Schedule of Benefits

HPHC Insurance Company, Inc.

PPO Access Platinum 250/10% - LP

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 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. Your emergency room Member Cost Sharing is listed in the tables below.

Select LP Providers

HPHC has designated certain In-Network facilities as Select LP Providers. These Providers render the same quality of service at a lower cost than other Plan Providers in the network. When you receive certain services from a Select LP Provider, your Member Cost Sharing will be less than if you received the same services from a Provider that is not a Select LP Provider. The tables set forth below identify the outpatient services which may be obtained from Select LP Providers and list the Member Cost Sharing for those services when provided by a Select LP Provider or other Plan Provider.

The Plan's Provider Directory lists all Plan Providers including those Providers that are Select LP Providers. You can access the Provider Directory at **www.harvardpilgrim.org**. You may also obtain a paper copy of the directory free of charge by calling the Member Services Department at **1-888-333-4742**.

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

In-Network coverage applies when you use a Plan Provider for Covered Benefits.

Out-of-Network coverage applies when you use a Non-Plan Provider for Covered Benefits. If a Non-Plan Provider charges any amount in excess of the Allowed Amount, you are responsible for the excess amount.

Prior Approval

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

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

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

Medical Necessity Guidelines

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

Office Visit Cost Sharing Levels

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

Level 1 applies to covered outpatient professional services received from the following types of providers: all Primary Care Providers (PCPs); obstetricians and gynecologists; Licensed Mental Health Professionals; certified 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.

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:	In-Network Member Cost Sharing:	Out-of-Network Member Cost Sharing:
Coinsurance and Copayments		
	See the benefits table below	
Deductible		
	\$250 per Member per Calendar Year \$750 per family per Calendar Year	\$2,000 per Member per Calendar Year \$4,000 per family per Calendar Year
Your In-Network and Out-of-Network Deductible amounts are separate and do not accumulate toward each other.		

General Cost Sharing Features:	In-Network Member Cost Sharing:	Out-of-Network Member Cost Sharing:
Out-of-Pocket Maximum		
Includes all Member Cost Sharing – Any charges above the Allowed Amount and any penalty for failure to receive Prior Approval when using Non-Plan Providers do not apply to the Out-of-Pocket Maximum	$3,500 per Member per Calendar Year $7,000 per family per Calendar Year	$7,000 per Member per Calendar Year $14,000 per family per Calendar Year
Your In-Network and Out-of-Network Out-of-Pocket Maximum amounts are separate and do not accumulate toward each other.		
Out-of-Network Penalty Payment for failure to obtain Prior Approval		
Certain Out-of-Network services require Prior Approval as described earlier in this Schedule of Benefits. If you do not obtain Prior Approval for these services, you are responsible for 50% of the benefit that would have otherwise been payable or $500 whichever is less. This Penalty charge is in addition to any Member Cost Sharing amounts and does not count toward the Deductible or Out-of-Pocket Maximum.		

Benefit:	In-Network Plan Providers Member Cost Sharing:	Out-of-Network Non-Plan Providers Member Cost Sharing:
Acupuncture Treatment		
	$20 Copayment per visit	Deductible, then 30% Coinsurance
Ambulance and Medical Transport		
Emergency ambulance transport	Deductible, then 10% Coinsurance	Same as In-Network
Non-emergency air ambulance transport	Deductible, then 10% Coinsurance	Same as In-Network
Non-emergency medical transport	Deductible, then 10% Coinsurance	Deductible, then 30% Coinsurance
Autism Spectrum Disorders Treatment		
Applied behavior analysis	$20 Copayment per visit	Deductible, then 30% Coinsurance
Chemotherapy and Radiation Therapy		
Chemotherapy	Deductible, then 10% Coinsurance	Deductible, then 30% Coinsurance
Radiation therapy	Deductible, then 10% Coinsurance	Deductible, then 30% Coinsurance
Chiropractic Care		
	$20 Copayment per visit	Deductible, then 30% Coinsurance
Dental Services		
Extraction of teeth impacted in bone	Not covered	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."	

Benefit:	In-Network Plan Providers Member Cost Sharing:	Out-of-Network Non-Plan Providers Member Cost Sharing:
If you purchased this Plan directly through HPHC with pediatric dental coverage, please see the pediatric dental benefit in this Schedule of Benefits.		
Dialysis		
	Deductible, then 10% Coinsurance	Deductible, then 30% Coinsurance
Durable Medical Equipment		
Durable medical equipment	Deductible, then 20% Coinsurance	Deductible, then 30% Coinsurance
Blood glucose monitors, infusion devices and insulin pumps (including supplies)	No charge	No charge
Oxygen and respiratory equipment	No charge	Deductible, then 30% Coinsurance
Early Intervention		
– Limited to 40 visits per Member per Calendar Year	No charge	Deductible, then 30% Coinsurance
Emergency Admission		
	Deductible, then 10% Coinsurance	Same as In-Network
Emergency Room Care		
Services that do not meet the definition of Medical Emergency	Deductible, then 50% Coinsurance	Same as In-Network
Medical Emergency services	Deductible, then $300 Copayment per visit	Same as In-Network
This Copayment is waived if you are (1) transferred to either Observation Services or Outpatient Surgery or (2) admitted to the hospital directly from the emergency room. Please see "Hospital – Inpatient Services," "Observation Services," or "Surgery – Outpatient" for the Member Cost Sharing that applies to these benefits.		
Hearing Aids		
– Limited to 1 hearing aid per hearing impaired ear as Medically Necessary	50% Coinsurance	Deductible, then 50% Coinsurance
Home Health Care		
	Deductible, then 10% Coinsurance	Deductible, then 30% Coinsurance
If services include the administration of drugs, please see the benefit for "Medical Drugs" for Member Cost Sharing details.		
Hospice – Outpatient		
	Deductible, then 10% Coinsurance	Deductible, then 30% Coinsurance
Hospital – Inpatient Services		
Acute hospital care	Deductible, then 10% Coinsurance	Deductible, then 30% Coinsurance
Inpatient maternity care	Deductible, then 10% Coinsurance	Deductible, then 30% Coinsurance
Inpatient routine nursery care	No charge	Deductible, then 30% Coinsurance
Inpatient rehabilitation – Limited to 100 days per Calendar Year	Deductible, then 10% Coinsurance	Deductible, then 30% Coinsurance

Benefit:	In-Network Plan Providers Member Cost Sharing:	Out-of-Network Non-Plan Providers Member Cost Sharing:
Skilled nursing facility – Limited to 100 days per Calendar Year	Deductible, then 10% Coinsurance	Deductible, then 30% Coinsurance
Infertility Treatment (see the Benefit Handbook for details)		
	Deductible, then 10% Coinsurance	Deductible, then 30% Coinsurance
Laboratory, Radiology and Other Diagnostic Services		
Laboratory	**Select LP Providers:** No charge **Other Plan Providers:** Deductible, then 10% Coinsurance	Deductible, then 30% Coinsurance
Genetic testing	Deductible, then 10% Coinsurance	Deductible, then 30% Coinsurance
Radiology	Deductible, then 10% Coinsurance	Deductible, then 30% Coinsurance
Breast Ultrasound	No charge	Deductible, then 30% Coinsurance
Advanced radiology, including CT scans, PET scans, MRI, MRA and nuclear medicine services	**In a physician's office or non-hospital affiliated facility:** $250 Copayment per visit **In a hospital or hospital affiliated facility:** Deductible, then 10% Coinsurance	Deductible, then 30% Coinsurance
Breast MRI	No charge	Deductible, then 30% Coinsurance
Other diagnostic services	Deductible, then 10% Coinsurance	Deductible, then 30% Coinsurance
Low Protein Foods		
	Deductible, then 10% Coinsurance	Deductible, then 30% Coinsurance
Maternity Care – Outpatient		
Routine outpatient prenatal and postpartum care	No charge	Deductible, then 30% Coinsurance
Routine prenatal and postpartum care is usually received and billed from the same Provider as a single or bundled service. Different Member Cost Sharing may apply to any specialized or non-routine service that is billed separately from your routine outpatient prenatal and postpartum care. For example, Member Cost Sharing for services provided by a specialist is listed under "Physician and Other Professional Office Visits" and Member Cost Sharing for an ultrasound billed as a specialized or non-routine service is listed under "Laboratory, Radiology and Other Diagnostic Services."		
Medical Drugs (drugs that cannot be self-administered)		
Medical drugs received in a physician's office or other outpatient facility	Deductible, then 10% Coinsurance	Deductible, then 30% Coinsurance
Medical drugs received in the home	Deductible, then 10% Coinsurance	Deductible, then 30% Coinsurance

Benefit:	In-Network Plan Providers Member Cost Sharing:	Out-of-Network Non-Plan Providers Member Cost Sharing:
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 10% Coinsurance	Deductible, then 30% Coinsurance
Mental Health and Substance Use Disorder Treatment		
Inpatient services	Deductible, then 10% Coinsurance	Deductible, then 30% Coinsurance
Intermediate services including Acute residential treatment, partial hospitalization, intensive outpatient programs and mobile crisis intervention	Deductible, then 10% Coinsurance	Deductible, then 30% Coinsurance
Outpatient group therapy	$10 Copayment per visit	Deductible, then 30% Coinsurance
Outpatient treatment, including individual therapy, detoxification and medication management	$20 Copayment per visit	Deductible, then 30% Coinsurance
Outpatient methadone maintenance	No charge	Deductible, then 30% Coinsurance
Outpatient psychological testing	$20 Copayment per visit	Deductible, then 30% Coinsurance
Outpatient telemedicine virtual visit – group therapy	$10 Copayment per visit	Deductible, then 30% Coinsurance
Outpatient telemedicine virtual visit – including individual therapy, detoxification, and medication management	$20 Copayment per visit	Deductible, then 30% Coinsurance
eVisits	No charge	Deductible, then 30% Coinsurance
Observation Services		
	Deductible, then 10% Coinsurance	Same as In-Network
Ostomy Supplies		
	Deductible, then 20% Coinsurance	Deductible, then 30% Coinsurance
Physician and Other Professional Office Visits **(This includes all covered Providers unless otherwise listed in this Schedule of Benefits)**		
Routine examinations for preventive care, including immunizations	No charge	Deductible, then 30% Coinsurance
Not all **In-Network** services you receive during your routine exam are covered at no charge. Only preventive services designated under the Patient Protection and Affordable Care Act (PPACA) are covered at no charge. Other services not included under PPACA may be subject to additional cost sharing. For the current list of preventive services covered at no charge under PPACA, please see the Preventive Services Notice on our website at **www.harvardpilgrim.org.** Please see "Laboratory, Radiology and Other Diagnostic Services" for the Member Cost Sharing that applies to diagnostic services not included on this list.		
Consultations, evaluations, sickness and injury care	**Level 1:** $20 Copayment per visit **Level 2:** $40 Copayment per visit	Deductible, then 30% Coinsurance

Benefit:	**In-Network Plan Providers Member Cost Sharing:**	**Out-of-Network Non-Plan Providers Member Cost Sharing:**
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	Deductible, then 30% Coinsurance
Office based treatments and procedures including, but not limited to, casting, suturing and the application of dressings, non-routine foot care, and surgical procedures	Deductible, then 10% Coinsurance	Deductible, then 30% Coinsurance
Administration of allergy injections	$20 Copayment per visit	Deductible, then 30% Coinsurance
Preventive Services and Tests		
	No charge	Deductible, then 30% Coinsurance
Under federal law, many preventive services and tests are covered with no Member Cost Sharing, including preventive colonoscopies, certain labs and x-rays, voluntary sterilization for women, and all FDA approved contraceptive devices. For a complete list of covered preventive services, please see the Preventive Services Notice on our website at **www.harvardpilgrim.org.** You may also get a copy of the Preventive Services Notice by calling the Member Services Department at **1-888-333-4742** . Harvard Pilgrim will add or delete services from this benefit for preventive services and tests in accordance with Federal guidance.		
Prosthetic Devices		
	Deductible, then 20% Coinsurance	Deductible, then 30% Coinsurance
Rehabilitation and Habilitation Services - Outpatient		
Cardiac rehabilitation	Deductible, then 10% Coinsurance	Deductible, then 30% Coinsurance
Pulmonary rehabilitation therapy	Deductible, then 10% Coinsurance	Deductible, then 30% Coinsurance
Occupational therapy – Rehabilitation Services – limited to 60 visits per Calendar Year – Habilitation Services – limited to 60 visits per Calendar Year Physical, speech, and occupational therapy limits are combined	**In a physician's office or non-hospital affiliated facility:** $20 Copayment per visit **In a hospital or hospital affiliated facility:** Deductible, then 10% Coinsurance	Deductible, then 30% Coinsurance
Physical therapy – Rehabilitation Services – limited to 60 visits per Calendar Year – Habilitation Services – limited to 60 visits per Calendar Year Physical, speech, and occupational therapy limits are combined	**In a physician's office or non-hospital affiliated facility:** $20 Copayment per visit **In a hospital or hospital affiliated facility:** Deductible, then 10% Coinsurance	Deductible, then 30% Coinsurance

Benefit:	In-Network Plan Providers Member Cost Sharing:	Out-of-Network Non-Plan Providers Member Cost Sharing:
Speech therapy – Rehabilitation Services – limited to 60 visits per Calendar Year – Habilitation Services – limited to 60 visits per Calendar Year Physical, speech, and occupational therapy limits are combined	**In a physician's office or non-hospital affiliated facility:** $20 Copayment per visit **In a hospital or hospital affiliated facility:** Deductible, then 10% Coinsurance	Deductible, then 30% Coinsurance
Outpatient physical, occupational and speech therapies are covered without limits to the extent Medically Necessary for: (1) children up to the age of three and (2) the treatment of Autism Spectrum Disorders.		
Scopic Procedures - Outpatient Diagnostic and Therapeutic		
Colonoscopy, endoscopy and sigmoidoscopy	**Select LP Providers:** $250 Copayment per visit **Other Plan Providers:** Deductible, then 10% Coinsurance	Deductible, then 30% Coinsurance
Surgery – Outpatient		
	Select LP Providers: $250 Copayment per visit **Other Plan Providers:** Deductible, then 10% Coinsurance	Deductible, then 30% Coinsurance
Telemedicine Virtual Visit Services - Outpatient		
	Level 1: $20 Copayment per visit **Level 2:** $40 Copayment per visit	Deductible, then 30% Coinsurance
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	$20 Copayment per visit	Deductible, then 30% Coinsurance
Urgent care center	$30 Copayment per visit	Deductible, then 30% Coinsurance
Hospital urgent care center	Deductible, then $150 Copayment per visit	Deductible, then 30% Coinsurance
Additional Member Cost Sharing may apply. Please refer to the specific benefit in this Schedule of Benefits. For example, if you have an x-ray or have blood drawn, please refer to "Laboratory, Radiology and Other Diagnostic Services."		
Vision Services		
Routine adult eye examinations – Limited to 1 exam every 2 Calendar Years	$20 Copayment per visit	Deductible, then 30% Coinsurance

Benefit:	**In-Network Plan Providers Member Cost Sharing:**	**Out-of-Network Non-Plan Providers Member Cost Sharing:**
Routine pediatric eye examinations (including a contact lens fitting) – Limited to 1 exam per Calendar Year	$20 Copayment per visit	Deductible, then 30% Coinsurance
Vision hardware for special conditions	Deductible, then 10% Coinsurance	Deductible, then 30% Coinsurance
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		
	Deductible, then 10% Coinsurance	Deductible, then 30% Coinsurance
Voluntary Termination of Pregnancy – Outpatient		
	Deductible, then 10% Coinsurance	Deductible, then 30% Coinsurance
Wigs and Scalp Hair Prostheses (as required by law)		
See the Benefit Handbook for details	Deductible, then 20% Coinsurance	Deductible, then 30% Coinsurance

CORE NH 5-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:	$2 Copayment per prescription or prescription refill
Tier 2:	$25 Copayment per prescription or prescription refill
Tier 3:	$65 Copayment per prescription or prescription refill
Tier 4:	Deductible, then 35% Coinsurance subject to a maximum Coinsurance amount of $550 maximum per prescription or refill
Tier 5:	Deductible, then 40% Coinsurance subject to a maximum Coinsurance amount of $550 maximum per prescription or refill
Your pharmacy Member Cost Sharing for up to a 90-day supply of maintenance medications at a retail pharmacy is:	
Tier 1:	$6 Copayment per prescription or prescription refill
Tier 2:	$75 Copayment per prescription or prescription refill
Tier 3:	$195 Copayment per prescription or prescription refill
Tier 4:	Deductible, then 35% Coinsurance subject to a maximum Coinsurance amount of $1,650 maximum per prescription or refill
Tier 5:	Deductible, then 40% Coinsurance subject to a maximum Coinsurance amount of $1,650 maximum per prescription or 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:	$4 Copayment per prescription or prescription refill
Tier 2:	$50 Copayment per prescription or prescription refill
Tier 3:	$130 Copayment per prescription or prescription refill
Tier 4:	Deductible, then 35% Coinsurance subject to a maximum Coinsurance amount of $1,100 maximum per prescription or refill
Tier 5:	Deductible, then 40% Coinsurance subject to a maximum Coinsurance amount of $1,100 maximum per prescription or refill

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

Pediatric 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 In-Network Out-of-Pocket Maximum. Please see the General Cost Sharing Table at the beginning of this Schedule of Benefits for the Out-of-Pocket Maximum amount that applies to your plan.

WHERE TO PURCHASE EYEWEAR WITH YOUR PEDIATRIC VISION CARE BENEFIT

You can purchase your eyewear from any vision hardware provider with a valid prescription from your doctor.

HOW TO RECEIVE REIMBURSEMENT FOR THE PEDIATRIC VISION CARE BENEFIT

To receive reimbursement for prescription eyeglasses and frames or prescription contact lenses that you have paid for, you must follow these simple steps:

1. Complete a member reimbursement form. You can obtain this form by visiting our website at **www.harvardpilgrim.org** or by calling the Member Services Department at **1-888-333-4742** to request a form. For TTY service, please call **711**. A representative will be happy to assist you.
2. Each Member must use a separate member reimbursement form.
3. Attach the copy of an itemized bill to the form, showing proof of payment. Make a copy of the form for your records.
4. Mail the original form, together with the bill and proof of payment to:
   HPHC Claims
   P.O. Box 699183
   Quincy, MA 02269-9183

We will reimburse you for your payment of covered eyeglasses or contact lenses as described above. The reimbursement is applied AFTER application of discounts, coupons or other offers. Please allow 30 days to receive your reimbursement.

WHERE TO CALL WITH QUESTIONS

If you have any questions about your Pediatric VisionCare benefit, including how to receive reimbursement or eyewear discounts, please contact the Member Services Department at **1-888-333-4742** . This telephone number is also listed on your ID card. If you are deaf or hearing impaired, call **711** for TTY service. A representative will be happy to assist you.

EXCLUSIONS

- Expenses incurred prior to your effective date
- Colored contact lenses, special effect contact lenses
- Deluxe or designer frames
- Eyeglass or contact lens supplies
- Lost or broken lenses or frames, unless the Member has reached his/her normal interval for service
- Non-prescription or plano lenses
- Plain or prescription sunglasses, no-line bifocals, blended lenses or oversize lenses
- Safety glasses and accompanying frames
- Spectacle lens styles, materials, treatments or add ons
- Sunglasses and accompanying frames
- Two pairs of glasses in lieu of bifocals
- Vision hardware (with the exception of contact lenses) purchased from an internet provider

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

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

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

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

COVERED DENTAL SERVICES

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

Benefit Description and Limitations	In-Network Plan Providers Member Cost Sharing	Out-of-Network Non-Plan Providers Member Cost Sharing
Endodontics (Root Canal Therapy) performed on anterior or posterior primary teeth – Limited to once per tooth per lifetime	50% Coinsurance	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	50% Coinsurance
Repairs or Adjustments to Full Dentures, Partial Dentures, Bridges, or Crowns	50% Coinsurance	50% Coinsurance
Scaling and Root Planing (Deep Cleanings) – Limited to once per quadrant per 24 months	50% Coinsurance	50% Coinsurance
Periodontal Maintenance (Gum Maintenance) – Limited to 4 times per 12 month period following completion of active periodontal therapy	50% Coinsurance	50% Coinsurance
Simple Extractions (Simple tooth removal)	50% Coinsurance	50% Coinsurance
Oral Surgery, including Surgical Extraction	50% Coinsurance	50% Coinsurance
Adjunctive Services		
General Services (including Emergency Treatment of dental pain) General anesthesia is covered when clinically necessary	50% Coinsurance	50% 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	50% Coinsurance
Endodontics (root canal therapy) performed on anterior teeth, bicuspids, and molars – Limited to once per tooth per lifetime	50% Coinsurance	50% Coinsurance
Endodontic Surgery	50% Coinsurance	50% Coinsurance
Fixed Prosthetics (Bridges) – Limited to once per tooth per 60 months	50% Coinsurance	50% Coinsurance

Benefit Description and Limitations	In-Network Plan Providers Member Cost Sharing	Out-of-Network Non-Plan Providers Member Cost Sharing
Occlusal guards for Members age 13 and older – Limited to one guard every 12 months	50% Coinsurance	50% Coinsurance
Periodontal Surgery (Gum Surgery) – Limited to one quadrant or site per 36 months per surgical area	50% Coinsurance	50% Coinsurance
Removable Prosthetics (Full or partial dentures) – Limited to one per 60 months	50% Coinsurance	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	50% Coinsurance
Oral Surgery, including Surgical Extraction	50% Coinsurance	50% Coinsurance
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	50% Coinsurance
TYPE IV SERVICES: ***MEDICALLY NECESSARY ORTHODONTIA***		
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.		

Benefit Description and Limitations	In-Network Plan Providers Member Cost Sharing	Out-of-Network Non-Plan Providers Member Cost Sharing
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	50% Coinsurance

General List of Exclusions
HPHC Insurance Company, 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. • 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
• Services provided by a doula.
Mental Health Care
• 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 (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. • Services or supplies for the diagnosis or treatment of mental health and substance use disorder treatment that, in the reasonable judgment of the Behavioral Health Access Center, are any of the following: not consistent with prevailing national standards of clinical practice for the treatment of such conditions; not consistent with prevailing professional research demonstrating that the services or supplies will have a measurable and beneficial health outcome; typically do not result in outcomes demonstrably better than other available treatment alternatives that are less intensive or more cost effective.

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

Exclusion
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, 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. Please note: 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 received in Massachusetts, Maine, Rhode Island or New Hampshire is listed as requiring that it be provided at a Center of Excellence, no In-Network coverage will be provided under this Handbook if that service is received in Massachusetts, Maine, Rhode Island or New Hampshire from a Provider that has not been designated as a Center of Excellence. (See your Benefit Handbook for more information.) • Nutritional or cosmetic therapy using vitamins, minerals or elements, and other nutrition-based therapy. Examples include supplements, electrolytes, and foods of any kind (including high protein foods and low carbohydrate foods). • Physical examinations and testing for insurance, licensing or employment. • Services for Members who are donors for non-members, except as described under Human Organ Transplant Services. • Testing for central auditory processing. • Group diabetes training, educational programs or camps.
Providers
• Charges for services which were provided after the date on which your membership ends. • Charges for any products or services, including, but not limited to, professional fees, medical equipment, drugs, and hospital or other facility charges, that are related to any care that is not a Covered Benefit. • Charges for missed appointments. • Concierge service fees. (See your Benefit Handbook for more information.) • Inpatient charges after your hospital discharge. • Provider's charge to file a claim or to transcribe or copy your medical records. • Services or supplies provided by: (1) anyone related to you by blood, marriage or adoption, or (2) anyone who ordinarily lives with you.
Reproduction
• Infertility drugs if a Member is not in a Plan authorized cycle of infertility treatment. • Infertility treatment for Members who are not medically infertile. • Sperm collection, freezing and storage except as described in section *III. Covered Benefits, "Infertility Services and Treatment".* • Sperm identification when not Medically Necessary (e.g., gender identification). • 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.
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.

Exclusion
Telemedicine
• Telemedicine services involving fax. • Provider fees for technical costs for the provision of telemedicine services.
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 that is required by a third party that is not otherwise Medically Necessary (examples of a third party are an employer, an insurance company, a school or court). • Beauty or barber service. • Any drug or other product obtained at an outpatient pharmacy, except for pharmacy supplies covered under the benefit for diabetes services, unless your Plan includes outpatient pharmacy coverage. • Diabetes equipment replacements when solely due to manufacturer warranty expiration. • Donated or banked breast milk. • 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. • 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.

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 اللُغة العربية ، خَدَمات المُساعَدة اللُغوية 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.

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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.

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

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

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



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

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