Schedule of Benefits

Harvard Pilgrim Health Care of New England, Inc.

HMO 1000
RHODE ISLAND

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**.

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 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. 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**.

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, 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	
	$1,000 per Member per Plan Year $2,000 per family per Plan Year
Important Notice: If a family Deductible applies, it can be met in one of two ways: a. If a Member in a covered family meets an individual Deductible, then that Member has no additional Deductible Member Cost Sharing for Covered Benefits for the rest of the Plan Year. b. If any number of Members in a covered family together meet a family Deductible, then all Members in that covered family have no additional Deductible Member Cost Sharing for Covered Benefits for the rest of the Plan Year.	
Out-of-Pocket Maximum	
Includes all Member Cost Sharing	$7,750 per Member per Plan year $15,500 per family per Plan year
Important Notice: If a family Out-of-Pocket Maximum applies, it can be met in one of two ways: a. If a Member in a covered family meets an individual Out-of-Pocket Maximum, then that Member has no additional Member Cost Sharing for Covered Benefits for the rest of the Plan Year. b. If any number of Members in a covered family together meet a family Out-of-Pocket Maximum, then all Members in that covered family have no additional Member Cost Sharing for Covered Benefits for the rest of the Plan Year.	

Benefit	Member Cost Sharing:
Acupuncture Treatment	
	$35 Copayment per visit
Ambulance and Medical Transport	
Emergency ambulance transport	Deductible, then $50 Copayment per transport
Non-emergency medical transport	Deductible, then $50 Copayment per transport
Autism Spectrum Disorders Treatment	
Applied behavior analysis	$35 Copayment per visit
Chemotherapy and Radiation Therapy	
Chemotherapy	Deductible, then no charge
Radiation therapy	Deductible, then no charge
Chiropractic Care, including Spinal Manipulation Therapy	
	$35 Copayment per visit
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
If your Plan provides coverage for pediatric dental services, please see your pediatric dental Schedule of Benefits and Benefit Handbook for coverage information.	

Benefit	Member Cost Sharing:
Dialysis	
	Deductible, then no charge
Durable Medical Equipment	
Durable medical equipment	Deductible, then 20% Coinsurance
Blood glucose monitors, infusion devices and insulin pumps (including supplies)	Deductible, then 20% Coinsurance
Oxygen and respiratory equipment	No charge
Early Intervention Services	
	No charge
Emergency Room Care	
	$350 Copayment per visit
This Copayment is waived if you are (1) transferred to either Observation Services or Outpatient Surgery or (2) admitted to the hospital directly from the emergency room. Please see "Hospital - Inpatient Services," "Observation Services," or "Surgery – Outpatient" for the Member Cost Sharing that applies to these benefits.	
Hearing Aids	
– Limited to 1 hearing aid every 3 years, for each hearing impaired ear	Deductible, then 20% Coinsurance
Home Health Care	
	Deductible, then no charge
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
Hospital – Inpatient Services	
Acute hospital care	Deductible, then $150 Copayment per admission
Inpatient maternity care	Deductible, then $150 Copayment per admission
Inpatient routine nursery care	No charge
Inpatient rehabilitation – limited to 100 days per Plan Year Inpatient rehabilitation and skilled nursing facility limits are combined	Deductible, then $150 Copayment per admission
Skilled nursing facility – limited to 100 days per Plan Year Inpatient rehabilitation and skilled nursing facility limits are combined	Deductible, then $150 Copayment per admission

Benefit	Member Cost Sharing:
Infertility Treatment (see the Benefit Handbook for details)	
	Deductible, then 20% Coinsurance
Laboratory, Radiology and Other Diagnostic Services	
Laboratory	$25 Copayment per visit
Genetic testing and biomarker testing	Deductible, then no charge
Radiology	$40 Copayment per visit
Advanced radiology, including CT scans, PET scans, MRI, MRA and nuclear medicine services	Deductible, then $75 Copayment per visit
Other diagnostic services, including allergy testing	Deductible, then no charge
Low Protein Foods	
	Deductible, then no charge
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."	
Maternity Care – Doula Services	
	No charge
Medical Drugs (drugs that cannot be self-administered)	
Medical drugs received in a physician's office or other outpatient facility	Deductible, then no charge
Medical drugs received in the home	Deductible, then 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	
	Deductible, then no charge
Mental Health and Substance Use Disorder Treatment	
Inpatient services, including Community Residence	Deductible, then $150 Copayment per admission
Intermediate care services	No charge
Outpatient group therapy	$10 Copayment per visit
Outpatient treatment, including individual therapy, detoxification and medication management	$35 Copayment per visit

Benefit	Member Cost Sharing:
Mental Health and Substance Use Disorder Treatment (Continued)	
Medication assisted treatment, including methadone maintenance	No charge
Outpatient psychological testing and neuropsychological assessment	$35 Copayment per visit
Outpatient telemedicine virtual visits - group therapy	$10 Copayment per visit
Outpatient telemedicine virtual visits - including individual therapy, detoxification and medication management	$35 Copayment per visit
Observation Services	
	Deductible, then $150 Copayment per observation stay
Orthoses	
See Benefit Handbook for details on custom fabricated orthoses.	Deductible, then 20% Coinsurance
Ostomy Supplies	
	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
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:** $35 Copayment per visit **Level 2:** $55 Copayment per visit
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, non-routine foot care, and surgical procedures	Deductible, then no charge
Administration of allergy injections	$5 Copayment per visit

Benefit	Member Cost Sharing:
Preventive Services and Tests	
	No charge
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.	
Private Duty Nursing Services in the Home	
	Deductible, then no charge
Prosthetic Devices	
Prosthetic Devices	Deductible, then 20% Coinsurance
Breast prostheses	No charge
Reconstructive Surgery	
Reconstructive Surgery	Your Member Cost Sharing will depend upon where the service is provided, as listed in this Schedule of Benefits. For example, for services provided by a physician, see "Physician and Other Professional Office Visits." For inpatient hospital care, see "Hospital - Inpatient Services."
Mastectomy Care	No charge
Rehabilitation and Habilitation Services - Outpatient	
Cardiac rehabilitation	Deductible, then no charge
Pulmonary rehabilitation therapy	Deductible, then no charge
Occupational therapy – Rehabilitation Services - limited to 30 visits per Plan Year – Habilitation Services - limited to 30 visits per Plan Year	Deductible, then $45 Copayment per visit
Physical therapy – Rehabilitation Services - limited to 30 visits per Plan Year – Habilitation Services - limited to 30 visits per Plan Year	Deductible, then $45 Copayment per visit
Speech therapy – Rehabilitation Services - limited to 30 visits per Plan Year – Habilitation Services - limited to 30 visits per Plan Year	Deductible, then $45 Copayment per visit
Outpatient physical, occupational and speech 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.	

Benefit	Member Cost Sharing:
Scopic Procedures - Outpatient Diagnostic and Therapeutic	
Colonoscopy and sigmoidoscopy	Deductible, then $75 Copayment per visit
Endoscopy	Deductible, then $75 Copayment per visit
See Preventive Services and Tests above for coverage of preventive colonoscopies. In accordance with Rhode Island law, a follow up colonoscopy will be covered in full if the results of an initial screening colonoscopy (or other screening medical test or procedure) for colorectal cancer is abnormal.	
Surgery – Outpatient	
	Deductible, then $75 Copayment per visit
Telemedicine Virtual Visit Services - Outpatient	
	Level 1: $35 Copayment per visit **Level 2:** $55 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	$35 Copayment per visit
Urgent care center	$50 Copayment per visit
Hospital urgent care center	$50 Copayment per visit
Additional Member Cost Sharing may apply. Please refer to the specific benefit in this Schedule of Benefit. 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	$35 Copayment per visit
Routine pediatric eye examinations (including contact lens fitting) - limited to 1 exam per Plan Year	No charge
Vision hardware for special conditions	Deductible, then no charge
Your Plan also includes coverage for pediatric vision hardware. Please see your Pediatric Vision Care Schedule of Benefits and Benefit Handbook for more information.	
Voluntary Sterilization in a Physician's Office	
	Deductible, then no charge
Voluntary Termination of Pregnancy – Outpatient	
	Deductible, then no charge
Wigs and Scalp Hair Prostheses as required by law	
– Limited to $350 per wig See the Benefit Handbook for details. The number of wigs provided in accordance with RI law per Plan Year is not limited.	Deductible, then 20% Coinsurance

ID:_RX0000201283

Prescription Drug Schedule of Benefits

Harvard Pilgrim Health Care of New England, Inc.

CORE RI Five-Tier Prescription Drug Plan
RHODE ISLAND

Cost Sharing Features:	Member Cost Sharing:
Out-of-Pocket Maximum	
	Please see your medical *Schedule of Benefits*
Your Member Cost Sharing for up to a 30-day supply at a retail pharmacy is:	
Tier 1:	$5 Copayment per prescription or prescription refill.
Tier 2:	$30 Copayment per prescription or prescription refill.
Tier 3:	$75 Copayment per prescription or prescription refill.
Tier 4:	$90 Copayment per prescription or prescription refill.
Tier 5:	25% Coinsurance subject to a maximum Coinsurance* amount of $150 per prescription or prescription refill.
Infertility Drugs	All infertility drugs will apply 20% Coinsurance. Copayments and/or Coinsurance maximums listed above (if any) will never apply. If a Deductible applies to a particular tier, you will be responsible for paying the Deductible, then 20% Coinsurance.
Your Member Cost Sharing for up to a 90-day supply of maintenance medications at a retail pharmacy are:	
Tier 1:	$15 Copayment per prescription or prescription refill.
Tier 2:	$90 Copayment per prescription or prescription refill.
Tier 3:	$225 Copayment per prescription or prescription refill.
Tier 4:	$270 Copayment per prescription or prescription refill.
Tier 5:	25% Coinsurance subject to a maximum Coinsurance* amount of $450 per prescription or prescription refill.
Harvard Pilgrim's mail service prescription drug program.	
You may purchase up to a 90-day supply of maintenance medications through the Plan's Mail Service Prescription Drug Program. Your mail service Member Cost Sharing for a up to a 90-day supply is:	
Tier 1:	$10 Copayment per prescription or prescription refill.
Tier 2:	$60 Copayment per prescription or prescription refill.
Tier 3:	$225 Copayment per prescription or prescription refill.
Tier 4:	$270 Copayment per prescription or prescription refill.
Tier 5:	25% Coinsurance subject to a maximum Coinsurance* amount of $450 per prescription or prescription refill.

*Once the Deductible is met, Coinsurance is based on the full cost of the medication. The full cost will be the lower of the participating pharmacy's retail price or the price of the medication at Harvard Pilgrim's discount rate.

Please see Appendix A of your Benefit Handbook for more information on your outpatient Prescription Drug Benefit, including the tier definitions.

EFFECTIVE DATE: 01/01/2025

Important Notes:

A two (2) pack of epinephrine auto-injectors or cartridges is covered once every 12 months with no Member Cost Sharing. Additional epinephrine auto-injectors or cartridges will be subject to Member Cost Sharing.

Copayments and Coinsurance for certain high dollar specialty drugs, as defined under Rhode Island law, are limited to not exceed $150 for up to a 30 day supply.

Please see Appendix A of your Benefit Handbook for more information on your outpatient Prescription Drug Benefit, including the tier definitions.

A summary of your cost sharing amounts for your prescription drug coverage is also shown on your Plan identification (ID) card. 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.

ID: VS0000201180
DATE: 01/01/2025

Pediatric Vision Care Schedule of Benefits

Harvard Pilgrim Health Care of New England, Inc.
RHODE ISLAND

Dependents up to the age of 19 are eligible for coverage of vision hardware as described below. 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 and in your Benefit Handbook. In addition, coverage is also provided for **(C)** Medically Necessary contact lenses, and **(D)** Medically Necessary low vision services.

Please see *Appendix B: Pediatric Vision Care Benefits* in your Benefit Handbook for additional information.

General Cost Sharing Features	Member Cost Sharing
Out-of-Pocket Maximum	
	Please see your medical *Schedule of Benefits*

Benefit	Member Cost Sharing
(A) Prescription eyeglass frames and lenses – Limited to 1 pair every 12 months	Covered in full for the first $50, then 50% Coinsurance.
(B) Prescription contact lenses – Limited to 1 purchase every 12 months **Please Note:** Daily wear disposable lenses are limited to one purchase of a 6 month supply every 12 months.	Covered in full for the first $50, then 50% Coinsurance.
(C) Medically Necessary contact lenses (see the Benefit Handbook for details)	Covered in full for the first $50, then 50% Coinsurance.
(D) Low vision services (see the Benefit Handbook for details)	Covered in full for the first $50, then 50% Coinsurance.

ID: DN0000201225
DATE: 01/01/2025

Pediatric Dental Schedule of Benefits

Harvard Pilgrim Health Care of New England, Inc.
HMO
RHODE ISLAND

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

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

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

General Cost Sharing Features	Member Cost Sharing
Out-of-Pocket Maximum	
	Please see your medical *Schedule of Benefits*

Benefit Description and Limitations	Your Cost Sharing
TYPE I SERVICES: *PREVENTIVE & DIAGNOSTIC COVERED SERVICES*	
Diagnostic Services	
Intraoral Bitewing Radiographs (Bitewing X-ray) – Limited to 1 set every 6 months	No charge
Panorex Radiographs (Full Jaw X-ray) or Complete Series Radiographs (Full Set of X- rays) – Limited to 1 film every 60 months	No charge
Periodic Oral Evaluation (Checkup Exam) – Limited to 1 every 6 months	No charge
Preventive Services	
Dental Prophylaxis (Cleanings) – Limited to 1 every 6 months	No charge

Benefit Description and Limitations	Your Cost Sharing
TYPE I SERVICES: *PREVENTIVE & DIAGNOSTICCOVERED SERVICES* (Continued)	
Fluoride Treatments – Limited to 2 treatments per 12 months.	No charge No charge for children up to age 5.
Sealants (Protective Coating) – Limited to one sealant per tooth every 36 months.	No charge
Space Maintainers	No charge
TYPE II SERVICES: *MINOR RESTORATIVE COVERED SERVICES*	
Minor Restorative Services, Endodontics, Periodontics, and Oral Surgery	
Amalgam Restorations (Silver Fillings)	25% Coinsurance
Composite Resin Restorations (Tooth Colored Fillings) – For anterior (front) teeth only.	25% Coinsurance
Endodontics (Root Canal Therapy) performed on anterior or posterior primary teeth – Limited to once per tooth per lifetime.	25% Coinsurance
Relining and Rebasing Dentures – Limited to relining/rebasing performed more than 6 months after the initial insertion. Limited to once per 36 months.	25% Coinsurance
Repairs or Adjustments to Full Dentures, Partial Dentures, Bridges, or Crowns	25% Coinsurance
Scaling and Root Planing (Deep Cleanings) – Limited to once per quadrant per 24 months.	25% Coinsurance
Periodontal Maintenance (Gum Maintenance) – Limited to 4 times per 12 month period following completion of active periodontal therapy	25% Coinsurance
Simple Extractions (Simple tooth removal)	25% Coinsurance
Oral Surgery, including Surgical Extraction	25% Coinsurance

Benefit Description and Limitations	Your Cost Sharing
TYPE II SERVICES: *MINOR RESTORATIVE COVERED SERVICES* (Continued)	
Adjunctive Services	
General Services (including Emergency Treatment of dental pain) General anesthesia is covered when clinically necessary.	25% Coinsurance
TYPE III SERVICES: *MAJOR RESTORATIVE COVERED SERVICES*	
Inlays/Onlays/Crowns (Partial to Full Crowns) – Limited to once per tooth per 60 months. Covered only when silver fillings cannot restore the tooth.	50% Coinsurance
Endodontics (root canal therapy) performed on anterior teeth, bicuspids, and molars – Limited to once per tooth per lifetime.	50% Coinsurance
Endodontic Surgery	50% Coinsurance
Fixed Prosthetics (Bridges) – Limited to once per tooth per 60 months.	50% Coinsurance
Occlusal guards for Members age 13 and older – Limited to one guard every 12 months.	50% Coinsurance
Periodontal Surgery (Gum Surgery) – Limited to one quadrant or site per 36 months per surgical area.	50% Coinsurance
Removable Prosthetics (Full or partial dentures) – Limited to one per 60 months.	50% Coinsurance
Relining and Rebasing Dentures – Limited to relining/rebasing performed more than 6 months after the initial insertion. Limited to once per 36 months.	50% Coinsurance
Oral Surgery, including Surgical Extraction	50% Coinsurance

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

General List of Exclusions
RHODE ISLAND

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, 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*. • Pediatric dental care, except when specifically listed as a Covered Benefit.
Durable Medical Equipment, Orthoses 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
• Non-custom and prefabricated foot orthotics, fittings and arch supports, except for therapeutic/molded shoes and shoe inserts for a Member diagnosed with severe diabetic foot disease or systemic circulatory illnesses that compromise the blood supply to the foot. • 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
• Planned home births. • Routine pre-natal and post-partum care when you are traveling outside the Service Area. • The following doula services or expenses: travel expenses and mileage; any childcare services or services for children other than the newborn; housekeeping assistance; doula services provided in connection with home births.

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

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. • 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. • 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 review for 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 toward symptom reduction and functional recovery related to specific mental health disorders; tuition based programs that offer educational, vocational, recreational or personal development activities.
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. • Skin abrasion procedures performed as a treatment for acne. • Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures). • 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; pannicudectomy; removal of redundant skin; silicone injections (e.g., for breast enlargement), except for what is Medical 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. • Commercial diet plans, weight loss programs and any services in connection with such plans or programs. • If a service is listed as requiring that it be provided at a Center of Excellence, no coverage will be provided if that service is received from a provider that has not been designated as a Center of Excellence. • Nutritional or cosmetic therapy using vitamins, minerals or elements, and other nutrition-based therapy. Examples include supplements, electrolytes, and foods of any kind (including high protein foods and low carbohydrate foods). • Physical examinations and testing for insurance, licensing or employment. • Services for Members who are donors for non-members, except as described under Human Organ Transplant Services. • Testing for central auditory processing. • Group diabetes training, educational programs or camps.

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.) • 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. • Birth control drugs, implant and devices. This exclusion may apply when coverage is provided by a church or church controlled organization, as allowed by law. Check this Schedule of Benefits to see if your Plan covers this benefit. • Infertility drugs if a Member is not in a Plan authorized cycle of infertility treatment. • Infertility treatment for Members who are not medically infertile. • 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 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 or an automated computer program used to diagnose and/or treat ocular or refractive conditions. • 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. • Private duty nursing as follows: services when the primary duties are limited to bathing, feeding, exercising, homemaking, giving oral medications or acting as a companion or sitter; services provided by a member of your household or the cost of any care provided by a member's relatives (by blood, marriage, or adoption); services after the caregiver or patient has demonstrated the ability to carry out the plan of care; services that are provided outside the home (e.g., school, nursing facility or assisted living facility); services that duplicate or overlap services (e.g., when a person is receiving hospice care services or for the same hours of a skilled nursing home care visit); services for observation only; services of a nurse's aide; services for a person without an available caregiver in the home (24 hour private duty nursing is not covered); maintenance care when the condition has stabilized, including routine ostomy care or tube feeding administration, or if the anticipated need is indefinite; respite care (e.g., care during a caregiver's vacation) or private duty nursing so that the caregiver may attend work or school. • 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.

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

Exclusion
All Other Exclusions
• Any service or supply furnished in connection with a non-Covered Benefit. • 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). • Any service or supply (with the exception of contact lenses) purchased from the internet. •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. • 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* or this Schedule of Benefits. • 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 *Benefit Handbook* under 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. • Transportation by wheelchair van. • Voice modification surgery, except when Medical 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.

Language Assistance Services

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

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

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

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

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

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

العربية (Arabic)

إنتباه: إذا أنت تتكلم أللُغةِ **ألعربية** ، خَدَمات ألمُساعَدة أللُغَوية مُتَوفرة لك مَجانا.ً **إتصل على 1 888-333-4742**
(TTY: 711)

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

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

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

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

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

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

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

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

ພາສາລາວ (Lao) ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-888-333-4742 (TTY: 711).

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

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

(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.