# Schedule of Benefits

THE HARVARD PILGRIM CHOICENET BEST BUY HMO
City of Worcester
MASSACHUSETTS

**Please Note:** This plan includes a tiered provider network called the "ChoiceNet" Network. In this plan, Members pay different levels of Copayments, Coinsurance or Deductibles depending on the tier of the provider delivering a covered service or supply. This plan may make changes to a Provider's benefit tier annually on January 1. Please consult the HPHC ChoiceNet Provider Directory or visit the provider search tool at **www.harvardpilgrim.org** to determine the tier of Providers in the ChoiceNet Network.

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

In a Medical Emergency you should go to the nearest emergency facility or call 911 or other local emergency access number. A Referral from your PCP is not needed. Your emergency room Member Cost Sharing is listed in the tables below.

### 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**.

### Tiered Providers

Most hospitals and physicians covered by the Plan are placed into one of three benefit levels or "tiers" based on national measures of cost efficiency and relative quality. Member Cost Sharing for these providers depends upon the tier in which a provider is placed. Tier 1 is the lowest cost tier. Tier 2 is the medium cost tier. Tier 3 is the highest cost tier. Please see your Benefit Handbook for more information on how hospitals and physicians are tiered under the Plan. Only acute care hospitals, Primary Care Providers (PCPs) and medical specialists are assigned to one of three tiers. All other covered providers are assigned to Tier 1. Tiering also does not apply to physicians and hospitals that specialize in the provision of mental health care. These include psychiatrists and psychiatric hospitals.

You can lower your out-of-pocket cost by selecting the physicians and hospitals in the lower cost tiers. The tables set forth below list the Member Cost Sharing for each type of tiered service. The Plan's Provider Directory lists all Plan Providers and their tier. You can access the Provider Directory at **www.harvardpilgrim.org**. You may also obtain a paper copy of the directory, free of charge, by calling Harvard Pilgrim's Member Services Department at **1–888–333–4742**.

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

### Deductibles

A Deductible is a specific annual dollar amount that is payable by the Member for Covered Benefits received each Plan Year before any benefits subject to the Deductible are payable by the

Plan. If a family Deductible applies, it is met when any combination of Members in a covered family incur expenses for services to which the Deductible applies. Your Plan's Deductible amounts are listed in the tables below.

The Plan has a maximum Deductible, which is the total amount of Deductible payments you are responsible for in a Plan Year. Any Deductible amount you incur for Covered Plan Year will apply toward the maximum Deductible. In addition, any Deductible amount you incur during a Plan Year applies towards a Deductible of any tier.

The Plan also has limits on the Deductible amounts that apply to each tier. If you only use services in Tier 1 during the Plan Year, you would only be responsible for the Tier 1 Deductible amount in that Plan Year. If you only use services in Tiers 1 and 2 in a Plan Year, you would only be responsible for the Tier 2 Deductible amount in that Plan Year. As explained above, even if you use Tier 3 services, your total liability for Deductible charges is limited to the maximum Deductible amount stated in the table below.

## Office Visit Copayments

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

The Primary Care Copayment applies to covered outpatient professional services, other than services received at a professional office operated by a hospital, from the following types of providers: all Primary Care Providers (PCPs); obstetricians and gynecologists; Licensed Mental Health Professionals; certified nurse midwives; and nurse practitioners who bill independently.

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

If a provider is categorized as both Copayment levels, the Primary Care Copayment applies. For example, if a provider is both a PCP and a cardiologist, you will be responsible for the Primary Care Copayment.

Your Plan may have other Copayment amounts. Please see the benefit table below for specific Copayment requirements.

## Covered Benefits

Your Covered Benefits are administered on a Plan Year basis.Your Plan Year begins on your Employer's Anniversary Date. Please see your Benefit Handbook for more details. If you do not know your Employer's Anniversary Date, please contact your Employer's benefits office or call the Member Services Department at **1-888-333-4742**. Your Member Cost Sharing will depend upon the type of service provided and the location the service is provided in, as listed in this Schedule of Benefits. For example, for services provided in a physician's office, see "Physician and Other Professional Office Visits." For services provided in a hospital emergency room, see "Emergency Room Care," and for outpatient surgical procedures, please see "Surgery - Outpatient."

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: | Tier 1 Member Cost Sharing: | Tier 2 Member Cost Sharing: | Tier 3 Member Cost Sharing: |
|---|---|---|---|
| **Coinsurance and Copayments** | | | |
| | See the benefits table below | | |
| **Deductibles** | | | |
| The following Deductibles apply to all services except where specifically noted below.<br>The Deductible amount listed in each tier is the maximum you would pay for all services during the Plan Year in that tier or a lower tier. | $500 per Member per Plan Year<br>$1,000 per family per Plan Year | $500 per Member per Plan Year<br>$1,000 per family per Plan Year | $500 per Member per Plan Year<br>$1,000 per family per Plan Year |
| **Maximum Deductible** | | | |
| | $500 per Member per Plan Year<br>$1,000 per family per Plan Year | | |
| **Deductible Rollover** | | | |
| | None | | |
| **Out-of-Pocket Maximum** | | | |
| Includes all Member Cost Sharing except Member Cost Sharing for prescription drugs, which has a separate Out-of-Pocket Maximum | $5,000 per Member per Plan Year<br>$10,000 per family per Plan Year | | |

| Benefit | Tier 1 Member Cost Sharing | Tier 2 Member Cost Sharing | Tier 3 Member Cost Sharing |
|---|---|---|---|
| **Acupuncture Treatment for Injury or Illness** | | | |
| | Not covered | | |
| **Ambulance and Medical Transport** | | | |
| Emergency ambulance transport | Tier 1 Deductible, then no charge | | |
| Non-emergency medical transport | Tier 1 Deductible, then no charge | | |
| **Autism Spectrum Disorders Treatment** | | | |
| Applied behavior analysis | $20 Copayment per visit | | |
| **Chemotherapy and Radiation Therapy** | | | |
| Chemotherapy | Tier 1 Deductible, then no charge | | |
| Radiation therapy | Tier 1 Deductible, then no charge | | |

| Benefit | Tier 1 Member Cost Sharing | Tier 2 Member Cost Sharing | Tier 3 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) | $40 Copayment per visit | $50 Copayment per visit | $50 Copayment per visit |
| Preventive dental care for children (up to the age of 13) – limited to 2 preventive dental exams per Plan Year, only the following services are included: cleaning, fluoride treatment, teaching plaque control and bitewing x-rays. | $25 Copayment per visit | | |
| **Dialysis** | | | |
| | Tier 1 Deductible, then no charge | | |
| Installation of home equipment | No charge | | |
| **Durable Medical Equipment** | | | |
| Durable medical equipment | Tier 1 Deductible, then 20% Coinsurance | | |
| Blood glucose monitors, infusion devices and insulin pumps (including supplies) | No charge | | |
| Oxygen and respiratory equipment | No charge | | |
| **Early Intervention Services** | | | |
| | No charge | | |
| The Plan does not cover the family participation fee required by the Massachusetts Department of Public Health | | | |
| **Emergency Admission Services** | | | |
| | Tier 1 Deductible, then $275 Copayment per admission | | |
| **Emergency Room Care** | | | |
| | $150 Copayment per visit | | |
| 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. | | | |
| **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 | Tier 1 Deductible, then 20% Coinsurance | | |
| **Home Health Care** | | | |
| | Deductible, then no charge | | |
| 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 | | |

| Benefit | Tier 1 Member Cost Sharing | Tier 2 Member Cost Sharing | Tier 3 Member Cost Sharing |
|---|---|---|---|
| **Hospital – Inpatient Services** | | | |
| Acute hospital care | Deductible, then $275 Copayment per admission | Deductible, then $500 Copayment per admission | Deductible, then $750 Copayment per admission |
| Inpatient maternity care | Deductible, then $275 Copayment per admission | Deductible, then $500 Copayment per admission | Deductible, then $750 Copayment per admission |
| Inpatient routine nursery care | No charge | | |
| Inpatient rehabilitation | Tier 1 Deductible, then no charge | | |
| Skilled nursing facility – limited to 100 days per Plan Year | Tier 1 Deductible, then no charge | | |
| **Infertility Services and Treatments (see the Benefit Handbook for details)** | | | |
| | Your Member Cost Sharing will depend upon where the service is provided and the tier placement of the provider rendering services, as listed in this Schedule of Benefits. For example, for services provided 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<br>Note: All non-hospital based providers are in Tier 1 | Deductible, then no charge | Deductible, then no charge | Deductible, then no charge |
| Radiology<br>Note: All non-hospital based providers are in Tier 1 | Deductible, then no charge | Deductible, then no charge | Deductible, then no charge |
| Genetic testing<br>Note: All non-hospital based providers are in Tier 1 | Deductible, then no charge | Deductible, then no charge | Deductible, then no charge |
| Non-hospital based advanced radiology, including CT scans, PET scans, MRI, MRA and nuclear medicine services | Tier 1 Deductible, then $50 Copayment per procedure | | |
| Hospital based advanced radiology, including CT scans, PET scans, MRI, MRA and nuclear medicine services | Deductible, then $100 Copayment per procedure | Deductible, then $100 Copayment per procedure | Deductible, then $100 Copayment per procedure |
| Diagnostic services<br>Note: All non-hospital based providers are in Tier 1 | Deductible, then no charge | Deductible, then no charge | Deductible, then no charge |
| **Low Protein Foods** | | | |
| | Tier 1 Deductible, then no charge | | |
| **Maternity Care - Outpatient** | | | |
| Routine outpatient prenatal and postpartum care | No charge | | |
| 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." | | | |

| Benefit | Tier 1 Member Cost Sharing | Tier 2 Member Cost Sharing | Tier 3 Member Cost Sharing |
|---|---|---|---|
| **Medical Drugs (drugs that cannot be self-administered)** | | | |
| Medical drugs received in a physician's office or other outpatient facility | Deductible, then no charge | Deductible, then no charge | Deductible, then no charge |
| Medical drugs received in the home | Deductible, then no charge | Deductible, then no charge | Deductible, then no charge |
| 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.<br>**Please Note:** Some medical drugs may be covered under your prescription drug benefit. Please contact your pharmacy benefit manager for additional coverage information. | | | |
| **Medical Formulas** | | | |
| | Tier 1 Deductible, then no charge | | |
| **Mental Health and Substance Use Disorder Treatment** | | | |
| Inpatient Services | No charge | | |
| Intermediate care services<br>– Acute residential treatment (including detoxification), crisis stabilization and in-home family stabilization<br>– Intensive outpatient programs, partial hospitalization and day treatment programs | No charge | | |
| Outpatient group therapy | $10 Copayment per visit | | |
| Outpatient treatment, including individual therapy, outpatient detoxification and medication management | $20 Copayment per visit | | |
| Outpatient methadone maintenance | No charge | | |
| Outpatient psychological testing and neuropsychological assessment<br>– Performed by a licensed mental health professional | Tier 1 Primary Care Copayment: $20 per visit | | |
| – Performed by a neurologist or other medical specialist | See the benefit for "Treatments and Procedures" under "Physicians and other Professional Office Visits." | | |
| Outpatient telemedicine virtual visit services | $20 Copayment per visit | | |
| **Observation Services** | | | |
| | Tier 1 Deductible, then $275 Copayment per observation stay | | |
| **Ostomy Supplies** | | | |
| | Tier 1 Deductible, then 20% Coinsurance | | |

| Benefit | Tier 1 Member Cost Sharing | Tier 2 Member Cost Sharing | Tier 3 Member Cost Sharing |
|---|---|---|---|
| **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 | | |
| Not all services you receive during your routine exam are covered at no charge. Only preventive services designated under the Patient Protection and Affordable Care Act (PPACA) are covered at no charge. Other services not included under PPACA may be subject to additional cost sharing. For the current list of preventive services covered at no charge under PPACA, please see the Preventive Services Notice on our website at **www.harvardpilgrim.org**. Please see "Laboratory, Radiology and Other Diagnostic Services" for the Member Cost Sharing that applies to diagnostic services not included on this list. | | | |
| Consultations, evaluations, sickness and injury care | Primary Care Copayment: $20 per visit Specialty and Hospital Based Care Copayment: $40 per visit | Primary Care Copayment: $25 per visit Specialty and Hospital Based Care Copayment: $50 per visit | Primary Care Copayment: $25 per visit Specialty and Hospital Based Care Copayment: $50 per visit |
| Additional Member Cost Sharing may apply. Please refer to the specific benefit in this Schedule of Benefits. For example, if you need sutures, please refer to office based treatments and procedures below. If you need an x-ray or have blood drawn, please refer to "Laboratory, Radiology and Other Diagnostic Services." | | | |
| Office based treatments and procedures, including but not limited to: administration of injections, casting, suturing and the application of dressings, genetic counseling, non-routine foot care, and surgical procedures | Deductible, then no charge | Deductible, then no charge | Deductible, then no charge |
| Administration of allergy injections | No charge | No charge | No charge |
| **Preventive Services and Tests** | | | |
| | No charge | | |
| 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 | | |

| Benefit | Tier 1 Member Cost Sharing | Tier 2 Member Cost Sharing | Tier 3 Member Cost Sharing |
|---|---|---|---|
| **Prosthetic Devices** | | | |
| | Tier 1 Deductible, then 20% Coinsurance | | |
| **Rehabilitation and Habilitation Services - Outpatient** | | | |
| Cardiac rehabilitation | Deductible, then $25 Copayment per visit | Deductible, then $25 Copayment per visit | Deductible, then $25 Copayment per visit |
| Pulmonary rehabilitation therapy | Tier 1 Deductible, then no charge | | |
| Speech-language and hearing services | Tier 1 Deductible, then $25 Copayment per visit | | |
| Occupational therapy – limited to 60 visits per Plan Year<br>Limits combined with physical therapy. | Tier 1 Deductible, then $25 Copayment per visit | | |
| Physical therapy – limited to 60 visits per Plan Year<br>Limits combined with occupational therapy. | Tier 1 Deductible, then $25 Copayment per visit | | |
| Outpatient physical and occupational therapy is not subject to the limit listed above and is covered to the extent Medically Necessary for: (1) children up to the age of three and (2) the treatment of Autism Spectrum Disorders. | | | |
| **Scopic Procedures - Outpatient Diagnostic and Therapeutic** | | | |
| Endoscopy and sigmoidoscopy | Your Member Cost Sharing will depend upon where the service is provided and the tier placement of the provider rendering services, as listed in this Schedule of Benefits. For example, for a service provided in an outpatient surgical center, see "Surgery – Outpatient." For services provided in a physician's office, see "Physician and Other Professional Office Visits." For inpatient hospital care, see "Hospital – Inpatient Services." | | |
| Colonoscopy | Deductible, then no charge | Deductible, then no charge | Deductible, then no charge |
| **Spinal Manipulative Therapy (including care by a chiropractor)** | | | |
| – Limited to 12 visits per Plan Year | $25 Copayment per visit | | |
| **Surgery – Outpatient** | | | |
| | Deductible, then $250 Copayment per visit | Deductible, then $350 Copayment per visit | Deductible, then $500 Copayment per visit |
| **Telemedicine Virtual Visit Services- Outpatient** | | | |
| | Primary Care Copayment: $20 per visit<br>Specialty and Hospital Based Care Copayment: $40 per visit | Primary Care Copayment: $25 per visit<br>Specialty and Hospital Based Care Copayment: $50 per visit | Primary Care Copayment: $25 per visit<br>Specialty and Hospital Based Care Copayment: $50 per visit |
| For inpatient hospital care, see "Hospital – Inpatient Services" for cost sharing details. | | | |
| **Urgent Care Services** | | | |
| Doctors On Demand | $20 Copayment per visit | | |

| Benefit | Tier 1 Member Cost Sharing | Tier 2 Member Cost Sharing | Tier 3 Member Cost Sharing |
|---|---|---|---|
| **Urgent Care Services (Continued)** | | | |
| Doctors On Demand is a specific network of providers contracted to provide virtual Urgent Care services. For more information on Doctors On Demand, including how to access them, please visit our website at **www.harvardpilgrim.org**. | | | |
| Convenience care clinic | $20 Copayment per visit | $20 Copayment per visit | $20 Copayment per visit |
| Urgent care center | $20 Copayment per visit | $20 Copayment per visit | $20 Copayment per visit |
| Hospital urgent care center | $20 Copayment per visit | $20 Copayment per visit | $20 Copayment per visit |
| Additional Member Cost Sharing may apply. Please refer to the specific benefit in this Schedule of Benefit. For example, if you have an x-ray or have blood drawn, please refer to "Laboratory, Radiology and Other Diagnostic Services." | | | |
| **Vision Services** | | | |
| Routine eye examinations – limited to 1 exam per Plan Year | No charge | No charge | No charge |
| Vision hardware for special conditions | Tier 1 Deductible, then no charge | | |
| **Voluntary Sterilization in a Physician's Office** | | | |
| | Deductible, then no charge | Deductible, then no charge | Deductible, then no charge |
| **Voluntary Termination of Pregnancy** | | | |
| | Your Member Cost Sharing will depend upon where the service is provided and the tier placement of the provider rendering services, as listed in this Schedule of Benefits. For example, for a service provided in an outpatient surgical center, see "Surgery– Outpatient." For services provided in a physician's office, see "Office based treatments and procedures." For inpatient hospital care, see "Hospital – Inpatient Services | | |
| **Wigs and Scalp Hair Prostheses as required by law** | | | |
| | Tier 1 Deductible, then 20% Coinsurance | | |

## Language Assistance Services

**Español (Spanish)** ATENCIÓN: Si usted habla español, servicios de asistencia lingüística, de forma gratuita, están a su disposición. Llame al 1-888-333-4742 (TTY: 711).

**Português (Portuguese)** ATENÇÃO: Se você fala português, encontram-se disponíveis serviços linguísticos gratuitos. Ligue para 1-888-333-4742 (TTY: 711).

**Kreyòl Ayisyen (French Creole)** ATANSYON: Si nou palé Kreyòl Ayisyen, gen asistans pou sèvis ki disponib nan lang nou pou gratis. Rele 1-888-333-4742 (TTY: 711).

**繁體中文 (Traditional Chinese)** 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-888-333-4742（TTY：711）。

**Tiếng Việt (Vietnamese)** CHÚ Ý: Nếu quí vị nói Tiếng Việt, dịch vụ thông dịch của chúng tôi sẵn sàng phục vụ quí vị miễn phí. Gọi số 1-888-333-4742 (TTY: 711).

**Русский (Russian)** ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-888-333-4742 (телетайп: 711).

**العربية (Arabic)**
**إنتباه:** إذا أنت تتكلم اللغة العربية ، خدمات المساعدة اللغوية متوفرة لك مجانا. ً إتصل على **1 888-333-4742**
(TTY: 711 )

**ខ្មែរ (Cambodian)** ប្រសិនជាអ្នកនិយាយភាសាខ្មែរ, 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, ໂດຍບໍ່ສັ້ງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-888-333-4742 (TTY: 711).

ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call 1-888-333-4742 (TTY: 711).

Harvard Pilgrim Health Care includes Harvard Pilgrim Health Care, Harvard Pilgrim Health Care of 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, sex, sexual orientation, or gender identity. HPHC does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, sexual orientation, or 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, sex, sexual orientation, or 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
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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.

# General List of Exclusions
# MASSACHUSETTS

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

| Exclusion |
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| **Alternative Treatments** |
| • Acupuncture care, except when specifically listed as a Covered Benefit. • Acupuncture services that are outside the scope of standard acupuncture care. • Alternative, holistic or naturopathic services and all procedures, laboratories and nutritional supplements associated with such treatments, except when specifically listed as a Covered Benefit. • Aromatherapy, treatment with crystals and alternative medicine. • Any of the following types of programs: Health resorts, spas, recreational programs, camps, outdoor skills programs, therapeutic or educational boarding schools, educational programs for children in residential care, self-help programs, life skills programs, relaxation or lifestyle programs, and wilderness programs (therapeutic outdoor programs). • Massage therapy. • Myotherapy. |
| **Dental Services** |
| • Dental Care, except when specifically listed as a Covered Benefit. • Temporomandibular Joint Dysfunction (TMD) care, except as described in the Plan's *Benefit Handbook*. • Extraction of teeth, except when specifically listed as a Covered Benefit. • Pediatric dental care, except when specifically listed as a Covered Benefit. |
| **Durable Medical Equipment and Prosthetic Devices** |
| • Any devices or special equipment needed for sports or occupational purposes. • Any home adaptations, including, but not limited to home improvements and home adaptation equipment. • Non-durable medical equipment, unless used as part of the treatment at a medical facility or as part of approved home health care services. • Repair or replacement of durable medical equipment or prosthetic devices as a result of loss, negligence, willful damage, or theft. |
| **Experimental, Unproven or Investigational Services** |
| • Any products or services, including, but not limited to, drugs, devices, treatments, procedures, and diagnostic tests that are Experimental, Unproven, or Investigational. |
| **Foot Care** |
| • Foot orthotics, except for the treatment of severe diabetic foot disease or systemic circulatory 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 diagnosed with diabetes or systemic circulatory disease. |
| **Maternity Services** |
| • Delivery outside the Service Area after the 37th week of pregnancy, or after you have been told that you are at risk for early delivery. • Planned home births. • Routine pre-natal and post-partum care when you are traveling outside the Service Area. |

| Exclusion |
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| **Mental Health and Substance Use Disorder Treatment** |
| • Biofeedback. • Educational services or testing, except services covered under the benefit for Early Intervention Services. No benefits are provided (1) for educational services intended to enhance educational achievement or developmental functioning, (2) to resolve problems of school performance, (3) to treat learning disabilities, (4) for driver alcohol education, or (5) for community reinforcement approach and assertive continuing care. • Any of the following types of programs: programs in which the patient has a pre-defined duration of care without the Plan's ability to conduct concurrent determinations of continued medical necessity, programs that only provide meetings or activities not based on individualized treatment plans, programs that focus solely on interpersonal or other skills rather than directed toward symptom reduction and functional recovery related to specific mental health disorders, and tuition based programs that offer educational, vocational, recreational, or personal developmental activities. • Methadone maintenance, except when specifically listed as a Covered Benefit. • Sensory integrative praxis tests. • Services for any condition with only a "Z Code" designation in the Diagnostic and Statistical Manual of Mental Disorders, which means that the condition is not attributable to a mental disorder. • Mental health and substance use disorder treatment that is (1) provided to 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. • Wigs and scalp hair prostheses when hair loss is due to male pattern baldness, female pattern baldness, or natural or premature aging. |
| **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 affirming services including 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 |

| Exclusion |
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| **Procedures and Treatments (Continued)** |
| 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.) • Follow-up care after an emergency room visit, unless provided or arranged by your PCP. • 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. |
| **Reproduction** |
| • 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 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, except when 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 or fax. • 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. |

| Exclusion |
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| **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. • 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 described in the Plan's *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. • 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*, this Schedule of Benefits, or Prescription Drug Brochure (if applicable). • Services that are not Medically Necessary. • Services your PCP or a Plan Provider has not provided, arranged or approved except as described in the *Handbook* sections *"Your PCP Manages Your Health Care"* and *"Using Plan Providers"*. • Taxes or governmental assessments on services or supplies. • Transportation, except for emergency ambulance transport, and non-emergency medical transport needed for transfer between hospitals or other covered health care facilities or from a covered facility to your home when Medically Necessary. • 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. |

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