	30-day supply at a retail pharmacy: • $10 Copayment for Tier 1 items • $30 Copayment for Tier 2 items • $65 Copayment for Tier 3 items 90-day supply at a retail pharmacy: • $30 Copayment for Tier 1 items • $90 Copayment for Tier 2 items • $195 Copayment for Tier 3 items 90-day supply through mail-order pharmacy: • $25 Copayment for Tier 1 items • $75 Copayment for Tier 2 items • $165 Copayment for Tier 3 items	
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

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
Early Intervention Services		
	No charge	Deductible, then 20% Coinsurance
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 This $100 Copayment is waived if the patient is admitted directly to the hospital from the emergency room.	Same as In-Network
Gender Reassignment Surgery		
	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
Hearing Aids		
– Hearing aids - (for Member ages 22 and older) every 2 Plan Years	No charge for the first $500, then 20% Coinsurance of the next $1,500, up to a maximum benefit of $1,700 every 2 Plan Years.	

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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
Hearing Aids (Continued)		
– Hearing Aids (for Members up to the age of 22) – $2,000 per hearing aid every 36 months, for each hearing impaired ear	No charge	Deductible, then 20% Coinsurance
Home Health Care		
	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
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

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
Infertility Services and Treatments (see the Benefit Handbook for details)		
Please Note: Advanced reproductive technologies are limited to 5 cycles per lifetime	PCP Copayment: $20 per visit Tier 1 Specialist Copayment: $30 per visit Tier 2 Specialist Copayment: $60 per visit Tier 3 Specialist Copayment: $90 per visit	Deductible, then 20% Coinsurance
Laboratory and Radiology Services		
– Laboratory and x-rays	Deductible, then no charge	Deductible, then 20% Coinsurance
Advanced radiology – CT scans – PET scans – MRI – MRA – Nuclear medicine services	$100 Copayment per scan, then Deductible. There is a maximum of one Copayment per Member per day.	Deductible, then 20% Coinsurance
No In-Network 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/GIC**.		
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
No In-Network 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/GIC**.		
Medical Formulas		
	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
Mental Health Care (Including the Treatment of Substance Abuse Disorders)		
Inpatient Services – Mental health services – Drug and Alcohol Rehabilitation Services – Detoxification	$275 Copayment per admission	Deductible, then 20% Coinsurance
Intermediate Mental Health Care 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 for mental health and drug and alcohol rehabilitation services, 24-hour intermediate care facilities, and therapeutic foster care	No charge	Deductible, then 20% Coinsurance
Outpatient Services – Mental health services – Drug and alcohol rehabilitation services	Group therapy – $15 Copayment per visit Individual therapy – $20 Copayment per visit	Deductible, then 20% Coinsurance
– Detoxification	No charge	Deductible, then 20% Coinsurance
– Medication management	$15 Copayment per visit	Deductible, then 20% Coinsurance
– Methadone maintenance	No charge	Deductible, then 20% Coinsurance
– Psychological testing and neuropsychological assessment	No charge	Deductible, then 20% Coinsurance
Please Note: Prior Approval is not required to obtain substance abuse 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 abuse 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.		
Ostomy Supplies		
	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
Outpatient Prescription Drug Coverage		
Please see the Prescription Drug Brochure for more information on your prescription drug coverage.	30-day supply at a retail pharmacy: • $10 Copayment for Tier 1 items • $30 Copayment for Tier 2 items • $65 Copayment for Tier 3 items 90-day supply at a retail pharmacy: • $30 Copayment for Tier 1 items • $90 Copayment for Tier 2 items • $195 Copayment for Tier 3 items 90-day supply through mail-order pharmacy: • $25 Copayment for Tier 1 items • $75 Copayment for Tier 2 items • $165 Copayment for Tier 3 items **Please Note:** oral medications for the treatment of cancer are covered in full at a retail pharmacy or through mail-order pharmacy.	
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
– Consultations, evaluations, sickness and injury care – Nutritional counseling (limited to 3 visits for non-diabetes and non-eating disorder related conditions per Plan Year)	PCP Copayment: $20 per visit Tier 1 Specialist Copayment: $30 per visit Tier 2 Specialist Copayment: $60 per visit Tier 3 Specialist Copayment: $90 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	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
Preventive Services and Tests (Continued)		
also get a copy of the Preventive Services Notice by calling the Member Services Department at **1–888–333–4742**.		
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 US Department of Health and Human Services at: **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/GIC**.		
Prosthetics		
– Prosthetic devices	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	PCP Copayment: $20 per visit Tier 1 Specialist Copayment: $30 per visit Tier 2 Specialist Copayment: $60 per visit Tier 3 Specialist Copayment: $90 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

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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
Rehabilitation and Habilitation Services - Outpatient (Continued)		
– Occupational therapy limited to 90 consecutive days per illness or injury – Physical therapy limited to 90 consecutive days per illness or injury **Please Note:** Please note: 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.	$20 Copayment per visit	Deductible, then 20% Coinsurance
Scopic Procedures - Outpatient Diagnostic and Therapeutic		
– Colonoscopy, endoscopy and sigmoidoscopy	Surgical Day Care: $250 Copayment per visit, then Deductible	Deductible, then 20% Coinsurance
Please Note: No In-Network Member Cost Sharing applies to certain preventive care services, including screening colonoscopies. For a list of covered preventive services, please see the Preventive Services notice at: **www.harvardpilgrim.org/GIC**.		
Smoking Cessation		
– Smoking Cessation (please see your Benefit Handbook for details on your coverage)	No charge	Deductible, then 20% Coinsurance
Surgery Day Care		
	$250 Copayment per visit, then Deductible There is a maximum of four Surgical Day Care Copayments per Member per Plan Year.	Deductible, then 20% Coinsurance
Temporomandibular Joint Dysfunction Services		
	PCP Copayment: $20 per visit Tier 1 Specialist Copayment: $30 per visit Tier 2 Specialist Copayment: $60 per visit Tier 3 Specialist Copayment: $90 per visit	Deductible, then 20% Coinsurance
Please Note: No Dental Care is covered for the treatment of Temporomandibular Joint Dysfunction (TMD).		
Urgent Care Services		
– Convenience care clinic	$20 Copayment per visit	Deductible, then 20% Coinsurance
– Urgent care clinic (including hospital urgent care clinic)	$20 Copayment per visit	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
Urgent Care Services (Continued)		
Please Note: Additional Member Cost Sharing may apply. Please refer to the specific benefit in this Schedule of Benefit. For example, if you have an x-ray or have blood drawn, please refer to "Laboratory and Radiology 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: $90 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
Voluntary Sterilization		
	Office visits: Tier 1 Specialist Copayment: $30 per visit Tier 2 Specialist Copayment: $60 per visit Tier 3 Specialist Copayment: $90 per visit Surgical Day Care: $250 Copayment per visit, then Deductible	Deductible, then 20% Coinsurance
Please Note: No In-Network 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/GIC**.		
Voluntary Termination of Pregnancy		
	Office visits: Tier 1 Specialist Copayment: $30 per visit Tier 2 Specialist Copayment: $60 per visit Tier 3 Specialist Copayment: $90 per visit Surgical Day Care: $250 Copayment per visit, then Deductible	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
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