

Schedule of Benefits

Harvard Pilgrim Health Care of New England, Inc.

ELEVATEHEALTH HSA HMO

NEW HAMPSHIRE

IMPORTANT INFORMATION: This policy reflects the known requirements for compliance under The Affordable Care Act as passed on March 23, 2010. As additional guidance is forthcoming from the U.S. Department of Health and Human Services, and the New Hampshire Insurance Department, those changes will be incorporated into your health insurance policy.

Coverage under this Plan is under the jurisdiction of the New Hampshire Insurance Commissioner.

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.

Accessing Plan Providers

This plan provides access to a network that is smaller than HPHC's full provider network. There are two types of providers that make up the ElevateHealth Provider Network: (1) Easy Access Providers and (2) Authorized Access Providers. Your Provider's status may change at any time throughout the year. For example, an Easy Access Provider may change to an Authorized Access Provider or may become a Non-Plan Provider. Please consult the Provider Directory or visit the provider search tool at www.harvardpilgrim.org to confirm the status of your provider prior to each visit or to determine which providers are included in the ElevateHealth Provider Network.

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

Important Information regarding Authorized Access Providers:

In order to be covered to see an Authorized Access Provider, Prior Approval must be obtained from HPHC-NE. If HPHC-NE does not grant Prior Approval, you will not be covered to see this provider and will be liable for all costs associated with the visit. Additionally, if you see an Authorized Access Provider with a Referral from your PCP but without Prior Approval from HPHC-NE, you will be liable for all costs associated with the visit. HPHC-NE will only grant Prior Approval to see an Authorized Access Provider when we have determined that there are no Easy Access providers with the professional expertise needed to provide the required care.

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 Member Services at 1-888-333-4742.

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."

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		\$3,500 for Individual Coverage per Calendar Year \$7,000 for Family Coverage per Calendar Year - with a \$3,500 embedded individual Deductible per Calendar Year
<p>Important Notice: If you have Individual Coverage, the Individual Coverage Deductible applies (the Family Coverage Deductible will never apply). If you have Family Coverage, the Family Coverage Deductible can be satisfied in one of two ways:</p> <ol style="list-style-type: none"> If a Member of a covered family meets the embedded individual Deductible, then services for that Member that are subject to that Deductible are covered by the Plan for the remainder of the Calendar Year. If any number of Members in a covered family collectively meet the Family Coverage Deductible, then all Members of the covered family have no additional Deductible Member Cost Sharing for Covered Benefits for the remainder of the Calendar Year. No one family member may contribute more than the embedded individual Deductible amount toward the Family Coverage Deductible. <p>An embedded individual Deductible may not be less than the applicable minimum family Deductible, as defined by the Internal Revenue Service.</p> <p>Once a Deductible is met, coverage by the Plan is subject to any other Member Cost Sharing that may apply.</p>		
Out-of-Pocket Maximum		\$5,000 for Individual Coverage per Calendar Year \$10,000 for Family Coverage per Calendar Year – with a \$5,000 embedded individual Out-of-Pocket Maximum per Calendar Year
<p>Important Notice: If you have Individual Coverage, the Individual Coverage Out-of-Pocket Maximum applies (the Family Coverage Out-of-Pocket Maximum will never apply). If you have Family Coverage, the Family Coverage Out-of-Pocket Maximum can be satisfied in one of two ways:</p> <ol style="list-style-type: none"> If a Member of a covered family meets the embedded individual Out-of-Pocket Maximum, then that Member has no additional Member Cost Sharing for the remainder of the Calendar Year. If any number of Members in a covered family collectively meet the Family Coverage Out-of-Pocket Maximum, then all Members of the covered family have no additional Member Cost Sharing for the remainder of the Calendar Year. No one family member may contribute more than the embedded individual Out-of-Pocket Maximum amount to the Family Coverage Out-of-Pocket Maximum. 		

Benefit		Member Cost Sharing
Acupuncture Treatment for Injury or Illness		
– Limited to 20 visits per Calendar Year		Deductible, then 20% Coinsurance
Ambulance and Medical Transport		
Emergency ambulance transport		Deductible, then 20% Coinsurance
Non-emergency medical transport		Deductible, then 20% Coinsurance
Autism Spectrum Disorders Treatment		
Applied behavior analysis		Deductible, then 20% Coinsurance
Chemotherapy and Radiation Therapy		
Chemotherapy		Deductible, then 20% Coinsurance
Radiation therapy		Deductible, then 20% Coinsurance
Chiropractic Care		
– Limited to 12 visits per Calendar Year		Deductible, then 20% Coinsurance
Dental Services		
Important Notice: Coverage of Dental Care is very limited. Please see your Benefit Handbook for the details of your coverage.		
Extraction of teeth impacted in bone (performed in a physician's office)		Not covered
Preventive dental care for children		Not covered
Outpatient surgery expenses for dental care		Your Member Cost Sharing will depend upon the types of services provided, as listed in this Schedule of Benefits. For example, for services provided by a physician, see "Physician and Other Professional Office Visits." For day surgery, see "Surgery – Outpatient."
Dialysis		
		Deductible, then 20% Coinsurance
Durable Medical Equipment		
Durable medical equipment		Deductible, then 20% Coinsurance
Blood glucose monitors, infusion devices and insulin pumps (including supplies)		Deductible, then 20% Coinsurance
Oxygen and respiratory equipment		Deductible, then 20% Coinsurance
Early Intervention		
– Limited to \$3,200 per Member per Calendar Year, up to \$9,600 per lifetime		Deductible, then no charge
Emergency Room Care		
		Deductible, then 20% Coinsurance
Hearing Aids		
– Limited to \$1,500 per hearing aid every 60 months, for each hearing impaired ear		Deductible, then 20% Coinsurance
Home Health Care		
		Deductible, then 20% Coinsurance
If services include the administration of drugs, please see the benefit for "Medical Drugs" for Member Cost Sharing details.		

Benefit		Member Cost Sharing
Hospice - Outpatient		
		Deductible, then 20% Coinsurance
Hospital – Inpatient Services		
Acute hospital care		Deductible, then 20% Coinsurance
Inpatient maternity care		Deductible, then 20% Coinsurance
Inpatient routine nursery care		No charge
Inpatient rehabilitation – limited to 100 days per Calendar Year Day limits combined with skilled nursing facility care		Deductible, then 20% Coinsurance
Skilled nursing facility – limited to 100 days per Calendar Year Day limits combined with inpatient rehabilitation care		Deductible, then 20% Coinsurance
Infertility Services and Treatments		
Diagnostic services for infertility including: consultation, evaluation and laboratory tests		Your Member Cost Sharing will depend upon the types of services provided, as listed in this Schedule of Benefits. For example, for services provided by a physician, see “Physician and Other Professional Office Visits”.
Infertility treatment (see the Benefit Handbook for details)		Deductible, then 20% Coinsurance
Laboratory, Radiology and Other Diagnostic Services		
Laboratory		Deductible, then 20% Coinsurance
Genetic Testing		Deductible, then 20% Coinsurance
Radiology		Deductible, then 20% Coinsurance
Advanced radiology, including CT scans, PET scans, MRI, MRA and nuclear medicine services		Deductible, then 20% Coinsurance
Other diagnostic tests		Deductible, then 20% Coinsurance
Low Protein Foods		
– Limited to \$1,800 per Member per Calendar Year		Deductible, then 20% Coinsurance
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.”		
Medical Drugs (drugs that cannot be self-administered)		
Medical drugs received in a physician’s office or other outpatient facility		Deductible, then 20% Coinsurance
Medical drugs received in the home		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.		

Benefit		Member Cost Sharing
Medical Formulas		
		Deductible, then 20% Coinsurance
Mental Health and Substance Use Disorder Treatment		
Inpatient services		Deductible, then 20% Coinsurance
Partial hospitalization services		Deductible, then 20% Coinsurance
Outpatient group therapy		Deductible, then 20% Coinsurance
Outpatient treatment including individual therapy, detoxification, and medication management		Deductible, then 20% Coinsurance
Outpatient methadone maintenance		Deductible, then 20% Coinsurance
Outpatient psychological testing		Deductible, then 20% Coinsurance
Outpatient telemedicine virtual visit – group therapy		Deductible, then 20% Coinsurance
Outpatient telemedicine virtual visit – including individual therapy, detoxification and medication management		Deductible, then 20% Coinsurance
eVisits		Deductible, then no charge
Observation Services		
		Deductible, then 20% Coinsurance
Ostomy Supplies		
		Deductible, then 20% 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
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		Deductible, then 20% Coinsurance
Additional Member Cost Sharing may apply. Please refer to the specific benefit in this Schedule of Benefits. For example, if you need sutures, please refer to office based treatments and procedures below. If you need an x-ray or have blood drawn, please refer to "Laboratory, Radiology and Other Diagnostic Services."		
Office based treatments and procedures including but not limited to: casting, suturing and the application of dressings, non-routine foot care, and surgical procedures		Deductible, then 20% Coinsurance
Administration of allergy injections		Deductible, then 20% Coinsurance
eVisits		Deductible, then no charge

Benefit		Member Cost Sharing
Preventive Services and Tests		
		No charge
Under federal 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 guidance.		
Additional preventive services, tests and devices include: 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
Prosthetic Devices		
		Deductible, then 20% Coinsurance
Rehabilitation and Habilitation Services – Outpatient		
Cardiac rehabilitation		Deductible, then 20% Coinsurance
Pulmonary rehabilitation therapy		Deductible, then 20% Coinsurance
Occupational therapy – limited to 60 visits combined per Calendar Year Physical, speech and occupational therapy limits are combined		Deductible, then 20% Coinsurance
Physical therapy – limited to 60 visits combined per Calendar Year Physical, speech and occupational therapy limits are combined		Deductible, then 20% Coinsurance
Speech therapy – limited to 60 visits combined per Calendar Year Physical, speech and occupational therapy limits are combined		Deductible, then 20% Coinsurance
Please Note: 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.		
Scopic Procedures - Outpatient Diagnostic and Therapeutic		
Colonoscopy, endoscopy and sigmoidoscopy		Deductible, then 20% Coinsurance
Surgery – Outpatient		
		Deductible, then 20% Coinsurance
Telemedicine Virtual Visit Services – Outpatient		
		Deductible, then 20% Coinsurance
For inpatient hospital care, see “Hospital – Inpatient Services” for cost sharing details.		

Benefit		Member Cost Sharing
Urgent Care Services		
Doctor on Demand		Deductible, then 20% Coinsurance
Important Note: Doctor On Demand is a specific network of providers contracted to provide virtual Urgent Care services. For more information on Doctor on Demand, including how to access them, please visit our website at www.harvardpilgrim.org .		
Convenience care clinic		Deductible, then 20% Coinsurance
Urgent care center		Deductible, then 20% Coinsurance
Hospital urgent care center		Deductible, then 20% Coinsurance
Additional Member Cost Sharing may apply. Please refer to the specific benefit in this Schedule of Benefit. For example, if you have an x-ray or have blood drawn, please refer to "Laboratory, Radiology and Other Diagnostic Services."		
Vision Services		
Routine eye examinations – limited to 1 exam per Calendar Year		No charge
Vision hardware for special conditions		Deductible, then 20% Coinsurance
Voluntary Sterilization – in a Physician's Office		
		Deductible, then 20% Coinsurance
Wigs and Scalp Hair Prostheses as required by law		
See the Benefit Handbook for details		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 quý vị nói Tiếng Việt, dịch vụ thông dịch của chúng tôi sẵn sàng phục vụ quý vị miễn phí. Gọi số 1-888-333-4742 (TTY: 711).

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

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

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

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

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

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

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

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

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

ગુજરાતી (Gujarati) ધ્યાન આપો : જો તમે ગુજરાતી બોલતા 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 ທ່ານເວົ້າພາສາລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ຄ່າ, ຄ່າມີພ້ອມໃຫ້ທ່ານ. ໂທ 1-888-333-4742 (TTY: 711).

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



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

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

HPHC:

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

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

If you believe that HPHC has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex (including pregnancy, sexual orientation, and gender identity), you can file a grievance with: Civil Rights Compliance Officer, 1 Wellness Way, Canton, MA 02021-1166, (866) 750-2074, TTY service: 711, Fax: (617) 509-3085, Email: civil_rights@point32health.org. You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, the Civil Rights Compliance Officer is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

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

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



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

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General List of Exclusions

Harvard Pilgrim Health Care of New England, Inc. | NEW HAMPSHIRE

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

Exclusion
Alternative Treatments <ul style="list-style-type: none"> • Acupuncture care except when specifically listed as a Covered Benefit. • Acupuncture services that are outside the scope of standard acupuncture care. • Alternative or holistic services and all procedures, laboratories and nutritional supplements associated with such treatments. • Aromatherapy, treatment with crystals and alternative medicine. • Any of the following types of programs: Health resorts, spas, recreational programs, camps, outdoor skills programs, therapeutic or educational boarding schools, relaxation or lifestyle programs and wilderness programs (therapeutic outdoor 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.
Dental Services <ul style="list-style-type: none"> • Dental Care, except when specifically listed as a Covered Benefit. • Temporomandibular Joint Dysfunction (TMD) care, except the specific medical treatments listed as Covered Benefits in your 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 <ul style="list-style-type: none"> • Any devices or special equipment needed for sports or occupational purposes. • Any home adaptations, including, but not limited to home improvements and home adaptation equipment. • Non-durable medical equipment, unless used as part of the treatment at a medical facility or as part of approved home health care services. • Repair or replacement of durable medical equipment or prosthetic devices as a result of loss, negligence, willful damage, or theft.
Experimental, Unproven or Investigational Services <ul style="list-style-type: none"> • Any products or services, including, but not limited to, drugs, devices, treatments, procedures, and diagnostic tests that are Experimental, Unproven, or Investigational.
Foot Care <ul style="list-style-type: none"> • Foot orthotics, except for the treatment of severe diabetic foot disease or systemic circulatory diseases. • 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 diseases.
Maternity Services <ul style="list-style-type: none"> • 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. • Routine pre-natal and post-partum care when you are traveling outside the Service Area. • Services provided by a Doula.

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

Exclusion

Mental Health Care

- Educational services or testing. No benefits are provided: (1) for educational services intended to enhance educational achievement; or (2) to resolve problems of school performance.
- Methadone maintenance, except when specifically listed as a Covered Benefit.
- Sensory integrative praxis tests.
- Mental health care that is (1) provided to Members who are confined or committed to a jail, house of correction, or prison, or (2) provided by the Department of Youth Services or 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) 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 prosthesis when hair loss is due to male pattern baldness, female pattern baldness, or natural or premature aging.

Procedures and Treatments

- Chiropractic care, except when specifically listed as a Covered Benefit.
- Care by a chiropractor outside the scope of standard chiropractic practice, including but not limited to, surgery, prescription or dispensing of drugs or medications, internal examinations, obstetrical practice, or treatment of infections and diagnostic testing for chiropractic care.
- Commercial diet plans, weight loss programs and any services in connection with such plans or programs. **Please note:** Your employer may participate in other wellness and health improvement incentive programs offered by Harvard Pilgrim. Please review all your Plan documents for the amount of incentives, if any, available under your Plan.
- Gender affirming 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 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 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.

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 other than covered maternity services for a Member of the Plan.
- Infertility drugs if a Member is not in a Plan authorized cycle of infertility treatment.
- Infertility drugs, if infertility services are not a Covered Benefit.
- Infertility drugs that must be purchased at an outpatient pharmacy, unless your Plan includes outpatient pharmacy coverage.
- Infertility treatment for Members who are not medically infertile.
- Infertility treatment except when specifically listed as a Covered Benefit.
- Reversal of voluntary sterilization (including any services for infertility related to voluntary sterilization or its reversal).
- Sperm collection, freezing and storage except as described in Section III. Covered Benefits.
- Sperm identification when not Medically Necessary (e.g., gender identification).
- The following fees; wait list fees, non-medical costs, shipping and handling charges etc.
- Voluntary sterilization, including tubal ligation and vasectomy, except when specifically listed as a Covered Benefit.
- Voluntary termination of pregnancy, unless either: 1) the life of the mother is in danger, or 2) voluntary termination of pregnancy 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

- Telemedicine services involving fax.
- 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 when specifically listed as a Covered Benefit.
- Hearing aid batteries, cords, and individual or group auditory training devices and any instrument or device used by a public utility in providing telephone or other communication services.
- Over the counter hearing aids.
- Refractive eye surgery, including, but not limited to, lasik surgery, orthokeratology and lens implantation for the correction of naturally occurring myopia, hyperopia and astigmatism.
- Routine eye examinations, except when specifically listed as a Covered Benefit.

All Other Exclusions

- 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.
- Any service, supply or medication when there is a less intensive Covered Benefit or more 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).
- Beauty or barber service.
- Any drug or other product obtained at an outpatient pharmacy, except for pharmacy supplies covered under the benefit for diabetes services, unless your Plan includes outpatient pharmacy coverage.
- Diabetes equipment replacements when solely due to manufacturer warranty expiration.
- Donated or banked breast milk.
- 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 the Benefit Handbook.
- Medical services that are provided to Members who are confined or committed to jail, house of correction, or prison, or (2) provided by the Department of Youth Services.
- Services for non-Members.
- Reimbursement for travel expenses, except as described in your Benefit Handbook. Excluded services include, but are not limited to: alcohol and tobacco, childcare expenses, entertainment, expenses for anyone other than you and your companion, first class, business class and other luxury transportation services, lodging other than at a hotel or motel, lost wages, meals, personal care and hygiene items, telephone calls, Tips and gratuities.
- Services for which no charge would be

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)

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 (if applicable). • 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. • Services your PCP or a Plan Provider has not provided, arranged or approved except as described in the Benefit Handbook. • 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 or when specifically listed as a Covered Benefit. • Air conditioners, air purifiers and filters, dehumidifiers and humidifiers. • Car seats. • Chairs, bath chairs, feeding chairs, toddler chairs, chair lifts, recliners. • Electric scooters. • Exercise equipment. • Home modifications including but not limited to elevators, handrails and ramps. • Hot tubs, jacuzzis, saunas or whirlpools. • Mattresses. • Medical alert systems. • Motorized beds. • Pillows. • Power-operated vehicles. • Stair lifts and stair glides. • Strollers. • Safety equipment. • Vehicle modifications including but not limited to van lifts. • Telephone. • Television.

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