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Schedule of Benefits

Harvard Pilgrim Health Care of New England, Inc.

BEST BUY HSA HMO
NEW HAMPSHIRE

Coverage under this Plan is under the jurisdiction of the New Hampshire Insurance Commissioner.

IMPORTANT INFORMATION: This policy reflects the known requirements for compliance under The Affordable Care Act as passed on March 23, 2010. As additional guidance is forthcoming from the U.S. Department of Health and Human Services, and the New Hampshire Insurance Department, those changes will be incorporated into your health insurance policy.

This Schedule of Benefits states any Benefit Limits and Member Cost Sharing amounts you must pay for Covered Benefits. However, it is only a summary of your benefits. Please see your Benefit Handbook for details. Your Member Cost Sharing may include a Deductible, Coinsurance, and Copayments. Please see the tables below for details.

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 in the tables below.

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 on our website at **www.harvardpilgrim.org** or by calling **1-888-888-4742 ext. 38723**.

Covered Benefits

Your Covered Benefits are administered on a Calendar Year basis. Your Member Cost Sharing will depend upon the type of service provided and the location the service is provided in, as listed in this Schedule of Benefits. For example, for services provided in a physician's office, see "Physician and Other Professional Office Visits." For services provided in a hospital emergency room, see "Emergency Room Care," and for outpatient surgical procedures, please see "Surgery – Outpatient."

General Cost Sharing Features:	Member Cost Sharing:
Coinsurance and Copayments	
	See the benefits table below
Deductible	
	$5,000 for Individual Coverage per Calendar Year $10,000 for Family Coverage per Calendar Year - with a $5,000 embedded individual Deductible per Calendar Year

General Cost Sharing Features:	Member Cost Sharing:
Deductible (Continued)	
Important Notice: If your Plan has a family Deductible with an embedded individual Deductible, the Deductible can be satisfied in one of two ways: a. If a Member of a covered family meets an individual embedded 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 have no additional Deductible Member Cost Sharing for Covered Benefits for the remainder of the Calendar Year. No one family member may contribute more that the individual embedded Deductible amount to the family Deductible. An embedded individual Deductible may **not** be less than the applicable minimum family Deductible, as defined by the Internal Revenue Service . Once a Deductible is met, coverage by the Plan is subject to any other Member Cost Sharing that may apply.	
Out-of-Pocket Maximum	
Includes all Member Cost Sharing	$5,000 for Individual Coverage per Calendar Year $10,000 for Family Coverage per Calendar Year – with a $5,000 embedded individual Out-of-Pocket Maximum per Calendar Year
Important Notice: If your Plan has a family Out-of-Pocket Maximum with an embedded individual Out-of-Pocket Maximum, the Out-of-Pocket Maximum can be satisfied in one of two ways: a. If a Member of a covered family meets an individual embedded Out-of-Pocket Maximum, then that Member has no additional Member Cost Sharing for the remainder of the Calendar Year. b. If any number of Members in a covered family collectively meet the family Out-of-Pocket Maximum, then all Members of the covered family have no additional Member Cost Sharing for the remainder of the Calendar Year. No one family member may contribute more that the individual embedded Out-of-Pocket Maximum amount to the family Out-of-Pocket Maximum.	

Benefit	Member Cost Sharing
Acupuncture Treatment for Injury or Illness	
– Limited to 20 visits per Calendar Year	Deductible, then no charge
Ambulance Transport	
Emergency ambulance transport	Deductible, then no charge
Non-emergency ambulance transport	Deductible, then no charge
Autism Spectrum Disorders Treatment	
Applied behavior analysis	Deductible, then no charge
Chemotherapy and Radiation Therapy	
Chemotherapy	Deductible, then no charge
Radiation therapy	Deductible, then no charge
Chiropractic Care	
– Limited to 12 visits per Calendar Year	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.	
Extraction of teeth impacted in bone (performed in a physician's office)	Not covered

Benefit	Member Cost Sharing
Dental Services (Continued)	
Preventive dental care for children	Not covered
Outpatient surgery expenses for dental care	Deductible, then no charge
Dialysis	
	Deductible, then no charge
Durable Medical Equipment	
Durable medical equipment	Deductible, then 20% Coinsurance
Blood glucose monitors, infusion devices and insulin pumps (including supplies)	Deductible, then 20% Coinsurance
Oxygen and respiratory equipment	Deductible, then 20% Coinsurance
Early Intervention	
– Limited to $3,200 per Member per Calendar Year, up to $9,600 per lifetime	Deductible, then no charge
Emergency Room Care	
– Medical Emergency services	Deductible, then no charge
– Services that do not meet the definition of Medical Emergency	Deductible, then 50% Coinsurance
Hearing Aids	
– Limited to $1,500 per hearing aid every 60 months, for each hearing impaired ear	Deductible, then 20% Coinsurance
Home Health Care	
	Deductible, then no charge
If services include the administration of drugs, please see the benefit for "Medical Drugs" for Member Cost Sharing details.	
Hospice - Outpatient	
	Deductible, then no charge
Hospital – Inpatient Services	
Acute hospital care	Deductible, then no charge
Inpatient maternity care	Deductible, then no charge
Inpatient routine nursery care	No charge
Inpatient rehabilitation – limited to 100 days per Calendar Year Day limits combined with skilled nursing facility care	Deductible, then no charge
Skilled nursing facility – limited to 100 days per Calendar Year Day limits combined with inpatient rehabilitation care	Deductible, then no charge
Infertility Services and Treatments	
Diagnostic services for infertility including: consultation, evaluation and laboratory tests	Deductible, then no charge
Infertility treatment (see the Benefit Handbook for details)	Not covered

Benefit	Member Cost Sharing
Laboratory, Radiology and Other Diagnostic Services	
Laboratory	Deductible, then no charge
Genetic Testing	Deductible, then no charge
Radiology	Deductible, then no charge
Advanced radiology, including CT scans, PET scans, MRI, MRA and nuclear medicine services	Deductible, then no charge
Other diagnostic tests	Deductible, then no charge
Low Protein Foods	
– Limited to $1,800 per Member per Calendar Year	Deductible, then 20% Coinsurance
Maternity Care – Outpatient	
Routine outpatient prenatal and postpartum care	No charge
Routine prenatal and postpartum care is usually received and billed from the same Provider as a single or bundled service. Different Member Cost Sharing may apply to any specialized or non-routine service that is billed separately from your routine outpatient prenatal and postpartum care. For example, Member Cost Sharing for services provided by a specialist is listed under "Physician and Other Professional Office Visits" and Member Cost Sharing for an ultrasound billed as a specialized or non-routine service is listed under "Laboratory and Radiology Services."	
Medical Drugs (drugs that cannot be self-administered)	
Medical drugs received in a physician's office or other outpatient facility	Deductible, then no charge
Medical drugs received in the home	Deductible, then no charge
Some Medical Drugs may be supplied by a specialty pharmacy. When Medical Drugs are supplied by a specialty pharmacy, the Member Cost Sharing listed above will apply.	
Medical Formulas	
	Deductible, then 20% Coinsurance
Mental Health and Substance Use Disorder Treatment	
Inpatient services	Deductible, then no charge
Partial hospitalization services	Deductible, then no charge
Outpatient group therapy	Deductible, then no charge
Outpatient treatment including individual therapy, detoxification, and medication management	Deductible, then no charge
Outpatient methadone maintenance	Deductible, then no charge
Outpatient psychological testing	Deductible, then no charge
eVisits	Deductible, then no charge
Observation Services	
	Deductible, then no charge
Ostomy Supplies	
	Deductible, then 20% Coinsurance

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
Not all services you receive during your routine exam are covered at no charge. Only preventive services designated under the Patient Protection and Affordable Care Act (PPACA) are covered at no charge. Other services not included under PPACA may be subject to additional cost sharing. For the current list of preventive services covered at no charge under PPACA, please see the Preventive Services Notice on our website at **www.harvardpilgrim.org**. Please see "Laboratory and Radiology Services" for the Member Cost Sharing that applies to diagnostic services not included on this list.	
Consultations, evaluations, sickness and injury care	Deductible, then no charge
Additional Member Cost Sharing may apply. Please refer to the specific benefit in this Schedule of Benefits. For example, if you need sutures, please refer to office based treatments and procedures below. If you need an x-ray or have blood drawn, please refer to "Laboratory, Radiology and Other Diagnostic Services."	
Office based treatment and procedures including but not limited to: casting, suturing and the application of dressings, non-routine foot care, and surgical procedures	Deductible, then no charge
Administration of allergy injections	Deductible, then no charge
eVisits	Deductible, then no charge
Preventive Services and Tests	
	No charge
Under federal law, many preventive services and tests are covered with no Member Cost Sharing, including preventive colonoscopies, certain labs and x-rays, voluntary sterilization for women, and all FDA approved contraceptive devices. For a complete list of covered preventive services, please see the Preventive Services Notice on our website at **www.harvardpilgrim.org**. You may also get a copy of the Preventive Services Notice by calling the Member Services Department at **1–888–333–4742**. Harvard Pilgrim will add or delete services from this benefit for preventive services and tests in accordance with Federal guidance.	
The following additional preventive services and tests: alpha-fetoprotein (AFP), fetal ultrasound, hepatitis C testing, lead level testing, prostate-specific antigen (PSA) screening, routine hemoglobin tests, group B streptococcus (GBS), and routine urinalysis	No charge
Prosthetic Devices	
	Deductible, then 20% Coinsurance
Rehabilitation and Habilitation Services – Outpatient	
Cardiac rehabilitation Pulmonary rehabilitation therapy	Deductible, then no charge
Occupational, physical and speech therapy – limited to 60 visits combined per Calendar Year	Deductible, then no charge
Please Note: Outpatient physical, occupational and speech therapies are covered without limits to the extent Medically Necessary for children under the age of three.	

Benefit	Member Cost Sharing
Scopic Procedures - Outpatient Diagnostic and Therapeutic	
Colonoscopy, endoscopy and sigmoidoscopy	Deductible, then no charge
Surgery – Outpatient	
	Deductible, then no charge
Telemedicine – Outpatient	
	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."
For inpatient hospital care, see "Hospital – Inpatient Services" for cost sharing details.	
Urgent Care Services	
Convenience care clinic	Deductible, then no charge
Urgent care center	Deductible, then no charge
Hospital urgent care center	Deductible, then no charge
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 per Calendar Year	No charge
Vision hardware for special conditions	Deductible, then no charge
Voluntary Sterilization – in a Physician's Office	
	Deductible, then no charge
Voluntary Termination of Pregnancy	
	Deductible, then no charge
Wigs and Scalp Hair Prostheses as required by law	
See the Benefit Handbook for details	Deductible, then 20% Coinsurance

Language Assistance Services

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

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

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

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

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

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

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

ខ្មែរ (Cambodian) [ប្រសូជូនដំណឹង៖ បើអ្នកនិយាយភាសាខ្មែរ, សេវាកម្មបកប្រែ ជូនលោកអ្នកដោយឥតគិតថ្លៃ។ ចូរ ទូរស័ព្ទ 1-888-333-4742 (TTY: 711)។

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

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

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

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

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

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

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

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

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

Harvard Pilgrim Health Care includes Harvard Pilgrim Health Care, Harvard Pilgrim Health Care of Connecticut, Harvard Pilgrim Health Care of New England and HPHC Insurance Company.

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General Notice About Nondiscrimination and Accessibility Requirements

Harvard Pilgrim Health Care and its affiliates as noted below ("HPHC") comply with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. HPHC does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

HPHC:

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

If you need these services, contact our Civil Rights Compliance Officer.

If you believe that HPHC has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with: Civil Rights Compliance Officer, 93 Worcester St, Wellesley, MA 02481, (866) 750-2074, TTY service: 711, Fax: (617) 509-3085, Email: civil_rights@harvardpilgrim.org. You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, the Civil Rights Compliance Officer is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

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

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

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