

Schedule of Benefits

HPHC Insurance Company, Inc.

BEST BUY HSA PPO

MASSACHUSETTS

This Schedule of Benefits states any Benefit Limits and Member Cost Sharing amounts you must pay for Covered Benefits. However, it is only a summary of your benefits. Please see your Benefit Handbook for details. Your Member Cost Sharing may include a Deductible, Coinsurance, and Copayments. Please see the tables below for details.

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

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

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

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

Prior Approval

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

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

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

Clinical Review Criteria

We use clinical review criteria to evaluate whether certain services or procedures are Medically Necessary for a Member's care. Members or their practitioners may obtain a copy of our clinical review criteria on our website at www.harvardpilgrim.org or by calling **1-888-888-4742**.

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."

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| General Cost Sharing Features: | In-Network Member Cost Sharing: | Out-of-Network Member Cost Sharing: |
|---|--|---|
| Coinsurance and Copayments | | |
| | See the benefits table below | |
| Deductible | | |
| | \$1,500 for Individual Coverage per Calendar Year \$3,000 for Family Coverage per Calendar Year | \$3,000 for Individual Coverage per Calendar Year \$6,000 for Family Coverage per Calendar Year |
| <p>Important Notice: If you have Family Coverage, the Deductible may be met by any combination of covered family Members. The individual Deductible does not apply.</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 except: – Any charges above the Allowed Amount and any penalty for failure to receive Prior Approval when using Non-Plan Providers | \$3,000 for Individual Coverage per Calendar Year \$6,000 for Family Coverage per Calendar Year | \$5,500 for Individual Coverage per Calendar Year \$11,000 for Family Coverage per Calendar Year |
| <p>Important Notice: If you have Family Coverage, the Out-of-Pocket Maximum may be met by any combination of covered family Members. The individual Out-of-Pocket Maximum does not apply. Once the Out-of-Pocket Maximum has been reached, no additional Member Cost Sharing will be applied for the remainder of the Calendar Year.</p> | | |
| Out-of-Network Penalty Payment | | |
| Does not count toward the Deductible or Out-of-Pocket Maximum | \$500 | |

| Benefit | In-Network Plan Providers Member Cost Sharing | Out-of-Network Non-Plan Providers Member Cost Sharing |
|--|--|--|
| Acupuncture Treatment for Injury or Illness | | |
| – Limited to 20 visits per Calendar Year | Deductible, then no charge | Deductible, then 20% Coinsurance |
| Ambulance Transport | | |
| Emergency ambulance transport | Deductible, then no charge | Same as In-Network |
| Non-emergency ambulance transport | Deductible, then no charge | Deductible, then 20% Coinsurance |
| Autism Spectrum Disorders Treatment | | |
| Applied behavior analysis | Deductible, then no charge | Deductible, then 20% Coinsurance |
| Chemotherapy and Radiation Therapy | | |
| | Deductible, then no charge | Deductible, then 20% Coinsurance |

| Benefit | In-Network Plan Providers Member Cost Sharing | Out-of-Network Non-Plan Providers Member Cost Sharing |
|--|--|--|
| Dental Services | | |
| Important Notice: Coverage of Dental Care is very limited. Please see your Benefit Handbook for the details of your coverage. | | |
| Extraction of teeth impacted in bone (performed in a physician's office) | Deductible, then no charge | Deductible, then 20% Coinsurance |
| Pediatric dental care for children | Not covered | Not covered |
| Dialysis | | |
| | Deductible, then no charge | Deductible, then 20% Coinsurance |
| Durable Medical Equipment | | |
| Durable medical equipment | Deductible, then 30% Coinsurance | Deductible, then 30% Coinsurance |
| Blood glucose monitors, infusion devices and insulin pumps (including supplies) | Deductible, then no charge | Same as In-Network |
| Oxygen and respiratory equipment | Deductible, then 20% Coinsurance | Deductible, then 20% Coinsurance |
| Early Intervention Services | | |
| | Deductible, then no charge | Deductible, then 20% Coinsurance |
| The Plan does not cover the family participation fee required by the Massachusetts Department of Public Health. | | |
| Emergency Admission | | |
| | Deductible, then no charge | Same as In-Network |
| Emergency Room Care | | |
| | Deductible, then \$250 Copayment per visit | Same as In-Network |
| This Copayment is waived if admitted to the hospital directly from the emergency room. | | |
| Hearing Aids (for Members up to the age of 22) | | |
| – Limited to \$2,000 per hearing aid every 36 months, for each hearing impaired ear | Deductible, then no charge | Deductible, then 20% Coinsurance |
| Home Health Care | | |
| | Deductible, then no charge | Deductible, then 20% Coinsurance |
| If services include the administration of drugs, please see the benefit for "Medical Drugs" for Member Cost Sharing details. | | |
| Hospice - Outpatient | | |
| | Deductible, then no charge | Deductible, then 20% Coinsurance |
| Hospital – Inpatient Services | | |
| Acute hospital care | Deductible, then no charge | Deductible, then 20% Coinsurance |
| Inpatient maternity care | Deductible, then no charge | Deductible, then 20% Coinsurance |

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| Benefit | In-Network Plan Providers Member Cost Sharing | Out-of-Network Non-Plan Providers Member Cost Sharing |
|---|---|--|
| Hospital – Inpatient Services (Continued) | | |
| Inpatient routine nursery care | No charge | 20% Coinsurance |
| Inpatient rehabilitation – limited to 60 days per Calendar Year | Deductible, then no charge | Deductible, then 20% Coinsurance |
| Skilled nursing facility – limited to 100 days per Calendar Year | Deductible, then no charge | Deductible, then 20% Coinsurance |
| Infertility Services and Treatments (see the Benefit Handbook for details) | | |
| | Your Member Cost Sharing will depend upon where the service is provided, as listed in this Schedule of Benefits. For example, for services provided by a physician, see “Physician and Other Professional Office Visits.” For inpatient hospital care, see “Hospital – Inpatient Services.” | |
| Laboratory, Radiology and Other Diagnostic Services | | |
| Laboratory | Deductible, then no charge | Deductible, then 20% Coinsurance |
| Genetic testing | Deductible, then no charge | Deductible, then 20% Coinsurance |
| Radiology | Deductible, then no charge | Deductible, then 20% Coinsurance |
| Advanced radiology, including CT scans, PET scans, MRI, MRA and nuclear medicine services | Deductible, then no charge | Deductible, then 20% Coinsurance |
| Other diagnostic services | Deductible, then no charge | Deductible, then 20% Coinsurance |
| Low Protein Foods | | |
| – Limited to \$5,000 per Calendar Year | Deductible, then no charge | Deductible, then 20% Coinsurance |
| Maternity Care - Outpatient | | |
| Routine outpatient prenatal and postpartum care | No charge | 20% 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 when not specifically listed above, Member Cost Sharing for an ultrasound billed as a specialized or non-routine service is listed under “Laboratory, Radiology and Other Diagnostic Services.” | | |
| Medical Drugs (drugs that cannot be self-administered) | | |
| Medical drugs received in a physician’s office or other outpatient facility | Deductible, then no charge | Deductible, then 20% Coinsurance |
| Medical drugs received in the home | Deductible, then no charge | Deductible, then 20% Coinsurance |
| Some Medical Drugs may be supplied by a specialty pharmacy. When Medical Drugs are supplied by a specialty pharmacy, the Member Cost Sharing listed above will apply. | | |
| Medical Formulas | | |
| | Deductible, then no charge | Deductible, then 20% Coinsurance |

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| Benefit | In-Network Plan Providers Member Cost Sharing | Out-of-Network Non-Plan Providers Member Cost Sharing |
|--|--|--|
| Mental Health and Substance Use Disorder Treatment | | |
| Inpatient services | Deductible, then no charge | Deductible, then 20% Coinsurance |
| Intermediate care services | Deductible, then no charge | Deductible, then 20% Coinsurance |
| Outpatient group therapy | Deductible, then \$10 Copayment per visit | Deductible, then 20% Coinsurance |
| Outpatient individual therapy | Deductible, then \$20 Copayment per visit | Deductible, then 20% Coinsurance |
| Outpatient treatment, including outpatient detoxification and medication management | Deductible, then no charge | Deductible, then 20% Coinsurance |
| Outpatient methadone maintenance | Deductible, then no charge | Deductible, then 20% Coinsurance |
| Outpatient psychological testing and neuropsychological assessment | Deductible, then no charge | Deductible, then 20% Coinsurance |
| Observation Services | | |
| | Deductible, then no charge | Same as In-Network |
| Ostomy Supplies | | |
| | Deductible, then 30% Coinsurance | Deductible, then 30% Coinsurance |
| Physician and Other Professional Office Visits (This includes all covered Plan Providers unless otherwise listed in this Schedule of Benefits.) | | |
| Routine examinations for preventive care, including immunizations | No charge | 20% Coinsurance |
| <p>Not all In-Network services you receive during your routine exam are covered at no charge. Only preventive services designated under the Patient Protection and Affordable Care Act (PPACA) are covered at no charge. Other services not included under PPACA may be subject to additional cost sharing. For the current list of preventive services covered at no charge under PPACA, please see the Preventive Services Notice on our website at www.harvardpilgrim.org. Please see "Laboratory, Radiology and Other Diagnostic Services" for the Member Cost Sharing that applies to diagnostic services not included on this list.</p> | | |
| Consultations, evaluations, sickness and injury care | Deductible, then \$20 Copayment per visit | Deductible, then 20% Coinsurance |
| <p>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."</p> | | |
| Office based treatments and procedures, including, but not limited to administration of injections, allergy treatments, casting, suturing and the application of dressings, genetic counseling, non-routine foot care, pregnancy testing, and surgical procedures | Deductible, then no charge | Deductible, then 20% Coinsurance |
| Administration of allergy injections | Deductible, then no charge | Deductible, then 20% Coinsurance |

| Benefit | In-Network Plan Providers Member Cost Sharing | Out-of-Network Non-Plan Providers Member Cost Sharing |
|---|--|--|
| Preventive Services and Tests | | |
| | No charge | 20% Coinsurance |
| Under federal and state law, many preventive services and tests are covered with no Member Cost Sharing, including preventive colonoscopies, certain labs and x-rays, voluntary sterilization for women, and all FDA approved contraceptive devices. For a complete list of covered preventive services, please see the Preventive Services Notice on our website at www.harvardpilgrim.org . You may also get a copy of the Preventive Services Notice by calling the Member Services Department at 1-888-333-4742 . Harvard Pilgrim will add or delete services from this benefit for preventive services and tests in accordance with federal and state guidance. | | |
| The following additional preventive services, tests and devices: alpha-fetoprotein (AFP), fetal ultrasound, hepatitis C testing, lead level testing, prostate-specific antigen (PSA) screening, routine hemoglobin tests, group B streptococcus (GBS), routine urinalysis, blood pressure monitor, retinopathy screening, and international normalized ratio (INR) testing. | No charge | 20% Coinsurance |
| Prosthetic Devices | | |
| | Deductible, then 20% Coinsurance | Deductible, then 20% Coinsurance |
| Rehabilitation and Habilitation Services - Outpatient | | |
| Cardiac rehabilitation | Deductible, then \$20 Copayment per visit | Deductible, then 20% Coinsurance |
| Pulmonary rehabilitation therapy | Deductible, then \$20 Copayment per visit | Deductible, then 20% Coinsurance |
| Speech-language and hearing services | Deductible, then \$20 Copayment per visit | Deductible, then 20% Coinsurance |
| Physical and occupational therapies – combined up to 24 visits per condition per Calendar Year | Deductible, then \$20 Copayment per visit | Deductible, then 20% Coinsurance |
| Outpatient physical and occupational therapy is not subject to the limit listed above and is covered to the extent Medically Necessary for: (1) children under the age of three and (2) the treatment of Autism Spectrum Disorders. | | |
| Scopic Procedures - Outpatient Diagnostic and Therapeutic | | |
| Colonoscopy, endoscopy and sigmoidoscopy | Deductible, then no charge | Deductible, then 20% Coinsurance |
| Spinal Manipulative Therapy (including care by a chiropractor) | | |
| – Limited to 12 visits per Calendar Year | Deductible, then \$20 Copayment per visit | Deductible, then 20% Coinsurance |
| Surgery – Outpatient | | |
| | Deductible, then no charge | Deductible, then 20% Coinsurance |

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| Benefit | In-Network Plan Providers Member Cost Sharing | Out-of-Network Non-Plan Providers Member Cost Sharing |
|--|--|--|
| Telemedicine Virtual Visit Services - Outpatient | | |
| | Deductible, then \$20 Copayment per visit | Deductible, then 20% Coinsurance |
| For inpatient hospital care, see "Hospital — Inpatient Services" for cost sharing details. | | |
| Urgent Care Services | | |
| Convenience care clinic | Deductible, then \$20 Copayment per visit | Deductible, then 20% Coinsurance |
| Urgent care center | Deductible, then \$20 Copayment per visit | Deductible, then 20% Coinsurance |
| Hospital urgent care center | Deductible, then \$20 Copayment per visit | Deductible, then 20% Coinsurance |
| Additional Member Cost Sharing may apply. Please refer to the specific benefit in this Schedule of Benefits. For example, if you have an x-ray or have blood drawn, please refer to "Laboratory, Radiology and Other Diagnostic Services." | | |
| Vision Services | | |
| Routine eye examinations – limited to 1 exam per Calendar Year | No charge | Deductible, then 20% Coinsurance |
| Vision hardware for special conditions | Deductible, then no charge | Deductible, then 20% Coinsurance |
| Voluntary Sterilization in a Physician's Office | | |
| | Deductible, then no charge | Deductible, then 20% Coinsurance |
| Voluntary Termination of Pregnancy | | |
| | Your Member Cost Sharing will depend upon where the service is provided as listed in this Schedule of Benefits. For example, for a service provided in an outpatient surgical center, see "Surgery – Outpatient." For services provided in a physician's office, see "Office based treatments and procedures." For inpatient hospital care, see "Hospital – Inpatient Services." | |
| Wigs and Scalp Hair Protheses as required by law | | |
| – Limited to \$350 per Calendar Year (see the Benefit Handbook for details) | Deductible, then 30% Coinsurance | Deductible, then 30% 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)

انتباه: إذا أنت تتكلم اللغة العربية، خدمات المساعدة اللغوية متوفرة لك مجاناً. اتصل على 1 888-333-4742 (TTY: 711)

ខ្មែរ (Cambodian) ចូលជូនដំណឹង: បើអ្នកនិយាយភាសាខ្មែរ, យើងមានសេវាកម្មបកប្រែ ជូនលោកអ្នកដោយឥតគិតថ្លៃ។ ចូរ ទូរស័ព្ទ 1-888-333-4742 (TTY: 711)។

Français (French) ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-888-333-4742 (ATS: 711).

Italiano (Italian) ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-888-333-4742 (TTY: 711).

한국어 (Korean) '알림': 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-888-333-4742 (TTY: 711) 번으로 전화해 주십시오.

Ελληνικά (Greek) ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, υπάρχουν στη διάθεσή σας δωρεάν υπηρεσίες γλωσσικής υποστήριξης. Καλέστε 1-888-333-4742 (TTY: 711).

Polski (Polish) UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-888-333-4742 (TTY: 711).

हिंदी (Hindi) ध्यान दीजिए: अगर आप हिंदी बोलते हैं तो आपके लिये भाषाकी सहायता मुफ्त में उपलब्ध है. जानकारी के लिये फोन करे. 1-888-333-4742 (TTY: 711)

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

ພາສາລາວ (Lao) ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ຈະມີມີ້ພ້ອມໃຫ້ທ່ານ. 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 Connecticut, Harvard Pilgrim Health Care of New England and HPHC Insurance Company.

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General Notice About Nondiscrimination and Accessibility Requirements

Harvard Pilgrim Health Care and its affiliates as noted below ("HPHC") comply with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. HPHC does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

HPHC:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, audio, other formats)
- Provides free language services to people whose primary language is not English, such as qualified interpreters.

If you need these services, contact our Civil Rights Compliance Officer.

If you believe that HPHC has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with: Civil Rights Compliance Officer, 93 Worcester St, Wellesley, MA 02481, (866) 750-2074, TTY service: 711, Fax: (617) 509-3085, Email: civil_rights@harvardpilgrim.org. You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, the Civil Rights Compliance Officer is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
(800) 368-1019, (800) 537-7697 (TTY)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.



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

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General List of Exclusions

HPHC Insurance Company, Inc. | MASSACHUSETTS

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

| Exclusion |
|--|
| <p>Alternative Treatments</p> <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, holistic or naturopathic services and all procedures, laboratories and nutritional supplements associated with such treatments, except when specifically listed as a Covered Benefit. • Aromatherapy, treatment with crystals and alternative medicine. • Any of the following types of programs: Health resorts, spas, recreational programs, camps, outdoor skills programs, therapeutic or educational boarding schools, educational programs for children in residential care, self-help programs, life skills programs, relaxation or lifestyle programs, and wilderness programs (therapeutic outdoor programs). • Massage therapy. • Myotherapy. |
| <p>Dental Services</p> <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. |
| <p>Durable Medical Equipment and Prosthetic Devices</p> <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. |
| <p>Experimental, Unproven or Investigational Services</p> <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. |
| <p>Foot Care</p> <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. |
| <p>Maternity Services</p> <ul style="list-style-type: none"> • Planned home births. |
| <p>Mental Health and Substance Use Disorder Treatment</p> <ul style="list-style-type: none"> • Biofeedback. • Educational services or testing, except services covered under the benefit for Early Intervention Services. No benefits are provided (1) for educational services intended to enhance educational achievement or developmental functioning, (2) to resolve problems of school performance, (3) to treat learning disabilities, (4) for driver alcohol education, or (5) for community reinforcement approach and assertive continuing care. • Any of the following types of programs: programs in which the patient has a pre-defined duration of care without the Plan's ability to conduct concurrent determinations of continued medical necessity, programs that only provide meetings or activities not based on individualized treatment plans, programs that focus solely on interpersonal or other skills rather than directed toward symptom reduction and functional recovery related to specific mental health disorders, and tuition based programs that offer educational, vocational, recreational, or personal developmental activities. • Methadone maintenance, except when specifically listed as a Covered Benefit. • Sensory integrative praxis tests. • Services for any condition with only a "Z Code" designation in the Diagnostic and Statistical Manual of Mental Disorders, which means that the condition is not attributable to a mental disorder. • Mental health and substance use disorder treatment that is (1) provided to |

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 and Substance Use Disorder Treatment (Continued)

Members who are confined or committed to a jail, house of correction, prison, or custodial facility of the Department of Youth Services; or (2) provided by the Department of Mental Health. • Services or supplies for the diagnosis or treatment of mental health and substance use disorders that, in the reasonable judgment of the Behavioral Health Access Center, are any of the following: not consistent with prevailing national standards of clinical practice for the treatment of such conditions; not consistent with prevailing professional research demonstrating that the services or supplies will have a measurable and beneficial health outcome; typically do not result in outcomes demonstrably better than other available treatment alternatives that are less intensive or more cost effective. • Services related to autism spectrum disorders provided under an individualized education program (IEP), including any services provided under an IEP that are delivered by school personnel or any services provided under an IEP purchased from a contractor or vendor.

Physical Appearance

• Cosmetic Services, including drugs, devices, treatments and procedures, except for (1) Cosmetic Services that are incidental to the correction of Physical Functional Impairment, (2) restorative surgery to repair or restore appearance damaged by an accidental injury, and (3) post-mastectomy care. • Hair removal or restoration, including, but not limited to, electrolysis, laser treatment, transplantation or drug therapy. • Liposuction or removal of fat deposits considered undesirable. • Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures). • Skin abrasion procedures performed as a treatment for acne. • Treatment for skin wrinkles and skin tags or any treatment to improve the appearance of the skin. • Treatment for spider veins.

Procedures and Treatments

• Care by a chiropractor outside the scope of standard chiropractic practice, including but not limited to, surgery, prescription or dispensing of drugs or medications, internal examinations, obstetrical practice, or treatment of infections and diagnostic testing for chiropractic care other than an initial X-ray. • Spinal manipulative therapy (including care by a chiropractor), except when specifically listed as a Covered Benefit. • Commercial diet plans, weight loss programs and any services in connection with such plans or programs, except when specifically listed as a Covered Benefit. **Please note:** If you have coverage through an employer group plan, your employer may participate in other wellness and health improvement incentive programs offered by Harvard Pilgrim. Please review all your Plan documents for the amount of incentives, if any, available under your Plan. • Gender reassignment surgery and all related drugs and procedures for self-insured groups, unless covered under a separate rider. • If a service is listed as requiring that it be provided at a Center of Excellence, no In-Network coverage will be provided if that service is received from a provider that has not been designated as a Center of Excellence. • Nutritional or cosmetic therapy using vitamins, minerals or elements, and other nutrition-based therapy. Examples include supplements, electrolytes, and foods of any kind (including high protein foods and low carbohydrate foods). • Physical examinations and testing for insurance, licensing or employment. • Services for Members who are donors for non-members, except as described under Human Organ Transplant Services. • Testing for central auditory processing. • Group diabetes training, educational programs or camps.

Providers

• Charges for services which were provided after the date on which your membership ends. • Charges for any products or services, including, but not limited to, professional fees, medical equipment, drugs, and hospital or other facility charges, that are related to any care that is not a Covered Benefit. • Charges for missed appointments. • Concierge service fees. (See the Plan's *Benefit Handbook* for more information.) • Inpatient charges after your hospital discharge. • Provider's charge to file a claim or to transcribe or copy your medical records. • Services or supplies provided by: (1) anyone related to you by blood, marriage or adoption, or (2) anyone who ordinarily lives with you.

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

Exclusion

Reproduction

- Any form of Surrogacy or services for a gestational carrier.
- Infertility drugs if a Member is not in a Plan authorized cycle of infertility treatment.
- Infertility drugs, if infertility services are not a Covered Benefit.
- Infertility drugs that must be purchased at an outpatient pharmacy, unless your Plan includes outpatient pharmacy coverage.
- Infertility treatment for Members who are not medically infertile.
- Infertility treatment and birth control drugs, implants and devices, except when specifically listed as a Covered Benefit.
- Reversal of voluntary sterilization (including any services for infertility related to voluntary sterilization or its reversal).
- Sperm collection, freezing and storage except as described in the Plan's *Benefit Handbook*.
- Sperm identification when not Medically Necessary (e.g., gender identification).
- The following fees: wait list fees, non-medical costs, shipping and handling charges etc.
- Voluntary sterilization, including tubal ligation and vasectomy, except when specifically listed as a Covered Benefit.
- Voluntary termination of pregnancy, unless the life of the mother is in danger or unless it is specifically listed as a Covered Benefit.

Services Provided Under Another Plan

- Costs for any services for which you are entitled to treatment at government expense, including military service connected disabilities.
- Costs for services for which payment is required to be made by a Workers' Compensation plan or an Employer under state or federal law.

Telemedicine Services

- Telemedicine services involving e-mail, fax, texting, or audio-only telephone.
- Provider fees for technical costs for the provision of telemedicine services.

Types of Care

- Custodial Care.
- Recovery programs including rest or domiciliary care, sober houses, transitional support services, and therapeutic communities.
- All institutional charges over the semi-private room rate, except when a private room is Medically Necessary.
- Pain management programs or clinics.
- Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, and diversion or general motivation, except when specifically listed as a Covered Benefit.
- Private duty nursing.
- Sports medicine clinics.
- Vocational rehabilitation, or vocational evaluations on job adaptability, job placement, or therapy to restore function for a specific occupation.

Vision and Hearing

- Eyeglasses, contact lenses and fittings, except when specifically listed as a Covered Benefit.
- Hearing aids, except when specifically listed as a Covered Benefit.
- Hearing aid batteries, and any device used by individuals with hearing impairment to communicate over the telephone or internet, such as TTY or TDD.
- Refractive eye surgery, including, but not limited to, lasik surgery, orthokeratology and lens implantation for the correction of naturally occurring myopia, hyperopia and astigmatism.
- Routine eye examinations, except when specifically listed as a Covered Benefit.

All Other Exclusions

- Any drug or other product obtained at an outpatient pharmacy, except for pharmacy supplies covered under the benefit for diabetes services and hypodermic syringes and needles, as required by Massachusetts law, unless your Plan includes outpatient pharmacy coverage.
- Any service or supply furnished in connection with a non-Covered Benefit.
- Any service or supply (with the exception of contact lenses) purchased from the internet.
- Beauty or barber service.
- Diabetes equipment replacements when solely due to manufacturer warranty expiration.
- Donated or banked breast milk.
- Food or nutritional supplements, including, but not limited to, FDA-approved medical foods obtained by prescription, except as required by law and prescribed for Members who meet HPHC policies for enteral tube feedings.
- Guest services.
- Medical services that are provided to Members who are confined or committed to jail, house of correction, prison, or custodial facility of the Department of Youth Services.
- Services for non-Members.
- Services for which no charge would be made in the absence of insurance.
- Services for which no coverage is provided in the Benefit Handbook, this Schedule of Benefits, or Prescription Drug Brochure (if applicable).
- Services that are not Medically Necessary.
- Taxes or governmental assessments on services or supplies.
- Transportation other than by ambulance.
- Air conditioners, air purifiers and filters, dehumidifiers and humidifiers.
- Car seats.
- Chairs, bath chairs, feeding chairs, toddler chairs, chair lifts, recliners.
- Electric scooters.
- Exercise equipment.
- Home modifications including but not limited to elevators, handrails and ramps.
- Hot tubs, jacuzzis, saunas or whirlpools.
- Mattresses.
- Medical alert

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Exclusion**All Other Exclusions (Continued)**

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

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