Schedule of Benefits

HPHC Insurance Company, Inc.

Clear Choice PPO Gold 1500
MAINE

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** if you are covered under an Employer Group plan, or **1–877–907–4742** if you are covered under an individual Member plan for the complete listing of services that require Prior Approval. To obtain Prior Approval please call:

- **1–800–708–4414** for medical services
- **1–888–333–4742** 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, **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** if you are covered under an Employer Group plan or **1–877-907-4742** if you are covered under an individual Member plan.

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.

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:	**Member Cost Sharing:**	
Coinsurance and Copayments		
	See the benefits table below	
Deductible		
	\$1,500 per Member per Calendar Year \$3,000 per family per Calendar Year	\$3,000 per Member per Calendar Year \$6,000 per family per Calendar Year
Important Notice: If a family Deductible applies, it can be met in one of two ways: a. If a Member of a covered family meets an individual Deductible, then that Member has no additional Deductible Member Cost Sharing responsibilities for Covered Benefits for the remainder of the Calendar Year. b. If any number of Members in a covered family collectively meets a family Deductible, then all Members in that covered family have no additional Deductible Member Cost Sharing responsibilities for Covered Benefits for the remainder of the Calendar Year.		
Deductible Rollover		
None		

General Cost Sharing Features:	Member Cost Sharing:	
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	$5,000 per Member per Calendar Year $10,000 per family per Calendar Year	$10,000 per Member per Calendar Year $20,000 per family per Calendar Year
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 Member Cost Sharing	Out-of-NetworkNon-Plan Providers Member Cost Sharing
Acupuncture Treatment for Injury or Illness		
	$25 Copayment per visit	Deductible, then 50% Coinsurance
Ambulance and Medical Transport		
Emergency ambulance transport	Deductible, then 30% Coinsurance	Same as In-Network
Non-emergency air ambulance transport	Deductible, then 30% Coinsurance	Same as In-Network
Non-emergency medical transport	Deductible, then 30% Coinsurance	Deductible, then 50% Coinsurance
Autism Spectrum Disorders Treatment		
Applied behavior analysis	No Member Cost Sharing applies for your first office visit per Calendar Year with a licensed mental health professional. After the first visit, the following cost sharing applies: $25 Copayment per visit	Deductible, then 50% Coinsurance
Copayments for outpatient mental health services, including mental health services in the home, will accumulate toward the Deductible.		
Chemotherapy and Radiation Therapy		
Chemotherapy	Deductible, then 30% Coinsurance	Deductible, then 50% Coinsurance
Radiation therapy	Deductible, then 30% Coinsurance	Deductible, then 50% Coinsurance
Chiropractic Care		
	$30 Copayment per visit	Deductible, then 50% Coinsurance

Benefit	In-Network Plan Providers Member Cost Sharing	Out-of-NetworkNon-Plan Providers Member Cost Sharing
Clinical Trials		
	Your Member Cost Sharing will depend upon the types of services provided, 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."	
Dental Services		
Important Notice: Coverage of Dental Services is very limited. Please see your Benefit Handbook for the details of your coverage.		
Emergency Dental Care (within six months of injury or within six months of the effective date of coverage, whichever is later) Other dental services, including setting a jaw fracture and removing a tumor (but not a root cyst) General anesthesia for dentistry	Your Member Cost Sharing will depend upon the types of services provided, 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."	
Extraction of teeth impacted in bone (performed in a Physician's office)	Deductible, then 30% Coinsurance	Deductible, then 50% Coinsurance
Dialysis		
Dialysis services, including dialysis training	Deductible, then 30% Coinsurance	Deductible, then 50% Coinsurance
Durable Medical Equipment		
Durable medical equipment, including orthotic devices as described in the Benefit Handbook	Deductible, then 30% Coinsurance	Deductible, then 50% Coinsurance
Blood glucose monitors, infusion devices, and insulin pumps (including supplies)	No charge	No charge
Oxygen and respiratory equipment	No charge	Deductible, then 50% Coinsurance
Early Intervention Services (for Members up to the age of 3)		
– Limited to 40 visits per Calendar Year	$25 Copayment per visit	Deductible, then 50% Coinsurance
Emergency Admission		
	Deductible, then 30% Coinsurance	Same as In-Network
Emergency Room Care		
	Deductible, then 30% Coinsurance	Same as In-Network
Fertility Treatment (see the Benefit Handbook for details)		
	Deductible, then 20% Coinsurance	Deductible, then 50% Coinsurance

Benefit	In-Network Plan Providers Member Cost Sharing	Out-of-NetworkNon-Plan Providers Member Cost Sharing
Hearing Aids		
For Members up to age 19: – Limited to 1 hearing aid per hearing impaired ear every 36 months For all other Members: – Limited to $3,000 per hearing aid every 36 months, for each hearing impaired ear	Deductible, then 50% Coinsurance	Deductible, then 50% Coinsurance
Home Health Care		
Including infusion therapy and nutritional counseling	Deductible, then 30% Coinsurance	Deductible, then 50% Coinsurance
If services include the administration of drugs, please see the benefit for "Medical Drugs" for Member Cost Sharing details.		
Hospice Services		
	Deductible, then 30% Coinsurance	Deductible, then 50% Coinsurance
If inpatient services or respite care are required, please see "Hospital – Inpatient Services" for Member Cost Sharing details.		
Hospital – Inpatient Services		
Acute Hospital care, including bariatric surgery, blood transfusions, infusion therapy, inhalation therapy, organ or tissue transplants and breast reduction surgery and symptomatic varicose vein surgery	Deductible, then 30% Coinsurance	Deductible, then 50% Coinsurance
Inpatient maternity care	Deductible, then 30% Coinsurance	Deductible, then 50% Coinsurance
Inpatient routine nursery care	No charge	Deductible, then 50% Coinsurance
Inpatient rehabilitation – limited to 150 days per Calendar Year Inpatient rehabilitation and skilled nursing facility care limits are combined	Deductible, then 30% Coinsurance	Deductible, then 50% Coinsurance
Skilled nursing facility – limited to 150 days per Calendar Year Inpatient rehabilitation and skilled nursing facility care limits are combined	Deductible, then 30% Coinsurance	Deductible, then 50% Coinsurance
Laboratory, Radiology and Other Diagnostic Services (including Independent Laboratories and Freestanding Imaging Centers)		
Laboratory, including but not limited to human leukocyte antigen testing as described in the Benefit Handbook	**In a Physician's office or non-Hospital affiliated facility:** $15 Copayment per visit **In a Hospital or Hospital affiliated facility:** Deductible, then 30% Coinsurance	Deductible, then 50% Coinsurance

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Benefit	In-Network Plan Providers Member Cost Sharing	Out-of-NetworkNon-Plan Providers Member Cost Sharing
Laboratory, Radiology and Other Diagnostic Services (including Independent Laboratories and Freestanding Imaging Centers) (Continued)		
Genetic testing	Deductible, then 30% Coinsurance	Deductible, then 50% Coinsurance
Radiology	Deductible, then 30% Coinsurance	Deductible, then 50% Coinsurance
Breast ultrasound screening	No charge	Deductible, then 50% Coinsurance
Advanced radiology, including CT scans, PET scans, MRI, MRA and nuclear medicine services	**In a Physician's office or non-Hospital affiliated facility:** $250 Copayment per visit **In a Hospital or Hospital affiliated facility:** Deductible, then 30% Coinsurance	Deductible, then 50% Coinsurance
Breast MRI screening	No charge	Deductible, then 50% Coinsurance
Other diagnostic services (including allergy testing)	Deductible, then 30% Coinsurance	Deductible, then 50% Coinsurance
Low Protein Foods		
	Deductible, then 30% Coinsurance	Deductible, then 50% Coinsurance
Maternity Care – Outpatient		
Routine outpatient prenatal and postpartum care	No charge	Deductible, then 50% 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, including infusion therapy, received in a Physician's office or other outpatient facility	Deductible, then 30% Coinsurance	Deductible, then 50% Coinsurance
Medical drugs, including infusion therapy, received in the home	Deductible, then 30% Coinsurance	Deductible, then 50% 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 30% Coinsurance	Deductible, then 50% Coinsurance
Mental Health and Substance Use Disorder Treatment		
Inpatient Services	Deductible, then 30% Coinsurance	Deductible, then 50% Coinsurance

Benefit	In-Network Plan Providers Member Cost Sharing	Out-of-NetworkNon-Plan Providers Member Cost Sharing
Mental Health and Substance Use Disorder Treatment (Continued)		
Partial hospitalization services	Deductible, then 30% Coinsurance	Deductible, then 50% Coinsurance
Outpatient group therapy	No Member Cost Sharing applies for your first office visit per Calendar Year with a licensed mental health professional. After the first visit, the following cost sharing applies: $10 Copayment per visit	Deductible, then 50% Coinsurance
Mental health services in the home	No Member Cost Sharing applies for your first office visit per Calendar Year with a licensed mental health professional. After the first visit, the following cost sharing applies: $25 Copayment per visit	Deductible, then 50% Coinsurance
Outpatient treatment, including individual therapy, detoxification, and medication management	No Member Cost Sharing applies for your first office visit per Calendar Year with a licensed mental health professional. After the first visit, the following cost sharing applies: $25 Copayment per visit	Deductible, then 50% Coinsurance
Outpatient methadone maintenance	No charge	Deductible, then 50% Coinsurance
Outpatient psychological testing and neuropsychological assessment	No Member Cost Sharing applies for your first office visit per Calendar Year with a licensed mental health professional. After the first visit, the following cost sharing applies: $25 Copayment per visit	Deductible, then 50% Coinsurance
Outpatient telemedicine virtual visit – group therapy	No Member Cost Sharing applies for your first office visit per Calendar Year with a licensed mental health professional. After the first visit, the following cost sharing applies: $10 Copayment per visit	Deductible, then 50% Coinsurance
Outpatient telemedicine virtual visit - including individual therapy, detoxification, and medication management	No Member Cost Sharing applies for your first office visit per Calendar Year with a licensed mental health professional. After the first visit, the following cost sharing applies:	Deductible, then 50% Coinsurance

Benefit	In-Network Plan Providers Member Cost Sharing	Out-of-NetworkNon-Plan Providers Member Cost Sharing
Mental Health and Substance Use Disorder Treatment (Continued)		
	$25 Copayment per visit	
Copayments for outpatient mental health services, including mental health services in the home, will accumulate toward the Deductible.		
Observation Services		
	Deductible, then 30% Coinsurance	Same as In-Network
Ostomy Supplies		
	Deductible, then 30% Coinsurance	Deductible, then 50% Coinsurance
Physician and Other Professional Office Visits (This includes all covered Providers unless otherwise listed in this Schedule of Benefits.)		
Routine examinations, including annual gynecological exams, for preventive care, including immunizations and annual digital rectal exams	No charge	Deductible, then 50% 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, including nutritional counseling	**PCP:** No Member Cost Sharing for the first visit per Calendar Year with a PCP. After the first visit, the following cost sharing applies: Level 1: $25 Copayment per visit **All Other Providers:** Level 1: $25 Copayment per visit Level 2: $50 Copayment per visit	Deductible, then 50% Coinsurance
Copayments for office visits with a PCP will accumulate toward the Deductible.		
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, the application of dressings, inhalation therapy, non-routine foot care, and surgical procedures	Deductible, then 30% Coinsurance	Deductible, then 50% Coinsurance
Administration of allergy injections	$25 Copayment per visit	Deductible, then 50% Coinsurance

Benefit	In-Network Plan Providers Member Cost Sharing	Out-of-NetworkNon-Plan Providers Member Cost Sharing
Preventive Services and Tests		
	No charge	Deductible, then 50% Coinsurance
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 50% Coinsurance
Prosthetic Devices		
Prosthetic devices (other than arms and legs)	Deductible, then 30% Coinsurance	Deductible, then 50% Coinsurance
Prosthetic arms and legs	Deductible, then 20% Coinsurance	Deductible, then 50% Coinsurance
Rehabilitation and Habilitation Services – Outpatient		
Cardiac rehabilitation – limited to 36 visits per cardiac episode	$50 Copayment per visit	Deductible, then 50% Coinsurance
Pulmonary rehabilitation therapy	$50 Copayment per visit	Deductible, then 50% Coinsurance
Occupational therapy **Rehabilitation Services (including treatment for head injuries)** – limited to 60 visits per Calendar Year **Habilitation Services (including treatment for head injuries)** – limited to 60 visits per Calendar Year Occupational, physical, and speech therapy limits are combined	$30 Copayment per visit	Deductible, then 50% Coinsurance

Benefit	In-Network Plan Providers Member Cost Sharing	Out-of-NetworkNon-Plan Providers Member Cost Sharing
Rehabilitation and Habilitation Services – Outpatient (Continued)		
Physical therapy **Rehabilitation Services (including treatment for head injuries)** – limited to 60 visits per Calendar Year **Habilitation Services (including treatment for head injuries)** – limited to 60 visits per Calendar Year Occupational, physical, and speech therapy limits are combined	$30 Copayment per visit	Deductible, then 50% Coinsurance
Speech therapy **Rehabilitation Services (including treatment for head injuries)** – limited to 60 visits per Calendar Year **Habilitation Services (including treatment for head injuries)** – limited to 60 visits per Calendar Year Occupational, physical, and speech therapy limits are combined	$30 Copayment per visit	Deductible, then 50% 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.		
Scopic Procedures - Outpatient Diagnostic and Therapeutic		
Colonoscopy, endoscopy and sigmoidoscopy	**In a non-Hospital affiliated facility:** $300 Copayment per visit **In a Hospital or Hospital affiliated facility:** Deductible, then 30% Coinsurance	Deductible, then 50% Coinsurance
Surgery – Outpatient		
	In a non-Hospital affiliated facility: $300 Copayment per visit **In a Hospital or Hospital affiliated facility:** Deductible, then 30% Coinsurance	Deductible, then 50% Coinsurance

Benefit	In-Network Plan Providers Member Cost Sharing	Out-of-NetworkNon-Plan Providers Member Cost Sharing
Telemedicine Virtual Visit Services – Outpatient		
	PCP: No Member Cost Sharing for the first visit per Calendar Year with a PCP. After the first visit, the following cost sharing applies: Level 1: $25 Copayment per visit **All Other Providers:** Level 1: $25 Copayment per visit Level 2: $50 Copayment per visit	Deductible, then 50% Coinsurance
For inpatient Hospital care, see "Hospital – Inpatient Services" for cost sharing details.		
Copayments for office visits with a PCP will accumulate toward the Deductible.		
Urgent Care Services		
Doctor on Demand	No charge	
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 (retail health clinic)	$25 Copayment per visit	Deductible, then 50% Coinsurance
Urgent care center	$40 Copayment per visit	Deductible, then 50% Coinsurance
Hospital urgent care center	$40 Copayment per visit	Deductible, then 50% 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	**PCP:** No Member Cost Sharing for the first visit per Calendar Year with a PCP. After the first visit, the following cost sharing applies: Level 1: $25 Copayment per visit **All Other Providers:** Level 1: $25 Copayment per visit Level 2: $50 Copayment per visit	Deductible, then 50% Coinsurance
Copayments for office visits with a PCP will accumulate toward the Deductible.		
Routine adult eye examinations – limited to 1 exam per Calendar Year	$25 Copayment per visit	Deductible, then 50% Coinsurance

Benefit	In-Network Plan Providers Member Cost Sharing	Out-of-NetworkNon-Plan Providers Member Cost Sharing
Vision Services (Continued)		
Routine pediatric eye examinations – limited to 1 exam per Calendar Year	$25 Copayment per visit	Deductible, then 50% Coinsurance
Vision hardware for special conditions	Deductible, then 30% Coinsurance	Deductible, then 50% Coinsurance
Your Plan also includes coverage for pediatric vision hardware. Please see the additional Pediatric Vision section later in this Schedule of Benefits for more information.		
Voluntary Sterilization – in a Physician's Office		
	Deductible, then 30% Coinsurance	Deductible, then 50% Coinsurance
Voluntary Termination of Pregnancy – Outpatient		
	No charge	Deductible, then 50% Coinsurance

Pediatric VisionCare

Dependents up to the age of 19 are eligible for coverage of prescription eyeglasses or contact lenses. Coverage under this benefit terminates at the end of the month in which the Dependent turns 19. Each Dependent is eligible for coverage every 24 months for *either* (A) prescription eyeglass frames and lenses or (B) prescription contact lenses, as described below:

(A) PRESCRIPTION EYEGLASS FRAMES AND LENSES

The Plan will reimburse you for the purchase of one pair of Standard or Basic prescription eyeglass frames and lenses up to the following amounts:

The Plan will reimburse you for the first $50 you pay toward covered prescription eyeglass frames and lenses. Thereafter, the Plan will reimburse you 50% of your remaining covered charges. Standard or Basic lenses are limited to glass or plastic single vision lenses, conventional bifocal lenses, conventional trifocal lenses and lenticular lenses. Coverage is excluded for lenses larger than 55mm and upgrades such as tints, scratch proofing and progressive lenses. Coverage is also excluded for deluxe and designer eyeglass frames.

(B) PRESCRIPTION CONTACT LENSES

The Plan will reimburse you for the purchase of your first order of prescription contact lenses up to the following amounts:

The Plan will reimburse you for the first $50 you pay toward your first order of covered prescription contact lenses. Thereafter, the plan will reimburse you 50% of your remaining covered charges. Reimbursement for disposable contact lenses is limited to a 6 month supply.

OUT-OF-POCKET MAXIMUM

All Member Cost Sharing under this benefit applies toward your annual In-Network Out-of-Pocket Maximum. Please see the General Cost Sharing Table at the beginning of this Schedule of Benefits for the In-Network Out-of-Pocket Maximum amount that applies to your plan.

WHERE TO PURCHASE EYEWEAR WITH YOUR PEDIATRIC VISION CARE BENEFIT

You can purchase your eyewear from any vision hardware provider with a valid prescription from your doctor. Only contact lenses may be purchased from an internet provider.

HOW TO RECEIVE REIMBURSEMENT FOR THE PEDIATRIC VISION CARE BENEFIT

1. Complete a member reimbursement form. You can obtain this form by visiting our website at **www.harvardpilgrim.org** or by calling the Member Services Department at **1–888–333–4742** if you are covered under an Employer Group plan or **1–877-907-4742** if you are covered under an individual Member plan to request a form. For TTY service, please call **711**. A representative will be happy to assist you.
2. Each Member must use a separate member reimbursement form.
3. Attach the copy of an itemized bill to the form, showing proof of payment. Make a copy of the form for your records.
4. Mail the original form, together with the bill and proof of payment to:

   HPHC Claims
   P.O. Box 699183
   Quincy, MA 02269–9183

We will reimburse you for your payment of covered eyeglasses or contact lenses as described above. The reimbursement is applied AFTER application of discounts, coupons or other offers. Please allow 30 days to receive your reimbursement.

WHERE TO CALL WITH QUESTIONS

If you have any questions about your Pediatric Vision Care benefit, including how to receive reimbursement or eyewear discounts, please contact the Member Services Department at **1-888-333-4742** if you are covered under an Employer Group plan or **1–877-907-4742** if you are covered under an individual Member plan. This telephone number is also listed on your ID card. If you are deaf or hearing impaired, call **711** for TTY service. A representative will be happy to assist you.

EXCLUSIONS

- Expenses incurred prior to your effective date
- Colored contact lenses, special effect contact lenses
- Deluxe or designer frames
- Eyeglass or contact lens supplies
- Lost or broken lenses or frames, unless the Member has reached his/her normal interval for service
- Non-prescription or plano lenses
- Plain or prescription sunglasses, no-line bifocals, blended lenses or oversize lenses
- Safety glasses and accompanying frames
- Spectacle lens styles, materials, treatments or add ons
- Sunglasses and accompanying frames
- Two pairs of glasses in lieu of bifocals
- Vision hardware (with the exception of contact lenses) purchased from an internet provider

Language Assistance Services

Español (Spanish) ATENCIÓN: Si usted habla español, servicios de asistencia lingüística, de forma gratuita, están a su disposición. Llame al 1-877-907-4742 (TTY: 711).

Português (Portuguese) ATENÇÃO: Se você fala português, encontram-se disponíveis serviços linguísticos gratuitos. Ligue para 1-877-907-4742 (TTY: 711).

Kreyòl Ayisyen (French Creole) ATANSYON: Si nou palé Kreyòl Ayisyen, gen asistans pou sèvis ki disponib nan lang nou pou gratis. Rele 1-877-907-4742 (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 1-877-907-4742（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 1-877-907-4742 (TTY: 711).

Русский (Russian) ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-877-907-4742 (телетайп: 711).

العربية (Arabic)
إنتباه: إذا أنت تتكلم اللُّغة العربية ، خدمات المساعدة اللُّغوية متوفرة لك مجانا. ً إتصل على **1 877-907-4742**
(TTY: 711)

ខ្មែរ (Cambodian) ប្រសិនជាអ៊ំ: បើអ្នកនិយាយភាសាខ្មែរ, យើងមានសេវាកម្មបកប្រែ ជូនលោកអ្នកដោយឥតគិតថ្លៃ។ ចូរ ទូរស័ព្ទ 1-877-907-4742 (TTY: 711)។

Français (French) ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-877-907-4742 (ATS: 711).

Italiano (Italian) ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-877-907-4742 (TTY: 711).

한국어 (Korean) '알림': 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-877-907-4742 (TTY: 711) 번으로 전화해 주십시오.

Ελληνικά (Greek) ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, υπάρχουν στη διάθεσή σας δωρεάν υπηρεσίες γλωσσικής υποστήριξης. Καλέστε 1-877-907-4742 (TTY: 711).

Polski (Polish) UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-877-907-4742 (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. 1-877-907-4742 (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. 1-877-907-4742 (TTY: 711)

ພາສາລາວ (Lao) ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-877-907-4742 (TTY: 711).

ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call 1-877-907-4742 (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
HPHC Insurance Company, 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
• 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 Providers under the Plan.
Clinical Trials
Coverage is not provided for the following: • 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
• Dental Care, except the specific dental services listed in this Benefit Handbook, your Schedule of Benefits, and any associated Riders. • Office visits, consultations, and all related services for Temporomandibular Joint Dysfunction (TMD). • 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 with the exception of prosthetics arms and legs for Members under the age of 18. • 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 systemic circulatory diseases or 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 or systemic circulatory diseases.
Maternity Services
• Routine pre-natal and post-partum care when you are traveling outside the Service Area. • Planned home births.

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
• 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, (3) post-mastectomy care, and (4) gender affirming procedures and related services. • Electrolysis or laser hair removal, except for what is Medically Necesssary as part of gender affirming services. • Hair removal or restoration, including, but not limited to, transplantation or drug therapy. • Liposuction, except for what is Medically Necessary as part of gender affirming services, 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. • Treatments and procedures related to appearance including but not limited to, abdominoplasty; chemical peels; collagen injections; dermabrasion; implantations (e.g. cheek, calf, pectoral, gluteal); lip reduction/enhancement; panniculectomy; removal of redundant skin; and silicone injections (e.g. for breast enlargement), except for what is Medically Necessary as part of gender affirming services or another Covered Benefit. • Treatment for skin wrinkles and skin tags or any treatment to improve the appearance of the skin. • Treatment for spider veins. • Wigs.
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 the initial x-ray • Commercial diet plans, weight loss programs and any services in connection with such plans or programs. • 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 received in Massachusetts, Maine, Rhode Island or New Hampshire is listed as requiring that it be provided at a Center of Excellence, no In-Network coverage will be provided under this Handbook if that service is received in Massachusetts, Maine, Rhode Island or New Hampshire 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 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.

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

Exclusion
Reproduction
• Services for a surrogate or gestational carrier who is not a Member of the Plan. • Reversal of voluntary sterilization (including any services for infertility related to voluntary sterilization or its reversal). • Sperm identification when not Medically Necessary (e.g., gender identification). • The following fees: wait list fees, non-medical costs, shipping and handling charges etc.
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 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
• Telemedicine services involving e-mail or 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.
Types of 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
• Eyeglasses, contact lenses and fittings, except as listed in the Plan's Benefit Handbook 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.
All Other Exclusions
• 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. • 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, an 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. • Externally powered exoskeleton assistive devices and orthoses. • 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, prison, or custodial facility of the Department of Youth Services.. • Reimbursement for travel expenses. • 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 Plan's Benefit Handbook, Schedule of Benefits, or Prescription Drug Brochure. • Services 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. • Services that are not Medically Necessary. • Taxes or governmental assessments on services or supplies. • Transportation, except for emergency ambulance transport, and non-emergency medical transport needed to transfer between Hospitals or other covered health care facilities or from a covered facility to your home when Medically Necessary. • Voice modification surgery, except when Medically Necessary for gender affirming services. • Air

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)
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.