# Schedule of Benefits

## Harvard Pilgrim Health Care, Inc.

## Clear Choice HMO Silver 3500

MAINE

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

In a Medical Emergency, you should go to the nearest emergency facility or call 911 or other local emergency access number. A Referral from your PCP is not needed. Your emergency room Member Cost Sharing is listed in the tables below.

### Medical Necessity Guidelines

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

### Office Visit Cost Sharing Levels

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

Level 1 applies to covered outpatient professional services received from the following types of providers: all Primary Care Providers (PCPs); obstetricians and gynecologists; licensed mental health professionals; certified Nurse midwives; and Nurse practitioners who bill independently.

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

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

### Covered Benefits

Your Covered Benefits are administered on a Calendar Year basis. Your Member Cost Sharing will depend upon the type of service provided and the location the service is provided in, as listed in this Schedule of Benefits. For example, for services provided in a Physician's office, see "Physician and Other Professional Office Visits." For services provided in a Hospital emergency room, see "Emergency Room Care." For inpatient hospital care, see "Hospital - Inpatient Services," and for outpatient surgical procedures, please see "Surgery - Outpatient."

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

| General Cost Sharing Features: | Member Cost Sharing: |
|---|---|
| **Coinsurance and Copayments** | |
| | See the benefits table below |
| **Deductible** | |
| | $3,500 per Member per Calendar Year<br>$7,000 per family per Calendar Year |
| **Important Notice**: If a family Deductible applies, it can be met in one of two ways: a. If a Member of a covered family meets an individual Deductible, then that Member has no additional Deductible Member Cost Sharing responsibilities for Covered Benefits for the remainder of the Calendar Year. b. If any number of Members in a covered family collectively meets a family Deductible, then all Members in that covered family have no additional Deductible Member Cost Sharing responsibilities for Covered Benefits for the remainder of the Calendar Year. | |
| **Deductible Rollover** | |
| None | |
| **Out-of-Pocket Maximum** | |
| Includes all Member Cost Sharing | $8,500 per Member per Calendar Year<br>$17,000 per family per Calendar Year |

| Benefit: | Your Cost Sharing: |
|---|---|
| **Acupuncture Treatment** | |
| | $40 Copayment per visit |
| **Ambulance and Medical Transport** | |
| Emergency ambulance transport | Deductible, then 30% Coinsurance |
| Non-emergency medical transport | Deductible, then 30% Coinsurance |
| **Autism Spectrum Disorders Treatment** | |
| Applied behavior analysis | No Member Cost Sharing for your first office visit per Calendar Year with a licensed mental health professional. After the first visit, the following cost sharing applies:<br>$40 Copayment per visit |
| Copayments for outpatient mental health services, including mental health services in the home, will accumulate toward the Deductible. | |
| **Chemotherapy and Radiation Therapy** | |
| Chemotherapy | Deductible, then 30% Coinsurance |
| Radiation therapy | Deductible, then 30% Coinsurance |
| **Chiropractic Care** | |
| | $40 Copayment per visit |

| Benefit: | Your Cost Sharing: |
|---|---|
| **Clinical Trials** | |
| | Your Member Cost Sharing will depend upon the types of services provided, 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 inpatient Hospital care, see "Hospital – Inpatient Services." |
| **Dental Services** | |
| **Important Notice:** Coverage of Dental Care is very limited. Please see your Benefit Handbook for the details of your coverage. | |
| Emergency Dental Care (within six months of injury or within six months of the effective date of coverage, whichever is later)<br>Other dental services, including setting a jaw fracture and removing a tumor (but not a root cyst)<br>General anesthesia for dentistry | Your Member Cost Sharing will depend upon the types of services provided, 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 inpatient Hospital care, see "Hospital – Inpatient Services." |
| Extraction of teeth impacted in bone (performed in a Physician's office) | Deductible, then 30% Coinsurance |
| **Dialysis** | |
| Dialysis services, including dialysis training | Deductible, then 30% Coinsurance |
| **Durable Medical Equipment** | |
| Durable medical equipment, including orthotic devices as described in the Benefit Handbook | Deductible, then 30% Coinsurance |
| Blood glucose monitors, infusion devices, and insulin pumps (including supplies) | No charge |
| Oxygen and respiratory equipment | No charge |
| **Early Intervention Services (for Members up to the age of 3)** | |
| – Limited to 40 visits per Calendar Year | $40 Copayment per visit |
| **Emergency Room Care** | |
| | Deductible, then 30% Coinsurance |
| **Fertility Treatment (see the Benefit Handbook for details)** | |
| | Deductible, then 20% Coinsurance |
| **Hearing Aids** | |
| For Members up to age 19:<br>– Limited to 1 hearing aid per hearing impaired ear every 36 months<br>For all other Members:<br>– Limited to $3,000 per hearing aid every 36 months, for each hearing impaired ear | Deductible, then 50% Coinsurance |
| **Home Health Care** | |
| Including infusion therapy and nutritional counseling | Deductible, then 30% Coinsurance |

| Benefit: | Your Cost Sharing: |
|---|---|
| If services include the administration of drugs, please see the benefit for "Medical Drugs" for Member Cost Sharing details. | |
| **Hospice Services** | |
| | Deductible, then 30% Coinsurance |
| If inpatient services or respite care are required, please see "Hospital – Inpatient Services" for Member Cost Sharing details. | |
| **Hospital – Inpatient Services** | |
| Acute Hospital care, including bariatric surgery, blood transfusions, infusion therapy, inhalation therapy, organ or tissue transplants and breast reduction surgery and symptomatic varicose vein surgery | Deductible, then 30% Coinsurance |
| Inpatient maternity care | Deductible, then 30% Coinsurance |
| Inpatient routine nursery care | No charge |
| Inpatient rehabilitation – limited to 150 days per Calendar Year<br>Inpatient rehabilitation and skilled nursing facility care limits are combined | Deductible, then 30% Coinsurance |
| Skilled nursing facility care – limited to 150 days per Calendar Year<br>Inpatient rehabilitation and skilled nursing facility care limits are combined | Deductible, then 30% Coinsurance |
| **Laboratory, Radiology and Other Diagnostic Services (including Independent Laboratories and Freestanding Imaging Centers)** | |
| Laboratory, including but not limited to human leukocyte antigen testing as described in the Benefit Handbook | **In a Physician's office or non-Hospital affiliated facility:**<br>$15 Copayment per visit<br>**In a Hospital or Hospital affiliated facility:**<br>Deductible, then 30% Coinsurance |
| Genetic testing | Deductible, then 30% Coinsurance |
| Radiology | Deductible, then 30% Coinsurance |
| Breast ultrasound screening | No charge |
| Advanced radiology, including CT scans, PET scans, MRI, MRA and nuclear medicine services | **In a Physician's office or non-Hospital affiliated facility:**<br>$250 Copayment per visit<br>**In a Hospital or Hospital affiliated facility:**<br>Deductible, then 30% Coinsurance |
| Breast MRI screening | No charge |
| Other diagnostic services (including allergy testing) | Deductible, then 30% Coinsurance |

| Benefit: | Your Cost Sharing: |
|---|---|
| **Low Protein Foods** | |
| | Deductible, then 30% Coinsurance |
| **Maternity Care - Outpatient** | |
| Routine outpatient prenatal and postpartum care | No charge |
| Routine prenatal and postpartum care is usually received and billed from the same Provider as a single or bundled service. Different Member Cost Sharing may apply to any specialized or non-routine service that is billed separately from your routine outpatient prenatal and postpartum care. For example, Member Cost Sharing for services provided by a specialist is listed under "Physician and Other Professional Office Visits" and Member Cost Sharing for an ultrasound billed as a specialized or non-routine service is listed under "Laboratory, Radiology and Other Diagnostic Services (including Independent Laboratories and Freestanding Imaging Centers)." | |
| **Medical Drugs (drugs that cannot be self-administered)** | |
| Medical drugs, including infusion therapy, received in a Physician's office or other outpatient facility | Deductible, then 30% Coinsurance |
| Medical drugs, including infusion therapy, received in the home | Deductible, then 30% Coinsurance |
| Some Medical Drugs may be supplied by a specialty pharmacy. When Medical Drugs are supplied by a specialty pharmacy, the Member Cost Sharing listed above will apply. | |
| **Medical Formulas and Donor Breast Milk** | |
| State mandated formulas and donor breast milk | Deductible, then 30% Coinsurance |
| **Mental Health and Substance Use Disorder Treatment** | |
| Inpatient Services | Deductible, then 30% Coinsurance |
| Intermediate services including acute residential treatment, partial hospitalization, and intensive outpatient programs | Deductible, then 30% Coinsurance |
| Outpatient group therapy | No Member Cost Sharing for your first office visit per Calendar Year with a licensed mental health professional. After the first visit, the following cost sharing applies:<br>$10 Copayment per visit |
| Mental health services in the home | No Member Cost Sharing for your first office visit per Calendar Year with a licensed mental health professional. After the first visit, the following cost sharing applies:<br>$40 Copayment per visit |
| Outpatient treatment, including individual therapy, detoxification and medication management | No Member Cost Sharing for your first office visit per Calendar Year with a licensed mental health professional. After the first visit, the following cost sharing applies:<br>$40 Copayment per visit |
| Outpatient methadone maintenance | No charge |

| Benefit: | Your Cost Sharing: |
|---|---|
| Outpatient psychological testing and neuropsychological assessment | No Member Cost Sharing for your first office visit per Calendar Year with a licensed mental health professional. After the first visit, the following cost sharing applies:<br>$40 Copayment per visit |
| Outpatient telemedicine virtual visit – group therapy | No Member Cost Sharing for your first office visit per Calendar Year with a licensed mental health professional. After the first visit, the following cost sharing applies:<br>$10 Copayment per visit |
| Outpatient telemedicine virtual visit – including individual therapy, detoxification, and medication management | No Member Cost Sharing for your first office visit per Calendar Year with a licensed mental health professional. After the first visit, the following cost sharing applies:<br>$40 Copayment per visit |
| Copayments for outpatient mental health services, including mental health services in the home, will accumulate toward the Deductible. | |
| **Observation Services** | |
| | Deductible, then 30% Coinsurance |
| **Ostomy Supplies** | |
| | Deductible, then 30% Coinsurance |
| **Physician and Other Professional Office Visits (This includes all covered Plan Providers unless otherwise listed in this Schedule of Benefits.)** | |
| Routine examinations, including annual gynecological exams, for preventive care, including immunizations and annual digital rectal exams | No charge |
| Not all services you receive during your routine exam are covered at no charge. Only preventive services designated under the Patient Protection and Affordable Care Act (PPACA) are covered at no charge. Other services not included under PPACA may be subject to additional cost sharing. For the current list of preventive services covered at no charge under PPACA, please see the Preventive Services Notice on our website at **www.harvardpilgrim.org.** Please see "Laboratory, Radiology and Other Diagnostic Services (including Independent Laboratories and Freestanding Imaging Centers)," for the Member Cost Sharing that applies to diagnostic services not included on this list. | |
| Consultations, evaluations, and Sickness and injury care, including nutritional counseling | **PCP:**<br>No Member Cost Sharing for the first visit per Calendar Year with a PCP. After the first visit, the following cost sharing applies:<br>Level 1: $40 Copayment per visit<br>**All Other Providers:**<br>Level 1: $40 Copayment per visit<br>Level 2: $60 Copayment per visit |

| **Benefit:** | **Your Cost Sharing:** |
|---|---|
| Copayments for office visits with a PCP will accumulate toward the Deductible.<br>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 (including Independent Laboratories and Freestanding Imaging Centers)." | |
| Office based treatments and procedures, including but not limited to administration of injections, casting, suturing, the application of dressings, inhalation therapy, non-routine foot care, and surgical procedures | Deductible, then 30% Coinsurance |
| Administration of allergy injections | $40 Copayment per visit |
| **Preventive Services and Tests** | |
| | No charge |
| Under Federal and state law, many preventive services and tests are covered with no Member Cost Sharing, including preventive colonoscopies, (even if polyp removal or other necessary medically necessary procedure is required), screening mammograms (including a second screening in the event that the initial screening is inconclusive or an abnormality is discovered), pap tests, certain labs and x-rays voluntary sterilization for women and all FDA approved contraceptive devices. For a complete list of covered preventive services, please see the Preventive Services Notice on our website at **www.harvardpilgrim.org.** You may also get a copy of the Preventive Services Notice by calling the Member Services Department at **1-888-333-4742** if you are covered under an Employer Group plan or **1-877-907-4742** if you are covered under an individual Member plan. Harvard Pilgrim will add or delete services from this benefit for preventive services and tests in accordance with Federal and state guidance. | |
| The following additional preventive services, tests and devices: alpha-fetoprotein (AFP), fetal ultrasound, hepatitis C testing, lead level testing, prostate-specific antigen (PSA) screening, routine hemoglobin tests, group B streptococcus (GBS), routine urinalysis, blood pressure monitor, retinopathy screening, and international normalized ratio (INR) testing. | No charge |
| **Prosthetic Devices** | |
| Prosthetic devices (other than arms and legs) | Deductible, then 30% Coinsurance |
| Prosthetic arms and legs | Deductible, then 20% Coinsurance |
| **Rehabilitation and Habilitation Services - Outpatient** | |
| Cardiac rehabilitation – limited to 36 visits per cardiac episode | $60 Copayment per visit |
| Pulmonary rehabilitation therapy | $60 Copayment per visit |

| Benefit: | Your Cost Sharing: |
|---|---|
| Occupational therapy<br>**Rehabilitation Services (including treatment for head injuries)** – limited to 60 visits per Calendar Year<br>**Habilitation Services (including treatment for head injuries)** – limited to 60 visits per Calendar Year<br>Occupational, physical, and speech therapy limits are combined | $40 Copayment per visit |
| Physical therapy<br>**Rehabilitation Services (including treatment for head injuries)** – limited to 60 visits per Calendar Year<br>**Habilitation Services (including treatment for head injuries)** – limited to 60 visits per Calendar Year<br>Occupational, physical, and speech therapy limits are combined | $40 Copayment per visit |
| Speech therapy<br>**Rehabilitation Services (including treatment for head injuries)** – limited to 60 visits per Calendar Year<br>**Habilitation Services (including treatment for head injuries)** – limited to 60 visits per Calendar Year<br>Occupational, physical, and speech therapy limits are combined | $40 Copayment per visit |
| Outpatient physical, occupational and speech therapies are covered to the extent Medically Necessary for: (1) children up to the age of three and (2) the treatment of Autism Spectrum Disorders.<br>Outpatient physical therapy for postpartum related pelvic floor disorders is not subject to visit limits. | |
| **Scopic Procedures - Outpatient Diagnostic and Therapeutic** | |
| Colonoscopy, endoscopy and sigmoidoscopy | **In a non-Hospital affiliated facility:**<br>$300 Copayment per visit<br>**In a Hospital or Hospital affiliated facility:**<br>Deductible, then 30% Coinsurance |
| **Surgery – Outpatient** | |
| | **In a non-Hospital affiliated facility:**<br>$300 Copayment per visit<br>**In a Hospital or Hospital affiliated facility:**<br>Deductible, then 30% Coinsurance |
| **Telemedicine Virtual Visit Services - Outpatient** | |
| | **PCP:**<br>No Member Cost Sharing for the first visit per Calendar Year with a PCP. After the first visit, the following cost sharing applies:<br>Level 1: $40 Copayment per visit<br>**All Other Providers:**<br>Level 1: $40 Copayment per visit<br>Level 2: $60 Copayment per visit |

| Benefit: | Your Cost Sharing: |
|---|---|
| Copayments for office visits with a PCP will accumulate toward the Deductible.<br>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 (retail health clinic) | $40 Copayment per visit |
| Urgent care center | $40 Copayment per visit |
| Hospital urgent care center | $40 Copayment per visit |
| 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 (including Independent Laboratories and Freestanding Imaging Centers)." | |
| **Vision Services** | |
| Urgent eye care | **PCP:**<br>No Member Cost Sharing for the first visit per Calendar Year with a PCP. After the first visit, the following cost sharing applies:<br>Level 1: $40 Copayment per visit<br>**All Other Providers:**<br>Level 1: $40 Copayment per visit<br>Level 2: $60 Copayment per visit |
| Copayments for office visits with a PCP will accumulate toward the Deductible. | |
| Routine adult eye examinations<br>– limited to 1 exam per Calendar Year | $40 Copayment per visit |
| Routine pediatric eye examinations<br>– limited to 1 exam per Calendar Year | $40 Copayment per visit |
| Vision hardware for special conditions | 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 30% Coinsurance |
| **Voluntary Termination of Pregnancy – Outpatient** | |
| | No charge |

## 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 24 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 $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 and lenticular lenses. Coverage is excluded for lenses larger than 55mm and upgrades such as tints, scratch proofing and progressive lenses. 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 $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.

## 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.

## HOW TO RECEIVE REIMBURSEMENT FOR THE PEDIATRIC VISION CARE BENEFIT

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

**ID: DN0000201189**
**DATE: 01/01/2025**

# Pediatric Dental Rider - HMO

## Harvard Pilgrim Health Care, Inc.

(for children up to the age of 19)
MAINE

The pediatric dental rider identifies the Covered Dental Services as described below for Dependents up to the age of 19 enrolled in the HMO plan (the Plan). Coverage under this rider terminates at the end of the month in which the Dependent reaches the age of 19.

Because this rider is part of your Evidence of Coverage and is a legal document, we want to give you information about the document that will help you understand it. Certain capitalized words have special meanings. We have defined these words in either the *Benefit Handbook* in *Section II: Glossary* or in this rider in *Section 5: Defined Terms for Pediatric Dental Services*.

When we use the words "we," "us," and "our" in this document, we are referring to Harvard Pilgrim Health Care. When we use the words "you" and "your" we are referring to people who are Dependents, as the term is defined in the *Benefit Handbook* in *Section II: Glossary.*

### SECTION 1: ACCESSING PEDIATRIC DENTAL SERVICES

#### Network Benefits

These Covered Benefits apply when you choose to obtain Covered Dental Services from a Plan Dental Provider. You generally are required to pay less to the provider than you would pay for services from a Non-Plan Dental Provider. Network Benefits are determined based on the contracted fee for each Covered Dental Service. In no event, will you be required to pay a Plan Dental Provider an amount for a Covered Dental Service in excess of the contracted fee.

In order for Covered Dental Services to be paid as In-Network Benefits, you must obtain all Covered Dental Services directly from or through a Plan Dental Provider.

You must always verify the participation status of a Plan Dental Provider prior to seeking services. From time to time, the participation status of a provider may change. You can verify the participation status by calling us and/or the provider. If necessary, we can provide assistance in referring you to a Plan Dental Provider.

A *Directory of Network Dental Providers* is available online at **https://www.harvardpilgrim.org/public/pediatric-dental-coverage**. You can also call *Customer Service* at **1-800-460-0315** to determine which providers participate in the Network. The telephone number for *Customer Service* is also listed on your ID card.

#### Non-Plan Dental Providers

If you are unable to find a Plan Dental Provider to render your care, you can obtain Covered Dental Services from a Non-Plan Dental Provider. Non-Plan Dental Providers are reimbursed at the Usual and Customary fee for similarly situated Plan Dental Providers for each Covered Dental Service. The actual charge made by a Non-Plan Dental Provider for a Covered Dental Service may exceed the Usual and Customary fee. As a result, you may be required to pay a Non–Plan Dental Provider an amount for a Covered Dental Service in excess of the Usual and Customary fee. In addition, when you obtain Covered Dental Services from Non-Plan Dental Providers, you must file a claim with us to be reimbursed for Eligible Dental Expenses.

Covered Dental Services received from a Dental Provider outside the United States will be reimbursed at the same level as a Non-Plan Dental Provider.

### Covered Dental Services

You are eligible for Covered Dental Services listed in this rider. Dental Services must be Medically Necessary and provided by or under the direction of a Dental Provider.

The fact that a Dental Provider has performed or prescribed a procedure or treatment, or the fact that it may be the only available treatment, for a dental disease does not mean that the procedure or treatment is a Covered Dental Service.

### Pre-Treatment Estimate

We will provide you with a pre-treatment estimate if:

- The charge for a Dental Service is expected to exceed $300 or
- If a dental exam reveals the need for fixed bridgework.

You or your Dental Provider should send a notice to us, via claim form, within 20 calendar days of the exam. If requested, the Dental Provider must provide us with dental x-rays, study models or other information necessary to evaluate the treatment plan for purposes of benefit determination.

We will determine if the proposed treatment is a Covered Dental Service and will estimate the amount of payment. The estimate will be sent to the Dental Provider and will be subject to all terms, conditions and provisions of the Policy. Clinical situations that can be effectively treated by a less costly, clinically acceptable alternative procedure will be assigned a benefit based on the less costly procedure.

A pre-treatment estimate is not an agreement to pay for expenses. This procedure lets you know in advance approximately what portion of the expenses will be considered for payment.

### Pre-Authorization

Pre-authorization is required for all Orthodontic Services. Speak to your Dental Provider about obtaining a pre-authorization before Dental Services are rendered. You or your Dental Provider can request pre-authorization for these services by contacting us at **1-800-460-0315**. If you do not obtain a pre-authorization, we have a right to deny your claim.

You will be responsible for payment of any dental treatment not approved by us. Conditions that can be effectively treated by a less costly, clinically acceptable alternative procedure will be assigned a Benefit based on the less costly procedure.

## SECTION 2: BENEFITS FOR PEDIATRIC DENTAL SERVICES

Covered Benefits are provided for the Dental Services stated in this Section when such services are:

A. Necessary.

B. Provided by or under the direction of a Dental Provider.

C. The least costly clinically appropriate service. Conditions that can be treated by a less costly, clinically appropriate alternative procedure will be covered based on the least costly procedure.

D. Not excluded as described in *Section 3: Pediatric Dental Services exclusions* of this rider.

### Benefits

Dental Services Deductibles are calculated on a Calendar Year basis.

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

| Benefit Description and Limitations | Your Cost Sharing |
|---|---|
| **TYPE I SERVICES: *PREVENTIVE & DIAGNOSTIC BASIC COVERED SERVICES*** | |
| **Diagnostic Services** | |
| Intraoral Bitewing Radiographs (Bitewing X-ray)<br>– Limited to 1 set every 6 months | No charge |
| Panorex Radiographs (Full Jaw X-ray) or Complete Series Radiographs (Full Set of X-rays)<br>– Limited to 1 film every 60 months | No charge |
| Periodic Oral Evaluation (Check up Exam)<br>– Limited to 1 every 6 months | No charge |
| **Preventive Services** | |
| Dental Prophylaxis (Cleanings)<br>– Limited to 1 every 6 months | No charge |
| Fluoride Treatments<br>– Limited to 2 treatments per 12 months | No charge |
| Sealants (Protective Coating)<br>– Limited to 1 sealant per tooth every 36 months | No charge |
| Space Maintainers | No charge |
| **TYPE II SERVICES: *MINOR RESTORATIVE COVERED SERVICES*** | |
| **Minor Restorative Services, Endodontics, Periodontics, and Oral Surgery** | |
| Amalgam Restorations (Silver Fillings) | Deductible, then 20% Coinsurance |
| Composite Resin Restorations (Tooth Colored Fillings)<br>– For anterior (front) teeth only | Deductible, then 20% Coinsurance |
| Endodontics (Root Canal Therapy) performed on anterior or posterior primary teeth<br>– Limited to once per tooth per lifetime | Deductible, then 20% Coinsurance |
| Relining and Rebasing Dentures<br>– Limited to relining/rebasing performed more than 6 months after the initial insertion. Limited to once per 36 months | Deductible, then 20% Coinsurance |
| Repairs or Adjustments to Full Dentures, Partial Dentures, Bridges, or Crowns | Deductible, then 20% Coinsurance |

| Benefit Description and Limitations | Your Cost Sharing |
|---|---|
| Scaling and Root Planing (Deep Cleanings)<br>– Limited to once per quadrant per 24 months | Deductible, then 20% Coinsurance |
| Periodontal Maintenance (Gum Maintenance)<br>– Limited to 4 times per 12 month period following completion of active periodontal therapy | Deductible, then 20% Coinsurance |
| Simple Extractions (Simple tooth removal) | Deductible, then 20% Coinsurance |
| Oral Surgery, including Surgical Extraction | Deductible, then 20% Coinsurance |
| **Adjunctive Services** | |
| General Services (including medications, Emergency Treatment of dental pain, and post surgical services)<br><br>General anesthesia is covered when clinically necessary | Deductible, then 20% Coinsurance |
| **TYPE III SERVICES: *MAJOR RESTORATIVE SERVICES*** | |
| Inlays/Onlays/Crowns (Partial to Full Crowns)<br>– Limited to once per tooth per 60 months. Covered only when silver fillings cannot restore the tooth | Deductible, then 50% Coinsurance |
| Endodontics (root canal therapy) performed on anterior teeth, bicuspids, and molars<br>– Limited to once per tooth per lifetime | Deductible, then 50% Coinsurance |
| Endodontic Surgery | Deductible, then 50% Coinsurance |
| Fixed Prosthetics (Bridges)<br>– Limited to 1 per tooth per 60 months | Deductible, then 50% Coinsurance |
| Occlusal guards for Members age 13 and older<br>– Limited to 1 guard per 12 months | Deductible, then 50% Coinsurance |
| Periodontal Surgery (Gum Surgery)<br>– Limited to 1 quadrant or site per 36 months per surgical area | Deductible, then 50% Coinsurance |
| Removable Prosthetics (Full or partial dentures)<br>– Limited to 1 per 60 months. | Deductible, then 50% Coinsurance |
| Relining and Rebasing Dentures<br>– Limited to relining/rebasing performed more than 6 months after the initial insertion. Limited to once per 36 months | Deductible, then 50% Coinsurance |

| Benefit Description and Limitations | Your Cost Sharing |
|---|---|
| **Implants** | |
| Implant Placement<br>– Limited to once per 60 months<br><br>Implant Supported Prosthetics<br>– Limited to once per 60 months<br><br>Implant Maintenance Procedures<br>– Limited to once per 60 months<br><br>Repair Implant Supported Prosthesis by Report<br>– Limited to once per 60 months<br><br>Repair Implant Abutment by Support<br>– Limited to once per 60 months<br><br>Radiographic/Surgical Implant Index by Report<br>– Limited to once per 60 months | Deductible, then 50% Coinsurance |
| **TYPE IV SERVICES: *ORTHODONTIA*** | |
| **Orthodontic Services**<br><br>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. | |
| Benefits for comprehensive orthodontic treatment are approved, only in those instances that are related to an identifiable syndrome such as 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. Benefits are not available for comprehensive orthodontic treatment for crowded dentitions (crooked teeth), excessive spacing between teeth, temporomandibular joint (TMJ) conditions and/or having horizontal/vertical (overjet/overbite) discrepancies.<br><br>**Note:** All orthodontic treatment must be prior authorized. | Deductible, then 50% Coinsurance |

## SECTION 3: PEDIATRIC DENTAL EXCLUSIONS

### Exclusions

Except as may be specifically provided in this rider under *Section 2: Benefits for Covered Dental Services*, no benefits are provided under this rider for the following:

1. Any Dental Service or Procedure not listed as a Covered Dental Service in this rider in S*ection 2: Benefits for Covered Dental Services*.
2. Dental Services that are not Necessary.
3. Hospitalization or other facility charges.
4. Any Dental Procedure performed solely for cosmetic/aesthetic reasons. (Cosmetic procedures are those procedures that improve physical appearance.)
5. Reconstructive surgery, regardless of whether or not the surgery is incidental to a dental disease, Injury, or Congenital Anomaly, when the primary purpose is to improve physiological functioning of the involved part of the body.
6. Any Dental Procedure not directly associated with dental disease.
7. Any Dental Procedure not performed in a dental setting.
8. Procedures that are considered to be Experimental, Investigational, or Unproven Services. This includes pharmacological regimens not accepted by the *American Dental Association (ADA) Council on Dental Therapeutics*. The fact that an Experimental, Investigational, or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Covered Benefits if the procedure is considered to be Experimental, Investigational, or Unproven in the treatment of that particular condition.
9. Drugs/medications, obtainable with or without a prescription, unless they are dispensed and utilized in the dental office during the patient visit.
10. Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue.
11. Treatment of benign neoplasms, cysts, or other pathology involving benign lesions, except excisional removal. Treatment of malignant neoplasms or Congenital Anomalies of hard or soft tissue, including excision.
12. Replacement of complete dentures, fixed and removable partial dentures or crowns and implants, implant crowns and prosthesis if damage or breakage was directly related to provider error. This type of replacement is the responsibility of the Dental Provider. If replacement is Necessary because of patient non-compliance, the patient is liable for the cost of replacement.
13. Services related to the temporomandibular joint (TMJ), either bilateral or unilateral. Upper and lower jaw bone surgery (including that related to the temporomandibular joint). Orthognathic surgery, jaw alignment, and treatment for the temporomandibular joint.
14. Charges for failure to keep a scheduled appointment without giving the dental office 24 hours notice.
15. Expenses for Dental Procedures begun prior to the Dependent becoming enrolled for coverage provided through this rider to the Policy.
16. Dental Services otherwise covered under the Policy, but rendered after the date individual coverage under the Policy terminates, including Dental Services for dental conditions arising prior to the date individual coverage under the Policy terminates.
17. Services rendered by a provider with the same legal residence as a Dependent or who is a member of a Dependent's family, including spouse, brother, sister, parent or child.
18. Fixed or removable prosthodontic restoration procedures for complete oral rehabilitation or reconstruction.
19. Attachments to conventional removable prostheses or fixed bridgework. This includes semi-precision or precision attachments associated with partial dentures, crown or bridge abutments, full or partial overdentures, any internal attachment associated with an implant prosthesis, and any elective endodontic procedure related to a tooth or root involved in the construction of a prosthesis of this nature.

**Exclusions**

20. Procedures related to the reconstruction of a patient's correct vertical dimension of occlusion (VDO).
21. Occlusal guards used as safety items or to affect performance primarily in sports-related activities.
22. Placement of fixed partial dentures solely for the purpose of achieving periodontal stability.
23. Acupuncture; acupressure and other forms of alternative treatment, whether or not used as anesthesia.

## SECTION 4: APPEALS AND GRIEVANCES

### Appeals

If you are dissatisfied with a decision on our coverage of services, you may appeal. Appeals may also be filed by a Member's representative or a provider acting on a Member's behalf and must be received within 180 days of the initial denial. Our staff is available to assist you in filing an appeal. If you'd like assistance, please call *Customer Service* at **1-800-460-0315**.

To initiate your appeal, you or your representative should write a letter to us about the coverage you are requesting and why you feel it should be granted. Please be as specific as possible in your appeal request. We need all the important details in order to make a fair decision. Please send your request to the following address:

**Harvard Pilgrim Health Care**
**Attention: Appeals**
**P.O. Box 30569**
**Salt Lake City, UT 84130-0569**

You may also contact us at **1-800-460-0315** to initiate your appeal.

### Grievances

If you have a complaint about your care under the Plan or about our service, we want to know about it. For all grievances, please call or write to us at:

**Harvard Pilgrim Health Care**
**Attention: Grievances**
**P.O. Box 30569**
**Salt Lake City, UT 84130-0569**
**Telephone: 1-800-460-0315**

For additional information on the Appeals and Grievance process, please refer to your Benefit Handbook.

## SECTION 5: CLAIMS FOR PEDIATRIC DENTAL SERVICES

When obtaining Dental Services from a Non-Plan Dental Provider, you will be required to pay all billed charges directly to your Dental Provider. You may then seek reimbursement from us. Information about claim timelines and responsibilities listed below apply to Covered Dental Services provided under this rider, except that when you submit your claim, you must provide us with all of the information identified below.

### Reimbursement for Dental Services

You are responsible for sending a request for a claim for reimbursement (proof of loss) to our office, on a form provided by or satisfactory to us.

**Claim Forms**. It is not necessary to include a claim form with the proof of loss. However, the proof must include all of the following information:

- Dependent's name and address
- Dependent's identification number
- The name and address of the provider of the service(s)
- A diagnosis from the Dental Provider including a complete dental chart showing extractions, fillings or other Dental Services rendered before the charge was incurred for the claim.
- Radiographs, lab or hospital reports.
- Casts, molds or study models
- Itemized bill which includes the CPT or ADA codes or description of each charge.
- The date the dental disease began
- A statement indicating that you are or you are not enrolled for coverage under any other health or dental insurance plan or program. If you are enrolled for other coverage you must include the name of the other carrier(s).

If you would like to use a claim form, you can request one be mailed to you by calling *Customer Service* at **1-800-460-0315**. This number is also listed on your ID Card. If you do not receive the claim form within 15 calendar days of your request, send in the proof of loss with the information stated above.

Please mail your request for reimbursement to the following address:

**Claims – Harvard Pilgrim Health Care**
**P.O. Box 30567**
**Salt Lake City, UT 84130-0567**

Written proof of loss should be given to the Company within 90 days after the date of the loss. If it was not reasonably possible to give written proof in the time required, the Company will not reduce or deny the claim for this reason. However, proof must be filed as soon as reasonably possible, but no later than 1 year after the date of service.

## SECTION 6: DEFINED TERMS FOR PEDIATRIC DENTAL SERVICES

### Terms and Definitions

The following definitions are in addition to those listed in *Section II: Glossary of the Benefit Handbook*:

**Covered Dental Service** - a Dental Service or Dental Procedure for which Covered Benefits are provided under this rider.

**Dental Provider** - any dentist or dental practitioner who is duly licensed and qualified under the law of jurisdiction in which treatment is received to render Dental Services, perform dental surgery or administer anesthetics for dental surgery.

**Dental Service or Dental Procedures** - dental care or treatment provided by a Dental Provider to a Dependent up to the age of 19 while the Policy is in effect, provided such care or treatment is recognized by us as a generally accepted form of care or treatment according to prevailing standards of dental practice.

**Dental Services Deductible** - the amount a Dependent up to the age of 19 must pay for Covered Dental Services in a Calendar Year before we will begin paying for Covered Benefits in that year.

**Dental Services Out-of-Pocket Maximum** - a limit on the amount of Copayments, Coinsurance and Deductible's that you must pay for Covered Benefits in a Calendar Year

**Eligible Dental Expenses** - Eligible Dental Expenses for Covered Dental Services, incurred while the Policy is in effect, are determined as stated below:

## Terms and Definitions

- For Network Benefits, when Covered Dental Services are received from Plan Dental Providers, Eligible Dental Expenses are our contracted fee(s) for Covered Dental Services with that provider.
- For Non-Network Benefits, when Covered Dental Services are received from Non-Plan Dental Providers, Eligible Dental Expenses are the lesser of the Usual and Customary fees, as defined below or the billed charges.

**Necessary** - Dental Services and supplies under this rider which are determined by us through case-by-case assessments of care based on accepted dental practices to be appropriate and are all of the following:

- Necessary to meet the basic dental needs of the Dependent up to age 19.
- Rendered in the most cost-efficient manner and type of setting appropriate for the delivery of the Dental Service.
- Consistent in type, frequency and duration of treatment with scientifically based guidelines of national clinical, research, or health care coverage organizations or governmental agencies that are accepted by us.
- Consistent with the diagnosis of the condition.
- Required for reasons other than the convenience of the Dependent or his or her Dental Provider.
- Demonstrated through prevailing peer-reviewed dental literature to be either:
- Safe and effective for treating or diagnosing the condition or sickness for which their use is proposed; or
- Safe with promising efficacy
- For treating a life threatening dental disease or condition.
- Provided in a clinically controlled research setting.
- Using a specific research protocol that meets standards equivalent to those defined by the *National Institutes of Health*.

(For the purpose of this definition, the term life threatening is used to describe dental diseases or sicknesses or conditions, which are more likely than not to cause death within one year of the date of the request for treatment.)

The fact that a Dental Provider has performed or prescribed a procedure or treatment or the fact that it may be the only treatment for a particular dental disease does not mean that it is a Necessary Covered Dental Service as defined in this rider. The definition of Necessary used in this rider relates only to Benefits under this rider and differs from the way in which a Dental Provider engaged in the practice of dentistry may define necessary.

**Usual, Customary and Reasonable Charge** - Usual, Customary and Reasonable Charge is the maximum amount that we will pay for services from Dental Providers. The Usual, Customary and Reasonable Charge is calculated using the 80th percentile of provider reimbursement for services in the same geographic area under the FAIR Health database.

## Harvard Pilgrim Health Care
## Reduce My Costs Program
## Maine

### Reduce My Costs Program

As part of your plan, you and your dependents have the option of using the Reduce My Costs program. Reduce My Costs will help you identify lower cost Plan Providers for most outpatient services. If you choose to receive services from a lower cost Plan Provider suggested by Reduce My Costs, you may lower your own out-of-pocket costs and may earn a financial reward.

All providers suggested by Reduce My Costs are Harvard Pilgrim providers. They are the same providers available to you through our extensive provider network in Massachusetts, Maine, New Hampshire and Rhode Island. They all meet our credentialing and quality standards.

1. How does the Reduce My Costs Program work?
   If you are scheduled to receive an outpatient test or procedure, you can call Reduce My Costs at **(855-772-8366)**. You should call at the time your provider orders your test or procedure or soon thereafter. Although you may call about any outpatient service, please note that the following services are **not** included in the program: infertility services, mental health care, substance use disorder treatment, emergency care, prescription drugs, sleep studies and sleep therapies. If your service meets the minimum savings threshold, and lower cost Plan Providers are available in your area, you will be told who they are and how much your reward will be if you use a provider suggested by Reduce My Costs. The amount of the reward will range from $10 to $500 depending upon the type of services you receive.
2. What happens when I call Reduce My Costs?
   When you call Reduce My Costs, a nurse will provide you with information about the cost of Plan Providers available in your area. If you choose to obtain the services from a lower cost Plan Provider suggested by Reduce My Costs, they can make the necessary arrangements for your appointment with both the original provider and the new provider. After you receive services from the Plan Provider suggested by Reduce My Costs, they will send you the reward. Reduce My Costs will also work with you to review public sources of information about the quality of care of the providers they suggest.
3. Am I required to call Reduce My Costs?
   The Reduce My Costs program is completely voluntary. You do not have to call Reduce My Costs or use a lower cost Plan Provider they suggest. You may also choose to use the program for some services and not for others.
4. Where can I get more information?
   You can find additional information about the Reduce My Costs program, including the current list of services excluded from the program, on Harvard Pilgrim's web site at **www.harvardpilgrim.org**. You can also call the Member Services Department at **1-888-333-4742**.

The Reduce My Costs program is a health care cost savings program offered by Harvard Pilgrim and administered by Harlowe Health LLC. The Reduce My Costs program may be terminated by Harvard Pilgrim on January 1st of each year upon thirty (30) days' notice.

# General List of Exclusions
# **Harvard Pilgrim Health Care, Inc.** | MAINE

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, life 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 Plan Providers under the Plan. |
| **Clinical Trials** |
| Coverage is not provided for the following: • The investigational item, device, or service itself; or • For services, tests or items that are provided solely to satisfy data collection and analysis for the clinical trial and that are not used for the direct clinical management of your condition. |
| **Dental Services** |
| • Dental Care, except the specific dental services listed in this Benefit Handbook, Schedule of Benefits, and any associated Riders. • Office visits, consultations, and all related services for Temporomandibular Joint Dysfunction (TMD). • Pediatric dental care, except when specifically listed as a Covered Benefit in this Schedule of benefit or any associated Riders. Please see your Schedule of Benefits and any associated Riders to determine if your Plan provides coverage for this benefit. |
| **Durable Medical Equipment and Prosthetic Devices** |
| • Any devices or special equipment needed for sports or occupational purposes with the exception of prosthetics arms and legs for Members under the age of 18. • 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 systemic circulatory diseases or severe diabetic foot 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 with diabetes or systemic circulatory diseases. |
| **Maternity Services** |
| • Routine pre-natal and post-partum care when you are traveling outside the Service Area. • Planned home births. • 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 |

| Exclusion |
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| correction, prison, or custodial facility of the Department of Youth Services; or (2) provided by the Department of Mental Health. • Services or supplies for the diagnosis or treatment of mental health and substance use disorders that, in the reasonable judgment of the Plan, are any of the following: not consistent with prevailing national standards of clinical practice for the treatment of such conditions; not consistent with prevailing professional research demonstrating that the services or supplies will have a measurable and beneficial health outcome; typically do not result in outcomes demonstrably better than other available treatment alternatives that are less intensive or more cost effective. |
| **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) reconstructive surgery to repair or restore appearance damaged by an Accidental Injury, (3) post-mastectomy care, and (4) gender affirming procedures and related services. • Electrolysis or laser hair removal, except for what is Medically Necessary as part of gender affirming services. • Hair removal or restoration, including, but not limited to, transplantation or drug therapy. • Liposuction, except for what is Medically Necessary as part of gender affirming services, or removal of fat deposits considered undesirable. • Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures). • Skin abrasion procedures performed as a treatment for acne. • Treatments and procedures related to appearance including but not limited to, abdominoplasty; chemical peels; collagen injections; dermabrasion; implantations (e.g. cheek, calf, pectoral, gluteal); lip reduction/enhancement; panniculectomy; removal of redundant skin; and silicone injections (e.g. for breast enlargement), except for what is Medically Necessary as part of gender affirming services or another Covered Benefit. • Treatment for skin wrinkles and skin tags or any treatment to improve the appearance of the skin. • Treatment for spider veins. • Wigs. |
| **Procedures and Treatments** |
| • Care by a chiropractor outside the scope of standard chiropractic practice, including but not limited to, surgery, prescription or dispensing of drugs or medications, internal examinations, obstetrical practice, or treatment of infections and diagnostic testing for chiropractic care other than an initial X-ray. • Commercial diet plans, weight loss programs and any services in connection with such plans or programs. **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 is listed as requiring that it be provided at a Center of Excellence, no coverage will be provided under this Handbook if that service is received from a Provider that has not been designated as a Center of Excellence. • Nutritional or cosmetic therapy using vitamins, minerals or elements, and other nutrition-based therapy. Examples include supplements, electrolytes, and foods of any kind (including high protein foods and low carbohydrate foods). • Physical examinations and testing for insurance, licensing or employment. • Services for Members who are donors for non-members, except as described under Human Organ Transplant Services. • Testing for central auditory processing. • Group diabetes training, educational programs or camps. |
| **Providers** |
| • Charges for services which were provided after the date on which your membership ends, except as required by Maine law. • 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 under this Handbook. • Charges for missed appointments. • Concierge service fees. (See the *Handbook* section "*Provider Fees for Special Services*" for more information.) • Follow-up care after an emergency room visit, unless provided or arranged by your PCP or Direct Primary Care Provider. • 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** |
| • Birth control drugs, implants and devices. This exclusion may apply when coverage is provided by a religious organization, as allowed by law. Please see your Schedule of Benefits to determine if your Plan provides coverage for this benefit. • Services for a surrogate or gestational carrier who is not a Member of the Plan. • Reversal of voluntary sterilization (including any services for infertility related to voluntary sterilization or its reversal). • 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 |

| Exclusion |
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| Covered Benefit. Please see your Schedule of Benefits to determine if your Plan provides coverage for this benefit. • Voluntary termination of pregnancy, unless necessary to preserve the life or health of a Member or unless it is specifically listed as a Covered Benefit. Please see your Schedule of Benefits to determine if your Plan provides coverage for this benefit. |
| **Services Provided Under Another Plan** |
| • Costs for any services for which you are entitled to treatment at government expense, including military service connected disabilities. • Costs for services covered by third party liability, other insurance coverage, and which are required to be covered by a Workers' Compensation plan or an Employer under state or federal law, unless a notice of controversy has been filed with the Workers' Compensation Board contesting the work-relatedness of the claimant's condition and no decision has been made by the Board. |
| **Telemedicine** |
| • Telemedicine services involving e-mail or fax. • Telemedicine services involving audio-only telephone, except where telemedicine is technologically unavailable at a scheduled time and is medically appropriate for the corresponding covered health services. • 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 the Benefit Handbook and this Schedule of Benefits. • 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 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. • Any service or supply furnished in connection with a non-Covered Benefit. • Any service, supply or medication when there is a less intensive Covered Benefit or more cost-effective alternative that can be safely and effectively provided, in accordance with applicable Medical Necessity Guidelines. • Any service, supply or medication that is required by a third party that is not otherwise Medically Necessary (examples of a third party are an employer, an insurance company, a school or court). • Any service or supply (with the exception of contact lenses) purchased from the internet. • Beauty or barber service. • Diabetes equipment replacements when solely due to manufacturer warranty expiration. • 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 this Benefit Handbook. • Medical services that are provided to Members who are confined or committed to jail, house of correction, prison, or custodial facility of the Department of Youth Services. • Reimbursement for travel expenses. • Services for non-Members. • Services for which no charge would be made in the absence of insurance. • Services for which no coverage is provided in the Benefit Handbook, this Schedule of Benefits, or Prescription Drug Brochure. • Services provided under an individualized education program (IEP), including any services provided under an IEP that are delivered by school personnel or any services provided under an IEP purchased from a contractor or vendor. • Services that are not Medically Necessary. • Services your PCP or a Plan Provider has not provided, arranged or approved except as described in the *Handbook* sections *"Your PCP Manages Your Health Care"* and *"Using Plan Providers"*. • Taxes or governmental assessments on services or supplies. • Transportation, except for emergency ambulance transport, and non-emergency medical transport needed to 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 |

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

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

## Language Assistance Services

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

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

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

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

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

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

**العربية (Arabic)**

**إنتباه:** إذا أنت تتكلم اللُّغة العربية ، خَدَمات المُساعَدة اللُّغوية 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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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.

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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.



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