Schedule of Benefits

Harvard Pilgrim Health Care, Inc.
PPO Access HSA 5000 - Flex
MASSACHUSETTS

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

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

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

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

In a Medical Emergency, you should go to the nearest emergency facility or call 911 or other local emergency access number. Your emergency room Member Cost Sharing is listed in the tables below.

Prior Approval

Prior Approval is required for certain benefits. Before you receive services from a Non-Plan Provider or a Plan Provider outside the Service Area, please refer to our website, **www.harvardpilgrim.org** or contact the Member Services Department at **1-888-333-4742** if you are covered under an Employer Group plan or **1-877-907-4742** if you are covered under an Individual Member plan for the complete listing of services that require Prior Approval. To obtain Prior Approval please call:

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

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

Medical Necessity Guidelines

We use clinical review criteria to evaluate whether certain services or procedures are Medically Necessary for a Member's care. Members or their practitioners may obtain a copy of our Medical Necessity Guidelines on our website at **www.harvardpilgrim.org** or by calling the Member Services Department at **1-888-333-4742** if you are covered under an Employer Group plan or **1-877-907-4742** if you are covered under an Individual Member plan.

Flex Providers

This Plan includes Flex Providers. A Flex Provider is a Plan Provider who provides certain outpatient services with lower Member Cost Sharing. When you receive these Covered Benefits from a Flex Provider you will pay a lower Member Cost Sharing amount than if you received the same Covered Benefit from a provider that is not listed as a Flex Provider. The table below identifies the outpatient services which may be obtained from a Flex Provider and the applicable Member Cost Sharing.

The Plan's Provider Directory lists all Plan Providers including those providers listed as a Flex Provider. You can access the Provider Directory at **www.harvardpilgrim.org.** You may also obtain a paper copy free of charge by calling the Member Services Department.

Office Visit Cost Sharing Levels

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

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

Level 2 applies to covered outpatient professional services received from specialty care providers.

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

Virtual-Only Plan Providers

Your Plan includes a designated group of Virtual-Only Plan Providers who deliver care exclusively through virtual visits. These Plan Providers do not offer in-office visits and include:

- designated Virtual-Only Primary Care Providers (VPCP), and
- designated Virtual-Only Mental Health Providers (VMHP).

If you select a designated VPCP, all virtual visits with your VPCP or any designated VMHP will be covered with no Member Cost Sharing after the Deductible is met.

To find a designated VPCP or VMHP go to **www.harvardpilgrim.org and select Virtual-Only providers** or call the Member Services Department at **1-888-333-4742** if you are covered under an Employer Group plan or **1-877-907-4742** if you are covered under an Individual Member plan.

Important Note: Only services from designated Virtual-Only Plan Providers are covered as described above. Telehealth, virtual, or in-office services from other Providers are subject to the applicable Member Cost Sharing listed in the tables below.

Covered Benefits

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

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		
The following Deductibles apply to all services except where specifically noted below.	$5,000 for Individual Coverage per Plan Year $10,000 for Family Coverage per Plan Year	$10,000 for Individual Coverage per Plan Year $20,000 for Family Coverage per Plan Year
Your In-Network and Out-of-Network Deductible amounts are separate and do not count toward each other.		
Important Notice: If you have Individual Coverage, the Individual Coverage Deductible applies (the Family Coverage Deductible will never apply). If you have Family Coverage, the Family Coverage Deductible may be met by any combination of covered family Members (the Individual Coverage Deductible will never apply). Once a Deductible is met, coverage by the Plan is subject to any other Member Cost Sharing that may apply.		
Out-of-Pocket Maximum		
Includes all Member Cost Sharing except: – Any charges above the Allowed Amount and any penalty for failure to receive Prior Approval when using Non-Plan Providers	$8,500 for Individual Coverage per Plan Year $17,000 for Family Coverage per Plan Year – with a $8,500 embedded individual Out-of-Pocket Maximum per Plan Year	$17,000 for Individual Coverage per Plan Year $34,000 for Family Coverage per Plan Year – with a $17,000 embedded individual Out-of-Pocket Maximum per Plan Year
Your In-Network and Out-of-Network Out-of-Pocket Maximum amounts are separate and do not count toward each other.		
Important Notice: If you have Individual Coverage, the Individual Coverage Out-of-Pocket Maximum applies (the Family Coverage Out-of-Pocket Maximum will never apply). If you have Family Coverage, the Family Coverage Out-of-Pocket Maximum can be satisfied in one of two ways: a. If a Member of a covered family meets the embedded individual Out-of-Pocket Maximum, then that Member has no additional Member Cost Sharing for the remainder of the Plan Year. b. If any number of Members in a covered family collectively meet the Family Coverage Out-of-Pocket Maximum, then all Members of the covered family have no additional Member Cost Sharing for the remainder of the Plan Year. No one family member may contribute more than the embedded individual Out-of-Pocket Maximum amount toward the Family Coverage Out-of-Pocket Maximum.		
Out-of-Network Penalty Payment		
Applies when the Member fails to obtain required Prior Approval for medical services or Medical Drugs from a Non-Plan Provider. Does not count toward the Deductible or Out-of-Pocket Maximum	$500	

Benefit:	In-Network Plan Providers Member Cost Sharing:	Out-of-Network Non-Plan Providers Member Cost Sharing:
Acupuncture Treatment		
	Deductible, then $50 Copayment per visit	Deductible, then 20% Coinsurance
Ambulance and Medical Transport		
Emergency ambulance transport	Deductible, then $250 Copayment per transport	Same as In-Network
Non-emergency air ambulance transport	Deductible, then $250 Copayment per transport	Same as In-Network
Non-emergency medical transport	Deductible, then $250 Copayment per transport	Deductible, then 20% Coinsurance

Benefit:	In-Network Plan Providers Member Cost Sharing:	Out-of-Network Non-Plan Providers Member Cost Sharing:
Applied Behavior Analysis		
Applied behavior analysis for the treatment of: – Autism Spectrum Disorder – Down syndrome	Deductible, then no charge	Deductible, then 20% Coinsurance
Chemotherapy and Radiation Therapy		
Chemotherapy	Deductible, then no charge	Deductible, then 20% Coinsurance
Radiation therapy	Deductible, then no charge	Deductible, then 20% Coinsurance
Dental Services		
Important Notice: Coverage of Dental Care is very limited. Please see your Benefit Handbook for the details of your coverage.		
Extraction of teeth impacted in bone (performed in a physician's office)	Deductible, then no charge	Deductible, then 20% Coinsurance
For outpatient surgical procedures, see “Surgery - Outpatient,” for cost sharing details.		
If your Plan provides coverage for pediatric dental services, please see your pediatric dental rider for coverage information.		
Dialysis		
	Deductible, then no charge	Deductible, then 20% Coinsurance
Durable Medical Equipment		
Durable medical equipment	Deductible, then 35% Coinsurance	Deductible, then 55% Coinsurance
Blood glucose monitors, continuous glucose monitors, infusion devices, and insulin pumps (including supplies)	Deductible, then no charge	Deductible, then 20% Coinsurance
Oxygen and respiratory equipment	Deductible, then no charge	Deductible, then 20% Coinsurance
Early Intervention Services		
	Deductible, then no charge	Deductible, then 20% Coinsurance
The Plan does not cover the family participation fee required by the Massachusetts Department of Public Health.		
Emergency Admission		
	Deductible, then $1,500 Copayment per admission	Same as In-Network
Emergency Room Care		
	Deductible, then $1,500 Copayment per visit	Same as In-Network
This Copayment is waived if you are (1) transferred to either Observation Services or Outpatient Surgery or (2) admitted to the hospital directly from the emergency room. Please see “Hospital - Inpatient Services,” “Observation Services,” or “Surgery – Outpatient” for the Member Cost Sharing that applies to these benefits.		
Fertility Treatment (see the Benefit Handbook for details)		
	Deductible, then no charge	Deductible, then 20% Coinsurance
Hearing Aids (for Members up to the age of 22)		
– Limited to $2,000 per hearing aid every 36 months, for each hearing impaired ear	Deductible, then 35% Coinsurance	Deductible, then 55% Coinsurance

Benefit:	In-Network Plan Providers Member Cost Sharing:	Out-of-Network Non-Plan Providers Member Cost Sharing:
Home Health Care		
	Deductible, then no charge	Deductible, then 20% Coinsurance
If services include the administration of drugs, please see “Medical Drugs” for the Member Cost Sharing that applies to the Medical Drug.		
Hospice – Outpatient		
	Deductible, then no charge	Deductible, then 20% Coinsurance
Hospital – Inpatient Services		
Acute hospital care	Deductible, then $1,500 Copayment per admission	Deductible, then 20% Coinsurance
Inpatient maternity care	Deductible, then $1,500 Copayment per admission	Deductible, then 20% Coinsurance
Inpatient routine nursery care	No charge	Deductible, then 20% Coinsurance
Inpatient rehabilitation – Limited to 60 days per Plan Year	Deductible, then $1,500 Copayment per admission	Deductible, then 20% Coinsurance
Skilled nursing facility – Limited to 100 days per Plan Year	Deductible, then $1,500 Copayment per admission	Deductible, then 20% Coinsurance
Infertility Treatment (see the Benefit Handbook for details)		
	Deductible, then no charge	Deductible, then 20% Coinsurance
Laboratory, Radiology and Other Diagnostic Services		
Laboratory	**Flex Providers** Deductible, then $25 Copayment per visit **Other Plan Providers** Deductible, then $75 Copayment per visit	Deductible, then 20% Coinsurance
Genetic testing	Deductible, then $75 Copayment per visit	Deductible, then 20% Coinsurance
Radiology	Deductible, then $150 Copayment per visit	Deductible, then 20% Coinsurance
Advanced radiology, including CT scans, PET scans, MRI, MRA and nuclear medicine services	**In a physician’s office or non-hospital affiliated facility** Deductible, then $500 Copayment per procedure **In a hospital or hospital affiliated facility** Deductible, then $1,000 Copayment per procedure	Deductible, then 20% Coinsurance
Other diagnostic services	Deductible, then $75 Copayment per visit	Deductible, then 20% Coinsurance
Low Protein Foods		
	Deductible, then no charge	Deductible, then 20% Coinsurance

Benefit:	In-Network Plan Providers Member Cost Sharing:	Out-of-Network Non-Plan Providers Member Cost Sharing:
Maternity Care - Outpatient		
Childbirth classes – Limited to 1 initial childbirth course or 1 refresher course per pregnancy (see the Benefit Handbook for details)	No charge	
Routine outpatient prenatal and postpartum care	No charge The Deductible does not apply to prenatal and postpartum care provided in a physician's office. All other care is covered as stated in this Schedule of Benefits.	Deductible, then 20% Coinsurance
Member Cost Sharing applies to any specialized or non-routine service, or any service billed separately from your routine outpatient prenatal and postpartum care. Ultrasounds are billed separately. 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 is listed under "Laboratory, Radiology and Other Diagnostic Services." For more information, see the "Maternity Care" benefit in your Benefit Handbook or the Preventive Services notice on our website at **www.harvardpilgrim.org.**		
Medical Drugs (drugs that cannot be self-administered)		
	Deductible, then $250 Copayment per day	Deductible, then 20% Coinsurance
The Member Cost Sharing listed above applies to all Medical Drugs, including those received from a specialty pharmacy. Additional Member Cost Sharing may apply for the administration of the Medical Drug depending on where you receive the infusion.		
Medical Formulas		
	Deductible, then no charge	Deductible, then 20% Coinsurance
Mental Health and Substance Use Disorder Treatment		
Inpatient services	Deductible, then $1,500 Copayment per admission	Deductible, then 20% Coinsurance
Intermediate care services	Deductible, then no charge	Deductible, then 20% Coinsurance
Annual mental health wellness examination performed by a licensed mental health professional **Please Note:** Your annual mental health wellness examination may also be provided by a PCP as part of your annual routine examination for preventive care.	No charge	Deductible, then 20% Coinsurance
Outpatient group therapy	Deductible, then $80 Copayment per visit	Deductible, then 20% Coinsurance
Outpatient treatment, including individual therapy, outpatient detoxification and medication management	Deductible, then $80 Copayment per visit	Deductible, then 20% Coinsurance
Outpatient methadone maintenance	Deductible, then no charge	Deductible, then 20% Coinsurance
Outpatient services provided by a recovery coach, as required by law	Deductible, then no charge	Deductible, then 20% Coinsurance
Outpatient psychological testing and neuropsychological assessment	Deductible, then $80 Copayment per visit	Deductible, then 20% Coinsurance
Outpatient telemedicine virtual visit – group therapy	Deductible, then $80 Copayment per visit	Deductible, then 20% Coinsurance

Benefit:	In-Network Plan Providers Member Cost Sharing:	Out-of-Network Non-Plan Providers Member Cost Sharing:
Outpatient telemedicine virtual visit – including individual therapy, detoxification, and medication management	Deductible, then $80 Copayment per visit	Deductible, then 20% Coinsurance
Virtual visits with a designated Virtual-Only Mental Health Provider (VMHP) when you have a Virtual-Only PCP (VPCP)	Deductible, then no charge	
Observation Services		
	Deductible, then $1,500 Copayment per observation stay	Same as In-Network
Ostomy Supplies		
	Deductible, then 35% Coinsurance	Deductible, then 55% Coinsurance
Physician and Other Professional Office Visits (The Member Cost Sharing below applies to services provided in an office or other outpatient facility, including the outpatient department of a hospital, unless otherwise listed in this Schedule of Benefits.)		
Routine examinations for preventive care, including immunizations	No charge	Deductible, then 20% Coinsurance
Not all **In-Network** services you receive during your routine exam are covered at no charge. Only preventive services designated under the Patient Protection and Affordable Care Act (PPACA) are covered at no charge. Other services not included under PPACA may be subject to additional cost sharing. For the current list of preventive services covered at no charge under PPACA, please see the Preventive Services Notice on our website at **www.harvardpilgrim.org.** Please see "Laboratory, Radiology and Other Diagnostic Services" for the Member Cost Sharing that applies to diagnostic services not included on this list.		
Consultations, evaluations, sickness and injury care	**Level 1:** Deductible, then $80 Copayment per visit **Level 2:** Deductible, then $155 Copayment per visit	Deductible, then 20% Coinsurance
Virtual visits with a designated Virtual-Only PCP (VPCP)	Deductible, then no charge	
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 treatments and procedures below. If you need an x-ray or have blood drawn, please refer to "Laboratory, Radiology and Other Diagnostic Services."		
Treatments and procedures, including, but not limited to administration of injections, casting, suturing and the application of dressings, genetic counseling, non-routine foot care, surgical procedures and administration of Medical Drugs	Deductible, then no charge	Deductible, then 20% Coinsurance
Administration of allergy injections	Deductible, then no charge	Deductible, then 20% Coinsurance
Preventive Services and Tests		
	No charge	Deductible, then 20% Coinsurance

Benefit:	In-Network Plan Providers Member Cost Sharing:	Out-of-Network Non-Plan Providers Member Cost Sharing:
Under federal and state law, many preventive services and tests are covered with no Member Cost Sharing, including preventive colonoscopies, certain labs and x-rays, voluntary sterilization for women, and all FDA approved contraceptive devices. For a complete list of covered preventive services, please see the Preventive Services Notice on our website at **www.harvardpilgrim.org.** You may also get a copy of the Preventive Services Notice by calling the Member Services Department at **1-888-333-4742** if you are covered under an Employer Group plan or **1-877-907-4742** if you are covered under an Individual Member plan. Harvard Pilgrim will add or delete services from this benefit for preventive services and tests in accordance with federal and state guidance.		
The following additional preventive services, tests and devices: alpha-fetoprotein (AFP), fetal ultrasound, hepatitis C testing, lead level testing, prostate-specific antigen (PSA) screening, routine hemoglobin tests, group B streptococcus (GBS), routine urinalysis, blood pressure monitor, retinopathy screening, and international normalized ratio (INR) testing.	No charge	Deductible, then 20% Coinsurance
Prosthetic Devices		
	Deductible, then 35% Coinsurance	Deductible, then 55% Coinsurance
Rehabilitation and Habilitation Services - Outpatient		
Cardiac rehabilitation	Deductible, then $155 Copayment per visit	Deductible, then 20% Coinsurance
Pulmonary rehabilitation therapy	Deductible, then $155 Copayment per visit	Deductible, then 20% Coinsurance
Speech-language and hearing services	**In a physician's office or non-hospital affiliated facility** Deductible, then $155 Copayment per visit **In a hospital or hospital affiliated facility** Deductible, then $175 Copayment per visit	Deductible, then 20% Coinsurance
Occupational therapy – Rehabilitation Services – limited to 60 visits per Plan Year – Habilitation Services – limited to 60 visits per Plan Year Limits combined with physical therapy	**In a physician's office or non-hospital affiliated facility** Deductible, then $155 Copayment per visit **In a hospital or hospital affiliated facility** Deductible, then $175 Copayment per visit	Deductible, then 20% Coinsurance
Physical therapy – Rehabilitation Services – limited to 60 visits per Plan Year – Habilitation Services – limited to 60 visits per Plan Year Limits combined with occupational therapy	**In a physician's office or non-hospital affiliated facility** Deductible, then $155 Copayment per visit **In a hospital or hospital affiliated facility** Deductible, then $175 Copayment per visit	Deductible, then 20% Coinsurance

Benefit:	In-Network Plan Providers Member Cost Sharing:	Out-of-Network Non-Plan Providers Member Cost Sharing:
Outpatient physical and occupational therapy is not subject to the limit listed above and is covered to the extent Medically Necessary for: (1) children up to the age of three and (2) the treatment of Autism Spectrum Disorders.		
Scopic Procedures - Outpatient Diagnostic and Therapeutic		
Colonoscopy, endoscopy and sigmoidoscopy	**Flex Providers** Deductible, then $500 Copayment per visit **Other Plan Providers** Deductible, then $1,000 Copayment per visit	Deductible, then 20% Coinsurance
The lower Flex cost sharing listed above applies to services provided by Flex Providers only. Additional Member Cost Sharing may apply to services billed from other Providers. For example, if you have surgery with a Flex provider, but that provider sends a specimen out for pathology, please refer to "Laboratory, Radiology and Other Diagnostic Services" to determine the cost sharing applicable to diagnostic services.		
Spinal Manipulative Therapy (including care by a chiropractor)		
	Deductible, then $50 Copayment per visit	Deductible, then 20% Coinsurance
Surgery – Outpatient		
	Flex Providers Deductible, then $500 Copayment per visit **Other Plan Providers** Deductible, then $1,000 Copayment per visit	Deductible, then 20% Coinsurance
The lower Flex cost sharing listed above applies to services provided by Flex Providers only. Additional Member Cost Sharing may apply to services billed from other Providers. For example, if you have surgery with a Flex provider, but that provider sends a specimen out for pathology, please refer to "Laboratory, Radiology and Other Diagnostic Services" to determine the cost sharing applicable to diagnostic services.		
Telemedicine Virtual Visit Services - Outpatient		
	Level 1: Deductible, then $80 Copayment per visit **Level 2:** Deductible, then $155 Copayment per visit	Deductible, then 20% Coinsurance
For inpatient hospital care, see “Hospital – Inpatient Services” for cost sharing details.		
Urgent Care Services		
Doctor On Demand	Deductible, then 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	Deductible, then $80 Copayment per visit	Deductible, then 20% Coinsurance
Urgent care center	Deductible, then $155 Copayment per visit	Deductible, then 20% Coinsurance
Hospital urgent care center	Deductible, then $155 Copayment per visit	Deductible, then 20% 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 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	Deductible, then $155 Copayment per visit	Deductible, then 20% Coinsurance
Routine pediatric eye examinations (including contact lens fitting) – limited to 1 exam per Plan Year	Deductible, then $155 Copayment per visit	Deductible, then 20% Coinsurance
Vision hardware for special conditions	Deductible, then no charge	Deductible, then 20% 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 no charge	Deductible, then 20% Coinsurance
Voluntary Termination of Pregnancy		
	Deductible, then no charge	Deductible, then 20% Coinsurance
Wellness Reimbursement Benefits (see the Benefit Handbook for Details)		
Fitness – Coverage is provided for up to 2 Members per calendar year for membership in a qualified fitness facility, health club or fitness center **or** costs paid toward a fitness tracker as follows: • One Member is covered for reimbursement of the cost of one month of individual or family membership per calendar year **or** is covered for reimbursement of fitness membership costs and/or fitness tracker costs up to a combined maximum of $150 per calendar year.* • A second Member is covered for reimbursement of fitness membership costs and/or fitness tracker costs up to a combined maximum of $150 per calendar year.	No charge	
*If a Member receives reimbursement for one month of individual or family fitness membership which is less than $150, then the difference may be applied toward the cost of the Member's fitness tracker. If the cost of one month of individual or family fitness membership is greater than $150, then the 1 month is covered in full and there is no further coverage available for that Member.		
Weight management programs – Coverage provided for 3 months of membership at WW (Weight Watchers) digital, traditional meetings **or** Weight Watchers at Work programs per calendar year	No charge	

Benefit:	In-Network Plan Providers Member Cost Sharing:	Out-of-Network Non-Plan Providers Member Cost Sharing:
Wigs and Scalp Hair Prostheses as required by law		
– Limited to 1 synthetic monofilament wig per Plan Year (see the Benefit Handbook for details)	Deductible, then 35% Coinsurance	Deductible, then 55% Coinsurance

Pediatric VisionCare

Dependents up to the age of 19 are eligible for coverage of prescription eyeglasses or contact lenses. Coverage under this benefit terminates at the end of the month in which the Dependent turns 19. Each Dependent is eligible for coverage every 12 months for *either* (A) prescription eyeglass frames and lenses or (B) prescription contact lenses, as described below. Coverage is also provided for (C) Medically Necessary contact lenses, and (D) Medically Necessary low vision services.

(A) PRESCRIPTION EYEGLASS FRAMES AND LENSES

The Plan will reimburse you for the purchase of one pair of Standard or Basic prescription eyeglass frames and lenses up to the following amounts:

The Plan will reimburse you for the first $50 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
- lenticular lenses
- progressive lenses

The following optional lenses and treatments are also covered:

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

(B) PRESCRIPTION CONTACT LENSES

The Plan will reimburse you for the purchase of your first order of prescription contact lenses up to the following amounts:

The Plan will reimburse you for the first $50 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.

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

(C) MEDICALLY NECESSARY CONTACT LENSES

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

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

The Plan will reimburse you for the first $50 you pay toward Medically Necessary contact lenses. Thereafter, the Plan will reimburse you 50% of your remaining covered charges.

(D) LOW VISION SERVICES

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

See "Physician and Other Professional Office Visits" for your Member Cost Sharing that applies to consultations and evaluations. The Plan will reimburse you for the first $50 you pay toward visual aids as described above. Thereafter, the Plan will reimburse you 50% of your remaining covered charges for visual aids.

OUT-OF-POCKET MAXIMUM

All Member Cost Sharing under this benefit applies toward your annual Out-of-Pocket Maximum. Please see the General Cost Sharing Table at the beginning of this Schedule of Benefits for the Out-of-Pocket Maximum amount that applies to your plan.

WHERE TO PURCHASE EYEWEAR WITH YOUR PEDIATRIC VISION CARE BENEFIT

You can purchase your eyewear from any vision hardware provider with a valid prescription from your doctor. Only contact lenses may be purchased from an internet provider. Simply pay out-of-pocket and submit to the Plan for reimbursement.

HOW TO RECEIVE REIMBURSEMENT FOR THE PEDIATRIC VISION CARE BENEFIT

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

1. Complete a member reimbursement form. You may obtain the reimbursement form on our website, **www.harvardpilgrim.org** or by calling the Member Services Department at **1–888–333–4742** if you are covered under an Employer Group plan or **1–877–907–4742** if you are covered under an Individual Member plan. For TTY service, please call **711**. A representative will be happy to assist you.
2. Each Member must use a separate member reimbursement form.
3. Attach the copy of an itemized bill to the form, showing proof of payment. Make a copy of the form for your records.
4. Mail the original form, together with the bill and proof of payment to:
   HPHC Claims
   P.O. Box 699183
   Quincy, MA 02269 - 9183

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

WHERE TO CALL WITH QUESTIONS

If you have any questions about your Pediatric Vision Care benefit, including how to receive reimbursement or eyewear discounts, please contact the Member Services Department at **1-888-333-4742** if you are covered under an Employer Group plan or **1–877–907–4742** if you are covered under an Individual Member plan. This telephone number is also listed on your ID card. If you are deaf or hearing impaired, call **711** for TTY service. A representative will be happy to assist you.

EXCLUSIONS

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

General List of Exclusions
MASSACHUSETTS

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

Exclusion
Alternative Treatments
• Acupuncture care, except when specifically listed as a Covered Benefit. • Acupuncture services that are outside the scope of standard acupuncture care. • Alternative, holistic or naturopathic services and all procedures, laboratories and nutritional supplements associated with such treatments, except when specifically listed as a Covered Benefit. • Aromatherapy and treatment with crystals. • Any of the following types of programs including tuition based programs: Health resorts, spas, recreational programs, camps, outdoor skills programs, therapeutic or educational boarding schools, educational programs for children in residential care, self-help programs, life skills programs, relaxation or lifestyle programs, and wilderness programs (therapeutic outdoor programs). • Massage therapy. • Myotherapy.
Dental Services
• Dental Care, except when specifically listed as a Covered Benefit. • Temporomandibular Joint Dysfunction (TMD) care, except as described in the Plan's *Benefit Handbook*. • Extraction of teeth, except when specifically listed as a Covered Benefit. • Pediatric dental care, except when specifically listed as a Covered Benefit.
Durable Medical Equipment and Prosthetic Devices
• Any devices or special equipment needed for sports or occupational purposes. • Any home adaptations, including, but not limited to home improvements and home adaptation equipment. • Non-durable medical equipment, unless used as part of the treatment at a medical facility or as part of approved Home Health Care services. • Repair or replacement of durable medical equipment or prosthetic devices as a result of loss, negligence, willful damage, or theft.
Experimental, Unproven, or Investigational Services
• Any products or services, including, but not limited to, drugs, devices, treatments, procedures, and diagnostic tests that are Experimental, Unproven, or Investigational. • Novel gene therapy drugs or new to market reformulations or expansions of existing gene therapies that are approved by the FDA through its Accelerated Approval Program or other similar accelerated review pathway are excluded from coverage for a period of time from the date of FDA approval, see the glossary definition of "Experimental, Unproven, or Investigational" for more information.
Foot Care
• Foot orthotics, except for the treatment of severe diabetic foot disease or systemic circulatory disease. • Routine foot care. Examples include nail trimming, cutting or debriding and the cutting or removal of corns and calluses. This exclusion does not apply to preventive foot care for Members diagnosed with diabetes or systemic circulatory disease.
Maternity Services
• Planned home births. • Services provided by a doula. • If you are covered under an HMO Plan, routine pre-natal and post-partum care when you are traveling outside the Service Area.
Physical Appearance
• Cosmetic Services, including drugs, devices, treatments and procedures, except for (1) Cosmetic Services that are incidental to the correction of Physical Functional Impairment, (2) restorative surgery to repair or restore appearance damaged by an accidental injury, (3) post-mastectomy care, and (4) gender affirming procedures and related services. • Electrolysis or laser hair removal, except for what is Medically Necessary as part of gender affirming services. • Hair removal or restoration, including, but not limited to, transplantation or drug therapy. • Liposuction, except for what is Medically Necessary as part of gender affirming services, or removal of fat deposits considered undesirable. • Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures). • Skin abrasion procedures performed as a treatment for acne. • Treatments and procedures related to appearance including but not limited to,

Exclusion
abdominoplasty; chemical peels; collagen injections; dermabrasion; implantations (e.g. cheek, calf, pectoral, gluteal); lip reduction/enhancement; panniculectomy; removal of redundant skin; and silicone injections (e.g. for breast enlargement), except for what is Medically Necessary as part of gender affirming services or another Covered Benefit. • Treatment for skin wrinkles and skin tags or any treatment to improve the appearance of the skin. • Treatment for spider veins. • Wigs and scalp hair prostheses when hair loss is due to male pattern baldness, female pattern baldness, or natural or premature aging.
Procedures and Treatments
• Care by a chiropractor outside the scope of standard chiropractic practice, including but not limited to, surgery, prescription or dispensing of drugs or medications, internal examinations, obstetrical practice, or treatment of infections and diagnostic testing for chiropractic care other than an initial X-ray. • Spinal manipulative therapy (including care by a chiropractor), except when specifically listed as a Covered Benefit. • Commercial diet plans, weight loss programs and any services in connection with such plans or programs, except as provided in the Benefit Handbook under Wellness Reimbursement Benefits. **Please note**: If you have coverage through an employer group plan, your employer may participate in other wellness and health improvement incentive programs offered by Harvard Pilgrim. Please review all your Plan documents for the amount of incentives, if any, available under your Plan. • Nutritional or cosmetic therapy using vitamins, minerals or elements, and other nutrition-based therapy. Examples include supplements, electrolytes, and foods of any kind (including high protein foods and low carbohydrate foods). • Services for Members who are donors for non-members, except as described under Human Organ Transplant Services. • Testing for central auditory processing. • Group diabetes training, educational programs or camps.
Providers
• Charges for services which were provided after the date on which your membership ends. • Charges for any products or services, including, but not limited to, professional fees, medical equipment, drugs, and hospital or other facility charges, that are related to any care that is not a Covered Benefit. • Charges for missed appointments. • Concierge service fees. (See the Plan's *Benefit Handbook* for more information.) • Follow-up care after an emergency room visit, unless provided by a Plan Provider and/or arranged by your PCP when required under your Plan. • 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 for a Member of the Plan. • Any reproductive related services or drugs for Members who are not medically infertile, except when specifically listed as a Covered Benefit. • Infertility drugs if: (1) a Member is not in a Plan authorized cycle of infertility treatment, or (2) infertility services are not a Covered Benefit. • Intrauterine Insemination (IUI) services provided in the home. • Infertility treatment and birth control drugs, implants and devices. This exclusion may apply when coverage is provided by a religious diocese, as allowed by law. • Reversal of voluntary sterilization (including any services for infertility related to voluntary sterilization or its reversal). • Sperm collection, freezing and storage except as described in the Plan's *Benefit Handbook*. • Sperm identification when not Medically Necessary (e.g., gender identification). • The following fees: wait list fees, non-medical costs, shipping and handling charges etc. • Voluntary sterilization, including tubal ligation and vasectomy, except when specifically listed as a Covered Benefit. • Voluntary termination of pregnancy. This exclusion may apply when an employer is a church or church controlled organization, as allowed by law.
Services Provided Under Another Plan
• Costs for any services for which you are entitled to treatment at government expense, including military service connected disabilities. • Costs for services for which payment is required to be made by a Workers' Compensation plan or an Employer under state or federal law.
Telemedicine Services
• Telemedicine services involving e-mail or fax. • Provider fees for technical costs for the provision of telemedicine services.
Types of Care
• Acute Home Care or Long-term Home Health Care services. • Custodial Care. • Recovery programs including rest or domiciliary care, sober houses, transitional support services, and therapeutic communities. • All institutional charges over the semi-private room rate, except when a private room is Medically Necessary. • Pain management programs or clinics. • Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, and diversion or general motivation, except as provided in the Plan's Benefit Handbook under Wellness Reimbursement Benefits. • Private duty nursing. • Vocational rehabilitation,

Exclusion
or vocational evaluations on job adaptability, job placement, or therapy to restore function for a specific occupation.
Vision and Hearing
• Eyeglasses, contact lenses and fittings, except when specifically listed as a Covered Benefit. • Hearing aid batteries, and any device used by individuals with hearing impairment to communicate over the telephone or internet, such as TTY or TDD. • Over the counter hearing aids. • Refractive eye surgery, including, but not limited to, lasik surgery, orthokeratology and lens implantation for the correction of naturally occurring myopia, hyperopia and astigmatism. • Routine eye examinations, except when specifically listed as a Covered Benefit.
All Other Exclusions
• Any service or supply furnished in connection with a non-Covered Benefit. • Any service or supply (with the exception of contact lenses) purchased from the internet. • Any service, supply or medication when there is a less intensive Covered Benefit or more cost-effective alternative that can be safely and effectively provided, in accordance with applicable Medical Necessity Guidelines. • Any service, supply or medication, including physical examinations and testing, required by a third party that is not otherwise Medically Necessary (examples of a third party are an employer, an insurance company, a school, a camp, or court). • Beauty or barber service. • Cost of organs that are sold rather than donated to recipients. • Diabetes equipment replacements when solely due to manufacturer warranty expiration. • Digital therapeutics. • Donated or banked breast milk, except as specifically listed under the "*Hospital-Inpatient Services*" benefit in the Benefit Handbook. • 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. • 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 or prescribed for Members who meet HPHC policies for enteral nutrition or tube feedings. • Medical equipment, devices or supplies except as described in the Plan's *Benefit Handbook*. • Medical, mental health, or substance use disorder treatment services that are (1) provided to Members who are confined or committed to jail, house of correction, prison, or custodial facility of the Department of Youth Services or (2) provided by the Department of Mental Health. • Any of the following types of programs: programs in which the patient has a pre-defined duration of care without the Plan's ability to conduct concurrent determinations of continued medical necessity, programs that only provide meetings or activities not based on individualized treatment plans, programs that focus solely on interpersonal or other skills rather than directed toward symptom reduction and functional recovery related to specific mental health disorders, and tuition based programs that offer educational, vocational, recreational, or personal developmental activities. • New-to-market prescription drugs until reviewed by the Plan, which will be the earlier of December 31st of the following calendar year or as required by law. • Reimbursement for travel expenses. • Services for non-Members. • Services for which no coverage is provided in the Plan's *Benefit Handbook*, this Schedule of Benefits, or the Prescription Drug Brochure. • Services provided under an individualized education program (IEP), including any services provided under an IEP that are delivered by school personnel or any services provided under an IEP purchased from a contractor or vendor. • Services that are not Medically Necessary. • Services your PCP or a Plan Provider has not provided, arranged or approved when required under your Plan. • 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. • 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. • Stair lifts and stair glides. • Strollers. • Safety equipment. • Vehicle modifications including but not limited to van lifts. • Telephone. • Television.

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

Harvard Pilgrim Health Care

a Point32Health company

Language Assistance Services

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

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

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

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

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

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

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

Khmer (ភាសាខ្មែរ) ប្រសិនបើអ្នក កនិយាយភាសាបរទេសផ្សេងក្រៅពីភាសាអង់គ្លេស បសវាកម្មជំនួ យភាសា ដលែគតលិតថ្លៃ លើអាចរកបានសម្រាអ្នក ។ សូ ម្មបាល់ទៅកាន់បលខបាប លើ ID គាតសាជិការស់អ្នក ។

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

Lao (ພາສາລາວ) ກະລຸນາ ຮັບຊາບ: ຖ້າ ທ່ານເວົ້າພາສາອື່ນທີ່ບ່ແ ມ່ນພາສາ ອັງກດ, ທ່ານສາມາດໃຊ້ບໍລການບ້ດານພາສາ ໄ ດ້ ໂດຍ່ບ່ເສ ຍ ຄ່າ. ກະລຸນາໂທຫາເບີ້ ຢ ໃນ ບັດປະຈໍາ ຕົວສະມາຊິກຂອງ ທ່ານ.

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

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

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

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

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

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

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

Continued on next page

General Notice About Nondiscrimination and Accessibility Requirements

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

HPHC:

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

If you need these services, contact our Civil Rights Compliance Officer (see below for contact information).

If you believe that HPHC has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex (including pregnancy, sexual orientation and gender identity) you can file a grievance with:

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

866-750-2074, TTY service: 711
Fax: 617-668-2754
Email: **OCRCoordinator@point32health.org**

You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, the Civil Rights Compliance Officer is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201

800-368-1019, 800-537-7697 (TDD)

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

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

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