Schedule of Benefits

Harvard Pilgrim Health Care of New England, Inc.

POS Open Access HSA
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 US 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.

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

In-Network coverage applies when Covered Benefits are provided by your Primary Care Provider (PCP) or another Plan Provider. You do not need a referral from your PCP to see other Plan Providers.

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

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

Prior Approval

Prior Approval is required for certain benefits. Before you receive services from a Non-Plan Provider or a Plan Provider outside the Service Area, please refer 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
- **1–888–333–4742** for Medical Drugs
- **1–800–708–4414** for mental health and substance use disorder treatment

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

Medical Necessity Guidelines

We use clinical review criteria to evaluate whether certain services or procedures are Medically Necessary for a Member's care. Members or their practitioners may obtain a copy of our Medical Necessity Guidelines on our website at **www.harvardpilgrim.org** or by calling 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:	In-Network Member Cost Sharing:	Out-of-Network 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	\$7,000 for Individual Coverage per Calendar Year \$14,000 for Family Coverage per Calendar Year - with a \$7,000 embedded individual Deductible per Calendar Year
Important Notice: If you have Individual Coverage, the Individual Coverage Deductible applies (the Family Coverage Deductible will never apply). If you have Family Coverage, the Family Coverage Deductible can be satisfied in one of two ways: a. If a Member of a covered family meets the embedded individual Deductible, then services for that Member that are subject to that Deductible are covered by the Plan for the remainder of the Calendar Year. b. If any number of Members in a covered family collectively meet the Family Coverage Deductible, then all Members of the covered family have no additional Deductible Member Cost Sharing for Covered 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. An embedded individual Deductible may **not** be less that the applicable minimum family Deductible, as defined by the Internal Revenue Service. Once a Deductible is met, coverage by the Plan is subject to any other Member Cost Sharing that may apply.		

General Cost Sharing Features:	In-Network Member Cost Sharing:	Out-of-Network Member Cost Sharing:
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.	$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	$10,000 for Individual Coverage per Calendar Year $20,000 for Family Coverage per Calendar Year – with a $10,000 embedded individual Out-of-Pocket Maximum per Calendar Year
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: a. If a Member of a covered family meets the embedded individual Out-of-Pocket Maximum, then that Member has no additional Member Cost Sharing for the remainder of the Calendar Year. b. If any number of Members in a covered family collectively meet the Family Coverage Out-of-Pocket Maximum, then all Members of the covered family have no additional Member Cost Sharing for the remainder of the Calendar Year. No one family member may contribute more than the embedded individual Out-of-Pocket Maximum amount to the Family Coverage Out-of-Pocket Maximum.		
Out-of-Network Penalty Payment for failure to obtain Prior Approval		
Certain Out-of-Network services require Prior Approval as described earlier in this Schedule of Benefits. If you do not obtain Prior Approval for these services, you are responsible for 50% of the benefit that would have otherwise been payable or $500 whichever is less. This Penalty charge is in addition to any Member Cost Sharing amounts and does not count toward the Deductible or Out-of-Pocket Maximum. Please refer to your Benefit Handbook for more information on the Prior Approval Program.		

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 20% Coinsurance	Deductible, then 40% Coinsurance
Ambulance and Medical Transport		
Emergency ambulance transport	Deductible, then no charge	Same as In-Network
Non-emergency air ambulance transport	Deductible, then no charge	Same as In-Network
Non-emergency medical transport	Deductible, then no charge	Deductible, then 20% Coinsurance
Autism Spectrum Disorders Treatment		
Applied behavior analysis	Deductible, then 20% Coinsurance	Deductible, then 40% Coinsurance
Chemotherapy and Radiation Therapy		
Chemotherapy	Deductible, then no charge	Deductible, then 40% Coinsurance
Radiation therapy	Deductible, then 20% Coinsurance	Deductible, then 40% Coinsurance

Benefit	In-Network Plan Providers Member Cost Sharing	Out-of-Network Non-Plan Providers Member Cost Sharing
Chiropractic Care		
– Limited to 12 visits per Calendar Year	Deductible, then 20% Coinsurance	Deductible, then 40% 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	Not covered
Preventive dental care for children	Not covered	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 no charge	Deductible, then 40% Coinsurance
Durable Medical Equipment		
Durable medical equipment	Deductible, then 20% Coinsurance	Deductible, then 40% Coinsurance
Blood glucose monitors, infusion devices and insulin pumps (including supplies)	Deductible, then 20% Coinsurance	Deductible, then 40% Coinsurance
Oxygen and respiratory equipment	Deductible, then 20% Coinsurance	Deductible, then 40% Coinsurance
Early Intervention		
– Limited to $3,200 per Member per Calendar Year, up to $9,600 per lifetime	Deductible, then no charge	Deductible, then 40% Coinsurance
Emergency Admission		
	Deductible, then 20% Coinsurance	Same as In-Network
Emergency Room Care		
– Services that do not meet the definition of Medical Emergency	Deductible, then 50% Coinsurance	Same as In-Network
– Medical Emergency services	Deductible, then 20% Coinsurance	Same as In-Network
Hearing Aids		
– Limited to $1,500 per hearing aid every 60 months, for each hearing impaired ear	Deductible, then 20% Coinsurance	Deductible, then 40% Coinsurance
Home Health Care		
	Deductible, then 20% Coinsurance	Deductible, then 40% Coinsurance
If services include the administration of drugs, please see the benefit for "Medical Drugs" for Member Cost Sharing details.		

Benefit	In-Network Plan Providers Member Cost Sharing	Out-of-Network Non-Plan Providers Member Cost Sharing
Hospice – Outpatient		
	Deductible, then no charge	Deductible, then 40% Coinsurance
Hospital – Inpatient Services		
Acute hospital care	Deductible, then 20% Coinsurance	Deductible, then 40% Coinsurance
Inpatient maternity care	Deductible, then 20% Coinsurance	Deductible, then 40% Coinsurance
Inpatient routine nursery care	No charge	Deductible, then 40% Coinsurance
Inpatient rehabilitation – limited to 100 days per Calendar Year Day limits combined with skilled nursing facility care	Deductible, then 20% Coinsurance	Deductible, then 40% Coinsurance
Skilled nursing facility – limited to 100 days per Calendar Year Day limits combined with inpatient rehabilitation care	Deductible, then 20% Coinsurance	Deductible, then 40% 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 no charge	Deductible, then 40% Coinsurance
Laboratory, Radiology and Other Diagnostic Services		
Laboratory	Deductible, then 20% Coinsurance	Deductible, then 40% Coinsurance
Genetic Testing	Deductible, then 20% Coinsurance	Deductible, then 40% Coinsurance
Radiology	Deductible, then 20% Coinsurance	Deductible, then 40% Coinsurance
Advanced radiology, including CT scans, PET scans, MRI, MRA and nuclear medicine services	Deductible, then 20% Coinsurance	Deductible, then 40% Coinsurance
Other diagnostic services	Deductible, then 20% Coinsurance	Deductible, then 40% Coinsurance
Low Protein Foods		
– Limited to $1,800 per Member per Calendar Year	Deductible, then 20% Coinsurance	Deductible, then 40% Coinsurance

Benefit	In-Network Plan Providers Member Cost Sharing	Out-of-Network Non-Plan Providers Member Cost Sharing
Maternity Care – Outpatient		
Routine outpatient prenatal and postpartum care	No charge	Deductible, then 40% Coinsurance
Routine prenatal and postpartum care is usually received and billed from the same Provider as a single or bundled service. Different Member Cost Sharing may apply to any specialized or non-routine service that is billed separately from your routine outpatient prenatal and postpartum care. For example, Member Cost Sharing for services provided by a specialist is listed under "Physician and Other Professional Office Visits" and Member Cost Sharing for an ultrasound billed as a specialized or non-routine service is listed under "Laboratory, Radiology and Other Diagnostic Services."		
Medical Drugs (drugs that cannot be self-administered)		
Medical drugs received in a physician's office or other outpatient facility	Deductible, then 20% Coinsurance	Deductible, then 40% Coinsurance
Medical drugs received in the home	Deductible, then 20% Coinsurance	Deductible, then 40% Coinsurance
Some Medical Drugs may be supplied by a specialty pharmacy. When Medical Drugs are supplied by a speciality pharmacy, the Member Cost Sharing listed above will apply.		
Medical Formulas		
	Deductible, then 20% Coinsurance	Deductible, then 40% Coinsurance
Mental Health and Substance Use Disorder Treatments		
Inpatient services	Deductible, then 20% Coinsurance	Deductible, then 40% Coinsurance
Partial hospitalization services	Deductible, then 20% Coinsurance	Deductible, then 40% Coinsurance
Outpatient group therapy	Deductible, then 20% Coinsurance	Deductible, then 40% Coinsurance
Outpatient treatment including individual therapy, detoxification, and medication management	Deductible, then 20% Coinsurance	Deductible, then 40% Coinsurance
Outpatient methadone maintenance	Deductible, then 20% Coinsurance	Deductible, then 40% Coinsurance
Outpatient psychological testing	Deductible, then 20% Coinsurance	Deductible, then 40% Coinsurance
Outpatient telemedicine virtual visit – group therapy	Deductible, then 20% Coinsurance	Deductible, then 40% Coinsurance
Outpatient telemedicine virtual visit – including individual therapy, detoxification and medication management	Deductible, then 20% Coinsurance	Deductible, then 40% Coinsurance
eVisits	Deductible, then no charge	Deductible, then 40% Coinsurance
Observation Services		
	Deductible, then 20% Coinsurance	Same as In-Network
Ostomy Supplies		
	Deductible, then 20% Coinsurance	Deductible, then 40% Coinsurance

Benefit	In-Network Plan Providers Member Cost Sharing	Out-of-Network Non-Plan Providers Member Cost Sharing
Physician and Other Professional Office Visits (This includes all covered Providers unless otherwise listed in this Schedule of Benefits)		
Routine examinations for preventive care, including immunizations	No charge	Deductible, then 40% Coinsurance
Not all In-Network services you receive during your routine exam are covered at no charge. Only preventive services designated under the Patient Protection and Affordable Care Act (PPACA) are covered at no charge. Other services not included under PPACA may be subject to additional cost sharing. For the current list of preventive services covered at no charge under PPACA, please see the Preventive Services Notice on our website at **www.harvardpilgrim.org**. Please see "Laboratory, Radiology and Other Diagnostic Services" 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	Deductible, then 40% Coinsurance
Additional Member Cost Sharing may apply. Please refer to the specific benefit in this Schedule of Benefits. For example, if you need sutures, please refer to office based treatments and procedures below. If you need an x-ray or have blood drawn, please refer to "Laboratory, Radiology and Other Diagnostic Services."		
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	Deductible, then 40% Coinsurance
Administration of allergy injections	Deductible, then 20% Coinsurance	Deductible, then 40% Coinsurance
eVisits	Deductible, then no charge	Deductible, then 40% Coinsurance
Preventive Services and Tests		
	No charge	Deductible, then 40% Coinsurance
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.		
Prosthetic Devices		
	Deductible, then 20% Coinsurance	Deductible, then 40% Coinsurance
Rehabilitation and Habilitation Services – Outpatient		
Cardiac rehabilitation	Deductible, then 20% Coinsurance	Deductible, then 40% Coinsurance
Pulmonary rehabilitation therapy	Deductible, then 20% Coinsurance	Deductible, then 40% Coinsurance

Benefit	In-Network Plan Providers Member Cost Sharing	Out-of-Network Non-Plan Providers Member Cost Sharing
Rehabilitation and Habilitation Services – Outpatient (Continued)		
Occupational therapy – limited to 60 visits combined per Calendar Year Physical, speech and occupational therapy limits are combined	Deductible, then 20% Coinsurance	Deductible, then 40% Coinsurance
Physical therapy – limited to 60 visits combined per Calendar Year Physical, speech and occupational therapy limits are combined	Deductible, then 20% Coinsurance	Deductible, then 40% Coinsurance
Speech therapy – limited to 60 visits combined per Calendar Year Physical, speech and occupational therapy limits are combined	Deductible, then 20% Coinsurance	Deductible, then 40% 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	Deductible, then 40% Coinsurance
Surgery – Outpatient		
	Deductible, then 20% Coinsurance	Deductible, then 40% Coinsurance
Telemedicine Virtual Visit Services – Outpatient		
	Deductible, then 20% Coinsurance	Deductible, then 40% Coinsurance
For inpatient hospital care, see "Hospital – Inpatient Services" for cost sharing details.		
Travel Reimbursement Benefit		
– Limited to $2,500 per Calendar Year See the Benefit Handbook for details	Deductible, then no charge	Same as In-Network
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	Deductible, then 40% Coinsurance
Urgent care center	Deductible, then 20% Coinsurance	Deductible, then 40% Coinsurance
Hospital urgent care center	Deductible, then 20% Coinsurance	Deductible, then 40% Coinsurance
Additional Member Cost Sharing may apply. Please refer to the specific benefit in this Schedule of Benefits. For example, if you have an x-ray or have blood drawn, please refer to "Laboratory, Radiology and Other Diagnostic Services."		

Benefit	In-Network Plan Providers Member Cost Sharing	Out-of-Network Non-Plan Providers Member Cost Sharing
Vision Services		
Routine eye examinations – limited to 1 exam per Calendar Year	No charge	Deductible, then 40% Coinsurance
Vision hardware for special conditions	Deductible, then no charge	Deductible, then 40% Coinsurance
Voluntary Sterilization – in a Physician's Office		
	Deductible, then 20% Coinsurance	Deductible, then 40% Coinsurance
Voluntary Termination of Pregnancy – Outpatient		
	Deductible, then 20% Coinsurance	Deductible, then 40% Coinsurance
Wigs and Scalp Hair Prostheses as required by law		
See the Benefit Handbook for details	Deductible, then 20% Coinsurance	Deductible, then 40% Coinsurance

Language Assistance Services

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

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

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

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

Tiếng Việt (Vietnamese) CHÚ Ý: Nếu 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 اللُّغة **العربية**، خدمات المساعدة اللُّغوية متوفرة لك مجانا. **إتصل على 1 888-333-4742**
(TTY: 711)

ខ្មែរ (Cambodian) ប្រសិនជាអ្នកនិយាយភាសាខ្មែរ, 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, 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.

cc6589_memb_serv (08_23)

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
• 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
• 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
• 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 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.
Mental Health Care
• Biofeedback. • Educational services or testing, except services covered under the benefit for Early Intervention Services. No benefits are provided: (1) for educational services intended to enhance educational achievement; (2) to resolve problems of school performance; or (3) to treat learning disabilities. • Methadone maintenance, except when specifically listed as a Covered Benefit. • Sensory integrative praxis tests. • Services for any condition with only a "V Code" designation in the Diagnostic and Statistical Manual of Mental Disorders, which means that the condition is not attributable to a mental disorder. • Mental health care that is (1) provided to Members who are confined or committed to a jail, house of correction, 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;

Exclusion
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 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 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.
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.

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

Exclusion
Telemedicine
• Telemedicine services involving fax. • Provider fees for technical costs for the provision of telemedicine services.
Types of Care
• Custodial Care. • Rest or domiciliary care. • All institutional charges over the semi-private room rate, except when a private room is Medically Necessary. • Pain management programs or clinics. • Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, and diversion or general motivation. • Private duty nursing. • Sports medicine clinics. • Vocational rehabilitation, or vocational evaluations on job adaptability, job placement, or therapy to restore function for a specific occupation.
Vision and Hearing
• 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. • 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. • 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 when specifically listed as a Covered Benefit. • Services for which no charge would be made in the absence of insurance. • Services for which no coverage is provided in the Plan's Benefit Handbook, Schedule of Benefits or Prescription Drug Brochure (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 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.

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