





## Schedule of Benefits

Harvard Pilgrim Health Care, Inc.

THE HARVARD PILGRIM BEST BUY HSA HMO  
MASSACHUSETTS

This Schedule of Benefits summarizes your Benefits under The Harvard Pilgrim Best Buy HSA HMO (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 number. A Referral from your PCP is not needed. Your emergency room Member Cost Sharing is listed below under the heading "Emergency Room Care."

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.

### COVERED BENEFITS

Your Covered Benefits are administered on a Plan Year basis. Your Plan Year begins on your Employer's Anniversary Date. Please see your Benefit Handbook for more details. If you do not know your Employer's Anniversary Date, please contact your Employer's benefits office or call the Member Services Department at 1-888-333-4742.

General Cost Sharing Features:	Member Cost Sharing:
<b>Coinsurance and Other Copayments</b>	See Covered Benefits below
<b>Deductible</b>	
- Applies to all services except where specifically noted below.	\$2,000 for Individual Coverage per Plan Year \$4,000 for Family Coverage per Plan Year
<b>Important Notice:</b> If you have Family Coverage, the Deductible may be met by any combination of covered family Members. The Individual Deductible does not apply. No Member in the family is eligible for benefits subject to the Deductible until the Family Coverage Deductible is met. Once a Deductible is met, coverage by the Plan is subject to any other Member Cost sharing that may apply.	
<b>Deductible Rollover</b>	None

EFFECTIVE DATE: 01/01/2016

FORM #1610\_02

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<b>General Cost Sharing Features:</b>		<b>Member Cost Sharing:</b>
<b>Out-of-Pocket Maximum</b>		
Includes all Member Cost Sharing	\$4,000 for Individual Coverage per Plan Year \$8,000 for Family Coverage per Plan Year	
<b>Important Notice:</b> If you have Family Coverage, the Out-of-Pocket Maximum may be met by any combination of covered family Members. The individual Out-of-Pocket Maximum does not apply. Once the Out-of-Pocket Maximum has been reached, no additional Member Cost Sharing will be applied for the remainder of the Plan Year.		

<b>Benefit</b>	<b>Your Cost Sharing</b>
<b>Acupuncture Treatment for Injury or Illness</b>	
– Limited to 20 visits per Plan Year	Deductible, then no charge
<b>Ambulance Transport</b>	
– Emergency ambulance transport	Deductible, then no charge
– Non-emergency ambulance transport	Deductible, then no charge
<b>Autism Spectrum Disorders Treatment</b>	
– Applied behavior analysis	Deductible, then no charge
<b>Chemotherapy and Radiation Therapy</b>	
	Deductible, then no charge
<b>Dental Services</b>	
<b>Important Notice:</b> Coverage of Dental Care is very limited. Please see your Benefit Handbook for the details of your coverage.	
– Emergency Dental Care <b>Please Note:</b> Services must be received within 3 days of injury	Deductible, then no charge
– Extraction of teeth impacted in bone	Deductible, then no charge
– Preventive Dental Care for children (up to the age of 13) – limited to 2 preventive dental exams per Plan Year, only the following services are included: – Cleaning – Fluoride treatment – Teaching plaque control – X-rays	No charge
<b>Dialysis</b>	
– Dialysis services	Deductible, then no charge
– Installation of home equipment is covered up to \$300 in a Member's lifetime.	Deductible, then no charge
<b>Durable Medical Equipment</b>	
– Durable medical equipment	Deductible, then no charge
– Blood glucose monitors, infusion devices and insulin pumps (including supplies)	Deductible, then no charge
– Oxygen and respiratory equipment	Deductible, then no charge

Benefit	Your Cost Sharing
<b>Early Intervention Services</b>	
	Deductible, then no charge  <b>Please Note:</b> The Plan does not cover the family participation fee required by the Massachusetts Department of Public Health.
<b>Emergency Room Care</b>	
	Deductible, then no charge
<b>Hearing Aids (for Members up to the age of 22)</b>	
– Limited to \$2,000 per hearing aid every 36 months, for each hearing impaired ear	Deductible, then no charge
<b>Home Health Care</b>	
	Deductible, then no charge
<b>Please Note:</b> If your Home Health Care services include the administration of drugs, please see the benefit for “Medical Drugs” for Member Cost Sharing details.	
<b>Hospice – Outpatient</b>	
	Deductible, then no charge
<b>Hospital – Inpatient Services</b>	
– Acute hospital care	Deductible, then no charge
– Inpatient maternity care	Deductible, then no charge
– Inpatient routine nursery care, including prophylactic medication to prevent gonorrhea	No charge
– Inpatient rehabilitation – limited to 60 days per Plan Year	Deductible, then no charge
– Skilled nursing facility – limited to 100 days per Plan Year	Deductible, then no charge
<b>Hypodermic Syringes and Needles</b>	
	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 <a href="http://www.harvardpilgrim.org/members">www.harvardpilgrim.org/members</a> and select " <b>pharmacy/drug tier look up</b> " or contact the Member Services Department at 1-888-333-4742.
<b>Infertility Services and Treatments (see the Benefit Handbook for details)</b>	
	Deductible, then no charge
<b>Laboratory and Radiology Services</b>	
– Laboratory and x-rays	Deductible, then no charge

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Benefit	Your Cost Sharing
<b>Laboratory and Radiology Services (Continued)</b>	
<b>Advanced radiology</b> – CT scans – PET scans – MRI – MRA – Nuclear medicine services	Deductible, then no charge
<b>Please Note:</b> No Member Cost Sharing applies to certain preventive care services. For a list of covered preventive services, please see the Preventive Services notice at: <a href="http://www.harvardpilgrim.org">www.harvardpilgrim.org</a> .	
<b>Low Protein Foods</b>	
– Limited to \$5,000 per Plan Year	Deductible, then no charge
<b>Maternity Care - Outpatient</b>	
– Routine outpatient prenatal and postpartum care <b>Note:</b> Member Cost Sharing <b>may</b> apply to prenatal ultrasounds when billed as a specialized or non-routine service. See "Laboratory and Radiology Services" for your applicable Member Cost Sharing.	No charge The Deductible does not apply to prenatal and postpartum care provided in a physician's office. All other care is covered as stated in this Schedule of Benefits.
<b>Please Note:</b> 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.	
<b>Medical Drugs (drugs that cannot be self-administered)</b>	
– Medical drugs received in a doctor's office or other outpatient facility	Deductible, then no charge Coverage may also be provided under the Specialty Pharmacy Program. Please see your Prescription Drug Brochure for details.
– Medical drugs received in the home	Deductible, then no charge Coverage may also be provided under the Specialty Pharmacy Program. Please see your Prescription Drug Brochure for details.
<b>Please Note:</b> You may also have the Plan's outpatient prescription drug coverage. That benefit 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 provided by the Specialty Pharmacy Program under your outpatient prescription drug benefit. If you have outpatient prescription drug coverage, your Member Cost Sharing will be listed on your ID Card. Please see the Prescription Drug Brochure for a detailed explanation of your benefits.	
<b>Medical Formulas</b>	
	Deductible, then no charge

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Benefit	Your Cost Sharing
<b>Mental Health Care (Including the Treatment of Substance Abuse Disorders)</b>	
<b>Inpatient Services</b> – Mental health services – Drug and Alcohol Rehabilitation Services – Detoxification	Deductible, then no charge
<b>Intermediate Mental Health Care Services</b> – Acute residential treatment (including detoxification), 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	Deductible, then no charge
<b>Outpatient Services</b> – Mental health services – Drug and alcohol rehabilitation services	<b>Group therapy</b> – Deductible, then no charge <b>Individual therapy</b> – Deductible, then no charge
– Detoxification	Deductible, then no charge
– Medication management	Deductible, then no charge
– Methadone maintenance	Deductible, then no charge
– Psychological testing and neuropsychological assessment	Deductible, then no charge
<b>Ostomy Supplies</b>	
	Deductible, then no charge
<b>Physician and Other Professional Office Visits (This includes all covered Plan Providers unless otherwise listed in this Schedule of Benefits)</b>	
– Routine examinations for preventive care, including immunizations	No charge
– Consultations, evaluations, sickness and injury care	Deductible, then no charge
<b>Treatments and procedures, including but not limited to:</b> – Administration of injections – Allergy treatments – Casting, suturing and the application of dressings – Genetic counseling – Non-routine foot care – Pregnancy testing – Surgical procedures	Deductible, then no charge
– Administration of allergy injections	Deductible, then no charge

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## Harvard Pilgrim Health Care, Inc.

### General List of Exclusions

The following list identifies services that are generally excluded from Harvard Pilgrim HMO Plans. Additional services may be excluded related to access or product design. For a complete list of exclusions please refer to the specific plan's Benefit Handbook.

Exclusion	Description
<b>Alternative Treatments</b>	
	<ol style="list-style-type: none"> <li>1. Acupuncture care, except when specifically listed as a Covered Benefit.</li> <li>2. Acupuncture services that are outside the scope of standard acupuncture care.</li> <li>3. Alternative, holistic or naturopathic services and all procedures, laboratories and nutritional supplements associated with such treatments.</li> <li>4. Aromatherapy, treatment with crystals and alternative medicine.</li> <li>5. Any of the following types of programs: Health resorts, spas, recreational programs, camps, wilderness programs (therapeutic outdoor programs), outdoor skills programs, educational programs for children in residential care, self-help programs, life skills programs, relaxation or lifestyle programs, including any services provided in conjunction with, or as part of such types of programs.</li> <li>6. Massage therapy.</li> <li>7. Myotherapy.</li> </ol>
<b>Dental Services</b>	
	<ol style="list-style-type: none"> <li>1. Dental Care, except when specifically listed as a Covered Benefit.</li> <li>2. All services of a dentist for Temporomandibular Joint Dysfunction (TMD).</li> <li>3. Extraction of teeth, except when specifically listed as a Covered Benefit.</li> <li>4. Pediatric dental care, except when specifically listed as a Covered Benefit.</li> </ol>
<b>Durable Medical Equipment and Prosthetic Devices</b>	
	<ol style="list-style-type: none"> <li>1. Any devices or special equipment needed for sports or occupational purposes.</li> <li>2. Any home adaptations, including, but not limited to home improvements and home adaptation equipment.</li> <li>3. Myoelectric and bionic arms and legs.</li> <li>4. Non-durable medical equipment, unless used as part of the treatment at a medical facility or as part of approved home health care services.</li> <li>5. Repair or replacement of durable medical equipment or prosthetic devices as a result of loss, negligence, willful damage, or theft.</li> </ol>
<b>Experimental, Unproven or Investigational Services</b>	
	<ol style="list-style-type: none"> <li>1. Any products or services, including, but not limited to, drugs, devices, treatments, procedures, and diagnostic tests that are Experimental, Unproven, or Investigational.</li> </ol>

Exclusion	Description
<b>Foot Care</b>	
	<ol style="list-style-type: none"> <li>1. Foot orthotics, except for the treatment of severe diabetic foot disease.</li> <li>2. Routine foot care. Examples include nail trimming, cutting or debriding and the cutting or removal of corns and calluses. This exclusion does not apply to preventive foot care for Members with diabetes.</li> </ol>
<b>Maternity Services</b>	
	<ol style="list-style-type: none"> <li>1. Delivery outside the Service Area after the 37th week of pregnancy, or after you have been told that you are at risk for early delivery.</li> <li>2. Planned home births.</li> <li>3. Routine pre-natal and post-partum care when you are traveling outside the Service Area.</li> </ol>
<b>Mental Health Care</b>	
	<ol style="list-style-type: none"> <li>1. Biofeedback.</li> <li>2. Educational services or testing, except services covered under the benefit for Early Intervention Services. No benefits are provided: (1) for educational services intended to enhance educational achievement; (2) to resolve problems of school performance; (3) to treat learning disabilities; (4) for driver alcohol education; or (5) for community reinforcement approach and assertive continuing care.</li> <li>3. Methadone maintenance, except when specifically listed as a Covered Benefit.</li> <li>4. Sensory integrative praxis tests.</li> <li>5. Services for any condition with only a "V Code" designation in the Diagnostic and Statistical Manual of Mental Disorders, which means that the condition is not attributable to a mental disorder.</li> <li>6. Mental health care that is (1) provided to Members who are confined or committed to a jail, house of correction, prison, or custodial facility of the Department of Youth Services; or (2) provided by the Department of Mental Health.</li> <li>7. Services or supplies for the diagnosis or treatment of mental health and substance abuse disorders that, in the reasonable judgment of the Behavioral Health Access Center, are any of the following: <ul style="list-style-type: none"> <li>• Not consistent with prevailing national standards of clinical practice for the treatment of such conditions.</li> <li>• Not consistent with prevailing professional research demonstrating that the services or supplies will have a measurable and beneficial health outcome.</li> <li>• Typically do not result in outcomes demonstrably better than other available treatment alternatives that are less intensive or more cost effective.</li> </ul> </li> <li>8. Services related to autism spectrum disorders provided under an individualized education program (IEP), including any services provided under an IEP that are delivered by school personnel or any services provided under an IEP purchased from a contractor or vendor.</li> </ol>

Exclusion	Description
<b>Physical Appearance</b>	
	<ol style="list-style-type: none"> <li>1. Cosmetic Services, including drugs, devices, treatments and procedures, except for (1) Cosmetic Services that are incidental to the correction of a Physical Functional Impairment, (2) restorative surgery to repair or restore appearance damaged by an accidental injury, and (3) post-mastectomy care.</li> <li>2. Hair removal or restoration, including, but not limited to, electrolysis, laser treatment, transplantation or drug therapy.</li> <li>3. Liposuction or removal of fat deposits considered undesirable.</li> <li>4. Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures).</li> <li>5. Skin abrasion procedures performed as a treatment for acne.</li> <li>6. Treatment for skin wrinkles or any treatment to improve the appearance of the skin.</li> <li>7. Treatment for spider veins.</li> </ol>
<b>Procedures and Treatments</b>	
	<ol style="list-style-type: none"> <li>1. Care by a chiropractor outside the scope of standard chiropractic practice, including but not limited to, surgery, prescription or dispensing of drugs or medications, internal examinations, obstetrical practice, or treatment of infections and diagnostic testing for chiropractic care other than an initial X-ray.</li> <li>2. Spinal manipulative therapy (including care by a chiropractor), except when specifically listed as a Covered Benefit.</li> <li>3. Commercial diet plans, weight loss programs and any services in connection with such plans or programs, except when specifically listed as a Covered Benefit.</li> <li>4. Gender reassignment surgery and all related drugs and procedures for self-insured groups, unless covered under a separate rider.</li> <li>5. If a service is listed as requiring that it be provided at a Center of Excellence, no In-Network coverage will be provided if that service is received from a Provider that has not been designated as a Center of Excellence.</li> <li>6. Nutritional or cosmetic therapy using vitamins, minerals or elements, and other nutrition-based therapy. Examples include supplements, electrolytes, and foods of any kind (including high protein foods and low carbohydrate foods).</li> <li>7. Physical examinations and testing for insurance, licensing or employment.</li> <li>8. Services for Members who are donors for non-members, except as described under Human Organ Transplant Services.</li> <li>9. Testing for central auditory processing.</li> <li>10. Group diabetes training, educational programs or camps.</li> </ol>

Exclusion	Description
<b>Providers</b>	<ol style="list-style-type: none"> <li>1. Charges for services which were provided after the date on which your membership ends.</li> <li>2. Charges for any products or services, including, but not limited to, professional fees, medical equipment, drugs, and hospital or other facility charges, that are related to any care that is not a Covered Benefit.</li> <li>3. Charges for missed appointments.</li> <li>4. Concierge service fees. (See the Plan's <i>Benefit Handbook</i> for more information.)</li> <li>5. Follow-up care after an emergency room visit, unless provided or arranged by your PCP.</li> <li>6. Inpatient charges after your hospital discharge.</li> <li>7. Provider's charge to file a claim or to transcribe or copy your medical records.</li> <li>8. Services or supplies provided by: (1) anyone related to you by blood, marriage or adoption, or (2) anyone who ordinarily lives with you.</li> </ol>
<b>Reproduction</b>	<ol style="list-style-type: none"> <li>1. Any form of Surrogacy or services for a gestational carrier.</li> <li>2. Infertility drugs if a member is not in a Plan authorized cycle of infertility treatment.</li> <li>3. Infertility drugs, if infertility services are not a Covered Benefit.</li> <li>4. Infertility drugs that must be purchased at an outpatient pharmacy, unless your Plan includes outpatient pharmacy coverage.</li> <li>5. Infertility treatment for Members who are not medically infertile.</li> <li>6. Infertility treatment and birth control drugs, implants and devices, except when specifically listed as a Covered Benefit.</li> <li>7. Reversal of voluntary sterilization (including any services for infertility related to voluntary sterilization or its reversal).</li> <li>8. Sperm collection, freezing and storage except as described in the Plan's <i>Benefit Handbook</i>.</li> <li>9. Sperm identification when not Medically Necessary (e.g., gender identification).</li> <li>10. The following fees: wait list fees, non-medical costs, shipping and handling charges etc.</li> <li>11. Voluntary sterilization, including tubal ligation and vasectomy, except when specifically listed as a Covered Benefit.</li> <li>12. Voluntary termination of pregnancy, unless the life of the mother is in danger or unless it is specifically listed as a Covered Benefit.</li> </ol>
<b>Services Provided Under Another Plan</b>	<ol style="list-style-type: none"> <li>1. Costs for any services for which you are entitled to treatment at government expense, including military service connected disabilities.</li> <li>2. Costs for services for which payment is required to be made by a Workers' Compensation plan or an Employer under state or federal law.</li> </ol>

Exclusion	Description
<b>Types of Care</b>	<ol style="list-style-type: none"> <li>1. Custodial Care.</li> <li>2. Recovery programs including rest or domiciliary care, sober houses, transitional support services, and therapeutic communities.</li> <li>3. All institutional charges over the semi-private room rate, except when a private room is Medically Necessary.</li> <li>4. Pain management programs or-clinics.</li> <li>5. Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, and diversion or general motivation, except when specifically listed as a Covered Benefit.</li> <li>6. Private duty nursing.</li> <li>7. Sports medicine clinics.</li> <li>8. Vocational rehabilitation, or vocational evaluations on job adaptability, job placement, or therapy to restore function for a specific occupation.</li> </ol>
<b>Vision and Hearing</b>	<ol style="list-style-type: none"> <li>1. Eyeglasses, contact lenses and fittings, except when specifically listed as a Covered Benefit.</li> <li>2. Hearing aids, except when specifically listed as a Covered Benefit.</li> <li>3. Hearing aid batteries, and any device used by individuals with hearing impairment to communicate over the telephone or internet, such as TTY or TDD.</li> <li>4. Refractive eye surgery, including, but not limited to, lasik surgery, orthokeratology and lens implantation for the correction of myopia, hyperopia and astigmatism.</li> <li>5. Routine eye examinations, except when specifically listed as a Covered Benefit.</li> </ol>
<b>All Other Exclusions</b>	<ol style="list-style-type: none"> <li>1. Any service or supply furnished in connection with a non-Covered Benefit.</li> <li>2. Beauty or barber service.</li> <li>3. Any drug or other product obtained at an outpatient pharmacy, except for pharmacy supplies covered under the benefit for diabetes services and hypodermic syringes and needles, as required by Massachusetts law, unless your Plan includes outpatient pharmacy coverage.</li> <li>4. Food or nutritional supplements, including, but not limited to, FDA-approved medical foods obtained by prescription, except as required by law.</li> <li>5. Guest services.</li> <li>6. Services for non-Members.</li> <li>7. Services for which no charge would be made in the absence of insurance.</li> <li>8. Services for which no coverage is provided in the Plan's Benefit Handbook, Schedule of Benefits or Prescription Drug Brochure (if applicable).</li> <li>9. Services that are not Medically Necessary.</li> </ol>

Exclusion	Description
<b>All Other Exclusions (Continued)</b>	
	<ol style="list-style-type: none"> <li>10. Services your PCP or a Plan Provider has not provided, arranged or approved except as described in the <i>Handbook</i> sections "Your PCP Manages Your Health Care" and "Using Plan Providers".</li> <li>11. Taxes or governmental assessments on services or supplies.</li> <li>12. Transportation other than by ambulance.</li> <li>13. The following products and services: <ul style="list-style-type: none"> <li>• Air conditioners, air purifiers and filters, dehumidifiers and humidifiers.</li> <li>• Car seats.</li> <li>• Chairs, bath chairs, feeding chairs, toddler chairs, chair lifts, recliners.</li> <li>• Electric scooters.</li> <li>• Exercise equipment.</li> <li>• Home modifications including but not limited to elevators, handrails and ramps.</li> <li>• Hot tubs, jacuzzis, saunas or whirlpools.</li> <li>• Mattresses.</li> <li>• Medical alert systems.</li> <li>• Motorized beds.</li> <li>• Pillows.</li> <li>• Power-operated vehicles.</li> <li>• Stair lifts and stair glides.</li> <li>• Strollers.</li> <li>• Safety equipment.</li> <li>• Vehicle modifications including but not limited to van lifts.</li> <li>• Telephone.</li> <li>• Television.</li> </ul> </li> </ol>