Schedule of Benefits

THE HARVARD PILGRIM CHOICENET℠ BEST BUY PPO 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 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.

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

In-Network coverage applies when you use a Plan Provider for Covered Benefits.

Out-of-Network coverage applies when you use a Non-Plan Provider for Covered Benefits. If a Non-Plan Provider charges any amount in excess of the Allowed Amount, you are responsible for the excess amount.

In a Medical Emergency you should go to the nearest emergency facility or call 911 or other local emergency access number. Your emergency room Member Cost Sharing is listed in the tables below.

Prior Approval

Prior Approval is required for certain benefits. Before you receive services from a Non-Plan Provider or a Plan Provider outside the Service Area, please refer to our website, **www.harvardpilgrim.org** or contact the Member Services Department at **1-888-333-4742** for the complete listing of services that require Prior Approval. To obtain Prior Approval please call:

- **1–800–708–4414** for medical services
- **1–844–387–1435** for Medical Drugs
- **1–888–777–4742** for mental health and substance use disorder treatment

More information about Prior Approval can be found on our website, **www.harvardpilgrim.org** and in your Benefit Handbook.

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**.

Tiered Providers — In-Network

In-Network acute hospitals, Primary Care Providers (PCPs), and medical specialists 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 Providers (PCPs), and medical specialists are assigned to one of three tiers. All other covered providers are assigned to Tier 1. Tiering also does not apply to physicians and hospitals that specialize in the provision of mental health care. These include psychiatrists and psychiatric hospitals.

You can lower your out-of-pocket cost by selecting In-Network 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 ChoiceNet 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 our Member Services Department at **1–888–333–4742**.

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

Deductibles

A Deductible is a dollar amount a Member must pay each Plan Year before any benefits subject to the Deductible are payable by the Plan. Any eligible expenses you incur toward the Deductible in a Plan Year apply to **both** your Plan's In-Network and Out-of-Network Deductibles. Your Plan has an individual Deductible. If you have family coverage you also have a separate family deductible. 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 Deductibles are listed in the tables below.

For **In-Network Coverage**, the Plan has separate limits on the Deductible that apply to each tier. If you only use services in Tier 1 during the Plan Year, you will only be responsible for the Tier 1 Deductible in that Plan Year. If you only use services in Tiers 1 and 2 in a Plan Year, you will only be responsible for the Tier 2 Deductible amount in that Plan Year. Even if you use Tier 3 services, your Deductible for In-Network Services, is limited to the Tier 3 Deductible stated in the tables below.

For **Out-of-Network Coverage**, the Plan has a separate Deductible that applies to Out-of-Network Services. The Out-of Network Deductible is generally higher than the Tier 3 In-Network Deductible. Please see the tables below for your Out-of-Network Deductible.

Please Note: Any Deductible you incur for Covered Benefits under the Plan applies to both your In-Network and Out-of-Network Deductibles for the remainder of the Plan Year. For example, if you incurred $200 in Deductible charges for care by a Tier 1 physician in January, for the reminder of the Plan Year that $200 amount would apply toward any Deductible under the Plan. If you used Out-of-Network services later in the Plan Year, the $200 would count toward the Out-of-Network Deductible.

Copayment Levels

There are two types of In-Network office visit Copayments that apply to your plan: a lower Copayment, known as the "Primary Care Copayment," and a higher Copayment, known as the "Specialty and Hospital Based Care Copayment."

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 (PCPs); obstetricians and gynecologists; Licensed Mental Health Professionals; certified nurse midwives; and nurse practitioners who bill independently.

The Specialty and Hospital Based Care Copayment applies to most outpatient specialty care.

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 Plan Year basis. Your Plan Year begins on your Employer's Anniversary Date. Please see your Benefit Handbook for more details. If you do not know your Employer's Anniversary Date, please contact your Employer's benefits office or call the Member Services Department at **1-888-333-4742**. 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	In-Network Tier 1 Member Cost Sharing	In-Network Tier 2 Member Cost Sharing:	In-Network Tier 3 Member Cost Sharing	Out-of-Network Member Cost Sharing
Coinsurance and Copayments				
	See the benefits table below			
Deductibles				
Your Plan Deductible can be met by any combination of eligible In-Network and Out-of-Network expenses. – The following Deductibles apply to all services except where specifically noted below. The Deductible amount listed in each tier is the maximum you would pay for all services during the Plan Year in that tier or a lower tier.	$500 per Member per Plan Year $1,000 per family per Plan Year	$500 per Member per Plan Year $1,000 per family per Plan Year	$500 per Member per Plan Year $1,000 per family per Plan Year	$500 per Member per Plan Year $1,000 per family per Plan Year
Out-of-Pocket Maximum				
Includes all In-Network and Out-of-Network Member Cost Sharing except: – Any charges above the Allowed Amount and any penalty for failure to receive Prior Approval when using Non-Plan Providers.	$4,000 per Member per Plan Year $7,500 per family per Plan Year			
Out-of-Network Penalty Payment				
Does not count toward the Deductible or Out-of-Pocket Maximum.	$500			
Deductible Rollover				
None				

Benefit	In-Network Tier 1 Member Cost Sharing	In-Network Tier 2 Member Cost Sharing	In-Network Tier 3 Member Cost Sharing	Out-of-Network Member Cost Sharing
Acupuncture Treatment for Injury or Illness				
	Not covered			Not covered
Ambulance Transport				
Emergency ambulance transport	Tier 1 Deductible, then no charge			Same as In-Network
Non-emergency ambulance transport	Tier 1 Deductible, then no charge			Deductible, then 20% Coinsurance

Benefit	In-Network Tier 1 Member Cost Sharing	In-Network Tier 2 Member Cost Sharing	In-Network Tier 3 Member Cost Sharing	Out-of-Network Member Cost Sharing
Autism Spectrum Disorders Treatment				
Applied behavior analysis	Tier 1 Primary Care Copayment: $10 per visit			Deductible, then 20% Coinsurance
Chemotherapy and Radiation Therapy				
	Deductible, then no charge	Deductible, then no charge	Deductible, then no charge	Deductible, then 20% Coinsurance
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)	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 services provided in a dentist's office, see "Physician and Other Professional Office Visits."			Deductible, then 20% Coinsurance
Pediatric dental care for children up to the age of 13 – limited to 2 preventive dental exams per Plan Year, only the following services are included: cleaning, fluoride treatment, teaching plaque control and x-rays.	Tier 1 Primary Care Copayment: $20 per visit			Deductible, then 20% Coinsurance
Dialysis				
	Tier 1 Deductible, then no charge			Deductible, then 20% Coinsurance
– Installation of home equipment	No charge			Deductible, then 20% Coinsurance
Durable Medical Equipment				
Durable medical equipment	Tier 1 Deductible, then no charge			Deductible, then 20% Coinsurance
Blood glucose monitors, infusion devices and insulin pumps (including supplies)	No charge			No charge
Oxygen and respiratory equipment	No charge			Deductible, then 20% Coinsurance
Early Intervention Services				
	No charge			No charge
The Plan does not cover the Family Participation Fee required by the Massachusetts Department of Public Health				

Benefit	In-Network Tier 1 Member Cost Sharing	In-Network Tier 2 Member Cost Sharing	In-Network Tier 3 Member Cost Sharing	Out-of-Network Member Cost Sharing
Emergency Admission				
	Tier 1 Deductible, then $275 Copayment per admission			Same as In-Network
Emergency Room Care				
	Tier 1 Deductible, then $100 Copayment per visit			Same as In-Network
This Copayment is waived if admitted to the hospital directly from the emergency room.				
Hearing Aids (for Members up to the age of 22)				
– Limited to $2,000 per hearing aid every 36 months, for each hearing impaired ear	No charge			Deductible, then 20% Coinsurance
Home Health Care				
	Tier 1 Deductible, then no charge			Deductible, then 20% Coinsurance
If services include the administration of drugs, please see the benefit for "Medical Drugs" for Member Cost Sharing details.				
Hospice – Outpatient				
	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."			Deductible, then 20% Coinsurance
Hospital – Inpatient Services				
Acute hospital care	Deductible, then $275 Copayment per admission	Deductible, then $500 Copayment per admission	Deductible, then $1,500 Copayment per admission	Deductible, then 20% Coinsurance
Inpatient maternity care	Deductible, then $275 Copayment per admission	Deductible, then $500 Copayment per admission	Deductible, then $1,500 Copayment per admission	Deductible, then 20% Coinsurance
Inpatient routine nursery care	No charge			Deductible, then 20% Coinsurance
Inpatient rehabilitation	Tier 1 Deductible, then no charge			Deductible, then 20% Coinsurance
Skilled nursing facility – limited to 100 days per Plan Year	Tier 1 Deductible, then 20% Coinsurance			Deductible, then 20% Coinsurance

Benefit	In-Network Tier 1 Member Cost Sharing	In-Network Tier 2 Member Cost Sharing	In-Network Tier 3 Member Cost Sharing	Out-of-Network Member Cost Sharing
Infertility Services and Treatments (see the Benefit Handbook for details)				
	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 services provided in a physician's office, see "Physician and Other Professional Office Visits." For inpatient hospital care, see "Hospital – Inpatient Services."			Deductible, then 20% Coinsurance
Laboratory, Radiology and Other Diagnostic Services				
Non–hospital based laboratory	Tier 1 Deductible, then no charge			Deductible, then 20% Coinsurance
Physician and hospital based laboratory	Deductible, then no charge	Deductible, then no charge	Deductible, then no charge	Deductible, then 20% Coinsurance
Non–hospital based radiology	Tier 1 Deductible, then no charge			Deductible, then 20% Coinsurance
Physician and hospital based radiology	Deductible, then no charge	Deductible, then no charge	Deductible, then no charge	Deductible, then 20% Coinsurance
Non–hospital based genetic testing	Tier 1 Deductible, then no charge			Deductible, then 20% Coinsurance
Physician and hospital based genetic testing	Deductible, then no charge	Deductible, then no charge	Deductible, then no charge	Deductible, then 20% Coinsurance
Non–hospital based advanced radiology, including CT scans, PET scans, MRI, MRA and nuclear medicine services	Tier 1 Deductible, then $100 Copayment per procedure			Deductible, then 20% Coinsurance
Hospital based advanced radiology, including CT scans, PET scans, MRI, MRA and nuclear medicine services	Deductible, then $100 Copayment per procedure	Deductible, then $100 Copayment per procedure	Deductible, then $100 Copayment per procedure	Deductible, then 20% Coinsurance
Non–hospital based diagnostic services	Tier 1 Deductible, then no charge			Deductible, then 20% Coinsurance
Physician and hospital based diagnostic services	Deductible, then no charge	Deductible, then no charge	Deductible, then no charge	Deductible, then 20% Coinsurance
Low Protein Foods				
– Limited to $5,000 per Plan Year	Tier 1 Deductible, then no charge			Deductible, then 20% Coinsurance
Maternity Care - Outpatient				
Routine outpatient prenatal and postpartum care	No charge			Deductible, then 20% Coinsurance

Benefit	In-Network Tier 1 Member Cost Sharing	In-Network Tier 2 Member Cost Sharing	In-Network Tier 3 Member Cost Sharing	Out-of-Network Member Cost Sharing
Maternity Care - Outpatient (Continued)				
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, Radiology and Other Diagnostic 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	Deductible, then no charge	Deductible, then no charge	Deductible, then 20% Coinsurance
Medical drugs received in the home	Deductible, then no charge	Deductible, then no charge	Deductible, then no charge	Deductible, then 20% Coinsurance
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				
	Tier 1 Deductible, then no charge			Deductible, then 20% Coinsurance
Mental Health and Substance Use Disorder Treatment				
Inpatient Services	$200 Copayment per admission			Deductible, then 20% Coinsurance
Intermediate care services	No charge			Deductible, then 20% Coinsurance
Outpatient group therapy	$10 Copayment per visit			Deductible, then 20% Coinsurance
Outpatient treatment, including individual therapy, outpatient detoxification and medication management	Tier 1 Primary Care Copayment: $10 per visit			Deductible, then 20% Coinsurance
Outpatient methadone maintenance	Not covered			Not covered
Outpatient psychological testing and neuropsychological assessment – Performed by a licensed mental health professional	Tier 1 Deductible, then no charge			Deductible, then 20% Coinsurance
– Performed by a neurologist or other medical specialist	See the benefit for "Treatments and Procedures" under "Physicians and other Professional Office Visits."			Deductible, then 20% Coinsurance
Observation Services				
	Tier 1 Deductible, then $275 Copayment per observation stay			Same as In-Network

Benefit	In-Network Tier 1 Member Cost Sharing	In-Network Tier 2 Member Cost Sharing	In-Network Tier 3 Member Cost Sharing	Out-of-Network Member Cost Sharing
Ostomy Supplies				
	Tier 1 Deductible, then no charge			Deductible, then 20% Coinsurance
Physician and Other Professional Office Visits (This includes all covered Providers unless otherwise listed in this Schedule of Benefits)				
Routine examinations for preventive care, including immunizations	No charge			Deductible, then 20% Coinsurance
Not all In-Network 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, Radiology and Other Diagnostic Services" for the Member Cost Sharing that applies to diagnostic services not included on this list.				
Consultations, evaluations, sickness and injury care	Primary Care Copayment: $10 per visit Specialty and Hospital Based Care Copayment: $30 per visit	Primary Care Copayment: $20 per visit Specialty and Hospital Based Care Copayment: $60 per visit	Primary Care Copayment: $40 per visit Specialty and Hospital Based Care Copayment: $75 per visit	Deductible, then 20% Coinsurance
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 treatments and procedures, including, but not limited to: administration of injections, allergy treatments, casting, suturing and the application of dressings, genetic counseling, non-routine foot care, pregnancy testing, and surgical procedures	Deductible, then no charge	Deductible, then no charge	Deductible, then no charge	Deductible, then 20% Coinsurance
Administration of allergy injections	No charge	No charge	No charge	Deductible, then 20% Coinsurance
Preventive Services and Tests				
	No charge			Deductible, then 20% Coinsurance

Benefit	In-Network Tier 1 Member Cost Sharing	In-Network Tier 2 Member Cost Sharing	In-Network Tier 3 Member Cost Sharing	Out-of-Network Member Cost Sharing
Preventive Services and Tests (Continued)				
Under federal and state 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 and state guidance.				
The following additional preventive services, tests and devices: alpha-fetoprotein (AFP), fetal ultrasound, hepatitis C testing, lead level testing, prostate-specific antigen (PSA) screening, routine hemoglobin tests, group B streptococcus (GBS), routine urinalysis, blood pressure monitor, retinopathy screening, and international normalized ratio (INR) testing.	No charge			Deductible, then 20% Coinsurance
Prosthetic Devices				
	Tier 1 Deductible, then no charge			Deductible, then 20% Coinsurance
Rehabilitation and Habilitation Services - Outpatient				
Cardiac rehabilitation	$20 Copayment per visit	$20 Copayment per visit	$20 Copayment per visit	Deductible, then 20% Coinsurance
Pulmonary rehabilitation therapy	Tier 1 Primary Care Copayment: $20 per visit			Deductible, then 20% Coinsurance
Speech-language and hearing services	Tier 1 Primary Care Copayment: $20 per visit			Deductible, then 20% Coinsurance
Occupational therapy – limited to 30 visits per Plan Year Physical therapy – limited to 30 visits per Plan Year	Tier 1 Primary Care Copayment: $20 per visit			Deductible, then 20% Coinsurance
Outpatient physical and occupational therapy is not subject to the limit listed above and is covered to the extent Medically Necessary for: (1) children under the age of three and (2) the treatment of Autism Spectrum Disorders.				

Benefit	In-Network Tier 1 Member Cost Sharing	In-Network Tier 2 Member Cost Sharing	In-Network Tier 3 Member Cost Sharing	Out-of-Network Member Cost Sharing
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."			Deductible, then 20% Coinsurance
Spinal Manipulative Therapy (including care by a chiropractor)				
– Limited to 20 visits per Plan Year	$20 Copayment per visit			Deductible, then 20% Coinsurance
Surgery – Outpatient				
	Deductible, then $250 Copayment per visit	Deductible, then $250 Copayment per visit	Deductible, then $250 Copayment per visit	Deductible, then 20% Coinsurance
Telemedicine Virtual Visit Services - Outpatient				
	Primary Care Copayment: $10 per visit Specialty and Hospital Based Care Copayment: $30 per visit	Primary Care Copayment: $20 per visit Specialty and Hospital Based Care Copayment: $60 per visit	Primary Care Copayment: $40 per visit Specialty and Hospital Based Care Copayment: $75 per visit	Deductible, then 20% Coinsurance
For inpatient hospital care, see "Hospital – Inpatient Services" for cost sharing details.				
Urgent Care Services				
Convenience care clinic	$10 Copayment per visit	$20 Copayment per visit	$20 Copayment per visit	Deductible, then 20% Coinsurance
Urgent care center	$20 Copayment per visit	$20 Copayment per visit	$20 Copayment per visit	Deductible, then 20% Coinsurance
Hospital urgent care center	$20 Copayment per visit	$20 Copayment per visit	$20 Copayment per visit	Deductible, then 20% Coinsurance
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, Radiology and Other Diagnostic Services."				
Vision Services				
Routine eye examinations – limited to 1 exam per Plan Year	No charge	No charge	No charge	Deductible, then 20% Coinsurance
Vision hardware for special conditions	Tier 1 Deductible, then no charge			Deductible, then 20% Coinsurance

Benefit	In-Network Tier 1 Member Cost Sharing	In-Network Tier 2 Member Cost Sharing	In-Network Tier 3 Member Cost Sharing	Out-of-Network Member Cost Sharing
Voluntary Sterilization in a Physician's Office				
	Deductible, then no charge	Deductible, then no charge	Deductible, then no charge	Deductible, then 20% Coinsurance
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 "Office based treatments and procedures." For inpatient hospital care, see "Hospital – Inpatient Services"			Deductible, then 20% Coinsurance
Wigs and Scalp Hair Prostheses as required by law				
	No charge			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) ប្រសូមជូនដំណឹងៈ បើអ្នកនិយាយភាសាខ្មែរ, យើងមានសេវាកម្មបកប្រែ 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, ໂດຍບໍ່ສັງຄ່າ, 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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General List of Exclusions
MASSACHUSETTS

The following list identifies services that are generally excluded from Harvard Pilgrim Plans. Additional services may be excluded related to access or product design. For a complete list of exclusions please refer to the specific plan's Benefit Handbook.

Exclusion
Alternative Treatments
• Acupuncture care, except when specifically listed as a Covered Benefit. • Acupuncture services that are outside the scope of standard acupuncture care. • Alternative, holistic or naturopathic services and all procedures, laboratories and nutritional supplements associated with such treatments, except when specifically listed as a Covered Benefit. • Aromatherapy, treatment with crystals and alternative medicine. • Any of the following types of programs: Health resorts, spas, recreational programs, camps, outdoor skills programs, therapeutic or educational boarding schools, educational programs for children in residential care, self-help programs, life skills programs, relaxation or lifestyle programs, and wilderness programs (therapeutic outdoor programs). • Massage therapy. • Myotherapy.
Dental Services
• Dental Care, except when specifically listed as a Covered Benefit. • All services of a dentist for Temporomandibular Joint Dysfunction (TMD). • Extraction of teeth, except when specifically listed as a Covered Benefit. • Pediatric dental care, except when specifically listed as a Covered Benefit.
Durable Medical Equipment and Prosthetic Devices
• Any devices or special equipment needed for sports or occupational purposes. • Any home adaptations, including, but not limited to home improvements and home adaptation equipment. • Non-durable medical equipment, unless used as part of the treatment at a medical facility or as part of approved home health care services. • Repair or replacement of durable medical equipment or prosthetic devices as a result of loss, negligence, willful damage, or theft.
Experimental, Unproven or Investigational Services
• Any products or services, including, but not limited to, drugs, devices, treatments, procedures, and diagnostic tests that are Experimental, Unproven, or Investigational.
Foot Care
• Foot orthotics, except for the treatment of severe diabetic foot disease. • Routine foot care. Examples include nail trimming, cutting or debriding and the cutting or removal of corns and calluses. This exclusion does not apply to preventive foot care for Members with diabetes.
Maternity Services
• Planned home births.
Mental Health and Substance Use Disorder Treatment
• Biofeedback. • Educational services or testing, except services covered under the benefit for Early Intervention Services. No benefits are provided (1) for educational services intended to enhance educational achievement or developmental functioning, (2) to resolve problems of school performance, (3) to treat learning disabilities, (4) for driver alcohol education, or (5) for community reinforcement approach and assertive continuing care. • Any of the following types of programs: programs in which the patient has a pre-defined duration of care without the Plan's ability to conduct concurrent determinations of continued medical necessity, programs that only provide meetings or activities not based on individualized treatment plans, programs that focus solely on interpersonal or other skills rather than directed toward symptom reduction and functional recovery related to specific mental health disorders, and tuition based programs that offer educational, vocational, recreational, or personal developmental activities. • Methadone maintenance, except when specifically listed as a Covered Benefit. • Sensory integrative praxis tests. • Services for any condition with only a "Z Code" designation in the Diagnostic and Statistical Manual of Mental Disorders, which means that the condition is not attributable to a mental disorder. • Mental health and substance use disorder treatment that is (1) provided to

Exclusion
Mental Health and Substance Use Disorder Treatment (Continued)
Members who are confined or committed to a jail, house of correction, prison, or custodial facility of the Department of Youth Services; or (2) provided by the Department of Mental Health. • Services or supplies for the diagnosis or treatment of mental health and substance use disorders that, in the reasonable judgment of the Behavioral Health Access Center, are any of the following: not consistent with prevailing national standards of clinical practice for the treatment of such conditions; not consistent with prevailing professional research demonstrating that the services or supplies will have a measurable and beneficial health outcome; typically do not result in outcomes demonstrably better than other available treatment alternatives that are less intensive or more cost effective. • Services related to autism spectrum disorders provided under an individualized education program (IEP), including any services provided under an IEP that are delivered by school personnel or any services provided under an IEP purchased from a contractor or vendor.
Physical Appearance
• Cosmetic Services, including drugs, devices, treatments and procedures, except for (1) Cosmetic Services that are incidental to the correction of Physical Functional Impairment, (2) restorative surgery to repair or restore appearance damaged by an accidental injury, and (3) post-mastectomy care. • Hair removal or restoration, including, but not limited to, electrolysis, laser treatment, transplantation or drug therapy. • Liposuction or removal of fat deposits considered undesirable. • Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures). • Skin abrasion procedures performed as a treatment for acne. • Treatment for skin wrinkles and skin tags or any treatment to improve the appearance of the skin. • Treatment for spider veins.
Procedures and Treatments
• Care by a chiropractor outside the scope of standard chiropractic practice, including but not limited to, surgery, prescription or dispensing of drugs or medications, internal examinations, obstetrical practice, or treatment of infections and diagnostic testing for chiropractic care other than an initial X-ray. • Spinal manipulative therapy (including care by a chiropractor), except when specifically listed as a Covered Benefit. • Commercial diet plans, weight loss programs and any services in connection with such plans or programs, except when specifically listed as a Covered Benefit. **Please note**: If you have coverage through an employer group plan, your employer may participate in other wellness and health improvement incentive programs offered by Harvard Pilgrim. Please review all your Plan documents for the amount of incentives, if any, available under your Plan. • Gender reassignment surgery and all related drugs and procedures for self-insured groups, unless covered under a separate rider. • If a service is listed as requiring that it be provided at a Center of Excellence, no In-Network coverage will be provided if that service is received from a provider that has not been designated as a Center of Excellence. • Nutritional or cosmetic therapy using vitamins, minerals or elements, and other nutrition-based therapy. Examples include supplements, electrolytes, and foods of any kind (including high protein foods and low carbohydrate foods). • Physical examinations and testing for insurance, licensing or employment. • Services for Members who are donors for non-members, except as described under Human Organ Transplant Services. • Testing for central auditory processing. • Group diabetes training, educational programs or camps.
Providers
• Charges for services which were provided after the date on which your membership ends. • Charges for any products or services, including, but not limited to, professional fees, medical equipment, drugs, and hospital or other facility charges, that are related to any care that is not a Covered Benefit. • Charges for missed appointments. • Concierge service fees. (See the Plan's *Benefit Handbook* for more information.) • Inpatient charges after your hospital discharge. • Provider's charge to file a claim or to transcribe or copy your medical records. • Services or supplies provided by: (1) anyone related to you by blood, marriage or adoption, or (2) anyone who ordinarily lives with you.

Exclusion
Reproduction
• Any form of Surrogacy or services for a gestational carrier. • Infertility drugs if a Member is not in a Plan authorized cycle of infertility treatment. • Infertility drugs, if infertility services are not a Covered Benefit. • Infertility drugs that must be purchased at an outpatient pharmacy, unless your Plan includes outpatient pharmacy coverage. • Infertility treatment for Members who are not medically infertile. • Infertility treatment and birth control drugs, implants and devices, except when specifically listed as a Covered Benefit. • Reversal of voluntary sterilization (including any services for infertility related to voluntary sterilization or its reversal). • Sperm collection, freezing and storage except as described in the Plan's *Benefit Handbook.* • Sperm identification when not Medically Necessary (e.g., gender identification). • The following fees: wait list fees, non-medical costs, shipping and handling charges etc. • Voluntary sterilization, including tubal ligation and vasectomy, except when specifically listed as a Covered Benefit. • Voluntary termination of pregnancy, unless the life of the mother is in danger or unless it is specifically listed as a Covered Benefit.
Services Provided Under Another Plan
• Costs for any services for which you are entitled to treatment at government expense, including military service connected disabilities. • Costs for services for which payment is required to be made by a Workers' Compensation plan or an Employer under state or federal law.
Telemedicine Services
• Telemedicine services involving e-mail, fax, texting, or audio-only telephone. • Provider fees for technical costs for the provision of telemedicine services.
Types of Care
• Custodial Care. • Recovery programs including rest or domiciliary care, sober houses, transitional support services, and therapeutic communities. • All institutional charges over the semi-private room rate, except when a private room is Medically Necessary. • Pain management programs or clinics. • Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, and diversion or general motivation, except when specifically listed as a Covered Benefit. • Private duty nursing. • Sports medicine clinics. • Vocational rehabilitation, or vocational evaluations on job adaptability, job placement, or therapy to restore function for a specific occupation.
Vision and Hearing
• Eyeglasses, contact lenses and fittings, except when specifically listed as a Covered Benefit. • Hearing aids, except when specifically listed as a Covered Benefit. • Hearing aid batteries, and any device used by individuals with hearing impairment to communicate over the telephone or internet, such as TTY or TDD. • Refractive eye surgery, including, but not limited to, lasik surgery, orthokeratology and lens implantation for the correction of naturally occurring myopia, hyperopia and astigmatism. • Routine eye examinations, except when specifically listed as a Covered Benefit.
All Other Exclusions
• Any drug or other product obtained at an outpatient pharmacy, except for pharmacy supplies covered under the benefit for diabetes services and hypodermic syringes and needles, as required by Massachusetts law, unless your Plan includes outpatient pharmacy coverage. • Any service or supply furnished in connection with a non-Covered Benefit. • Any service or supply (with the exception of contact lenses) purchased from the internet. • Beauty or barber service. • Diabetes equipment replacements when solely due to manufacturer warranty expiration. • Donated or banked breast milk. • Food or nutritional supplements, including, but not limited to, FDA-approved medical foods obtained by prescription, except as required by law and prescribed for Members who meet HPHC policies for enteral tube feedings. • Guest services. • Medical services that are provided to Members who are confined or committed to jail, house of correction, prison, or custodial facility of the Department of Youth Services. • Services for non-Members. • Services for which no charge would be made in the absence of insurance. • Services for which no coverage is provided in the Benefit Handbook, this Schedule of Benefits, or Prescription Drug Brochure (if applicable). • Services that are not Medically Necessary. • Taxes or governmental assessments on services or supplies. • Transportation other than by ambulance. • Air conditioners, air purifiers and filters, dehumidifiers and humidifiers. • Car seats. • Chairs, bath chairs, feeding chairs, toddler chairs, chair lifts, recliners. • Electric scooters. • Exercise equipment. • Home modifications including but not limited to elevators, handrails and ramps. • Hot tubs, jacuzzis, saunas or whirlpools. • Mattresses. • Medical alert

This exclusion list is not binding and is provided exclusively for information purposes. Please see your Benefit Handbook and Schedule of Benefits.

Exclusion
All Other Exclusions (Continued)
systems. • Motorized beds. • Pillows. • Power-operated vehicles. • Stair lifts and stair glides. • Strollers. • Safety equipment. • Vehicle modifications including but not limited to van lifts. • Telephone. • Television.