# Schedule of Benefits

## Harvard Pilgrim Health Care of New England, Inc.

ElevateHealth Options HMO Gold
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.**

**Please Note: This Plan includes a tiered provider network called the "ElevateHealth Options Network." In this plan, you will pay different levels of Copayments, Coinsurance or Deductibles depending on the tier placement, practice or location of the provider delivering Covered Benefits. Tier 1 is made up of ElevateHealth providers. Tier 2 includes all remaining Harvard Pilgrim HMO Providers. Providers can change tier placement, practices and/or locations at any time throughout the year. When a Provider changes a practice or location, the tier of that Provider may also change. Please consult your ElevateHealth Options Provider Directory prior to your services to determine the tier placement of your provider or facility.**

**You have thirty (30) days from receipt of this Policy to review this document. If you are not satisfied for any reason with the Policy, you have the right to return the Policy to Harvard Pilgrim and have your premium returned.**

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.

Certain capitalized words in this Schedule of Benefits have special meaning. Unless indicated otherwise, please refer to *Section II: Glossary* of your Benefit Handbook for more information.

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

### 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**.

### Copayment Levels

There are two types of 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 received from the following types of providers: Primary Care Providers (PCPs); obstetricians and gynecologists; Licensed Mental Health Professionals; certified midwives; and nurse practitioners.

Level 2 applies to covered outpatient professional services received from specialty care providers.

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 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."

| General Cost Sharing Features: | Tier 1<br>ElevateHealth Provider<br>Member Cost Sharing: | Tier 2<br>Other HPHC Provider<br>Member Cost Sharing |
|---|---|---|
| **Coinsurance and Copayments** | | |
| | See the benefits table below | |
| **Deductible** | | |
| | $500 per Member per Calendar Year<br>$1,000 per family per Calendar Year | $4,000 per Member per Calendar Year<br>$8,000 per family per Calendar Year |
| **Deductible Rollover** | | |
| | None | |
| **Out-of-Pocket Maximum** | | |
| Includes all Member Cost Sharing | $7,500 per Member per Calendar Year<br>$15,000 per family per Calendar Year | |

| Benefit | Tier 1<br>ElevateHealth Provider<br>Member Cost Sharing | Tier 2<br>Other HPHC Provider<br>Member Cost Sharing |
|---|---|---|
| **Acupuncture Treatment for Injury or Illness** | | |
| | $25 Copayment per visit | |
| **Ambulance Transport** | | |
| Emergency ambulance transport | Tier 1 Deductible, then 10% Coinsurance | |
| Non-emergency ambulance transport | Tier 1 Deductible, then 10% Coinsurance | Tier 2 Deductible, then 40% Coinsurance |

| Benefit | Tier 1<br>ElevateHealth Provider<br>Member Cost Sharing | Tier 2<br>Other HPHC Provider<br>Member Cost Sharing |
|---|---|---|
| **Autism Spectrum Disorders Treatment** | | |
| Applied behavior analysis | $25 Copayment per visit | |
| **Chemotherapy and Radiation Therapy** | | |
| Chemotherapy | Tier 1 Deductible, then 10% Coinsurance | Tier 2 Deductible, then 40% Coinsurance |
| Radiation therapy | Tier 1 Deductible, then 10% Coinsurance | Tier 2 Deductible, then 40% Coinsurance |
| **Chiropractic Care** | | |
| | $25 Copayment per visit | Tier 2 Deductible, then 40% Coinsurance |
| **Dental Services** | | |
| Extraction of teeth impacted in bone | 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." | |
| **If you purchased this Plan directly through HPHC with pediatric dental coverage, please see the pediatric dental benefit in this Schedule of Benefits.** | | |
| **Dialysis** | | |
| | Tier 1 Deductible, then 10% Coinsurance | Tier 2 Deductible, then 40% Coinsurance |
| **Durable Medical Equipment** | | |
| Durable medical equipment | Tier 1 Deductible, then 20% Coinsurance | |
| Blood glucose monitors, infusion devices and insulin pumps (including supplies) | No charge | |
| Oxygen and respiratory equipment | No charge | |
| **Early Intervention** | | |
| – Limited to 40 visits per Member per Calendar Year | No charge | No charge |
| **Emergency Admission** | | |
| | Tier 1 Deductible, then 10% Coinsurance | |
| **Emergency Room Care** | | |
| Services that do not meet the definition of Medical Emergency | Tier 1 Deductible, then 50% Coinsurance | |
| Medical Emergency services | Tier 1 Deductible, then $300 Copayment per visit | |
| This Copayment is waived if you are (1) transferred to either Observation Services or Outpatient Surgery or (2) admitted to the hospital directly from the emergency room. Please see "Hospital – Inpatient Services," "Observation Services," or "Surgery – Outpatient" for the Member Cost Sharing that applies to these benefits. | | |
| **Hearing Aids** | | |
| – Limited to 1 hearing aid per hearing impaired ear as Medically Necessary | 50% Coinsurance | |

| Benefit | Tier 1<br>ElevateHealth Provider<br>Member Cost Sharing | Tier 2<br>Other HPHC Provider<br>Member Cost Sharing |
|---|---|---|
| **Home Health Care** | | |
| | Tier 1 Deductible, then 10% Coinsurance | Tier 2 Deductible, then 40% Coinsurance |
| If services include the administration of drugs, please see the benefit for "Medical Drugs" for Member Cost Sharing details. | | |
| **Hospice – Outpatient** | | |
| | Tier 1 Deductible, then 10% Coinsurance | Tier 2 Deductible, then 40% Coinsurance |
| **Hospital – Inpatient Services** | | |
| Acute hospital care | Tier 1 Deductible, then 10% Coinsurance | Tier 2 Deductible, then 40% Coinsurance |
| **Please Note:** Member Cost Sharing for physician's services will depend on the tier placement of the provider. For example, if you are inpatient in a Tier 1 facility, but your provider is a Tier 2 physician, you will be responsible for the Tier 2 Member Cost Sharing for the physician's services. | | |
| Inpatient maternity care | Tier 1 Deductible, then 10% Coinsurance | Tier 2 Deductible, then 40% Coinsurance |
| Inpatient routine nursery care | No charge | |
| Inpatient rehabilitation – limited to 100 days per Calendar Year | Tier 1 Deductible, then 10% Coinsurance | Tier 2 Deductible, then 40% Coinsurance |
| Skilled nursing facility – limited to 100 days per Calendar Year | Tier 1 Deductible, then 10% Coinsurance | Tier 2 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) | Not covered | |
| **Laboratory, Radiology and Other Diagnostic Services** | | |
| Laboratory | No charge | Tier 2 Deductible, then 40% Coinsurance |
| Genetic Testing | Tier 1 Deductible, then 10% Coinsurance | Tier 2 Deductible, then 40% Coinsurance |
| Radiology | Tier 1 Deductible, then 10% Coinsurance | Tier 2 Deductible, then 40% Coinsurance |
| Advanced radiology, including CT scans, PET scans, MRI, MRA and nuclear medicine services | Tier 1 Deductible, then 10% Coinsurance | Tier 2 Deductible, then 40% Coinsurance |
| Other diagnostic services | Tier 1 Deductible, then 10% Coinsurance | Tier 2 Deductible, then 40% Coinsurance |
| **Low Protein Foods** | | |
| | Tier 1 Deductible, then 10% Coinsurance | |

| Benefit | Tier 1<br>ElevateHealth Provider<br>Member Cost Sharing | Tier 2<br>Other HPHC Provider<br>Member Cost Sharing |
|---|---|---|
| **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 | Tier 1 Deductible, then 10% Coinsurance | |
| Medical drugs received in the home | Tier 1 Deductible, then 10% Coinsurance | |
| Some medical drugs may be supplied by a specialty pharmacy. When Medical Drugs are supplied by a specialty pharmacy, the Member Cost Sharing listed above will apply. | | |
| **Medical Formulas** | | |
| | Tier 1 Deductible, then 10% Coinsurance | |
| **Mental Health and Substance Use Disorder Treatment** | | |
| Inpatient services | Tier 1 Deductible, then 10% Coinsurance | |
| Partial hospitalization services | Tier 1 Deductible, then 10% Coinsurance | |
| Outpatient group therapy | $10 Copayment per visit | |
| Outpatient treatment, including individual therapy, detoxification and medication management | $25 Copayment per visit | |
| Outpatient methadone maintenance | No charge | |
| Outpatient psychological testing | $25 Copayment per visit | |
| Outpatient telemedicine virtual visit services | $25 Copayment per visit | |
| eVisits | No charge | |
| **Observation Services** | | |
| | Tier 1 Deductible, then 10% Coinsurance | |
| **Ostomy Supplies** | | |
| | Tier 1 Deductible, then 20% Coinsurance | |
| **Physician and Other Professional Office Visits**<br>**(This includes all covered Plan Providers unless otherwise listed in this Schedule of Benefits)** | | |
| Routine examinations for preventive care, including immunizations | No charge | |

| Benefit | Tier 1<br>ElevateHealth Provider<br>Member Cost Sharing | Tier 2<br>Other HPHC Provider<br>Member Cost Sharing |
|---|---|---|
| **Physician and Other Professional Office Visits<br>(This includes all covered Plan Providers unless otherwise listed in this Schedule of Benefits) (Continued)** | | |
| 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 | Level 1: $25 Copayment per visit<br>Level 2: $50 Copayment per visit | Tier 2 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." | | |
| eVisits | No charge | |
| Office based treatment and procedures including but not limited to casting, suturing and the application of dressings, non-routine foot care, and surgical procedures | Tier 1 Deductible, then 10% Coinsurance | Tier 2 Deductible, then 40% Coinsurance |
| Administration of allergy injections | $25 Copayment per visit | Tier 2 Deductible, then 40% Coinsurance |
| **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. | | |
| **Prosthetic Devices** | | |
| | Tier 1 Deductible, then 20% Coinsurance | |
| **Rehabilitation and Habilitation Services - Outpatient** | | |
| Cardiac rehabilitation | Tier 1 Deductible, then 10% Coinsurance | Tier 2 Deductible, then 40% Coinsurance |
| Pulmonary rehabilitation therapy | Tier 1 Deductible, then 10% Coinsurance | Tier 2 Deductible, then 40% Coinsurance |
| Occupational therapy<br>– Rehabilitation services limited to 60 visits per Calendar Year<br>– Habilitation Services limited to 60 visits per Calendar Year<br><br>Physical, speech, and occupational therapy limits are combined | $50 Copayment per visit | Tier 2 Deductible, then 40% Coinsurance |

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| Benefit | Tier 1<br>ElevateHealth Provider<br>Member Cost Sharing | Tier 2<br>Other HPHC Provider<br>Member Cost Sharing |
|---|---|---|
| **Rehabilitation and Habilitation Services - Outpatient (Continued)** | | |
| Physical therapy<br>– Rehabilitation services limited to 60 visits per Calendar Year<br>– Habilitation Services limited to 60 visits per Calendar Year<br><br>Physical, speech, and occupational therapy limits are combined | $50 Copayment per visit | Tier 2 Deductible, then 40% Coinsurance |
| Speech therapy<br>– Rehabilitation services limited to 60 visits per Calendar Year<br>– Habilitation Services limited to 60 visits per Calendar Year<br><br>Physical, speech, and occupational therapy limits are combined | $50 Copayment per visit | Tier 2 Deductible, then 40% Coinsurance |
| Outpatient physical, occupational and speech therapies are covered without limits 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**<br>– in a hospital or hospital affiliated facility | Tier 1 Deductible, then 10% Coinsurance | Tier 2 Deductible, then 40% Coinsurance |
| – in a non-hospital affiliated facility | $100 Copayment per visit | Tier 2 Deductible, then 40% Coinsurance |
| **Please Note:** Member Cost Sharing for physician's services will depend on the tier placement of the provider. For example: if you have scopic services in a Tier 1 facility, but your specialist is a Tier 2 physician, you will be responsible for the Tier 2 Member Cost Sharing for the specialists's services. | | |
| **Surgery – Outpatient** | | |
| – in a hospital or hospital affiliated facility | Tier 1 Deductible, then 10% Coinsurance | Tier 2 Deductible, then 40% Coinsurance |
| – in a non-hospital affiliated facility | $100 Copayment per visit | Tier 2 Deductible, then 40% Coinsurance |
| **Please Note:** Member Cost Sharing for physician's services will depend on the tier placement of the provider. For example, if you have surgical services in a Tier 1 facility, but your surgeon is a Tier 2 physician, you will be responsible for the Tier 2 Member Cost Sharing for the surgeon's services. | | |
| **Telemedicine Virtual Visit Services – Outpatient** | | |
| | Level 1: $25 Copayment per visit<br>Level 2: $50 Copayment per visit | Tier 2 Deductible, then 40% Coinsurance |
| For inpatient hospital care, see "Hospital – Inpatient Services" for cost sharing details. | | |
| **Urgent Care Services** | | |
| Doctor On Demand | No charge | |

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| Benefit | Tier 1<br>ElevateHealth Provider<br>Member Cost Sharing | Tier 2<br>Other HPHC Provider<br>Member Cost Sharing |
|---|---|---|
| **Urgent Care Services (Continued)** | | |
| **Please 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 | $25 Copayment per visit | |
| Urgent care center | $35 Copayment per visit | |
| Hospital urgent care center | Tier 1 Deductible, then $150 Copayment per visit | Tier 2 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." | | |
| **Vision Services** | | |
| Routine adult eye examinations – limited to 1 exam every 2 Calendar Years | $25 Copayment per visit | Tier 2 Deductible, then 40% Coinsurance |
| Routine pediatric eye examinations (including a contact lens fitting) – limited to 1 exam per Calendar Year | $25 Copayment per visit | Tier 2 Deductible, then 40% Coinsurance |
| Vision hardware for special conditions | No charge | |
| 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** | | |
| | Tier 1 Deductible, then 10% Coinsurance | Tier 2 Deductible, then 40% Coinsurance |
| **Voluntary Termination of Pregnancy** | | |
| Covered only when the life of the mother is endangered or when the pregnancy is a result of rape or incest. | Your Member Cost Sharing will depend upon where the service is provided as listed in the Schedule of Benefits. For example, for a service provided in an outpatient surgical center, see "Surgery – Outpatient." For services provided in a physician's office, see "Office based treatments and procedures." For inpatient hospital care, see "Hospital – Inpatient Services." | |
| **Wigs and Scalp Hair Prostheses (as required by law)** | | |
| See the Benefit Handbook for details | Tier 1 Deductible, then 20% Coinsurance | |

# Pediatric VisionCare

Dependents up to the age of 19 are eligible for coverage of prescription eyeglasses or contact lenses. Coverage under this benefit terminates at the end of the month in which the Dependent turns 19. Each Dependent 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 $100 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. 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 $100 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.

## 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 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 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
- Vision hardware (with the exception of contact lenses) purchased from an internet provider

# CORE NH PRESCRIPTION DRUG BENEFIT

| Benefit: | Member Cost Sharing: |
|---|---|
| **Your pharmacy Member Cost Sharing for up to a 30-day supply at a retail pharmacy is:** | |
| Tier 1: | $5 Copayment per prescription or prescription refill |
| Tier 2: | $25 Copayment per prescription or prescription refill |
| Tier 3: | $40 Copayment per prescription or prescription refill |
| Tier 4: | Deductible, then 25% Coinsurance subject to a maximum Coinsurance amount of $550 per prescription or prescription refill |
| Tier 5: | Deductible, then 35% Coinsurance subject to a maximum Coinsurance amount of $550 per prescription or prescription refill |
| **Your pharmacy Member Cost Sharing for up to a 90-day supply of maintenance medications at a retail pharmacy is:** | |
| Tier 1: | $15 Copayment per prescription or prescription refill |
| Tier 2: | $75 Copayment per prescription or prescription refill |
| Tier 3: | $120 Copayment per prescription or prescription refill |
| Tier 4: | Deductible, then 25% Coinsurance subject to a maximum Coinsurance amount of $1,650 per prescription or prescription refill |
| Tier 5: | Deductible, then 35% Coinsurance subject to a maximum Coinsurance amount of $1,650 per prescription or prescription refill |
| **Your pharmacy Member Cost Sharing for up to a 90-day supply of maintenance medications through the Plan's mail service prescription drug program is:** | |
| Tier 1: | $10 Copayment per prescription or prescription refill |
| Tier 2: | $50 Copayment per prescription or prescription refill |
| Tier 3: | $80 Copayment per prescription or prescription refill |
| Tier 4: | Deductible, then 25% Coinsurance subject to a maximum Coinsurance amount of $1,100 per prescription or prescription refill |
| Tier 5: | Deductible, then 35% Coinsurance subject to a maximum Coinsurance amount of $1,100 per prescription or prescription refill |

To obtain coverage for your prescription drugs bring your prescription or refill to a participating pharmacy, along with your ID card, and pay the appropriate amount. Please refer to your Prescription Drug Brochure for detailed information about your coverage, including tier definitions.

# PEDIATRIC DENTAL BENEFIT (for children up to the age of 19)

Dependents up to the age of 19 are eligible for the Covered Dental Services listed below when such Dental Services are Necessary and are provided by or under the direction of a Dental Provider.

Coverage under this benefit terminates at the end of the month in which the Dependent turns 19. Please see Appendix B of your Benefit Handbook for additional details.

Certain capitalized words in this section have special meanings. We have defined these words in your *Benefit Handbook*. Please see *Section II: Glossary* and *Appendix B: Pediatric Dental Benefit (for children up to the age of 19)* for more details.

## COVERED DENTAL SERVICES

| Benefit Description and Limitations | Your Cost Sharing |
|---|---|
| **TYPE I SERVICES:** ***PREVENTIVE & DIAGNOSTIC COVERED SERVICES*** | |
| **Diagnostic Services** | |
| Intraoral Bitewing Radiographs (Bitewing X-ray)<br>– Limited to 1 set every 6 months | 50% Coinsurance |
| Panorex Radiographs (Full Jaw X-ray) or Complete Series Radiographs (Full Set of X-rays)<br>– Limited to 1 film every 60 months | 50% Coinsurance |
| Periodic Oral Evaluation (Check up Exam)<br>– Limited to 1 every 6 months | 50% Coinsurance |
| **Preventive Services** | |
| Dental Prophylaxis (Cleanings)<br>– Limited to 1 every 6 months | 50% Coinsurance |
| Fluoride Treatments<br>– Limited to 2 treatments per 12 months. | 50% Coinsurance<br>No charge for children up to age 5. |
| Sealants (Protective Coating)<br>– Limited to one sealant per tooth every 36 months. | 50% Coinsurance |
| Space Maintainers | 50% Coinsurance |
| **TYPE II SERVICES:** ***MINOR RESTORATIVE COVERED SERVICES*** | |
| **Minor Restorative Services, Endodontics, Periodontics, and Oral Surgery** | |
| Amalgam Restorations (Silver Fillings) | 50% Coinsurance |
| Composite Resin Restorations (Tooth Colored Fillings)<br>– For anterior (front) teeth only. | 50% Coinsurance |
| Endodontics (Root Canal Therapy) performed on anterior or posterior primary teeth<br>– Limited to once per tooth per lifetime. | 50% Coinsurance |

| Benefit Description and Limitations | Your Cost Sharing |
|---|---|
| **TYPE II SERVICES: *MINOR RESTORATIVE COVERED SERVICES* (Continued)** | |
| Relining and Rebasing Dentures<br>– Limited to relining/rebasing performed more than 6 months after the initial insertion. Limited to once per 36 months. | 50% Coinsurance |
| Repairs or Adjustments to Full Dentures, Partial Dentures, Bridges, or Crowns | 50% Coinsurance |
| Scaling and Root Planing (Deep Cleanings)<br>– Limited to once per quadrant per 24 months. | 50% Coinsurance |
| Periodontal Maintenance (Gum Maintenance)<br>– Limited to 4 times per 12 month period following completion of active periodontal therapy | 50% Coinsurance |
| Simple Extractions (Simple tooth removal) | 50% Coinsurance |
| Oral Surgery, including Surgical Extraction | 50% Coinsurance |
| **Adjunctive Services** | |
| General Services (including Emergency Treatment of dental pain)<br>General anesthesia is covered when clinically necessary. | 50% Coinsurance |
| **TYPE III SERVICES: *MAJOR RESTORATIVE COVERED SERVICES*** | |
| Inlays/Onlays/Crowns (Partial to Full Crowns)<br>– Limited to once per tooth per 60 months. Covered only when silver fillings cannot restore the tooth. | 50% Coinsurance |
| Endodontics (root canal therapy) performed on anterior teeth, bicuspids, and molars<br>– Limited to once per tooth per lifetime. | 50% Coinsurance |
| Endodontic Surgery | 50% Coinsurance |
| Fixed Prosthetics (Bridges)<br>– Limited to once per tooth per 60 months. | 50% Coinsurance |
| Occlusal guards for Members age 13 and older<br>– Limited to one guard every 12 months. | 50% Coinsurance |
| Periodontal Surgery (Gum Surgery)<br>– Limited to one quadrant or site per 36 months per surgical area. | 50% Coinsurance |
| Removable Prosthetics (Full or partial dentures)<br>– Limited to one per 60 months. | 50% Coinsurance |

| Benefit Description and Limitations | Your Cost Sharing |
|---|---|
| **TYPE III SERVICES:** ***MAJOR RESTORATIVE COVERED SERVICES*** **(Continued)** | |
| Relining and Rebasing Dentures<br>– Limited to relining/rebasing performed more than 6 months after the initial insertion. Limited to once per 36 months. | 50% Coinsurance |
| Oral Surgery, including Surgical Extraction | 50% Coinsurance |
| **Implants** | |
| Implant Placement<br>– Limited to once per 60 months.<br>Implant Supported Prosthetics<br>– Limited to once per 60 months.<br>Implant Maintenance Procedures<br>– Limited to once per 60 months.<br>Repair Implant Supported Prosthesis by Report<br>– Limited to once per 60 months.<br>Repair Implant Abutment by Support<br>– Limited to once per 60 months.<br>Radiographic/Surgical Implant Index by Report<br>– Limited to once per 60 months. | 50% Coinsurance |
| **TYPE IV SERVICES:** ***MEDICALLY NECESSARY ORTHODONTIA*** | |
| **Orthodontic Services**<br>Covered Benefits will be paid in equal installments over the course of the entire orthodontic treatment plan as agreed upon between you and your Dental Provider, starting on the date that the orthodontic bands or appliances are first placed, or on the date a one-step orthodontic procedure is performed. | |
| Coverage is provided for Medically Necessary comprehensive orthodontic treatment including, but not limited to cleft lip and or palate, Crouzon's syndrome, Treacher-Collins syndrome, Pierre-Robin syndrome, hemi-facial atrophy, hemi-facial hypertrophy; or other severe craniofacial deformities which result in a physically handicapping malocclusion as determined by our dental consultants.<br>**Note:** Prior Authorization is required for all orthodontic treatment. | 50% Coinsurance |

## Language Assistance Services

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**ພາສາລາວ (Lao)** ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, 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 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 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** |
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| **Alternative Treatments** |
| • 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, wilderness programs (therapeutic outdoor programs), outdoor skills programs, therapeutic or educational boarding schools, and relaxation or lifestyle 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 the specific dental services listed in the Benefit Handbook and this Schedule of Benefits • Extraction of teeth. • For Temporomandibular Joint Dysfunction (TMD), all services of a dentist and fixed or removable appliances that involve movement or repositioning of teeth, repair of teeth (fillings), or prosthetics (crowns, bridges, dentures), except those services that are specifically listed under the TMD benefit or other benefits in the Benefit Handbook and Schedule of Benefits. • Pediatric dental care, except when specifically listed as a Covered Benefit in this Schedule of Benefits. |
| **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. • 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** |
| • 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. |

| Exclusion |
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| **Mental Health Care** |
| • Biofeedback. • Educational services or testing. 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. • 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 disorder treatment 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, except as required by law. |
| **Procedures and Treatments** |
| • Care by a chiropractor outside the scope of standard chiropractic practice, including but not limited to, surgery, prescription or dispensing of drugs or medications, internal examinations, obstetrical practice, or treatment of infections and diagnostic testing for chiropractic care. • Commercial diet plans, weight loss programs and any services in connection with such plans or programs. • 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. |

| Exclusion |
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| **Reproduction** |
| • Infertility drugs. • Infertility treatment including, but not limited to, therapeutic donor insemination, including related sperm procurement and banking; donor egg procedures, including related egg and inseminated egg procurement, processing and banking; assisted hatching; gamete intrafallopian transfer (GIFT); intra-cytoplasmic sperm injection (ICSI); intra-uterine insemination (IUI); in-vitro fertilization (IVF); zygote intrafallopian transfer (ZIFT); preimplantation genetic diagnosis (PGD); microsurgical epididiymal sperm aspiration (MESA); and testicular sperm extraction (TESE). • Any form of Surrogacy or services for a gestational carrier other than covered maternity services. • Reversal of voluntary sterilization (including any services for infertility related to voluntary sterilization or its reversal). • The following fees: wait list fees, non-medical costs, shipping and handling charges, etc. • Voluntary termination of pregnancy (except in cases of rape, incest, or when the life of the mother is endangered). |
| **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 (unless the Member has waived Workers Compensation) or an Employer under state or federal law. |
| **Telemedicine** |
| • Telemedicine services involving fax. • Provider fees for technical costs for the provision of telemedicine services. |
| **Transgender Health Services** |
| • Abdominoplasty. • Chemical peels. • Collagen injections. • Dermabrasion. • Electrolysis or laser hair removal (for all indications, except when required pre-operatively for genital surgery). • Hair transplantation. • Implantations (e.g. cheek, calf, pectoral, gluteal). • Lip reduction/enhancement. • Liposuction. • Panniculectomy. • Removal of redundant skin. • Reversal of transgender health services and all related drugs and procedures. • Silicone injections (e.g. for breast enlargement). • Voice modification therapy/surgery. • Reimbursement for travel expenses. |
| **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 as listed in the Benefit Handbook and this Schedule of Benefits. • Deluxe or designer frames. • 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. |

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

| Exclusion |
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| **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. • 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 your 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. • Services for which no charge would be made in the absence of insurance. • Services for which no coverage is provided in the Benefit Handbook, this Schedule of Benefits, or Prescription Drug Brochure. • 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 other than by ambulance. • Air conditioners, air purifiers and filters, dehumidifiers and humidifiers. • Car seats. • Chairs, bath chairs, feeding chairs, toddler chairs, chair lifts, recliners. • Electric scooters. • Exercise equipment. • Home modifications including but not limited to elevators, handrails and ramps. • Hot tubs, jacuzzis, saunas or whirlpools. • Mattresses. • Medical alert 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. |