

Schedule of Benefits

THE HARVARD PILGRIM BEST BUY HSA PPO MASSACHUSETTS

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

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

In-Network coverage applies when 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.

Prior Approval

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

- **1-800-708-4414** for medical services
- **1-888-333-4742** for Medical Drugs
- **1-800-708-4414** for mental health and substance use disorder treatment

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

Medical Necessity Guidelines

We use clinical review criteria to evaluate whether certain services or procedures are Medically Necessary for a Member's care. Members or their practitioners may obtain a copy of our Medical Necessity Guidelines on our website at www.harvardpilgrim.org or by calling the Member Services Department at **1-888-333-4742**.

Office Visit Cost Sharing Levels

Office visit cost sharing may include Copayments, Coinsurance, or Deductible amounts, as described throughout this Schedule of Benefits. There are two types of In-Network office visit cost sharing that apply to your Plan: a lower cost sharing, known as "Level 1," and a higher cost sharing known as "Level 2."

Level 1 applies to covered outpatient professional services received 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 covered outpatient professional services received from specialty care providers.

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

Covered Benefits

Your Covered Benefits are administered on a Plan Year basis. Your Plan Year begins on your Employer's Anniversary Date. Please see your Benefit Handbook for more details. If you do not know your Employer's Anniversary Date, please contact your Employer's benefits office or call the Member Services Department at **1-888-333-4742**.

Your Member Cost Sharing will depend upon the type of service provided and the location the service is provided in, as listed in this Schedule of Benefits. For example, for services provided in a physician's office, see "Physician and Other Professional Office Visits." For services provided in a hospital emergency room, see "Emergency Room Care." For inpatient hospital care, see "Hospital – Inpatient Services," and for outpatient surgical procedures, please see "Surgery - Outpatient."

When you receive a service at your home (other than home health care), your Member Cost Sharing will be the same as when the service is provided in an office or facility. For example, if you have a physician visit in your home, see "Physician and Other Professional Office Visits." If you have blood drawn at home, see "Laboratory, Radiology and Other Diagnostic Services."

| General Cost Sharing Features: | In-Network Member Cost Sharing: | Out-of-Network Member Cost Sharing: | | | | | | | | | |
|--|--|--|---|---|---|--|---|--|--|--|--|
| Coinsurance and Copayments | See the benefits table below | | | | | | | | | | |
| Deductible | | | | | | | | | | | |
| <p>The following Deductibles apply to all services except where specifically noted below.</p> <table> <tr> <td>\$2,000 for Individual Coverage per Plan Year</td> <td>\$4,000 for Individual Coverage per Plan Year</td> </tr> <tr> <td>\$4,000 for Family Coverage per Plan Year</td> <td>\$8,000 for Family Coverage per Plan Year</td> </tr> </table> <p>Your In-Network and Out-of-Network Deductible amounts are separate and do not accumulate toward each other.</p> <p>Important Notice: If you have Individual Coverage, the Individual Coverage Deductible applies (the Family Coverage Deductible will never apply). If you have Family Coverage, the Family Coverage Deductible may be met by any combination of covered family Members (the Individual Coverage Deductible will never apply).</p> <p>Once a Deductible is met, coverage by the Plan is subject to any other Member Cost Sharing that may apply.</p> | | | \$2,000 for Individual Coverage per Plan Year | \$4,000 for Individual Coverage per Plan Year | \$4,000 for Family Coverage per Plan Year | \$8,000 for Family Coverage per Plan Year | | | | | |
| \$2,000 for Individual Coverage per Plan Year | \$4,000 for Individual Coverage per Plan Year | | | | | | | | | | |
| \$4,000 for Family Coverage per Plan Year | \$8,000 for Family Coverage per Plan Year | | | | | | | | | | |
| <p>Out-of-Pocket Maximum</p> <table> <tr> <td>Includes all Member Cost Sharing except:</td> <td>\$4,000 for Individual Coverage per Plan Year</td> <td>\$8,000 for Individual Coverage per Plan Year</td> </tr> <tr> <td>– Any charges above the Allowed Amount and any penalty for failure to receive Prior Approval when using Non-Plan Providers</td> <td>\$8,000 for Family Coverage per Plan Year</td> <td>\$16,000 for Family Coverage per Plan Year</td> </tr> <tr> <td></td> <td>– with a \$4,000 embedded individual Out-of-Pocket Maximum per Plan Year</td> <td>– with a \$8,000 embedded individual Out-of-Pocket Maximum per Plan Year</td> </tr> </table> <p>Your In-Network and Out-of-Network Out-of-Pocket Maximum amounts are separate and do not accumulate toward each other.</p> <p>Important Notice: If you have Individual Coverage, the Individual Coverage Out-of-Pocket Maximum applies (the Family Coverage Out-of-Pocket Maximum will never apply). If you are a Member with Family Coverage, the Out-of-Pocket Maximum can be satisfied in one of two ways:</p> | | | Includes all Member Cost Sharing except: | \$4,000 for Individual Coverage per Plan Year | \$8,000 for Individual Coverage per Plan Year | – Any charges above the Allowed Amount and any penalty for failure to receive Prior Approval when using Non-Plan Providers | \$8,000 for Family Coverage per Plan Year | \$16,000 for Family Coverage per Plan Year | | – with a \$4,000 embedded individual Out-of-Pocket Maximum per Plan Year | – with a \$8,000 embedded individual Out-of-Pocket Maximum per Plan Year |
| Includes all Member Cost Sharing except: | \$4,000 for Individual Coverage per Plan Year | \$8,000 for Individual Coverage per Plan Year | | | | | | | | | |
| – Any charges above the Allowed Amount and any penalty for failure to receive Prior Approval when using Non-Plan Providers | \$8,000 for Family Coverage per Plan Year | \$16,000 for Family Coverage per Plan Year | | | | | | | | | |
| | – with a \$4,000 embedded individual Out-of-Pocket Maximum per Plan Year | – with a \$8,000 embedded individual Out-of-Pocket Maximum per Plan Year | | | | | | | | | |

| General Cost Sharing Features: | In-Network Member Cost Sharing: | Out-of-Network Member Cost Sharing: |
|---|---------------------------------|-------------------------------------|
| Out-of-Pocket Maximum (Continued) | | |
| a. If a Member of a covered family meets an individual embedded Out-of-Pocket Maximum, then that Member has no additional Member Cost Sharing for the remainder of the Plan Year. | | |
| b. If any number of Members in a covered family collectively meet the family Out-of-Pocket Maximum, then all Members of the covered family have no additional Member Cost Sharing for the remainder of the Plan Year. No one family member may contribute more than the individual embedded Out-of-Pocket Maximum amount to the family Out-of-Pocket Maximum. | | |
| Out-of-Network Penalty Payment | | |
| Applies when the Member fails to obtain required Prior Approval for services from a Non-Plan Provider. Does not count toward the Deductible or Out-of-Pocket Maximum | \$500 | |

| Benefit | In-Network Plan Providers Member Cost Sharing | Out-of-Network Non-Plan Providers Member Cost Sharing |
|--|---|---|
| Acupuncture Treatment | | |
| | Deductible, then \$30 Copayment per visit | Deductible, then 20% Coinsurance |
| Ambulance and Medical Transport | | |
| Emergency ambulance transport | Deductible, then no charge | Same as In-Network |
| Non-emergency air ambulance transport | Deductible, then no charge | Same as In-Network |
| Non-emergency medical transport | Deductible, then no charge | Deductible, then 20% Coinsurance |
| Autism Spectrum Disorders Treatment | | |
| Applied behavior analysis | Deductible, then \$30 Copayment per visit | Deductible, then 20% Coinsurance |
| Chemotherapy and Radiation Therapy | | |
| Chemotherapy | Deductible, then no charge | Deductible, then 20% Coinsurance |
| Radiation therapy | Deductible, then no charge | Deductible, then 20% Coinsurance |
| COVID-19 Services | | |
| COVID-19 Testing | 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 diagnostic testing, see "Laboratory, Radiology and Other Diagnostic Services." | |
| COVID-19 Treatment | 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 diagnostic testing, see "Laboratory, Radiology and Other Diagnostic Services." | |
| COVID-19 Vaccines | No charge | 20% Coinsurance |

| Benefit | In-Network Plan Providers Member Cost Sharing | Out-of-Network Non-Plan Providers Member Cost Sharing |
|--|--|---|
| Dental Services | | |
| Important Notice: Coverage of Dental Care is very limited. Please see your Benefit Handbook for the details of your coverage. | | |
| Extraction of teeth impacted in bone (performed in a physician's office) | Deductible, then no charge | Deductible, then 20% Coinsurance |
| Pediatric dental care for children (up to the age of 13) – limited to 2 preventive dental exams per Plan Year | Deductible, then \$30 Copayment per visit | Deductible, then 20% Coinsurance |
| Dialysis | | |
| | Deductible, then no charge | Deductible, then 20% Coinsurance |
| Installation of home equipment | Deductible, then no charge | Deductible, then 20% Coinsurance |
| Durable Medical Equipment | | |
| Durable medical equipment | Deductible, then 30% Coinsurance | Deductible, then 20% Coinsurance |
| Blood glucose monitors, infusion devices and insulin pumps (including supplies) | Deductible, then no charge | Same as In-Network |
| Oxygen and respiratory equipment | Deductible, then 30% Coinsurance | Deductible, then 20% Coinsurance |
| Early Intervention Services | | |
| | Deductible, then no charge | Deductible, then 20% Coinsurance |
| The Plan does not cover the family participation fee required by the Massachusetts Department of Public Health. | | |
| Emergency Admission | | |
| | Deductible, then no charge | Same as In-Network |
| Emergency Room Care | | |
| | Deductible, then \$100 Copayment per visit | Same as In-Network |
| 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. | | |
| Fertility Services (see the Benefit Handbook for details) | | |
| | Your Plan does not cover fertility services. | |
| Gender Affirming Services | | |
| | 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 a service provided in an outpatient surgical center, see "Surgery – Outpatient." For services provided in a physician's office, see "Physician and Other Professional Office Visits." For inpatient hospital care, see "Hospital – Inpatient Services." | |

THE HARVARD PILGRIM BEST BUY HSA PPO - MASSACHUSETTS

| Benefit | In-Network Plan Providers Member Cost Sharing | Out-of-Network Non-Plan Providers Member Cost Sharing |
|--|--|---|
| 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 30% 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. | | |
| Hospice - Outpatient | | |
| | Deductible, then no charge | Deductible, then 20% Coinsurance |
| Hospital – Inpatient Services | | |
| Acute hospital care | Deductible, then no charge | Deductible, then 20% Coinsurance |
| Inpatient maternity care | Deductible, then no charge | Deductible, then 20% Coinsurance |
| Inpatient routine nursery care | No charge | 20% Coinsurance |
| Inpatient rehabilitation – limited to 60 days per Plan Year | Deductible, then no charge | Deductible, then 20% Coinsurance |
| Skilled nursing facility – limited to 100 days per Plan Year | Deductible, then no charge | Deductible, then 20% Coinsurance |
| Infertility Treatment (see the Benefit Handbook for details) | | |
| | Deductible, then no charge | Deductible, then 20% Coinsurance |
| Laboratory, Radiology and Other Diagnostic Services | | |
| Laboratory | Deductible, then no charge | Deductible, then 20% Coinsurance |
| Genetic testing | Deductible, then no charge | Deductible, then 20% Coinsurance |
| Radiology | Deductible, then no charge | Deductible, then 20% Coinsurance |
| Advanced radiology, including CT scans, PET scans, MRI, MRA and nuclear medicine services | Deductible, then no charge | Deductible, then 20% Coinsurance |
| Other diagnostic services | Deductible, then no charge | Deductible, then 20% Coinsurance |
| Low Protein Foods | | |
| – Limited to \$5,000 per Plan Year | 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 |
|---|--|---|
| Maternity Care - Outpatient | | |
| Routine outpatient prenatal and postpartum care | No charge | 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 when not specifically listed above, Member Cost Sharing for an ultrasound billed as a specialized or non-routine service is listed under "Laboratory, Radiology and Other Diagnostic Services." | | |
| Medical Drugs (drugs that cannot be self-administered) | | |
| Medical drugs received in a physician's office or other outpatient facility | Deductible, then no charge | Deductible, then 20% Coinsurance |
| Medical drugs received in the home | Deductible, then no charge | Deductible, then 20% Coinsurance |
| Some Medical Drugs may be supplied by a specialty pharmacy. When Medical Drugs are supplied by a specialty pharmacy, the Member Cost Sharing listed above will apply. | | |
| Medical Formulas | | |
| | Deductible, then no charge | Deductible, then 20% Coinsurance |
| Mental Health and Substance Use Disorder Treatment | | |
| Inpatient services | Deductible, then no charge | Deductible, then 20% Coinsurance |
| Intermediate care services – Acute residential treatment (including detoxification), crisis stabilization and in-home family stabilization – Intensive outpatient programs, partial hospitalization and day treatment programs | Deductible, then no charge | Deductible, then 20% Coinsurance |
| Annual mental health wellness examination performed by a licensed mental health professional. Please Note: Your annual mental health wellness examination may also be provided by a PCP as part of your annual routine examination for preventive care. | No charge | Deductible, then 20% Coinsurance |
| Outpatient group therapy | Deductible, then \$10 Copayment per visit | Deductible, then 20% Coinsurance |
| Outpatient individual therapy | Deductible, then \$30 Copayment per visit | Deductible, then 20% Coinsurance |
| Outpatient treatment, including outpatient detoxification and medication management | Deductible, then \$30 Copayment per visit | Deductible, then 20% Coinsurance |
| Outpatient methadone maintenance | Deductible, then no charge | Deductible, then 20% Coinsurance |
| Outpatient psychological testing and neuropsychological assessment | Deductible, then no charge | Deductible, then 20% Coinsurance |

THE HARVARD PILGRIM BEST BUY HSA PPO - MASSACHUSETTS

| Benefit | In-Network Plan Providers Member Cost Sharing | Out-of-Network Non-Plan Providers Member Cost Sharing |
|--|--|---|
| Mental Health and Substance Use Disorder Treatment (Continued) | | |
| Outpatient telemedicine virtual visit – group therapy | Deductible, then \$10 Copayment per visit | Deductible, then 20% Coinsurance |
| Outpatient telemedicine virtual visit services – including individual therapy, detoxification, and medication management | Deductible, then \$30 Copayment per visit | Deductible, then 20% Coinsurance |
| Observation Services | | |
| | Deductible, then no charge | Same as In-Network |
| Ostomy Supplies | | |
| | Deductible, then 30% 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 | 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, Radiology and Other Diagnostic Services" for the Member Cost Sharing that applies to diagnostic services not included on this list. | | |
| Consultations, evaluations, sickness and injury care | Deductible, then Level 1: \$30 Copayment per visit Level 2: \$50 Copayment per visit | Deductible, then 20% Coinsurance |
| Cost sharing level varies depending on the type of provider. Please refer to the beginning of this Schedule of Benefits to determine which cost sharing level applies. | | |
| Additional Member Cost Sharing may apply. Please refer to the specific benefit in this Schedule of Benefits. For example, if you need sutures, please refer to office based treatments and procedures below. If you need an x-ray or have blood drawn, please refer to "Laboratory, Radiology and Other Diagnostic Services." | | |
| Office based treatments and procedures, including, but not limited to administration of injections, casting, suturing and the application of dressings, genetic counseling, non-routine foot care, and surgical procedures | Deductible, then no charge | Deductible, then 20% Coinsurance |
| Administration of allergy injections | Deductible, then no charge | Deductible, then 20% Coinsurance |
| Preventive Services and Tests | | |
| | No charge | 20% Coinsurance |

(Continued on next page)

THE HARVARD PILGRIM BEST BUY HSA PPO - MASSACHUSETTS

| Benefit | In-Network Plan Providers Member Cost Sharing | Out-of-Network Non-Plan Providers Member Cost Sharing |
|---|--|--|
| Preventive Services and Tests (Continued) | | |
| Under federal and state law, many preventive services and tests are covered with no Member Cost Sharing, including preventive colonoscopies, certain labs and x-rays, voluntary sterilization for women, and all FDA approved contraceptive devices. For a complete list of covered preventive services, please see the Preventive Services Notice on our website at www.harvardpilgrim.org . You may also get a copy of the Preventive Services Notice by calling the Member Services Department at 1-888-333-4742. Harvard Pilgrim will add or delete services from this benefit for preventive services and tests in accordance with federal and state guidance. | | |
| The following additional preventive services, tests and devices: alpha-fetoprotein (AFP), fetal ultrasound, hepatitis C testing, lead level testing, prostate-specific antigen (PSA) screening, routine hemoglobin tests, group B streptococcus (GBS), routine urinalysis, blood pressure monitor, retinopathy screening, and international normalized ratio (INR) testing. | No charge | 20% Coinsurance |
| Prosthetic Devices | | |
| | Deductible, then 30% Coinsurance | Deductible, then 20% Coinsurance |
| Rehabilitation and Habilitation Services - Outpatient | | |
| Cardiac rehabilitation | Deductible, then \$30 Copayment per visit | Deductible, then 20% Coinsurance |
| Pulmonary rehabilitation therapy | Deductible, then \$30 Copayment per visit | Deductible, then 20% Coinsurance |
| Speech-language and hearing services | Deductible, then \$30 Copayment per visit | Deductible, then 20% Coinsurance |
| Occupational therapy – limited to 60 visits per Plan Year | Deductible, then \$30 Copayment per visit | Deductible, then 20% Coinsurance |
| Physical therapy – limited to 60 visits per Plan Year | Deductible, then \$30 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 up to the age of three and (2) the treatment of Autism Spectrum Disorders. | | |
| Scopic Procedures - Outpatient Diagnostic and Therapeutic | | |
| Colonoscopy, endoscopy and sigmoidoscopy | Deductible, then no charge | Deductible, then 20% Coinsurance |
| Spinal Manipulative Therapy (including care by a chiropractor) | | |
| | Deductible, then \$30 Copayment per visit | Deductible, then 20% Coinsurance |
| Surgery – Outpatient | | |
| | 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 |
|---|---|---|
| Telemedicine Virtual Visit Services - Outpatient | | |
| | Deductible, then Level 1: \$30 Copayment per visit Level 2: \$50 Copayment per visit | Deductible, then 20% Coinsurance |
| For inpatient hospital care, see "Hospital — Inpatient Services" for cost sharing details. | | |
| Travel Reimbursement Benefit | | |
| – Limited to \$2,500 per Plan Year See the Benefit Handbook for details | Deductible, then no charge | |
| Urgent Care Services | | |
| Doctor On Demand | Deductible, then \$30 Copayment per visit | |
| Important Note: Doctor On Demand is a specific network of providers contracted to provide virtual Urgent Care services. For more information on Doctor On Demand, including how to access them, please visit our website at www.harvardpilgrim.org . | | |
| Convenience care clinic | Deductible, then \$30 Copayment per visit | Deductible, then 20% Coinsurance |
| Urgent care center | Deductible, then \$30 Copayment per visit | Deductible, then 20% Coinsurance |
| Hospital urgent care center | Deductible, then \$30 Copayment per visit | Deductible, then 20% Coinsurance |
| Additional Member Cost Sharing may apply. Please refer to the specific benefit in this Schedule of Benefits. For example, if you have an x-ray or have blood drawn, please refer to "Laboratory, Radiology and Other Diagnostic Services." | | |
| Vision Services | | |
| Routine eye examinations – limited to 1 exam per Plan Year | No charge | Deductible, then 20% Coinsurance |
| Vision hardware for special conditions | Deductible, then no charge | Deductible, then 20% Coinsurance |
| 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." | |
| Wigs and Scalp Hair Prostheses as required by law | | |
| – Limited to \$350 per Plan Year (see the Benefit Handbook for details) | Deductible, then 30% Coinsurance | Deductible, then 20% Coinsurance |

Language Assistance Services

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

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

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

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

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

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

العربية (Arabic)
إنتبهوا: إذا كنت تكلم اللغة العربية ، خدمات المساعدة للأغربة متوفرة لك مجاناً. اتصل على 1 888-333-4742 (TTY: 711)

ខ្មែរ (Cambodian) ចុះផ្លូវលេខ៖ ពីរមុខភាពយោបាយភាគខ្លួន; យើងមានសេវាការមួយក្នុង ផ្លូវលេខ៖ ចុះទូរសព្ទ 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 करें। 1-888-333-4742 (TTY: 711)

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

ລາວ (Lao) ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາວົາ ວາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ວຍພາວົາ, ໂດຍບໍ່ເສັງຄ່າ, ດູມຈົມມີຜົວມີໃຫ້ທ່ານ. ໂທດ 1-888-333-4742 (TTY: 711).

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



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

(Continued)

General Notice About Nondiscrimination and Accessibility Requirements

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

HPHC:

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

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

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

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

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



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

cc6589_memb_serv (08_23)

General List of Exclusions MASSACHUSETTS

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

| Exclusion |
|--|
| Alternative Treatments <ul style="list-style-type: none">• Acupuncture care, except when specifically listed as a Covered Benefit. • Acupuncture services that are outside the scope of standard acupuncture care.• Alternative, holistic or naturopathic services and all procedures, laboratories and nutritional supplements associated with such treatments, except when specifically listed as a Covered Benefit.• Aromatherapy, treatment with crystals and alternative medicine.• Any of the following types of programs: Health resorts, spas, recreational programs, camps, outdoor skills programs, therapeutic or educational boarding schools, educational programs for children in residential care, self-help programs, life skills programs, relaxation or lifestyle programs, and wilderness programs (therapeutic outdoor programs).• Massage therapy.• Myotherapy. |
| Dental Services <ul style="list-style-type: none">• Dental Care, except when specifically listed as a Covered Benefit.• Temporomandibular Joint Dysfunction (TMD) care, except as described in the Plan's <i>Benefit Handbook</i>.• Extraction of teeth, except when specifically listed as a Covered Benefit.• Pediatric dental care, except when specifically listed as a Covered Benefit.• Dentures |
| Durable Medical Equipment and Prosthetic Devices <ul style="list-style-type: none">• Any devices or special equipment needed for sports or occupational purposes.• Any home adaptations, including, but not limited to home improvements and home adaptation equipment.• Non-durable medical equipment, unless used as part of the treatment at a medical facility or as part of approved home health care services.• Repair or replacement of durable medical equipment or prosthetic devices as a result of loss, negligence, willful damage, or theft. |
| Experimental, Unproven, or Investigational Services <ul style="list-style-type: none">• Any products or services, including, but not limited to, drugs, devices, treatments, procedures, and diagnostic tests that are Experimental, Unproven, or Investigational. |
| Foot Care <ul style="list-style-type: none">• Foot orthotics, except for the treatment of severe diabetic foot disease or systemic circulatory disease.• Routine foot care. Examples include nail trimming, cutting or debriding and the cutting or removal of corns and calluses. This exclusion does not apply to preventive foot care for Members diagnosed with diabetes or systemic circulatory disease. |
| Maternity Services <ul style="list-style-type: none">• Planned home births.• Services provided by a doula. |

Exclusion

Mental Health and Substance Use Disorder Treatment

- Educational services or testing, except services covered under the benefit for Early Intervention Services. No benefits are provided (1) for educational services intended to enhance educational achievement or developmental functioning, (2) to resolve problems of school performance, (3) for driver alcohol education, or (4) for community reinforcement approach and assertive continuing care.
- Any of the following types of programs: programs in which the patient has a pre-defined duration of care without the Plan's ability to conduct concurrent determinations of continued medical necessity, programs that only provide meetings or activities not based on individualized treatment plans, programs that focus solely on interpersonal or other skills rather than directed toward symptom reduction and functional recovery related to specific mental health disorders, and tuition based programs that offer educational, vocational, recreational, or personal developmental activities.
- Sensory integrative praxis tests.
- Mental health and substance use disorder treatment that is (1) provided to Members who are confined or committed to a jail, house of correction, prison, or custodial facility of the Department of Youth Services; or (2) provided by the Department of Mental Health.
- Services or supplies for the diagnosis or treatment of mental health and substance use disorders that, in the reasonable judgment of the Plan, 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, (3) post-mastectomy care, and (4) gender affirming procedures and related services.
- Electrolysis or laser hair removal, except for what is Medically Necessary as part of gender affirming services.
- Hair removal or restoration, including, but not limited to transplantation or drug therapy.
- Liposuction, except for what is Medically Necessary as part of gender affirming services, 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.
- Treatments and procedures related to appearance including but not limited to, abdominoplasty; chemical peels; collagen injections; dermabrasion; implantations (e.g. cheek, calf, pectoral, gluteal); lip reduction/enhancement; panniculectomy; removal of redundant skin; and silicone injections (e.g. for breast enlargement), except for what is Medically Necessary as part of another Covered Benefit.
- Treatment for skin wrinkles and skin tags or any treatment to improve the appearance of the skin.
- Treatment for spider veins.
- Wigs and scalp hair prostheses when hair loss is due to male pattern baldness, female pattern baldness, or natural or premature aging.

Procedures and Treatments

- Care by a chiropractor outside the scope of standard chiropractic practice, including but not limited to, surgery, prescription or dispensing of drugs or medications, internal examinations, obstetrical practice, or treatment of infections and diagnostic testing for chiropractic care other than an initial X-ray.
- Spinal manipulative therapy (including care by a chiropractor), except when specifically listed as a Covered Benefit.
- Commercial diet plans, weight loss programs and any services in connection with such plans or programs. **Please note:** If you have coverage through an employer group plan, your employer may participate in other wellness and health improvement incentive programs offered by Harvard Pilgrim. Please review all your Plan documents for the amount of incentives, if any, available under your Plan.
- Gender affirming services including reassignment surgery and all related drugs and procedures for self-insured groups, except when specifically listed as a Covered Benefit.
- If a service is listed as requiring that it be provided at a Center of Excellence, no In-Network coverage will be provided if that service is received from a provider that has not been designated as a Center of Excellence.
- Nutritional or cosmetic therapy using vitamins, minerals or elements, and other nutrition-based therapy. Examples include supplements, electrolytes, and foods of any kind (including high protein foods and low carbohydrate foods).
- Physical examinations and testing for insurance, licensing or employment.
- Services for Members who are donors for non-members, except as described under Human Organ Transplant Services.
- Testing for central auditory processing.
- Group diabetes training, educational programs or camps.

Exclusion

Providers

- Charges for services which were provided after the date on which your membership ends.
- Charges for any products or services, including, but not limited to, professional fees, medical equipment, drugs, and hospital or other facility charges, that are related to any care that is not a Covered Benefit.
- Charges for missed appointments.
- Concierge service fees. (See the Plan's *Benefit Handbook* for more information.)
- Inpatient charges after your hospital discharge.
- Provider's charge to file a claim or to transcribe or copy your medical records.
- Services or supplies provided by: (1) anyone related to you by blood, marriage or adoption, or (2) anyone who ordinarily lives with you.

Reproduction

- Any form of Surrogacy or services for a gestational carrier other than covered maternity services.
- Any reproductive related services or drugs for Members who are not medically infertile, except when specifically listed as a Covered Benefit.
- Infertility drugs if a Member is not in a Plan authorized cycle of infertility treatment.
- Infertility drugs, if infertility services are not a Covered Benefit.
- Infertility drugs that must be purchased at an outpatient pharmacy, unless your Plan includes outpatient pharmacy coverage.
- Infertility treatment for Members who are not medically infertile, except as otherwise listed in this Benefit Handbook.
- Intrauterine Insemination (IUI) services provided in the home.
- Infertility treatment and birth control drugs, implants and devices, except when specifically listed as a Covered Benefit.
- Reversal of voluntary sterilization (including any services for infertility related to voluntary sterilization or its reversal).
- Sperm collection, freezing and storage except as described in the Plan's *Benefit Handbook*.
- Sperm identification when not Medically Necessary (e.g., gender identification).
- The following fees: wait list fees, non-medical costs, shipping and handling charges etc.
- Voluntary sterilization, including tubal ligation and vasectomy, except when specifically listed as a Covered Benefit.
- Voluntary termination of pregnancy, except when specifically listed as a Covered Benefit.

Services Provided Under Another Plan

- Costs for any services for which you are entitled to treatment at government expense, including military service connected disabilities.
- Costs for services for which payment is required to be made by a Workers' Compensation plan or an Employer under state or federal law.

Telemedicine Services

- Telemedicine services involving e-mail or fax.
- Provider fees for technical costs for the provision of telemedicine services.

Types of Care

- Custodial Care.
- Recovery programs including rest or domiciliary care, sober houses, transitional support services, and therapeutic communities.
- All institutional charges over the semi-private room rate, except when a private room is Medically Necessary.
- Pain management programs or clinics.
- Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, and diversion or general motivation.
- Private duty nursing.
- Sports medicine clinics.
- Vocational rehabilitation, or vocational evaluations on job adaptability, job placement, or therapy to restore function for a specific occupation.

Vision and Hearing

- Eyeglasses, contact lenses and fittings, except when specifically listed as a Covered Benefit.
- Hearing aids, except when specifically listed as a Covered Benefit.
- Hearing aid batteries, and any device used by individuals with hearing impairment to communicate over the telephone or internet, such as TTY or TDD.
- Over the counter hearing aids.
- Refractive eye surgery, including, but not limited to, lasik surgery, orthokeratology and lens implantation for the correction of naturally occurring myopia, hyperopia and astigmatism.
- Routine eye examinations, except when specifically listed as a Covered Benefit.

Exclusion

All Other Exclusions

- Any service or supply furnished in connection with a non-Covered Benefit. • Any service or supply (with the exception of contact lenses) purchased from the internet. • Any service, supply or medication when there is a less intensive Covered Benefit or more cost-effective alternative that can be safely and effectively provided, in accordance with applicable Medical Necessity Guidelines. • Any service, supply or medication that is required by a third party that is not otherwise Medically Necessary (examples of a third party are an employer, an insurance company, a school or court). • Beauty or barber service. • Diabetes equipment replacements when solely due to manufacturer warranty expiration. • Donated or banked breast milk. • Externally powered exoskeleton assistive devices and orthoses. • Food or nutritional supplements, including, but not limited to, FDA-approved medical foods obtained by prescription, except as required by law and prescribed for Members who meet HPHC policies for enteral tube feedings.
- Guest services. • Medical equipment, devices or supplies except as described in the Plan's *Benefit Handbook*. • Medical services that are provided to Members who are confined or committed to jail, house of correction, prison, or custodial facility of the Department of Youth Services. • Reimbursement for travel expenses, except as described in the Plan's *Benefit Handbook*. Excluded services include but are not limited to: Alcohol and tobacco; Childcare expenses; Entertainment; Expenses for anyone other than you and your companion; First class, business class and other luxury transportation services; Lodging other than at a hotel or motel; Lost wages; Meals; Personal care and hygiene items; Telephone calls; Tips and gratuities. • Services for non-Members. • Services for which no charge would be made in the absence of insurance. • Services for which no coverage is provided in the Plan's *Benefit Handbook*, this Schedule of Benefits, or the Prescription Drug Brochure (if applicable). • Services provided under an individualized education program (IEP), including any services provided under an IEP that are delivered by school personnel or any services provided under an IEP purchased from a contractor or vendor. • Services that are not Medically Necessary. • Taxes or governmental assessments on services or supplies. • Transportation, except for emergency ambulance transport, and non-emergency medical transport needed for transfer between hospitals or other covered health care facilities or from a covered facility to your home when Medically Necessary or when specifically listed as a Covered Benefit. • Voice modification surgery, except when Medically Necessary for gender affirming 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.