Schedule of Benefits

Harvard Pilgrim Health Care, Inc.

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MASSACHUSETTS

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

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.

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** if you are covered under an Employer Group plan or **1-877-907-4742** if you are covered under an Individual Member plan.

Covered Benefits

Your Covered Benefits are administered on a Plan Year basis. If you are covered under an Individual Member Plan, your Plan Year begins on January 1. If you are covered under an Employer Group Plan, 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.**

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

General Cost Sharing Features:	Member Cost Sharing:
Coinsurance and Copayments	
	See the benefits table below
Deductible	
	None
Out-of-Pocket Maximum	
	None

Benefit:	Member Cost Sharing:
Acupuncture Treatment	
	No charge
Ambulance and Medical Transport	
Emergency ambulance transport	No charge

Benefit:	Member Cost Sharing:
Non-emergency medical transport	No charge
Applied Behavioral Analysis (ABA)	
Applied behavior analysis for the treatment of: – Autism Spectrum Disorder – Down syndrome	No charge
Chemotherapy and Radiation Therapy	
Chemotherapy	No charge
Radiation therapy	No charge
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)	No charge
For outpatient surgical procedures, see "Surgery - Outpatient," for cost sharing details.	
If your Plan provides coverage for pediatric dental services, please see your pediatric dental rider for coverage information.	
Dialysis	
	No charge
Durable Medical Equipment	
Durable medical equipment	No charge
Blood glucose monitors, infusion devices, and insulin pumps (including supplies)	No charge
Oxygen and respiratory equipment	No charge
Early Intervention Services	
	No charge
The Plan does not cover the family participation fee required by the Massachusetts Department of Public Health.	
Emergency Room Care	
	No charge
Fertility Treatment (see the Benefit Handbook for details)	
	No charge
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	No charge
Home Health Care	
	No charge
If services include the administration of drugs, please see the benefit for "Medical Drugs" for Member Cost Sharing details.	
Hospice – Outpatient	
	No charge
Hospital – Inpatient Services	
Acute hospital care	No charge
Inpatient maternity care	No charge

Benefit:	Member Cost Sharing:
Inpatient routine nursery care	No charge
Inpatient rehabilitation – Limited to 60 days per Plan Year	No charge
Skilled nursing facility – Limited to 100 days per Plan Year	No charge
Infertility Treatment (see the Benefit Handbook for details)	
	No charge
Laboratory, Radiology and Other Diagnostic Services	
Laboratory	No charge
Genetic testing	No charge
Radiology	No charge
Advanced radiology, including CT scans, PET scans, MRI, MRA and nuclear medicine services	No charge
Other diagnostic services	No charge
Low Protein Foods	
	No charge
Maternity Care - Outpatient	
Childbirth classes – Limited to 1 initial childbirth course or 1 refresher course per pregnancy (see the Benefit Handbook for details)	No charge
Routine outpatient prenatal and postpartum care	No charge
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." For more information, see the "Maternity Care" benefit in your Benefit Handbook or the Preventive Services notice on our website at **www.harvardpilgrim.org.**	
Medical Drugs (drugs that cannot be self-administered)	
Medical drugs received in a physician's office or other outpatient facility	No charge
Medical drugs received in the home	No charge
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	
	No charge
Mental Health and Substance Use Disorder Treatment	
Inpatient services	No charge
Intermediate care services	No charge

Benefit:	Member Cost Sharing:
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
Outpatient group therapy	No charge
Outpatient treatment, including individual therapy, outpatient detoxification and medication management	No charge
Outpatient methadone maintenance	No charge
Outpatient services provided by a recovery coach, as required by law	No charge
Outpatient psychological testing and neuropsychological assessment	No charge
Outpatient telemedicine virtual visit – group therapy	No charge
Outpatient telemedicine virtual visit – including individual therapy, detoxification, and medication management	No charge
Observation Services	
	No charge
Ostomy Supplies	
	No charge
Physician and Other Professional Office Visits (This includes all covered Plan Providers unless otherwise listed in this Schedule of Benefits.)	
Routine examinations for preventive care, including immunizations	No charge
Not all services you receive during your routine exam are covered at no charge. Only preventive services designated under the Patient Protection and Affordable Care Act (PPACA) are covered at no charge. Other services not included under PPACA may be subject to additional cost sharing. For the current list of preventive services covered at no charge under PPACA, please see the Preventive Services Notice on our website at **www.harvardpilgrim.org.** Please see "Laboratory, Radiology and Other Diagnostic Services" for the Member Cost Sharing that applies to diagnostic services not included on this list.	
Consultations, evaluations, sickness and injury care	No charge
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	No charge
Administration of allergy injections	No charge
Preventive Services and Tests	
	No charge

Benefit:	Member Cost Sharing:
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** if you are covered under an Employer Group plan or **1-877-907-4742** if you are covered under an Individual Member plan. 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
Prosthetic Devices	
	No charge
Rehabilitation and Habilitation Services - Outpatient	
Cardiac rehabilitation	No charge
Pulmonary rehabilitation therapy	No charge
Speech-language and hearing services	No charge
Occupational therapy – Rehabilitation Services – limited to 60 visits per Plan Year – Habilitation Services – limited to 60 visits per Plan Year Limits combined with physical therapy	No charge
Physical therapy – Rehabilitation Services – limited to 60 visits per Plan Year – Habilitation Services – limited to 60 visits per Plan Year Limits combined with occupational therapy	No charge
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	No charge
Spinal Manipulative Therapy (including care by a chiropractor)	
	No charge
Surgery – Outpatient	
	No charge
Telemedicine Virtual Visit Services - Outpatient	
	No charge

Benefit:	Member Cost Sharing:
For inpatient hospital care, see "Hospital – Inpatient Services" for cost sharing details.	
Urgent Care Services	
Doctor On Demand	No charge
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	No charge
Urgent care center	No charge
Hospital urgent care center	No charge
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 per Plan Year	No charge
Routine pediatric eye examinations (including contact lens fitting) – limited to 1 exam per Plan Year	No charge
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	
	No charge
Voluntary Termination of Pregnancy	
	No charge
Wellness Reimbursement Benefits (see the Benefit Handbook for details)	
Fitness – Coverage is provided for up to 2 Members per calendar year for membership in a qualified fitness facility, health club or fitness center **or** costs paid toward a fitness tracker as follows: • One Member is covered for reimbursement of the cost of one month of individual or family membership per calendar year **or** is covered for reimbursement of fitness membership costs and/or fitness tracker costs up to a combined maximum of $150 per calendar year.* • A second Member is covered for reimbursement of fitness membership costs and/or fitness tracker costs up to a combined maximum of $150 per calendar year.	No charge

Benefit:	**Member Cost Sharing:**
*If a Member receives reimbursement for one month of individual or family fitness membership which is less than $150, then the difference may be applied toward the cost of the Member's fitness tracker. If the cost of one month of individual or family fitness membership is greater than $150, then the 1 month is covered in full and there is no further coverage available for that Member.	
Weight management programs – Coverage provided for 3 months of membership at WW (Weight Watchers) digital, traditional meetings or Weight Watchers at Work program per calendar year.	No charge
Wigs and Scalp Hair Prostheses as required by law	
– Limited to 1 synthetic monofilament wig per Plan Year (see the Benefit Handbook for details)	No charge

Core MA 3-Tier Prescription Drug Coverage

Benefit:	Member Cost Sharing:
Your pharmacy Copayments for up to a 30-day supply are:	
Tier 1:	No charge
Tier 2:	No charge
Tier 3:	No charge
Your pharmacy Copayments for up to a 90–day supply of maintenance medications at a retail pharmacy are:	
Tier 1:	No charge
Tier 2:	No charge
Tier 3:	No charge
Harvard Pilgrim's mail service prescription drug program.	
You may purchase a 90-day supply of maintenance medications through the Plan's Mail Service Prescription Drug Program. Your mail service Copayments for a 90-day supply are:	
Tier 1:	No charge
Tier 2:	No charge
Tier 3:	No charge
A summary of your cost sharing amounts for your prescription drug coverage is also listed on your outpatient prescription drug flyer and Summary of Benefits and Coverage. 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.	

Important Notes:

Opioid Antagonists

Prescribed, ordered or dispensed opioid antagonists used in the reversal of overdoses caused by opioids are covered by the Plan. These opioid antagonists do not require Prior Approval or a prescription from a health care provider.

Opioid antagonists are covered with no Member Cost Sharing.

Drugs to Treat Chronic Conditions

Your coverage also includes generic and brand name drugs used to treat each of the following chronic conditions: (i) diabetes; (ii) asthma; (iii) hypertension and iv) chronic ischemic heart disease. As required by law, at least one generic and one brand name drug identified by the Plan to treat these conditions will apply the following Member Cost Sharing:

Generic drugs are covered with no Member Cost Sharing.

Member Cost Sharing for brand name drugs will not exceed $25 for up to a 30–day supply. (Note: Insulin is the drug used to treat diabetes.)

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. Coverage is also provided for (C) Medically Necessary contact lenses, and (D) Medically Necessary low vision services.

(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 in full for covered prescription eyeglass frames and lenses. Standard or Basic lenses are limited to glass or plastic:

- single vision lenses
- conventional bifocal lenses
- conventional trifocal lenses
- lenticular lenses
- progressive lenses

The following optional lenses and treatments are also covered:

- Tint (fashion and gradient and glass-grey)
- Standard plastic scratch coating
- Standard polycarbonate
- Standard anti-reflective coating
- UV treatment
- Polarized
- Photochromatic/Transitions plastic
- Oversized

(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 in full for your first order of covered prescription contact lenses. Reimbursement for disposable contact lenses is limited to a 6 month supply.

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

(C) MEDICALLY NECESSARY CONTACT LENSES

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

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

The Plan will reimburse you in full for Medically Necessary contact lenses.

(D) LOW VISION SERVICES

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

See "Physician and Other Professional Office Visits" for your Member Cost Sharing that applies to consultations and evaluations. The Plan will reimburse you in full for visual aids as described above.

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. Only contact lenses may be purchased from an internet provider. Simply pay out-of-pocket and submit to the Plan for reimbursement.

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 may obtain the reimbursement form on our website, **www.harvardpilgrim.org** or by calling the Member Services Department at **1–888–333–4742** if you are covered under an Employer Group plan or **1–877–907–4742** if you are covered under an Individual Member plan. 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** if you are covered under an Employer Group plan or **1–877–907–4742** if you are covered under an Individual Member plan. 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
- Plano or prescription sunglasses, no-line bifocals, or blended lenses
- Safety glasses and accompanying frames
- Spectacle lens styles, materials, treatments or add ons (except as described above under prescription eyeglass frames and lenses)
- 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

General List of Exclusions
Harvard Pilgrim Health Care, Inc. | 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
• 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
• Dental Care, except when specifically listed as a Covered Benefit. • Temporomandibular Joint Dysfunction (TMD) care, except as described in the Plan's *Benefit Handbook*. • Extraction of teeth, except when specifically listed as a Covered Benefit. • Pediatric dental care, except when specifically listed as a Covered Benefit.
Durable Medical Equipment and Prosthetic Devices
• Any devices or special equipment needed for sports or occupational purposes. • Any home adaptations, including, but not limited to home improvements and home adaptation equipment. • Non-durable medical equipment, unless used as part of the treatment at a medical facility or as part of approved home health care services. • Repair or replacement of durable medical equipment or prosthetic devices as a result of loss, negligence, willful damage, or theft.
Experimental, Unproven, or Investigational Services
• Any products or services, including, but not limited to, drugs, devices, treatments, procedures, and diagnostic tests that are Experimental, Unproven, or Investigational.
Foot Care
• Foot orthotics, except for the treatment of severe diabetic foot disease or systemic circulatory 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
• 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. • Planned home births. • Services provided by a doula. • Routine pre-natal and post-partum care when you are traveling outside the Service Area.
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)

Exclusion
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.
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 gender affirming services or 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, except as provided in the Benefit Handbook under Wellness Reimbursement Benefits. **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. • 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). • 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 Plan's *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.
Reproduction
• Any form of Surrogacy or services for a gestational carrier other than covered maternity services. • 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 treatment for Members who are not medically infertile. • Infertility treatment and birth control drugs, implants and devices. This exclusion may apply when coverage is provided by a religious diocese, as allowed by law. • 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

Exclusion
pregnancy. This exclusion may apply when an employer is a church or church controlled organization, as allowed by law. Please see your Schedule of Benefits to determine if your Plan provides coverage for this 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, except as provided in the Plan's Benefit Handbook under Wellness Reimbursement Benefits. • Private duty nursing. • Sports medicine clinics. • Vocational rehabilitation, or vocational evaluations on job adaptability, job placement, or therapy to restore function for a specific occupation.
Vision and Hearing
• Eyeglasses, contact lenses and fittings, except when specifically listed as a Covered Benefit. • Hearing aid batteries, 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.
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, including physical examinations and testing, required by a third party that is not otherwise Medically Necessary (examples of a third party are an employer, an insurance company, a school, a camp, or court). • Beauty or barber service. • Cost of organs that are sold rather than donated to recipients. • Diabetes equipment replacements when solely due to manufacturer warranty expiration. • Digital therapeutics. • Donated or banked breast milk, except as specifically listed under the "*Hospital-Inpatient Services*" benefit in this Benefit Handbook. • 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. • 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. • Services provided under an individualized education program (IEP), including any services provided under an IEP that are delivered by school personnel or any services provided under an IEP purchased from a contractor or vendor. • Services that are not Medically Necessary. • Services your PCP or a Plan Provider has not provided, arranged or approved except as described in the *Handbook* sections "*Your PCP Manages Your Health Care*" and "*Using Plan Providers*". • 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. • 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

Exclusion
modifications including but not limited to elevators, handrails and ramps. • Hot tubs, jacuzzis, saunas or whirlpools. • Mattresses. • Medical alert systems. • Motorized beds. • Pillows. • Power-operated vehicles. • Stair lifts and stair glides. • Strollers. • Safety equipment. • Vehicle modifications including but not limited to van lifts. • Telephone. • Television.

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

Harvard Pilgrim Health Care

a Point32Health company

Language Assistance Services

Arabic (العربية) انتباه: إذا كنت تتحدث لغة أخرى غير الإنجليزية، فإن خدمات المساعدة اللغوية متاحة لك مجانًا. يرجى الاتصال بالرقم الموجود على بطاقة هوية العضو الخاصة بك.

French (Français) ATTENTION : Si vous parlez une langue autre que l'anglais, des services d'assistance linguistique gratuits sont à votre disposition. Veuillez appeler le numéro indiqué sur votre carte d'adhérent.

Greek (Ελληνικά) ΠΡΟΣΟΧΗ: Εάν μιλάτε κάποια άλλη γλώσσα πέρα από τα αγγλικά, γλωσσικές υπηρεσίες χωρίς χρέωση είναι στη διάθεσή σας. Καλέστε τον αριθμό στην κάρτα μέλους σας.

Gujarati (ગુજરાતી) ધ્યાન આપો: જો તમે અંગ્રેજી સિવાય બીજી ભાષા બોલો છો, તો ભાષા હિાય વિાઓ, તમારા માટે મફત ઉપલબ્ધ છે. કૃપા કરીને તમારા ભિય આઈડી કાડ પરના નંબર પર કોલ કરો.

Haitian Creole (Kreyòl Ayisyen) ATANSYON: Si w pale yon lang ki pa Anglè, gen sèvis èd pou lang ki disponib gratis pou ou. Tanpri rele nimewo ki sou kat ID manm ou a.

Hindi (हिंदी) ध्यान दें: अगर आप अंग्रेजी के अलावा कोई दूसरी भाषा बोलते हैं, तो भाषा सहायता सेवाएं आपके लिए निःशुल्क उपलब्ध हैं। कृपया अपने सदस्य आईडी कार्ड पर दिए गए नंबर पर कॉल करें।

Italian (Italiano) ATTENZIONE: se parli una lingua diversa dall'inglese, sono disponibili gratuitamente servizi di assistenza linguistica. Chiama il numero indicato sulla tua tessera membro identificativa.

Khmer (ភាសាខ្មែរ) ប្រសិនបើអ្នក កនិយាយភាសាបរទេសផ្សេងក្រៅពីភាសាអង់គ្លេស បសវាកម្មជំនួយភាសា ដលែគតលិតថ្លៃ លើអាចរកបានសម្រាប់អ្នក ។ សូ មុហៅទៅកាន់បលខទៅបលើ ID សាជសាជិករបស់អ្នក ។

Korean (한국어) 알림: 영어 이외의 언어를 사용하신다면 언어 지원 서비스를 무료로 제공해 드립니다. 가입자 ID 카드에 명시된 번호로 전화하시기 바랍니다.

Lao (ພາສາລາວ) ກະລຸນາ ຮັບຊາບ: ຖ້າ ທ່ານເວົ້າພາສາອື່ນທີ່ບໍ່ແມ່ນພາສາ ອັງກິດ, ທ່ານສາມາດໃຊ້ບໍລິການຊ່ວຍພາສາໄ ດ້ ໂດຍ່ບເສຍ ຄ່າ. ກະລຸນາໂທຫາເບີ່ຢູ່ ຢ່ໃນ ບັດປະຈໍາ ຕົວສະມາຊິກຂອງ ທ່ານ.

Polish (polski) UWAGA: Jeśli posługujesz się językiem innym niż angielski, możesz bezpłatnie korzystać z usług pomocy językowej. Zadzwoń pod numer podany na Twojej karcie członkowskiej.

Portuguese (Português) ATENÇÃO: caso fale outro idioma que não o inglês, são-lhe disponibilizados gratuitamente serviços de assistência linguística. Ligue para o número no seu cartão de identificação de membro.

Russian (Русский) ВНИМАНИЕ! Если вы не говорите на английском языке, то можете бесплатно воспользоваться услугами языковой поддержки. Позвоните по номеру, указанному на вашей идентификационной карте участника.

Spanish (Español) ATENCIÓN: Si usted habla un idioma que no sea inglés, están disponibles para usted, sin costo, servicios de asistencia en otros idiomas. Llame al número que figura en su tarjeta de identificación de miembro.

Traditional Chinese (繁體中文) 注意事項：如果您講非英語的其他語言，我們可以為您提供免費的語言協助服務。請撥打您會員 ID 卡上的電話號碼。

Vietnamese (Tiếng Việt) LƯU Ý: Nếu quý vị nói ngôn ngữ khác không phải tiếng Anh, chúng tôi cung cấp dịch vụ hỗ trợ ngôn ngữ miễn phí cho quý vị. Vui lòng gọi đến số điện thoại trên thẻ ID hội viên của quý vị.

ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Please call the number on your member ID card.

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General Notice About Nondiscrimination and Accessibility Requirements

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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 (see below for contact information).

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:

Point32Health Civil Rights Legal Coordinator
1 Wellness Way
Canton, MA 02021-1166

866-750-2074, TTY service: 711
Fax: 617-668-2754
Email: **OCRCoordinator@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 (TDD)

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

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