# Schedule of Benefits

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

## NH Local HMO Silver Standard CSR94 + $0 Rx list + $0 Virtual Urgent Care

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.**

**This Policy does not include pediatric dental services. Pediatric dental coverage is included in some health plans, but can also be purchased as a stand-alone product. Please contact your insurance carrier or producer, or seek assistance through Healthcare.gov, if you wish to purchase pediatric dental coverage or a stand-alone dental services product.**

**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 IS A STANDARDIZED HEALTH PLAN IN ACCORDANCE WITH FEDERAL LAW.*****

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.

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.

### Medical Necessity Guidelines

We use clinical review criteria to evaluate whether certain services or procedures are Medically Necessary for a Member's care. Members or their practitioners may obtain a copy of our Medical Necessity Guidelines on our website at **www.harvardpilgrim.org** or by calling Member Services at **1-877-907-4742**.

### 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 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 midwives; and nurse practitioners.

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.

## American Indian/Alaskan Natives

**Please Note**: If you purchased your coverage through New Hampshire's Federally Operated Health Insurance Marketplace and it has determined that you are eligible to enroll in this plan as an American Indian or Alaskan Native, you are exempt from any Member Cost Sharing requirements when Covered Benefits are received by an Indian Health Service (IHS), Indian Tribe, Tribal Organization, or Urban Indian Organization (UIO) or through referral under contract health services. There is no Member Cost Sharing responsibility for American Indians or Alaskan Natives when Covered Benefits are provided by one of these providers.

## 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." 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: | Member Cost Sharing: |
|---|---|
| **Coinsurance and Copayments** | |
| | See the benefits table below |
| **Deductible** | |
| | None |
| **Out-of-Pocket Maximum** | |
| Includes all Member Cost Sharing | $2,200 per Member per Calendar Year<br>$4,400 per family per Calendar Year |

| Benefit: | Member Cost Sharing: |
|---|---|
| **Acupuncture Treatment** | |
| | $10 Copayment per visit |
| **Ambulance and Medical Transport** | |
| Emergency ambulance transport | 25% Coinsurance |
| Non-emergency medical transport | 25% Coinsurance |
| **Applied Behavior Analysis (ABA)** | |
| Covered for the treatment of autism spectrum disorders | 25% Coinsurance |
| **Chemotherapy and Radiation Therapy** | |
| Chemotherapy | 25% Coinsurance |
| Radiation therapy | 25% Coinsurance |
| **Chiropractic Care** | |
| | $10 Copayment per visit |

| Benefit: | Member Cost Sharing: |
|---|---|
| **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 through New Hampshire's Federally Operated Health Insurance Marketplace, you may have other coverage under a separate dental plan.** | |
| **Dialysis** | |
| | 25% Coinsurance |
| **Durable Medical Equipment** | |
| Durable medical equipment | 25% 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 |
| **Emergency Admission** | |
| | 25% Coinsurance |
| **Emergency Room Care** | |
| Services that do not meet the definition of Medical Emergency | 50% Coinsurance |
| Medical Emergency services | 25% Coinsurance |
| **Hearing Aids** | |
| – Limited to 1 hearing aid per hearing impaired ear as Medically Necessary | 50% Coinsurance |
| **Home Health Care** | |
| | 25% Coinsurance |
| If services include the administration of drugs, please see the benefit for "Medical Drugs" for Member Cost Sharing details. | |
| **Hospice – Outpatient** | |
| | 25% Coinsurance |
| **Hospital – Inpatient Services** | |
| Acute hospital care | 25% Coinsurance |
| Inpatient maternity care | 25% Coinsurance |
| Inpatient routine nursery care | No charge |
| Inpatient rehabilitation<br>– Limited to 100 days per Calendar Year | 25% Coinsurance |
| Skilled nursing facility<br>– Limited to 100 days per Calendar Year | 25% Coinsurance |
| **Infertility Treatment** | |
| | Not covered |
| **Laboratory, Radiology and Other Diagnostic Services** | |
| Laboratory | 25% Coinsurance |
| Genetic testing | 25% Coinsurance |

| Benefit: | Member Cost Sharing: |
|---|---|
| Radiology | 25% Coinsurance |
| Advanced radiology, including CT scans, PET scans, MRI, MRA and nuclear medicine services | 25% Coinsurance |
| Other diagnostic services | 25% Coinsurance |
| **Low Protein Foods** | |
| | 25% Coinsurance |
| **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." 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 | 25% Coinsurance |
| Medical drugs received in the home | 25% 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** | |
| | 25% Coinsurance |
| **Mental Health and Substance Use Disorder Treatment** | |
| Inpatient services | 25% Coinsurance |
| Intermediate services including Acute residential treatment, partial hospitalization, intensive outpatient programs and mobile crisis intervention | 25% Coinsurance |
| Outpatient group therapy | No charge |
| Outpatient treatment, including individual therapy, detoxification and medication management | No charge |
| Outpatient methadone maintenance | No charge |
| Outpatient psychological testing | No charge |
| Outpatient telemedicine virtual visit – group therapy | No charge |
| Outpatient telemedicine virtual visit – including individual therapy, detoxification, and medication management | No charge |
| eVisits | No charge |
| **Observation Services** | |
| | 25% Coinsurance |
| **Ostomy Supplies** | |
| | 25% Coinsurance |

| Benefit: | Member Cost Sharing: |
|---|---|
| **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 | **Level 1:**<br>No charge<br>**Level 2:**<br>$10 Copayment per visit |
| 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 treatments and procedures including, but not limited to, casting, suturing and the application of dressings, non-routine foot care, and surgical procedures | 25% Coinsurance |
| Administration of allergy injections | $10 Copayment per visit |
| **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 **1-877-907-4742**. Harvard Pilgrim will add or delete services from this benefit for preventive services and tests in accordance with Federal guidance. | |
| **Prosthetic Devices** | |
| | 25% Coinsurance |
| **Rehabilitation and Habilitation Services - Outpatient** | |
| Cardiac rehabilitation | 25% Coinsurance |
| Pulmonary rehabilitation therapy | 25% Coinsurance |
| Occupational therapy<br>– Rehabilitation Services – limited to 60 visits per Calendar Year<br>– Habilitation Services – limited to 60 visits per Calendar Year<br>Physical, speech, and occupational therapy limits are combined | No charge |

| Benefit: | Member Cost Sharing: |
|---|---|
| Physical therapy<br>– Rehabilitation Services – limited to 60 visits per Calendar Year<br>– Habilitation Services – limited to 60 visits per Calendar Year<br>Physical, speech, and occupational therapy limits are combined | No charge |
| Speech therapy<br>– Rehabilitation Services – limited to 60 visits per Calendar Year<br>– Habilitation Services – limited to 60 visits per Calendar Year<br>Physical, speech, and occupational therapy limits are combined | No charge |
| 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 | 25% Coinsurance |
| **Surgery – Outpatient** | |
| | 25% Coinsurance |
| **Telemedicine Virtual Visit Services - Outpatient** | |
| | **Level 1:**<br>No charge<br>**Level 2:**<br>$10 Copayment per visit |
| 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 | $5 Copayment per visit |
| Urgent care center | $5 Copayment per visit |
| Hospital urgent care center | 25% 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<br>– Limited to 1 exam every 2 Calendar Years | $10 Copayment per visit |
| Routine pediatric eye examinations (including a contact lens fitting)<br>– Limited to 1 exam per Calendar Year | $10 Copayment per visit |
| Vision hardware for special conditions | 25% Coinsurance |

| Benefit: | Member Cost Sharing: |
|---|---|
| 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** | |
| | 25% Coinsurance |
| **Voluntary Termination of Pregnancy – Outpatient** | |
| Covered only when the life of the mother is endangered or when the pregnancy is a result of rape or incest. | 25% Coinsurance |
| **Wigs and Scalp Hair Prostheses (as required by law)** | |
| See the Benefit Handbook for details | 25% Coinsurance |

# CORE NH 4-TIER 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: | $0 Copayment per prescription or prescription refill |
| Tier 2: | $15 Copayment per prescription or prescription refill |
| Tier 3: | $50 Copayment per prescription or prescription refill |
| Tier 4: | $150 Copayment 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: | $0 Copayment per prescription or prescription refill |
| Tier 2: | $45 Copayment per prescription or prescription refill |
| Tier 3: | $150 Copayment per prescription or prescription refill |
| Tier 4: | $450 Copayment 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: | $0 Copayment per prescription or prescription refill |
| Tier 2: | $45 Copayment per prescription or prescription refill |
| Tier 3: | $150 Copayment per prescription or prescription refill |
| Tier 4: | $450 Copayment per prescription or prescription refill |

**Please Note:** In accordance with NH Law, you will pay no more than $200 per 30-day supply, per prescription or per prescription refill for oral or self-administered anticancer medications.

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 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 **1-877-907-4742** 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 VisionCare benefit, including how to receive reimbursement or eyewear discounts, please contact the Member Services Department at **1-877-907-4742**. 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

# General List of Exclusions
# **Harvard Pilgrim Health Care of New England, Inc.** | NEW HAMPSHIRE

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

| Exclusion |
|---|
| **Alternative Treatments** |
| • Acupuncture 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. Please Note: Covered Benefits received while a Member is participating in a program, such as a wilderness program, may be reimbursed if the provider separately identifies and submits bills for Medically Necessary Services that are Covered Benefits and all other terms of overage under the Plan are met, including any applicable provider network and Member Cost Sharing requirements. • 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 your Benefit Handbook and Schedule of Benefits • Temporomandibular Joint Dysfunction (TMD) care, except the specific medical treatments listed as Covered Benefits in your Benefit Handbook. • Extraction of teeth. |
| **Durable Medical Equipment and Prosthetic Devices** |
| • Any devices or special equipment needed for sports or occupational purposes. • Any home adaptations, including, but not limited to home improvements and home adaptation equipment. • Non-durable medical equipment, unless used as part of the treatment at a medical facility or as part of approved home health care services. • Repair or replacement of durable medical equipment or prosthetic devices as a result of loss, negligence, willful damage, or theft. |
| **Experimental, Unproven or Investigational Services** |
| • Any products or services, including, but not limited to, drugs, devices, treatments, procedures, and diagnostic tests that are Experimental, Unproven, or Investigational. |
| **Foot Care** |
| • Foot orthotics, except for the treatment of severe diabetic foot disease or systemic circulatory diseases. • Routine foot care. Examples include nail trimming, cutting or debriding and the cutting or removal of corns and calluses. This exclusion does not apply to preventive foot care for Members diagnosed with diabetes or systemic circulatory diseases. |
| **Maternity Services** |
| • Routine pre-natal and post-partum care when you are traveling outside the Service Area. • Services provided by a doula. |
| **Mental Health Care** |
| • Educational services or testing. No benefits are provided: (1) for educational services intended to enhance educational achievement; or (2) to resolve problems of school performance. • 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. |
| **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) |

| Exclusion |
| --- |
| 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, electrolysis, laser treatment, 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. • 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). • 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 your 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** |
| • 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 testing (PGT); 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. |

| Exclusion |
| --- |
| **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 your Benefit Handbook and 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. • 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. |
| **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. • 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. • Digital therapeutics. • Donated or banked breast milk. • Externally powered exoskeleton assistive devices and orthoses. • Food or nutritional supplements, including, but not limited to, FDA-approved medical foods obtained by prescription, except as required by law and prescribed for Members who meet HPHC policies for enteral tube feedings. • Guest services. • Medical equipment, devices or supplies except as listed in 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. • 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 your Benefit Handbook, Schedule of Benefits, or 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 your Benefit Handbook. • Taxes or governmental assessments on services or supplies. • Transportation, except for emergency ambulance transport, and non-emergency medical transport needed for transfer between hospitals or other covered health care facilities or from a covered facility to your home when Medically Necessary. • 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. |

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 មហៅទៅកាន់បលខបាប់ លើ ID ភាគសាជិករបស់អ្នក ។

**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 ທ່ານເວົ້າພາສາອື່ນທີ່ບໍ່ແມ່ນ ພາສາ ອັງກິດ, ທ່ານສາມາດໃຊ້ບໍລິການດ້ານພາສາ ໄດ້ ໂດຍບໍ່ເສຍ ຄ່າ. ກະລຸນາໂທຫາເບີ່ ຢູ່ ໃນ 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

**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 (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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