

HMO OA \$20

Harvard Pilgrim (MD25224) In-Network

| Benefits Covered in Full (no cost to the member) | | |
|--------------------------------------------------------------------------------------------------------------------|-----------------|--|
| Preventive Care Routine physical, gynecological, and well child exams; immunizations; age appropriate screenings. | | |
| Laboratory Tests | | |
| X-rays | | |
| Chemotherapy & Radiation Therapy | | |
| Routine Maternity Care & Delivery | | |
| Inpatient Mental Health & Substance Abuse | | |
| Home Health Care | Covered in Full | |
| Oxygen & Respiratory Equipment | | |
| Hospital Inpatient | | |
| Advanced Radiology CT Scans, PET Scans, MRI, MRA and Nuclear medicine services | | |
| Outpatient Surgery | | |
| Skilled Nursing Facility; 100 day visit limit | | |
| Inpatient Rehabilitation; 60 day visit limit | | |
| Ambulance - Emergency Transport | | |

| Benefits covered after a Copayment | | |
|--------------------------------------------------------|--------------------|--|
| Professional Visits: | | |
| Physician Services/Office Visit | \$20 Copay | |
| Routine Annual Eye Exam (1 per year) | | |
| Acupuncture; unlimited visits | | |
| Chiropractic Care; unlimited visits | | |
| Physical/Speech/Occupational Therapy; unlimited visits | | |
| Outpatient Mental Health & Substance Abuse | | |
| Allergy Injections | \$5 Copay | |
| Emergency Room (waived if admitted) | \$50 Copay | |
| Prescription Drugs: Retail (30 day supply) | \$0/\$10/\$20/\$30 | |
| Mail Order (90 day supply) | \$0/\$10/\$40/\$60 | |

| Other Benefit Features | | |
|--------------------------------|---------------------------|--|
| Deductible | None | |
| Durable Medical Equipment | 20% Coinsurance | |
| Out of Pocket Maximum: Medical | \$5,000 (\$10,000 Family) | |
| Prescription Drugs | | |

Benefit Year: Plan* Lifetime Benefit: Unlimited

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.

^{*}Deductible year will follow your medical plans renewal



HMO OA HSA \$2000

Harvard Pilgrim (MD25228) In-Network

| Benefits covered in Full (no cost to the member) | |
|---------------------------------------------------------------------|-----------------|
| Preventive Care | |
| Routine physical, gynecological, and well child exams; | |
| immunizations; age appropriate screenings. | |
| Routine Maternity Care - Prenatal and Postpartum | Covered in Full |
| Counseling about alcolhol and tobacco use, services to promote | |
| breastfeeding, routine urinalysis and screenings for complications. | |
| Routine Annual Eye Exam (1 per year) | |

| Benefits covered after a Deductible | |
|-----------------------------------------------------------------------------|----------------------------------|
| Laboratory Tests | |
| X-Rays | |
| Chemotherapy & Radiation Therapy | |
| Inpatient Mental Health & Substance Abuse | |
| Home Health Care | Deductible; then 20% Coinsurance |
| Oxygen & Respiratory Equipment | |
| Professional visits: | |
| Physician Services/Office Visit | |
| Acupuncture; unlimited visits | |
| Chiropractic Care; unlimited visits | |
| Physical/Occupational/Speech Therapy; unlimited visits | |
| Outpatient Mental Health & Substance Abuse | |
| Allergy Injections | |
| Emergency Room | |
| Hospital Inpatient | |
| Maternity Care - Delivery | |
| Advanced Radiology | |
| CT Scans, PET Scans, MRI, MRA and Nuclear medicine services | |
| Outpatient Surgery | |
| Skilled Nursing Facility & Inpatient Rehabilitation; combined 100 day limit | |
| Ambulance - Emergency Transport | |
| Prescription Drugs: Retail (30 day Supply) | Deductible; then 10% Coinsurance |
| Mail Order (90 day Supply) | Deductible; then 10% Coinsurance |
| Durable Medical Equipment | Deductible; then 20% Coinsurance |

| Other Benefit Features | | |
|--------------------------------|-----------------------------------|--|
| HSA Deductible: Individual | \$2,000 | |
| Family | \$4,000 | |
| Out of Pocket Maximum: Medical | Combined \$4,000 (\$8,000 Family) | |
| Prescription Drugs | | |

Deductible Carry-Over Provision: No

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.

*Deductible year will follow your medical plans renewal

Deductible Year: Plan*

Lifetime Benefit: Unlimited