ID: 0000022 3 2

Schedule of Benefits

There are two levels of coverage - In-Network and Out-of-Network

In-Network

Out-of-Network

Prior Approval

www.harvardpilgrim.org **1-888-333-4742**

1-800-708-4414

1-844-387-1435

1-888-777-4742

www.harvardpilgrim.org

Clinical Review Criteria

www.harvardpilgrim.org **1-888-888-4742**

Covered Benefits

General Cost Sharing Features:	In-Network Member Cost Sharing:	Out-of-Network Member Cost Sharing:
Coinsurance and Copayments		
Deductible		
		$2 0 k $ 00 k
Out-of-Pocket Maximum		
k t t t t	$2 00 k $ 000 k	$2 00 k $ 000 k
Out-of-Network Penalty Payment		
k t t k t k k	$ 00	
Deductible Rollover		
3k t k t		

Benefit	In-Network Plan Providers Member Cost Sharing	Out-of-Network Non-Plan Providers Member Cost Sharing
Acupuncture Treatment for Injury or Illness		
k 30 t	$2 k t	20
Ambulance Transport		
k k		k
k k		k
Autism Spectrum Disorders Treatment		
t	$2 k t	20
Chemotherapy and Radiation Therapy		
k		20
		20

Benefit	In-Network Plan Providers Member Cost Sharing	Out-of-Network Non-Plan Providers Member Cost Sharing
Dental Services		
Important Notice:		
	$2	20

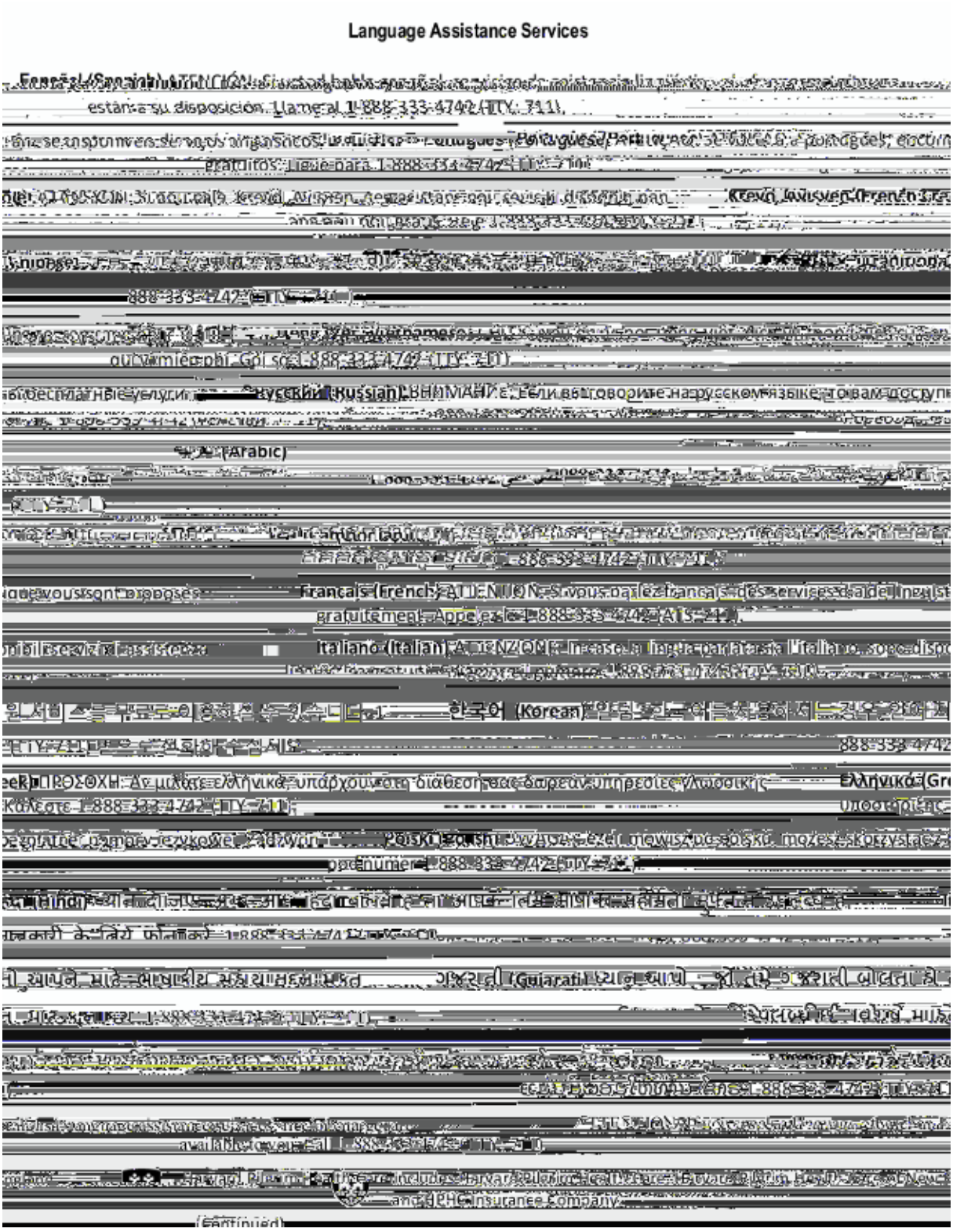
Benefit	In-Network Plan Providers Member Cost Sharing	Out-of-Network Non-Plan Providers Member Cost Sharing
Hospice - Outpatient		
		20
Hospital – Inpatient Services		
		20
k		20

Benefit	In-Network Plan Providers Member Cost Sharing	Out-of-Network Non-Plan Providers Member Cost Sharing

Benefit	In-Network Plan Providers Member Cost Sharing	Out-of-Network Non-Plan

Benefit	In-Network Plan Providers Member Cost Sharing	Out-of-Network Non-Plan Providers Member Cost Sharing
Voluntary Termination of Pregnancy		

Language Assistance Services




General Notice About Nondiscrimination and Accessibility Requirements
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Exclusion
Alternative Treatments

Exclusion

Mental Health and Substance Use Disorder Treatment (Continued)

(2)

Exclusion
Reproduction k

Exclusion
All Other Exclusions (Continued)
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