

Schedule of Benefits

HARVARD PILGRIM CHOICENETSM BEST BUY TIERED COPAYMENT HMO MASSACHUSETTS

Please Note: This plan includes a tiered provider network called the “ChoiceNet” Network. In this plan, Members pay different levels of Copayments, Coinsurance or Deductibles 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 HPHC ChoiceNet Provider Directory or visit the provider search tool at www.harvardpilgrim.org to determine the tier of Providers in the ChoiceNet Network.

This Schedule of Benefits summarizes your Benefits under Harvard Pilgrim ChoiceNetSM Best Buy Tiered Copayment 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 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**.

MEMBER COST SHARING

Members are required to share the cost of the Covered Benefits provided under the Plan. This section describes the payments for which you are responsible, called Member Cost Sharing. The tables, set forth below, show the specific Member Cost Sharing amounts for the different services covered by the Plan.

TIERED PROVIDERS

Most hospitals and physicians covered by the Plan are placed into one of three benefit levels or “tiers” based on national measures of cost efficiency and relative quality. Member Cost Sharing for these providers depends upon the tier in which a provider is placed. Tier 1 is the lowest cost tier. Tier 2 is the medium cost tier. Tier 3 is the highest cost tier. Please see your Benefit Handbook for more information on how hospitals and physicians are tiered under the Plan. 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 1.

You can lower your out-of-pocket cost by selecting the physicians and hospitals in the lower cost tiers. 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 tier. You can access the Provider Directory at www.harvardpilgrim.org. 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**.

Please Note: When you choose a PCP, it is important to consider the tier of the hospital that your PCP uses. For example, a Tier 1 PCP may admit patients to a Tier 2 or to a Tier 3 Hospital.

DEDUCTIBLES

A Deductible is a specific annual dollar amount that is payable by the Member for Covered Benefits received each calendar year before any benefits subject to the Deductible are payable by the Plan. If a family Deductible applies, it is met when any combination of Members in a covered family incur expenses for services to which the Deductible applies. Your Plan's Deductible amounts are listed in the tables below.

The Plan has a maximum Deductible, which is the total amount of Deductible payments you are responsible for in a calendar year. Any Deductible amount you incur for Covered Services in a calendar year will apply toward the maximum Deductible. In addition, any Deductible amount you incur during a calendar year applies towards a Deductible of any tier. However, if your Plan includes outpatient pharmacy coverage, your drug benefit may be subject to a separate Deductible. Payments made toward the prescription drug Deductible are not counted toward the Deductible amounts listed in the tables below. Please refer to your Prescription Drug Brochure for specific information on your prescription drug Deductible, if any.

The Plan also has limits on the Deductible amounts that apply to each tier. If you only use services in Tier 1 during the calendar year, you would only be responsible for the Tier 1 Deductible amount in that calendar year. If you only use services in Tiers 1 and 2 in a calendar year, you would only be responsible for the Tier 2 Deductible amount in that calendar year. As explained above, even if you use Tier 3 services, your total liability for Deductible charges, not including any prescription drug deductible, is limited to the maximum Deductible amount stated in the table below.

The Deductible is applicable to most services covered by the Plan. You can learn about the services that require payment of a Deductible and the amounts from the tables below. Deductible amounts are incurred on the date of service.

Your Plan has both an individual Deductible and a family Deductible. However, the family Deductible only applies if you have Family Coverage. Unless a family Deductible applies, you are responsible for the individual Deductible for Covered Benefits each calendar year. If you have family coverage, the Deductible can be satisfied in one of two ways:

- a. If a Member of a covered family meets the individual Deductible, then services for that Member that are subject to that Deductible are covered by the Plan for the remainder of the calendar year.
- b. If any number of Members in a covered family collectively meet the family Deductible, then all Members of the covered family are deemed to have met the Deductible for the remainder of the calendar year.

Any Deductible amount incurred for any Covered Service during a calendar year will apply toward the Deductible for that year. For example, a Member incurred a Deductible for care in a Tier 1 hospital in January. The Deductible amount incurred in January will apply toward the Deductible payable under the Plan for any Covered Service received later in the calendar year. This includes care in a Tier 2 or Tier 3 hospital to which a higher Deductible applies. Once the Deductible is met, no further Deductible applies for the remainder of the calendar year. However, coverage by the Plan remains subject to any other Member Cost Sharing that may apply.

DEDUCTIBLE AND OTHER COST SHARING

For certain services, both a Deductible and either a Copayment or Coinsurance may apply. In such cases, you must completely satisfy the Deductible before the Plan pays benefits on services subject to the Deductible. Once you have satisfied the annual Deductible, you are still responsible for any applicable Copayments or Coinsurance.

COINSURANCE

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

COPAYMENTS

A Copayment is a fixed dollar amount that is payable by the Member for certain covered services. Please see the table below for the Copayment amounts that apply to your Plan. Your identification card contains the Copayment amounts that apply to the Plan's most frequently used services.

Copayments are due at the time services are rendered or when billed by the provider. Different Copayments apply depending on the type of service, the tier placement of the provider, the specialty of the provider and the location of service.

Your Plan has two types of Copayments that apply to certain office visits with physicians and other health professionals covered by the Plan. A lower Copayment, known as the "Primary Care Copayment," applies to some outpatient services, including certain office visits for primary care, obstetrical care, gynecological care, and mental health care. Some outpatient specialty care requires payment of a higher Copayment, known as the "Specialty and Hospital Based Care Copayment." The Copayments that apply to your Plan are listed in the tables 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:

THE PRIMARY CARE COPAYMENT

The Primary Care Copayment always applies to the following outpatient services:

- Applied behavioral analysis
- Mental health care (including the treatment of substance abuse disorders)
- Pediatric preventive Dental Care

In addition to the services listed above, the Primary Care Copayment 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
- Chiropractors

THE SPECIALTY AND HOSPITAL BASED CARE COPAYMENT

The Specialty and Hospital Based Care Copayment applies to the following outpatient professional services:

HARVARD PILGRIM CHOICENETSM BEST BUY TIERED COPAYMENT HMO - MASSACHUSETTS

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

If a provider is categorized at both Copayment levels, the Primary Care Copayment applies. For example, if a provider is both a PCP and a cardiologist, you will be responsible for the Primary Care Copayment.

COVERED BENEFITS

Your Covered Benefits are administered on a calendar year basis.

General Cost Sharing Features:	Tier 1 Member Cost Sharing:	Tier 2 Member Cost Sharing:	Tier 3 Member Cost Sharing:
Coinsurance and Copayments			
	See Covered Benefits below		
Primary Care Copayments			
	Your Plan has a \$20 Copayment per visit	Your Plan has a \$20 Copayment per visit	Your Plan has a \$20 Copayment per visit
Specialty and Hospital Based Care Copayments			
	Your Plan has a \$25 Copayment per visit	Your Plan has a \$35 Copayment per visit	Your Plan has a \$45 Copayment per visit
Deductibles			
<ul style="list-style-type: none"> – Applies to all services except where specifically noted below. – The Deductible amount in each tier is the maximum you would pay for all services during the calendar year in that tier or a lower tier. 	\$250 per Member per calendar year \$750 per family per calendar year	\$250 per Member per calendar year \$750 per family per calendar year	\$250 per Member per calendar year \$750 per family per calendar year
Maximum Deductible			
	\$250 per Member per calendar year \$750 per family per calendar year		
Deductible Rollover			
	None		
Out-of-Pocket Maximum			
Includes all Member Cost Sharing except Member Cost Sharing for prescription drugs, which has a separate Out-of-Pocket Maximum	\$2,000 per Member per calendar year \$4,000 per family per calendar year		

HARVARD PILGRIM CHOICENETSM BEST BUY TIERED COPAYMENT HMO - MASSACHUSETTS

Benefit	Tier 1 Member Cost Sharing	Tier 2 Member Cost Sharing	Tier 3 Member Cost Sharing
Ambulance Transport			
– Emergency ambulance transport	Tier 1 Deductible, then no charge		
– Non-emergency ambulance transport	Tier 1 Deductible, then no charge		
Autism Spectrum Disorders Treatment			
– Applied behavior analysis	Tier 1 Primary Care Copayment: \$20 per visit		
Chemotherapy and Radiation Therapy			
	Tier 1 Deductible, then 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 and the tier placement of the provider rendering services, 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 and the tier placement of the provider rendering services, 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	Tier 1 Primary Care Copayment: \$20 per visit		
Dialysis			
– Non-hospital based dialysis services	Tier 1 Deductible, then no charge		
– Hospital based dialysis services	See "Hospital – Inpatient Services." for your Member Cost Sharing.		
– Installation of home equipment is covered up to \$300 in a Member's lifetime.	Tier 1 Deductible, then no charge		
Durable Medical Equipment			
– Durable medical equipment	Tier 1 Deductible, then no charge		
– Blood glucose monitors, infusion devices and insulin pumps (including supplies)	No charge		
– Oxygen and respiratory equipment	No charge		

HARVARD PILGRIM CHOICENETSM BEST BUY TIERED COPAYMENT HMO - MASSACHUSETTS

Benefit	Tier 1 Member Cost Sharing	Tier 2 Member Cost Sharing	Tier 3 Member Cost Sharing
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 Admission Services			
	Tier 1 Deductible, then \$300 Copayment per admission		
Emergency Room Care			
	Tier 1 Deductible, then \$100 Copayment per visit This Copayment is waived if admitted to the hospital directly from the emergency room.		
Hearing Aids			
- Limited to \$1,500 per hearing impaired ear every 2 calendar years	No charge		
Home Health Care			
	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." For inpatient hospital care, see "Hospital – Inpatient Services."		
Hospice – Outpatient Services			
	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." For inpatient hospital care, see "Hospital – Inpatient Services."		
Hospital – Inpatient Services			
- Acute hospital care	Deductible, then \$300 Copayment per admission	Deductible, then \$300 Copayment per admission	Deductible, then \$700 Copayment per admission
- Inpatient maternity care	Deductible, then \$300 Copayment per admission	Deductible, then \$300 Copayment per admission	Deductible, then \$700 Copayment per admission
- Inpatient routine nursery care, including prophylactic medication to prevent gonorrhea	No charge		
- Inpatient rehabilitation	Tier 1 Deductible, then no charge		
- Skilled nursing facility – limited to 100 days per calendar year	Tier 1 Deductible, then 20% Coinsurance		

HARVARD PILGRIM CHOICENETSM BEST BUY TIERED COPAYMENT HMO - MASSACHUSETTS

Benefit	Tier 1 Member Cost Sharing	Tier 2 Member Cost Sharing	Tier 3 Member Cost Sharing
Hypodermic Syringes and Needles			
	<p>Subject to the applicable pharmacy Member Cost Sharing in your Outpatient Prescription Drug Schedule of Benefits and listed on your ID Card.</p> <p>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.</p> <p>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.</p>		
Infertility Services and Treatments (see the Benefit Handbook for details)			
	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."		
Laboratory and Radiology Services			
- Non-hospital based laboratory and x-rays	Tier 1 Deductible, then no charge		
- Physician and hospital based laboratory and x-rays	Deductible, then no charge	Deductible, then no charge	Deductible, then no charge
Non-hospital based advanced radiology - CT scans - PET scans - MRI - MRA - Nuclear medicine services	Tier 1 Deductible, then \$100 Copayment per procedure		
Physician and hospital based advanced radiology - CT scans - PET scans - MRI - MRA - Nuclear medicine services	Deductible, then \$100 Copayment per procedure	Deductible, then \$100 Copayment per procedure	Deductible, then \$100 Copayment per procedure
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	Tier 1 Deductible, then no charge		
Maternity Care - Outpatient			
- Routine outpatient prenatal and postpartum care	No charge		

(Continued on next page)

HARVARD PILGRIM CHOICENETSM BEST BUY TIERED COPAYMENT HMO - MASSACHUSETTS

Benefit	Tier 1 Member Cost Sharing	Tier 2 Member Cost Sharing	Tier 3 Member Cost Sharing
Maternity Care - Outpatient (Continued)			
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			
	Tier 1 Deductible, then no charge		
Mental Health Care (Including the Treatment of Substance Abuse Disorders)			
– Inpatient mental health care services	Tier 1 Deductible, then \$200 Copayment per admission		
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	Tier 1 Deductible, then no charge		
– Outpatient mental health care services	Group therapy – \$10 Copayment per visit Individual therapy – Tier 1 Primary Care Copayment: \$20 per visit		
– Detoxification	Tier 1 Primary Care Copayment: \$20 per visit		
– Medication management	Tier 1 Primary Care Copayment: \$20 per visit		
Psychological testing and neuropsychological assessment – Performed by a licensed mental health professional	Tier 1 Deductible, then no charge		
– Performed by a neurologist or other medical specialist.	See the benefit for "Treatments and Procedures" under "Physicians and other Professional Office Visits."		
Ostomy Supplies			
	Tier 1 Deductible, then no charge		
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	Primary Care Copayment: \$20 per visit Specialty and Hospital Based Care Copayment: \$25 per visit	Primary Care Copayment: \$20 per visit Specialty and Hospital Based Care Copayment: \$35 per visit	Primary Care Copayment: \$20 per visit Specialty and Hospital Based Care Copayment: \$45 per visit

(Continued on next page)

HARVARD PILGRIM CHOICENETSM BEST BUY TIERED COPAYMENT HMO - MASSACHUSETTS

Benefit	Tier 1 Member Cost Sharing	Tier 2 Member Cost Sharing	Tier 3 Member Cost Sharing
Physician and Other Professional Office Visits (This includes all covered Plan Providers unless otherwise listed in this Schedule of Benefits.) (Continued)			
Treatments and Procedures, including but not limited to: – Administration of injections – Allergy treatments – Casting, suturing and the application of dressings – Genetic counseling – Neurological testing – Non-routine foot care – Office surgical procedure – Pregnancy testing	Deductible, then no charge	Deductible, then no charge	Deductible, then no charge
– Administration of allergy injections	No charge	No charge	No charge
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 .			
Additional Preventive Services and Tests – Fetal ultrasound – Hepatitis C testing – Lead level testing – Prostate-specific antigen (PSA) screening – Routine hemoglobin tests	No charge		

HARVARD PILGRIM CHOICENETSM BEST BUY TIERED COPAYMENT HMO - MASSACHUSETTS

Benefit	Tier 1 Member Cost Sharing	Tier 2 Member Cost Sharing	Tier 3 Member Cost Sharing
Prosthetic Devices			
	Tier 1 Deductible, then no charge		
Rehabilitation Therapy - Outpatient			
– Cardiac rehabilitation	Deductible, then no charge	Deductible, then no charge	Deductible, then no charge
– Pulmonary rehabilitation therapy	Tier 1 Primary Care Copayment: \$20 per visit		
– Speech-language and hearing services	Tier 1 Primary Care Copayment: \$20 per visit		
– Occupational therapy – limited to 30 visits per calendar year – Physical therapy – limited to 30 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.	Tier 1 Primary Care Copayment: \$20 per visit		
Scopic Procedures - Outpatient Diagnostic and Therapeutic			
– Colonoscopy, endoscopy and sigmoidoscopy	Your Member Cost Sharing will depend upon where the service is provided and the tier placement of the provider rendering services, 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 .			
Spinal Manipulative Therapy (including care by a chiropractor)			
– Limited to 20 visits per calendar year	Tier 1 Primary Care Copayment: \$20 per visit		
Surgery – Outpatient			
	Deductible, then \$150 Copayment per visit	Deductible, then \$150 Copayment per visit	Deductible, then \$150 Copayment per visit
Vision Services			
– Routine eye examinations – limited to 1 exam every 2 calendar years	No charge	No charge	No charge
– Vision hardware for special conditions (see the Benefit Handbook for details)	Tier 1 Deductible, then no charge		

HARVARD PILGRIM CHOICENETSM BEST BUY TIERED COPAYMENT HMO - MASSACHUSETTS

Benefit	Tier 1 Member Cost Sharing	Tier 2 Member Cost Sharing	Tier 3 Member Cost Sharing
Voluntary Sterilization			
	Your Member Cost Sharing will depend upon where the service is provided and the tier placement of the provider rendering services, 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 and the tier placement of the provider rendering services, 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 Protheses as required by law			
	No charge		