Schedule of Benefits

Harvard Pilgrim Health Care, Inc.

BEST BUY PPO 1000 - FLEX
MASSACHUSETTS

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

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

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

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

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

Out-of-Network Notification and Prior Approval

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

- **1–800–708–4414** for medical services
- **1–844–387–1435** for Medical Drugs
- **1–888–777–4742** for mental health care (including the treatment of substance use disorders)

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

Clinical Review Criteria

We use clinical review criteria to evaluate whether certain services or procedures are Medically Necessary for a Member's care. Members or their practitioners may obtain a copy of our clinical review criteria on our website at **www.harvardpilgrim.org** or by calling **1-888-888-4742 ext. 38723**.

Copayment Levels

There are two types of In-Network office visit Copayments that apply to your Plan: a lower Copayment, known as "Level 1," and a higher Copayment known as "Level 2."

Level 1 applies to covered outpatient professional services from the following types of providers: all Primary Care Providers (PCPs); obstetricians and gynecologists; Licensed Mental Health Professionals; certified nurse midwives; and nurse practitioners who bill independently.

Level 2 applies to most specialty care.

If a provider is categorized as both a Level 1 provider and a Level 2 provider, Level 1 applies. For example, if a provider is both a PCP and a cardiologist, you will be responsible for a Level 1 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 doctor'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."

General Cost Sharing Features:	In-Network Member Cost Sharing:	Out-of-Network Member Cost Sharing:
Coinsurance and Copayments		
	See the benefits table below	
Deductible		
	$1,000 per Member per Plan Year $2,500 per family per Plan Year	$2,500 per Member per Plan Year $5,000 per family per Plan Year
Out-of-Pocket Maximum		
Includes all Member Cost Sharing except: – Member Cost Sharing for Pediatric Dental Care, if applicable (if your Plan includes a pediatric dental rider, coverage for pediatric dental services – Any charges above the Allowed Amount and any penalty for failure to receive Prior Approval when using Non-Plan Providers	$5,750 per Member per Plan Year $11,500 per family per Plan Year	$11,500 per Member per Plan Year $23,000 per family per Plan Year
Out-of-Network Penalty Payment		
Does not count toward the Deductible or Out-of-Pocket Maximum	$500	
Deductible Rollover		
None		

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 Plan Year	$40 Copayment per visit	Deductible, then 20% Coinsurance

Benefit	In-Network Plan Providers Member Cost Sharing	Out-of-Network Non-Plan Providers Member Cost Sharing
Ambulance Transport		
Emergency ambulance transport	Deductible, then no charge	Same as In-Network
Non-emergency ambulance transport	Deductible, then no charge	Deductible, then 20% Coinsurance
Autism Spectrum Disorders Treatment		
Applied behavior analysis	Level 1: $25 Copayment per visit	Deductible, then 20% Coinsurance
Chemotherapy and Radiation Therapy		
	Deductible, then no charge	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)	Deductible, then no charge	Deductible, then 20% Coinsurance
If your Plan provides coverage for pediatric dental services, please see your pediatric dental rider for coverage information.		
Dialysis		
	Deductible, then no charge	Deductible, then 20% Coinsurance
Durable Medical Equipment		
Durable medical equipment	Deductible, then 20% Coinsurance	Deductible, then 20% Coinsurance
Blood glucose monitors, infusion devices and insulin pumps (including supplies)	No charge	No charge
Oxygen and respiratory equipment	No charge	Deductible, then 20% Coinsurance
Early Intervention Services		
	No charge	No charge
The Plan does not cover the family participation fee required by the Massachusetts Department of Public Health.		
Emergency Admission		
	Deductible, then $200 Copayment per admission	Same as In-Network
Emergency Room Care		
	$300 Copayment per visit	Same as In-Network
This Copayment is waived if admitted to the hospital directly from the emergency room.		
Hearing Aids (for Members up to the age of 22)		
– Limited to $2,000 per hearing aid every 36 months, for each hearing impaired ear	Deductible, then 20% Coinsurance	Deductible, then 20% Coinsurance
Home Health Care		
	Deductible, then no charge	Deductible, then 20% Coinsurance
If services include the administration of drugs, please see the benefit for "Medical Drugs" for Member Cost Sharing details.		

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 20% Coinsurance
Hospital – Inpatient Services		
Acute hospital care	Deductible, then $200 Copayment per admission	Deductible, then 20% Coinsurance
Inpatient maternity care	Deductible, then $200 Copayment per admission	Deductible, then 20% Coinsurance
Inpatient routine nursery care	No charge	Deductible, then 20% Coinsurance
Inpatient rehabilitation – limited to 60 days per Plan Year	Deductible, then $200 Copayment per admission	Deductible, then 20% Coinsurance
Skilled nursing facility – limited to 100 days per Plan Year	Deductible, then $200 Copayment per admission	Deductible, then 20% Coinsurance
Infertility Services and Treatments (see the Benefit Handbook for details)		
	Your Member Cost Sharing will depend upon where the service is provided, as listed in this Schedule of Benefits. For example, for services provided by a physician, see "Physician and Other Professional Office Visits." For inpatient hospital care, see "Hospital – Inpatient Services."	
Laboratory and Radiology Services		
Laboratory	**Flex Providers** No charge **Other Plan Providers** Deductible, then $40 Copayment per visit	Deductible, then 20% Coinsurance
Genetic testing	Deductible, then $40 Copayment per visit	Deductible, then 20% Coinsurance
X-rays	Deductible, then $40 Copayment per visit	Deductible, then 20% Coinsurance
Advanced radiology, including CT scans, PET scans, MRI, MRA and nuclear medicine services	Deductible, then $200 Copayment per procedure	Deductible, then 20% Coinsurance
Low Protein Foods		
	Deductible, then 20% Coinsurance	Deductible, then 20% Coinsurance

Benefit	In-Network Plan Providers Member Cost Sharing	Out-of-Network Non-Plan Providers Member Cost Sharing
Maternity Care - Outpatient		
Childbirth classes – Limited to 1 initial childbirth course or 1 refresher course per pregnancy (see the Benefit Handbook for details)	No charge	
Routine outpatient prenatal and postpartum care	No charge	Deductible, then 20% Coinsurance
Routine prenatal and postpartum care is usually received and billed from the same Provider as a single or bundled service. Different Member Cost Sharing may apply to any specialized or non-routine service that is billed separately from your routine outpatient prenatal and postpartum care. For example, Member Cost Sharing for services provided by a specialist is listed under "Physician and Other Professional Office Visits" and Member Cost Sharing for an ultrasound billed as a specialized or non-routine service is listed under "Laboratory and Radiology Services."		
Medical Drugs (drugs that cannot be self-administered)		
Medical drugs received in a doctor's office or other outpatient facility	Deductible, then no charge	Deductible, then 20% Coinsurance
Medical drugs received in the home	Deductible, then no charge	Deductible, then 20% Coinsurance
Some medical drugs received in a physician's office or outpatient facility may be provided by the Specialty Pharmacy Program under your outpatient prescription drug benefit. If you have outpatient prescription drug coverage, your Member Cost Sharing will be listed on your outpatient prescription drug flyer and Summary of Benefits and Coverage. Please see the Prescription Drug Brochure for a detailed explanation of your benefits.		
Medical Formulas		
	Deductible, then no charge	Deductible, then 20% Coinsurance
Mental Health Care (Including the Treatment of Substance Use Disorders)		
Inpatient services	Deductible, then $200 Copayment per admission	Deductible, then 20% Coinsurance
Intermediate services – Acute residential treatment (including detoxification), crisis stabilization and in-home family stabilization – Intensive outpatient programs, partial hospitalization and day treatment programs for mental health and drug and alcohol rehabilitation services	Deductible, then no charge	Deductible, then 20% Coinsurance
Outpatient group therapy	$10 Copayment per visit	Deductible, then 20% Coinsurance
Outpatient treatment, including individual therapy, outpatient detoxification and medication management	Level 1: $25 Copayment per visit	Deductible, then 20% Coinsurance
Outpatient methadone maintenance	No charge	Deductible, then 20% Coinsurance
Outpatient psychological testing and neuropsychological assessment	Deductible, then no charge	Deductible, then 20% Coinsurance

Benefit	In-Network Plan Providers Member Cost Sharing	Out-of-Network Non-Plan Providers Member Cost Sharing
Ostomy Supplies		
	Deductible, then 20% Coinsurance	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	Deductible, then 20% 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 and Radiology Services" for the Member Cost Sharing that applies to diagnostic services not included on this list.		
Consultations, evaluations, sickness and injury care	Level 1: $25 Copayment per visit Level 2: $40 Copayment per visit	Deductible, then 20% Coinsurance
Copayment level varies depending on the type of provider. Please refer to the beginning of this Schedule of Benefits to determine which Copayment level applies.		
Office based treatments and procedures, including, but not limited to administration of injections, allergy treatments, casting, suturing and the application of dressings, genetic counseling, non-routine foot care, pregnancy testing, and surgical procedures	Deductible, then no charge	Deductible, then 20% Coinsurance
Administration of allergy injections	Deductible, then no charge	Deductible, then 20% Coinsurance
Preventive Services and Tests		
	No charge	Deductible, then 20% 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.		
The following additional preventive services and tests: alpha-fetoprotein (AFP), fetal ultrasound, hepatitis C testing, lead level testing, prostate-specific antigen (PSA) screening, routine hemoglobin tests, group B streptococcus (GBS), and routine urinalysis	No charge	Deductible, then 20% Coinsurance

Benefit	In-Network Plan Providers Member Cost Sharing	Out-of-Network Non-Plan Providers Member Cost Sharing
Prosthetic Devices		
	Deductible, then 20% Coinsurance	Deductible, then 20% Coinsurance
Rehabilitation and Habilitation Services - Outpatient		
Cardiac rehabilitation	Deductible, then Level 1: $25 Copayment per visit	Deductible, then 20% Coinsurance
Pulmonary rehabilitation therapy	Deductible, then Level 1: $25 Copayment per visit	Deductible, then 20% Coinsurance
Speech-language and hearing services	Deductible, then Level 1: $25 Copayment per visit	Deductible, then 20% Coinsurance
Rehabilitation Services: – Physical and occupational therapies – combined up to 60 visits per Plan Year Habilitation Services: – Physical and occupational therapies – combined up to 60 visits per Plan Year	Deductible, then Level 1: $25 Copayment per visit	Deductible, then 20% Coinsurance
Outpatient physical and occupational therapy is not subject to the limit listed above and is covered to the extent Medically Necessary for: (1) children under the age of three and (2) the treatment of Autism Spectrum Disorders.		
Scopic Procedures - Outpatient Diagnostic and Therapeutic		
Colonoscopy, endoscopy and sigmoidoscopy	**Flex Providers** $50 Copayment per visit **Other Plan Providers** Deductible, then $200 Copayment per visit	Deductible, then 20% Coinsurance
Spinal Manipulative Therapy (including care by a chiropractor)		
	$40 Copayment per visit	Deductible, then 20% Coinsurance
Surgery – Outpatient		
	Flex Providers $50 Copayment per visit **Other Plan Providers** Deductible, then $200 Copayment per visit	Deductible, then 20% Coinsurance
Telemedicine		
Outpatient and inpatient telemedicine services	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 inpatient hospital care, see "Hospital - Inpatient Services."	
Urgent Care Services		
Convenience care clinic	Level 1: $25 Copayment per visit	Deductible, then 20% Coinsurance
Urgent care clinic (including hospital urgent care clinic)	$40 Copayment per visit	Deductible, then 20% Coinsurance

Benefit	In-Network Plan Providers Member Cost Sharing	Out-of-Network Non-Plan Providers Member Cost Sharing
Urgent Care Services (Continued)		
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 and Radiology Services."		
Vision Services		
Routine eye examinations – limited to 1 exam per Plan Year	Level 1: $25 Copayment per visit	Deductible, then 20% Coinsurance
Vision hardware for special conditions	Deductible, then no charge	Deductible, then 20% Coinsurance
Your Plan also includes coverage for pediatric vision hardware. Please see the additional Pediatric Vision section later in this Schedule of Benefits for more information.		
Voluntary Sterilization in a Physician's Office		
	Deductible, then no charge	Deductible, then 20% Coinsurance
Voluntary Termination of Pregnancy		
	Your Member Cost Sharing will depend upon where the service is provided as listed in this Schedule of Benefits. For example, for a service provided in an outpatient surgical center, see "Surgery– Outpatient." For services provided in a physician's office, see "Office based treatments and procedures." For inpatient hospital care, see "Hospital – Inpatient Services."	
Wellness Reimbursement Benefits		
Fitness – Coverage is provided for one month of membership in a qualified fitness facility, health club or fitness center with a minimum of $150 per individual or family membership per calendar year (see the Benefit Handbook for details)	No charge	
Weight management programs – Coverage provided for 3 months of membership at Weight Watchers traditional meetings or Weight Watchers at Work programs per calendar year (see the Benefit Handbook for details)	No charge	
Wigs and Scalp Hair Prostheses as required by law		
– Limited to 1 synthetic monofilament wig per Plan Year (see the Benefit Handbook for details)	Deductible, then 20% Coinsurance	Deductible, then 20% Coinsurance

Pediatric VisionCare

Dependents under the age of 19 are eligible for coverage of prescription eyeglasses or contact lenses. Each Dependent under the age of 19 is eligible for coverage every 12 months for *either* (A) prescription eyeglass frames and lenses or (B) prescription contact lenses, as described below:

(A) PRESCRIPTION EYEGLASS FRAMES AND LENSES

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

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

(B) PRESCRIPTION CONTACT LENSES

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

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

In addition to the Covered Benefits described above, Dependents under the age of 19 are also eligible for the following:

(C) MEDICALLY NECESSARY CONTACT LENSES

Contact lenses may be determined to be Medically Necessary and appropriate in the treatment of patients affected by certain conditions. In general, contact lenses may be Medically Necessary and appropriate when the use of contact lenses, in lieu of eyeglasses, will result in significantly better visual and/or improved binocular function, including avoidance of diplopia or suppression. Contact lenses may be determined to be Medically Necessary in the treatment of the following conditions: keratoconus, pathological myopia, aphakia, anisometropia, aniseikonia, aniridia, corneal disorders, post-traumatic disorders, irregular astigmatism.

Medically necessary contact lenses are dispensed in lieu of other eyewear.

The Plan will reimburse you for the first $50 you pay toward Medically Necessary contact lenses. Thereafter, the Plan will reimburse you 50% of your remaining covered charges.

(D) LOW VISION SERVICES

Low vision is a significant loss of vision but not total blindness. Ophthalmologists and optometrists specializing in low vision care can evaluate and prescribe optical devices, and provide training and instruction to maximize the remaining usable vision for our members with low vision. Covered low vision services will include (1) one comprehensive low vision evaluation every 5 years; (2) Medically Necessary visual aids such as high-power eyeglasses, magnifiers and telescopes; and (3) follow-up examinations as Medically Necessary.

See Physician and Other Professional Office Visits for your Member Cost Sharing that applies to consultations and evaluations. The Plan will reimburse you for the first $50 you pay toward visual aids as described above. Thereafter, the Plan will reimburse you 50% of your remaining covered charges for visual aids.

OUT-OF-POCKET MAXIMUM

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

WHERE TO PURCHASE EYEWEAR WITH YOUR PEDIATRIC VISION CARE BENEFIT

You can purchase your eyewear from any vision hardware provider with a valid prescription from your doctor.

HOW TO RECEIVE REIMBURSEMENT FOR THE PEDIATRIC VISION CARE BENEFIT

To receive reimbursement for prescription eyeglasses and frames or prescription contact lenses that you have paid for, you must follow these simple steps:

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

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

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

WHERE TO CALL WITH QUESTIONS

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

EXCLUSIONS

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

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) [ប្រសូជូនដំណឹង៖ បើអ្នកនិយាយភាសាខ្មែរ, សេវាកម្មបកប្រែ ជូនលោកអ្នកដោយ គិតគិតថ្លៃ។ 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, ໂດຍບໍ່ເສັງຄ່າ, 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 Connecticut, Harvard Pilgrim Health Care of New England and HPHC Insurance Company.

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General Notice About Nondiscrimination and Accessibility Requirements

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

HPHC:

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

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

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

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

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

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

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Harvard Pilgrim Health Care, Inc.
MASSACHUSETTS PPO
General List of Exclusions

The following list identifies services that are generally excluded from Harvard Pilgrim PPO and Access America 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	Description
Alternative Treatments	
	1. Acupuncture care except when specifically listed as a Covered Benefit. 2. Acupuncture services that are outside the scope of standard acupuncture care. 3. Alternative, holistic or naturopathic services and all procedures, laboratories and nutritional supplements associated with such treatments. 4. Aromatherapy, treatment with crystals and alternative medicine. 5. Any of the following types of programs: Health resorts, spas, recreational programs, camps, wilderness programs (therapeutic outdoor programs), outdoor skills programs, educational programs for children in residential care, self-help programs, life skills programs, relaxation or lifestyle programs, including any services provided in conjunction with, or as part of such types of programs and wellness clinics. 6. Massage therapy. 7. Myotherapy.
Dental Services	
	1. Dental Care, except when specifically listed as a Covered Benefit. 2. All services of a dentist for Temporomandibular Joint Dysfunction (TMD). 3. Extraction of teeth, except when specifically listed as a Covered Benefit. 4. Pediatric dental care, except when specifically listed as a Covered Benefit.
Durable Medical Equipment and Prosthetic Devices	
	1. Any devices or special equipment needed for sports or occupational purposes. 2. Any home adaptations, including, but not limited to home improvements and home adaptation equipment. 3. Non-durable medical equipment, unless used as part of the treatment at a medical facility or as part of approved home health care services. 4. 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	
	1. Any products or services, including, but not limited to, drugs, devices, treatments, procedures, and diagnostic tests that are Experimental, Unproven, or Investigational.

Exclusion	Description
Foot Care	
	1. Foot orthotics, except for the treatment of severe diabetic foot disease. 2. Routine foot care. Examples include nail trimming, cutting or debriding and the cutting or removal of corns and calluses. This exclusion does not apply to preventive foot care for Members with diabetes.
Maternity Services	
	1. Planned home births.
Mental Health Care	
	1. Biofeedback. 2. 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, (3) to treat learning disabilities, (4) for driver alcohol education, or (5) for community reinforcement approach and assertive continuing care. 3. Methadone maintenance, except when specifically listed as a Covered Benefit. 4. Sensory integrative praxis tests. 5. 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. 6. Mental health care that is (1) provided to Members who are confined or committed to a jail, house of correction, prison, or custodial facility of the Department of Youth Services; or (2) provided by the Department of Mental Health. 7. 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. 8. 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.

Exclusion	Description
Physical Appearance	
	1. Cosmetic Services, including drugs, devices, treatments and procedures, except for (1) Cosmetic Services that are incidental to the correction of a Physical Functional Impairment, (2) restorative surgery to repair or restore appearance damaged by an accidental injury, and (3) post-mastectomy care. 2. Hair removal or restoration, including, but not limited to, electrolysis, laser treatment, transplantation or drug therapy. 3. Liposuction or removal of fat deposits considered undesirable. 4. Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures). 5. Skin abrasion procedures performed as a treatment for acne. 6. Treatment for skin wrinkles or any treatment to improve the appearance of the skin. 7. Treatment for spider veins.
Procedures and Treatments	
	1. 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. 2. Spinal manipulative therapy (including care by a chiropractor), except when specifically listed as a Covered Benefit. 3. Commercial diet plans, weight loss programs and any services in connection with such plans or programs, except when specifically listed as a Covered Benefit. 4. Gender reassignment surgery and all related drugs and procedures for self-insured groups, unless covered under a separate rider. 5. 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. 6. 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). 7. Physical examinations and testing for insurance, licensing or employment. 8. Services for Members who are donors for non-Members, except as described under Human Organ Transplant Services. 9. Testing for central auditory processing. 10. Group diabetes training, educational programs or camps.

Exclusion	Description
Providers	
	1. Charges for services which were provided after the date on which your membership ends. 2. 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. 3. Charges for missed appointments. 4. Concierge service fees. (See the Plan's *Benefit Handbook* for more information.) 5. Inpatient charges after your hospital discharge. 6. Provider's charge to file a claim or to transcribe or copy your medical records. 7. Services or supplies provided by: (1) anyone related to you by blood, marriage or adoption, or (2) anyone who ordinarily lives with you.
Reproduction	
	1. Any form of Surrogacy or services for a gestational carrier. 2. Infertility drugs if a Member is not in a Plan authorized cycle of infertility treatment. 3. Infertility drugs, if infertility services are not a Covered Benefit. 4. Infertility drugs that must be purchased at an outpatient pharmacy, unless your Plan includes outpatient pharmacy coverage. 5. Infertility treatment for Members who are not medically infertile. 6. Infertility treatment and birth control drugs, implants and devices, except when specifically listed as a Covered Benefit. 7. Reversal of voluntary sterilization (including any services for infertility related to voluntary sterilization or its reversal). 8. Sperm collection, freezing and storage except as described in the Plan's *Benefit Handbook.* 9. Sperm identification when not Medically Necessary (e.g., gender identification). 10. The following fees: wait list fees, non-medical costs, shipping and handling charges etc. 11. Voluntary sterilization, including tubal ligation and vasectomy, except when specifically listed as a Covered Benefit. 12. Voluntary termination of pregnancy, unless the life of the mother is in danger or unless it is specifically listed as a Covered Benefit.
Services Provided Under Another Plan	
	1. Costs for any services for which you are entitled to treatment at government expense, including military service connected disabilities. 2. Costs for services for which payment is required to be made by a Workers' Compensation plan or an Employer under state or federal law.

Exclusion	Description
Telemedicine Services	
	1. Telemedicine services involving e-mail, fax, texting, or audio-only telephone. 2. Provider fees for technical costs for the provision of telemedicine services.
Types of Care	
	1. Custodial Care. 2. Recovery programs including rest or domiciliary care, sober houses, transitional support services, and therapeutic communities. 3. All institutional charges over the semi-private room rate, except when a private room is Medically Necessary. 4. Pain management programs or clinics. 5. Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, and diversion or general motivation, except , except when specifically listed as a Covered Benefit. 6. Private duty nursing. 7. Sports medicine clinics. 8. Vocational rehabilitation, or vocational evaluations on job adaptability, job placement, or therapy to restore function for a specific occupation.
Vision and Hearing	
	1. Eyeglasses, contact lenses and fittings, except when specifically listed as a Covered Benefit. 2. Hearing aids, except when specifically listed as a Covered Benefit. 3. Hearing aid batteries, and any device used by individuals with hearing impairment to communicate over the telephone or internet, such as TTY or TDD. 4. Refractive eye surgery, including, but not limited to, lasik surgery, orthokeratology and lens implantation for the correction of naturally occurring myopia, hyperopia and astigmatism. 5. Routine eye examinations, except when specifically listed as a Covered Benefit.
All Other Exclusions	
	1. Any service or supply furnished in connection with a non-Covered Benefit. 2. Beauty or barber service. 3. 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. 4. Food or nutritional supplements, including, but not limited to, FDA-approved medical foods obtained by prescription, except as required by law. 5. Guest services. 6. 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.

Exclusion	Description
All Other Exclusions (Continued)	
	7. Services for non-Members. 8. Services for which no charge would be made in the absence of insurance. 9. Services for which no coverage is provided in the Plan's Benefit Handbook, Schedule of Benefits or Prescription Drug Brochure (if applicable). 10. Services that are not Medically Necessary. 11. Taxes or governmental assessments on services or supplies. 12. Transportation other than by ambulance. 13. The following products and services: • 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.