

Schedule of Benefits

Harvard Pilgrim Health Care, Inc.

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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 Covered Benefits are provided or arranged by your Primary Care Provider (PCP) in the Service Area, or provided by a Plan Provider outside of the Service Area.

Out-of-Network coverage applies when Covered Benefits are provided by a Non-Plan Provider or a provided by a Plan Provider without a Referral when a Referral is required. 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 number. A Referral from your PCP is not needed. 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
- 1-800-708-4414 for mental health and substance use disorder treatment

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

Medical Necessity Guidelines

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 Medical Necessity Guidelines on our website at www.harvardpilgrim.org or by calling the Member Services Department at 1-888-333-4742.

Office Visit Cost Sharing Levels

Office visit cost sharing may include Copayments, Coinsurance, or Deductible amounts, as described throughout this Schedule of Benefits. There are two types of In-Network office visit cost sharing that apply to your Plan: a lower cost sharing, known as "Level 1," and a higher cost sharing known as "Level 2."

Level 1 applies to covered outpatient professional services received 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.

EFFECTIVE DATE: 11/01/2024

FORM #2497_06

SCHEDULE OF BENEFITS | 1

Level 2 applies to covered outpatient professional services received from specialty care providers. Your Plan may have other cost sharing amounts. Please see the benefit table below for specific cost sharing requirements.

Access to Lower-Priced Services

If you receive specific Covered Benefits from certain Non-Plan Providers located in Maine, New Hampshire, and Massachusetts, you may be able to receive credit for your payment for services provided by such Non-Plan Providers toward your Deductible and Out-of-Pocket Maximum. The specific Covered Benefits include services within the following categories:

- Physical and occupational therapy services
- Radiology and imaging services
- Laboratory services and x-rays
- Infusion therapy services

Go to HPHConnect for more information on this program.

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."

When you receive a service at your home (other than home health care), your Member Cost Sharing will be the same as when the service is provided in an office or facility. For example, if you have a physician visit in your home, see "Physician and Other Professional Office Visits." If you have blood drawn at home, see "Laboratory, Radiology and Other Diagnostic Services."

| General Cost Sharing Features: | | In-Network Member Cost Sharing: | Out-of-Network Member Cost Sharing |
|--|---|--|------------------------------------|
| Coinsurance and Copayments | | | |
| | See the benefits table below | | |
| Deductible | | | |
| | \$3,200 for Individual Coverage per Calendar Year \$6,400 for Family Coverage per Calendar Year – with a \$3,200 embedded individual Deductible per Calendar Year | \$6,000 for Individual Coverage per Calendar Year \$12,000 for Family Coverage per Calendar Year – with a \$6,000 embedded individual Deductible per Calendar Year | |
| Important Notice: If you have Individual Coverage, the Individual Coverage Deductible applies (the Family Coverage Deductible will never apply). If you have Family Coverage, the Family Coverage Deductible can be satisfied in one of two ways: a. If a Member of a covered family meets the embedded individual 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 Coverage Deductible, then all Members of the covered family have no additional Deductible Member Cost Sharing for Covered | | | |

| General Cost Sharing Features: | | In-Network Member Cost Sharing: | Out-of-Network Member Cost Sharing |
|---|--|---|---|
| Deductible (Continued) | | | |
| <p>Benefits for the remainder of the Calendar Year. No one family member may contribute more than the embedded individual Deductible amount toward the Family Coverage Deductible.</p> <p>An embedded individual Deductible may not be less than the applicable minimum family Deductible, as defined by the Internal Revenue Service.</p> <p>Once a Deductible is met, coverage by the Plan is subject to any other Member Cost sharing that may apply.</p> | | | |
| Out-of-Pocket Maximum | | | |
| Includes all Member Cost Sharing Any charges above the Allowed Amount and any penalty for failure to receive Prior Approval when using Non-Plan Providers do not apply to the Out-of-Pocket Maximum | | \$6,500 for Individual Coverage per Calendar Year \$13,000 for Family Coverage per Calendar Year – with a \$6,500 embedded individual Out-of-Pocket Maximum per Calendar Year | \$13,000 for Individual Coverage per Calendar Year \$26,000 for Family Coverage per Calendar Year – with a \$13,000 embedded individual Out-of-Pocket Maximum per Calendar Year |
| <p>Important Notice: If you have Individual Coverage, the Individual Coverage Out-of-Pocket Maximum applies (the Family Coverage Out-of-Pocket Maximum will never apply). If you have Family Coverage, the Family Coverage Out-of-Pocket Maximum can be satisfied in one of two ways:</p> <p>a. If a Member of a covered family meets the embedded individual Out-of-Pocket Maximum, then that Member has no additional Member Cost Sharing for the remainder of the Calendar Year.</p> <p>b. If any number of Members in a covered family collectively meet the Family Coverage 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 than the embedded individual Out-of-Pocket Maximum amount toward the Family Coverage Out-of-Pocket Maximum.</p> | | | |
| Out-of-Network Penalty Payment | | | |
| Applies when the Member fails to obtain required Prior Approval for services from a Non-Plan Provider. Does not count toward the Deductible or Out-of-Pocket Maximum. | | \$500 | |

| Benefit | In-Network Plan Providers with a proper Referral Member Cost Sharing | Out-of-Network Non-Plan Providers and Plan Providers without a Referral Member Cost Sharing |
|--|--|---|
| Acupuncture Treatment for Injury or Illness | | |
| – Limited to 20 visits per Calendar Year | Deductible, then \$25 Copayment per visit | Deductible, then 40% Coinsurance |
| Ambulance and Medical Transport | | |
| Emergency ambulance transport | Deductible, then 20% Coinsurance | Same as In-Network |
| Non-emergency air ambulance transport | Deductible, then 20% Coinsurance | Same as In-Network |
| Non-emergency medical transport | Deductible, then 20% Coinsurance | Deductible, then 40% Coinsurance |

| Benefit | | In-Network Plan Providers with a proper Referral Member Cost Sharing | Out-of-Network Non-Plan Providers and Plan Providers without a Referral Member Cost Sharing |
|--|--|---|--|
| Autism Spectrum Disorders Treatment | | | |
| Applied behavior analysis | | Deductible, then \$25 Copayment per visit | Deductible, then 40% Coinsurance |
| Chemotherapy and Radiation Therapy | | | |
| Chemotherapy | | Deductible, then 20% Coinsurance | Deductible, then 40% Coinsurance |
| Radiation therapy | | Deductible, then 20% Coinsurance | Deductible, then 40% Coinsurance |
| Chiropractic Care | | | |
| – Limited to 40 visits per Calendar Year | | Deductible, then \$25 Copayment per visit | Deductible, then 40% Coinsurance |
| Dental Services | | | |
| Important Notice: Coverage of Dental Services 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) | | Deductible, then 20% Coinsurance | Deductible, then 40% Coinsurance |
| Dialysis | | | |
| | | Deductible, then 20% Coinsurance | Deductible, then 40% Coinsurance |
| Durable Medical Equipment | | | |
| Durable medical equipment, including orthotic devices as described in the Benefit Handbook | | Deductible, then 20% Coinsurance | Deductible, then 40% Coinsurance |
| Blood glucose monitors, infusion devices, and insulin pumps (including supplies) | | Deductible, then 20% Coinsurance | Deductible, then 40% Coinsurance |
| Oxygen and respiratory equipment | | Deductible, then 20% Coinsurance | Deductible, then 40% Coinsurance |
| Early Intervention Services (for Members up to the age of 3) | | | |
| – Limited to \$3,200 per Member per Calendar Year, up to a maximum of \$9,600 | | Deductible, then 20% Coinsurance | Deductible, then 40% Coinsurance |
| Emergency Admission | | | |
| | | Deductible, then 20% Coinsurance | Same as In-Network |
| Emergency Room Care | | | |
| | | Deductible, then \$250 Copayment per visit | Same as In-Network |
| This Copayment is waived if you are (1) transferred to either Observation Services or Outpatient Surgery or (2) admitted to the Hospital directly from the emergency room. Please see "Hospital - Inpatient Services," "Observation Services," or "Surgery – Outpatient" for the Member Cost Sharing that applies to these benefits. | | | |
| Fertility Treatment (see the Benefit Handbook for details) | | | |
| | | Deductible, then 20% Coinsurance | Deductible, then 40% Coinsurance |

| Benefit | In-Network Plan Providers with a proper Referral Member Cost Sharing | Out-of-Network Non-Plan Providers and Plan Providers without a Referral Member Cost Sharing |
|--|---|--|
| Hearing Aids | | |
| – Limited to \$3,000 per hearing aid every 36 months, for each hearing impaired ear | Deductible, then 20% Coinsurance | Deductible, then 40% Coinsurance |
| Home Health Care | | |
| | Deductible, then 20% Coinsurance | Deductible, then 40% Coinsurance |
| If services include the administration of drugs, please see the benefit for “Medical Drugs” for Member Cost Sharing details. | | |
| Hospice – Outpatient | | |
| | Deductible, then 20% Coinsurance | Deductible, then 40% Coinsurance |
| Hospital – Inpatient Services | | |
| Acute Hospital care, including blood transfusions, and inhalation therapy | Deductible, then 20% Coinsurance | Deductible, then 40% Coinsurance |
| Inpatient maternity care | Deductible, then 20% Coinsurance | Deductible, then 40% Coinsurance |
| Inpatient routine nursery care | No charge | Deductible, then 40% Coinsurance |
| Inpatient rehabilitation – limited to 150 days per Calendar Year Inpatient rehabilitation and skilled nursing facility care limits are combined | Deductible, then 20% Coinsurance | Deductible, then 40% Coinsurance |
| Skilled nursing facility – limited to 150 days per Calendar Year Inpatient rehabilitation and skilled nursing facility care limits are combined | Deductible, then 20% Coinsurance | Deductible, then 40% Coinsurance |
| Laboratory, Radiology and Other Diagnostic Services (including Independent Laboratories and Freestanding Imaging Centers) | | |
| Laboratory | Deductible, then 20% Coinsurance | Deductible, then 40% Coinsurance |
| Genetic testing | Deductible, then 20% Coinsurance | Deductible, then 40% Coinsurance |
| Radiology | Deductible, then 20% Coinsurance | Deductible, then 40% Coinsurance |
| Breast ultrasound screening | Deductible, then 20% Coinsurance | Deductible, then 40% Coinsurance |
| Advanced radiology, including CT scans, PET scans, MRI, MRA and nuclear medicine services | Deductible, then 20% Coinsurance | Deductible, then 40% Coinsurance |
| Breast MRI screening | Deductible, then 20% Coinsurance | Deductible, then 40% Coinsurance |
| Other diagnostic services (including allergy testing) | Deductible, then 20% Coinsurance | Deductible, then 40% Coinsurance |

| Benefit | In-Network Plan Providers with a proper Referral Member Cost Sharing | Out-of-Network Non-Plan Providers and Plan Providers without a Referral Member Cost Sharing |
|---|--|---|
| Low Protein Foods | | |
| – Limited to \$3,000 per Calendar Year | Deductible, then 20% Coinsurance | Deductible, then 40% Coinsurance |
| Maternity Care – Outpatient | | |
| Routine outpatient prenatal and postpartum care | No charge | Deductible, then 40% Coinsurance |
| 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 (including Independent Laboratories and Freestanding Imaging Centers).” | | |
| Medical Drugs (drugs that cannot be self-administered) | | |
| Medical drugs received in a Physician’s office or other outpatient facility | Deductible, then 20% Coinsurance | Deductible, then 40% Coinsurance |
| Medical drugs received in the home | Deductible, then 20% Coinsurance | Deductible, then 40% 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 and Donor Breast Milk | | |
| State mandated formulas and Donor Breast Milk | Deductible, then 20% Coinsurance | Deductible, then 40% Coinsurance |
| Mental Health and Substance Use Disorder Treatment | | |
| Inpatient Services | Deductible, then 20% Coinsurance | Deductible, then 40% Coinsurance |
| Partial hospitalization services | No charge | Deductible, then 40% Coinsurance |
| Outpatient group therapy | Deductible, then \$10 Copayment per visit | Deductible, then 40% Coinsurance |
| Mental health services in the home | Deductible, then \$25 Copayment per visit | Deductible, then 40% Coinsurance |
| Outpatient treatment, including individual therapy, detoxification, and medication management | Deductible, then \$25 Copayment per visit | Deductible, then 40% Coinsurance |
| Outpatient methadone maintenance | Deductible, then 20% Coinsurance | Deductible, then 40% Coinsurance |
| Outpatient psychological testing and neuropsychological assessment | Deductible, then 20% Coinsurance | Deductible, then 40% Coinsurance |
| Outpatient telemedicine virtual visit – group therapy | Deductible, then \$10 Copayment per visit | Deductible, then 40% Coinsurance |
| Outpatient telemedicine virtual visit - including individual therapy, detoxification, and medication management | Deductible, then \$25 Copayment per visit | Deductible, then 40% Coinsurance |

| Benefit | In-Network Plan Providers with a proper Referral Member Cost Sharing | Out-of-Network Non-Plan Providers and Plan Providers without a Referral Member Cost Sharing |
|---|--|---|
| Observation Services | | |
| | Deductible, then 20% Coinsurance | Same as In-Network |
| Ostomy Supplies | | |
| | Deductible, then 20% Coinsurance | Deductible, then 40% 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 40% 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 (including Independent Laboratories and Freestanding Imaging Centers)" for the Member Cost Sharing that applies to diagnostic services not included on this list. | | |
| Consultations, evaluations, Sickness and injury care | Deductible, then Level 1: \$25 Copayment per visit Level 2: \$50 Copayment per visit | Deductible, then 40% 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 (including Independent Laboratories and Freestanding Imaging Centers)." | | |
| Office based treatments and procedures, including but not limited to administration of injections, casting, suturing, and the application of dressings, non-routine foot care, and surgical procedures | Deductible, then 20% Coinsurance | Deductible, then 40% Coinsurance |
| Administration of allergy injections | Deductible, then 20% Coinsurance | Deductible, then 40% Coinsurance |
| Preventive Services and Tests | | |
| | No charge | Deductible, then 40% Coinsurance |

| Benefit | In-Network Plan Providers with a proper Referral Member Cost Sharing | Out-of-Network Non-Plan Providers and Plan Providers without a Referral 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 (even if polyp removal or other necessary medically necessary procedure is required), screening mammograms (including a second screening in the event that the initial screening is inconclusive or an abnormality is discovered), pap tests, 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 40% Coinsurance |
| Prosthetic Devices | | |
| Prosthetic devices (other than arms and legs) | Deductible, then 20% Coinsurance | Deductible, then 40% Coinsurance |
| Prosthetic arms and legs | Deductible, then 20% Coinsurance | Deductible, then 40% Coinsurance |
| Rehabilitation and Habilitation Services – Outpatient | | |
| Cardiac rehabilitation | Deductible, then \$50 Copayment per visit | Deductible, then 40% Coinsurance |
| Pulmonary rehabilitation therapy | Deductible, then \$50 Copayment per visit | Deductible, then 40% Coinsurance |
| Occupational therapy – limited to 60 visits per Calendar Year Occupational, physical, and speech therapy limits are combined | Deductible, then \$50 Copayment per visit | Deductible, then 40% Coinsurance |
| Physical therapy – limited to 60 visits per Calendar Year Occupational, physical, and speech therapy limits are combined | Deductible, then \$50 Copayment per visit | Deductible, then 40% Coinsurance |
| Speech therapy – limited to 60 visits per Calendar Year Occupational, physical, and speech therapy limits are combined | Deductible, then \$50 Copayment per visit | Deductible, then 40% Coinsurance |
| Outpatient physical, occupational and speech therapies are covered to the extent Medically Necessary for: (1) children up to the age of three and (2) the treatment of Autism Spectrum Disorders. Outpatient physical therapy for postpartum related pelvic floor disorders is not subject to visit limits. | | |

| Benefit | | In-Network Plan Providers with a proper Referral Member Cost Sharing | Out-of-Network Non-Plan Providers and Plan Providers without a Referral Member Cost Sharing |
|--|---|--|---|
| Scopic Procedures - Outpatient Diagnostic and Therapeutic | | | |
| Colonoscopy, endoscopy and sigmoidoscopy | Deductible, then 20% Coinsurance | Deductible, then 40% Coinsurance | |
| Surgery – Outpatient | | | |
| | Deductible, then 20% Coinsurance | Deductible, then 40% Coinsurance | |
| Travel Reimbursement Benefit | | | |
| – Limited to \$2,500 per Calendar Year See the Benefit Handbook for details | Deductible, then no charge | | |
| Telemedicine Virtual Visit Services – Outpatient | | | |
| | Deductible, then Level 1: \$25 Copayment per visit Level 2: \$50 Copayment per visit | Deductible, then 40% Coinsurance | |
| For inpatient Hospital care, see “Hospital – Inpatient Services” for cost sharing details. | | | |
| Urgent Care Services | | | |
| Doctor on Demand | Deductible, then \$25 Copayment per visit | | |
| Important Note: Doctor On Demand is a specific network of providers contracted to provide virtual Urgent Care services. For more information on Doctor On Demand, including how to access them, please visit our website at www.harvardpilgrim.org . | | | |
| Convenience care clinic | Deductible, then \$25 Copayment per visit | Deductible, then 40% Coinsurance | |
| Urgent care center | Deductible, then \$25 Copayment per visit | Deductible, then 40% Coinsurance | |
| Hospital urgent care center | Deductible, then \$100 Copayment per visit | Deductible, then 40% Coinsurance | |
| Additional Member Cost Sharing may apply. Please refer to the specific benefit in this Schedule of Benefits. For example, if you have an x-ray or have blood drawn, please refer to “Laboratory, Radiology and Other Diagnostic Services (including Independent Laboratories and Freestanding Imaging Centers).” | | | |
| Vision Services | | | |
| Urgent eye care | Deductible, then Level 1: \$25 Copayment per visit Level 2: \$50 Copayment per visit | Deductible, then 40% Coinsurance | |
| Routine adult eye examinations – limited to 1 exam per Calendar Year | \$25 Copayment per visit | Deductible, then 40% Coinsurance | |
| Routine pediatric eye examinations – limited to 1 exam per Calendar Year | \$25 Copayment per visit | Deductible, then 40% Coinsurance | |
| Vision hardware for special conditions | Deductible, then 20% Coinsurance | Deductible, then 40% Coinsurance | |
| Voluntary Sterilization – in a Physician’s Office | | | |
| | Deductible, then 20% Coinsurance | Deductible, then 40% Coinsurance | |

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| Benefit | In-Network Plan Providers with a proper Referral Member Cost Sharing | Out-of-Network Non-Plan Providers and Plan Providers without a Referral Member Cost Sharing |
|---|---|--|
| Voluntary Termination of Pregnancy – Outpatient | | |
| | Deductible, then 20% Coinsurance | Deductible, then 40% Coinsurance |
| Wigs and Scalp Hair Prostheses | | |
| – Limited to \$350 per Calendar Year (see the Benefit Handbook for details) | Deductible, then 20% Coinsurance | Deductible, then 40% 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 quý vị nói Tiếng Việt, dịch vụ thông dịch của chúng tôi sẵn sàng phục vụ quý 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 مجاناً. اتصل على 1 888-333-4742 (TTY: 711)

ខ្មែរ (Cambodian) ប្រសិនបើអ្នកនិយាយភាសាខ្មែរ, 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 मुफ्तमें उपलब्ध है. जानकारी के लिये फोन करे. 1-888-333-4742 (TTY: 711)

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

ພາສາລາວ (Lao) ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ຄ່າ, ຄ່າມີພ້ອມໃຫ້ທ່ານ. ໂທ 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 New England and HPHC Insurance Company.

(Continued)

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 (including pregnancy, sexual orientation, and gender identity). HPHC does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex (including pregnancy, sexual orientation, and gender identity).

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 (including pregnancy, sexual orientation, and gender identity), you can file a grievance with: Civil Rights Compliance Officer, 1 Wellness Way, Canton, MA 02021-1166, (866) 750-2074, TTY service: 711, Fax: (617) 509-3085, Email: civil_rights@point32health.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>.



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

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General List of Exclusions

Harvard Pilgrim Health Care, Inc. | MAINE

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 |
| <ul style="list-style-type: none"> • Acupuncture care except when specifically listed as a Covered Benefit. • Acupuncture services that are outside the scope of standard acupuncture care. • Alternative or holistic services and all procedures, laboratories and nutritional supplements associated with such treatments. • Aromatherapy, treatment with crystals and alternative medicine. • Any of the following types of programs: Health resorts, spas, recreational programs, camps, wilderness programs (therapeutic outdoor programs), outdoor skills programs, life skills programs, therapeutic or educational boarding schools, and relaxation or lifestyle programs. • Massage therapy when performed by anyone other than a licensed physical therapist, physical therapy assistant, occupational therapist, or certified occupational therapy assistant. • Myotherapy. • Services by a naturopath that are not covered by other Plan Providers under the Plan. |
| Clinical Trials |
| Coverage is not provided for the following: <ul style="list-style-type: none"> • The investigational item, device, or service itself; or • For services, tests or items that are provided solely to satisfy data collection and analysis for the clinical trial and that are not used for the direct clinical management of your condition. |
| Dental Services |
| <ul style="list-style-type: none"> • 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 |
| <ul style="list-style-type: none"> • 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 |
| <ul style="list-style-type: none"> • Any products or services, including, but not limited to, drugs, devices, treatments, procedures, and diagnostic tests that are Experimental, Unproven, or Investigational. |
| Foot Care |
| <ul style="list-style-type: none"> • 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. Services provided by a doula |

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

Exclusion

Mental Health Care

- 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 (2) to resolve problems of school performance.
- 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 care that is (1) provided to 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.

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) reconstructive 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.
- Wigs, except when specifically listed as a Covered Benefit.

Procedures and Treatments

- Gender reassignment surgery and all related drugs and procedures, except when specifically listed as a Covered Benefit.
- 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.
- Commercial diet plans, weight loss programs and any services in connection with such plans or programs. **Please note:** 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.
- 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).
- If a service is listed as requiring that it be provided at a Center of Excellence, no coverage will be provided under this Handbook if that service is received from a Provider that has not been designated as a Center of Excellence.
- 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, except as required by Maine law.
- 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.

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| Exclusion |
|--|
| Reproduction |
| <ul style="list-style-type: none"> • Any form of Surrogacy or services for a gestational carrier other than covered maternity services. • 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, 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 when infertility treatment is specifically listed as a Covered Benefits. • 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 necessary to preserve the life or health of a Member,, or unless it is specifically listed as a Covered Benefit. |
| Services Provided Under Another Plan |
| <ul style="list-style-type: none"> • Costs for any services for which you are entitled to treatment at government expense, including military service connected disabilities. • Costs for services covered by third party liability, other insurance coverage, and which are required to be covered by a Workers' Compensation plan or an Employer under state or federal law, unless a notice of controversy has been filed with the Workers' Compensation Board contesting the work-relatedness of the claimant's condition and no decision has been made by the Board. |
| Telemedicine |
| <ul style="list-style-type: none"> • Telemedicine services involving e-mail, pr fax. • Telemedicine services involving audio-only telephone, except where telemedicine is technologically unavailable at a scheduled time and is medically appropriate for the corresponding covered health services. • Provider fees for technical costs for the provision of telemedicine services. |
| Transgender Health Services |
| <ul style="list-style-type: none"> • Abdominoplasty. • Chemical peels. • Collagen injections. • Dermabrasion. • Electrolysis or laser hair removal (for all indications, except when required pre-operatively for genital surgery). • Hair transplantation. • Reversal of transgender health services and all related drugs and procedures. • Implantations (e.g. cheek, calf, pectoral, gluteal). • Liposuction. • Lip reduction/enhancement. • Panniculectomy. • Removal of redundant skin. • Silicone injections (e.g. for breast enlargement). • Voice modification therapy/surgery. • Transgender health services and all related drugs and procedures for self-insured groups, unless covered under a separate rider. • Reimbursement for travel expenses |
| Types of Care |
| <ul style="list-style-type: none"> • Custodial Care. • Rest or domiciliary care. • 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. • 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 |
| <ul style="list-style-type: none"> • Eyeglasses, contact lenses and fittings, except as listed in the Plan's <i>Benefit Handbook</i> and any associated Riders. • Over the counter hearing aids • 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. |

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Exclusion

All Other Exclusions

• Any service or supply furnished in connection with a non-Covered Benefit. • Any service, supply or medication when there is a less intensive Covered Benefit or most cost-effective alternative that can be safely and effectively provided • Any service, supply or medication that is required by a third party that is not otherwise Medically Necessary (examples of a third party are an employer, and insurance company, a school or court). • Any service or supply (with the exception of contact lenses) purchased from the internet. • Beauty or barber service. • Any drug or other product obtained at an outpatient pharmacy, except for pharmacy supplies covered under the benefit for diabetes services, unless your Plan includes outpatient pharmacy coverage. • 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 equipment, devices or supplies except as listed in this Benefit Handbook. • Medical services that are provided to Members who are confined or committed to jail, house of correction, or 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, Schedule of Benefits, or Prescription Drug Brochure. • 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 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.

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