

**Benefits Covered in Full (no cost to the member)**

<b>Preventive Care</b> Routine physical, gynecological, and well child exams; immunizations; age appropriate screenings.	Covered in Full
<b>Chemotherapy &amp; Radiation Therapy</b>	
<b>Routine Maternity Care - Prenatal and Postpartum</b> Counseling about alcohol and tobacco use, services to promote breastfeeding, routine urinalysis and screenings for complications.	
<b>Inpatient Mental Health &amp; Substance Abuse</b>	
<b>Home Health Care</b>	
<b>Oxygen &amp; Respiratory Equipment</b>	

**Benefits Covered after a Copayment**

<b>Professional Visits:</b>	\$25 Copay
<b>Physician Services/Office Visit</b>	
<b>Routine Annual Eye Exam</b> (1 per year)	
<b>Acupuncture</b> ; 20 visit limit	
<b>Chiropractic Care</b> ; 20 visit limit	
<b>Outpatient Mental Health &amp; Substance Abuse</b>	
<b>Physical/Occupational/Speech Therapy</b> ; combined 60 visit limit	
<b>Allergy Injections</b>	\$5 Copay
<b>Emergency Room</b> (waived if admitted)	\$150 Copay
<b>Prescription Drugs: Retail</b> (30 day Supply)	\$5/\$20/\$30
<b>Mail Order</b> (90 day Supply)	\$5/\$20/\$30

**Benefits Covered after a Deductible**

<b>Best Buy Deductible:</b> Limit one per year	\$1,000 Deductible (\$3,000 Family Maximum)
<b>Hospital Inpatient</b>	Deductible; then Covered in Full
<b>Maternity Care - Delivery</b>	
<b>X-rays</b>	
<b>Advanced Radiology</b> CT Scans, PET Scans, MRI, MRA and Nuclear medicine services	
<b>Skilled Nursing Facility &amp; Inpatient Rehabilitation</b> ; combined 100 day limit per year	
<b>Ambulance - Emergency Transport</b>	
<b>Outpatient Surgery</b>	Covered in Full at <b>Select LP Providers</b> Deductible, then Covered in Full at <b>Other Plan Providers</b>
<b>Scopic Procedures</b>	
<b>Diagnostic Lab Services</b>	
<b>Durable Medical Equipment</b>	Separate \$100 Deductible; then 20% Coinsurance
<b>Out of Pocket Maximum:</b> Medical	\$5,000 (\$10,000 Family)
Prescription Drugs	

**Deductible Year:** Plan\*

**Deductible Carry-Over Provision:** No

**Lifetime Benefit:** Unlimited

Select LP Providers are pre-determined by Harvard Pilgrim and are subject to change.

Extraction of teeth impacted in bone is not a covered benefit.

This is only a summary of benefits, please consult corresponding schedule of benefits. Exceptions & exclusions apply.

Benefit limits, deductibles and out of pocket maximums are based on a plan year.