Schedule of Benefits

THE HARVARD PILGRIM PPO (Out of Area PPO) 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** 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**.

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," 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.	None	\$100 per Member per Calendar Year \$200 per family per Calendar Year
Out-of-Pocket Maximum		
Includes all In-Network and Out-of-Network Member Cost Sharing except:	\$6,350 per Member per Calendar Year \$12,700 per family per Calendar Year	
 Any charges above the Allowed Amount and any penalty for failure to receive Prior Approval when using Non-Plan Providers 		
Out-of-Network Penalty Payment		
Applies when the Member fails to obtain required Prior Approval for services from a Non-Plan Provider.	\$0	
Does not count toward the Deductible or Out-of-Pocket Maximum		
Deductible Rollover		
Your Plan has a Deductible Rollover. Dedu during the last 3 months of the Calendar ` the next Calendar Year. Deductible Rollov for the next Calendar Year.	Year will be applied toward the	Deductible requirement for

Benefit	In-Network Plan Providers Member Cost Sharing	Out-of-Network Non-Plan Providers Member Cost Sharing	
Acupuncture Treatment for Injury or Illness			
	\$20 Copayment per visit	Deductible, then 20% Coinsurance	
Ambulance and Medical Transport			
Emergency ambulance transport	No charge	Same as In-Network	
Non-emergency air ambulance transport	No charge	Same as In-Network	
Non-emergency medical transport	No charge	Deductible, then 20% Coinsurance	

Benefit	In-Network Plan Providers Member Cost Sharing	Out-of-Network Non-Plan Providers Member Cost Sharing
Autism Spectrum Disorders Treatment		
Applied behavior analysis	\$20 Copayment per visit	Deductible, then 20% Coinsurance
Chemotherapy and Radiation Therapy		
Chemotherapy	No charge	Deductible, then 20% Coinsurance
Radiation therapy	No charge	Deductible, then 20% Coinsurance
Dental Services	-	
Important Notice: Coverage of Dental Ca details of your coverage.	re is very limited. Please see you	r Benefit Handbook for the
Extraction of teeth impacted in bone (performed in a physician's office)	No charge	Deductible, then 20% Coinsurance
Pediatric dental care for children	Not covered	Not covered
Dialysis	·	· ·
	No charge	Deductible, then 20% Coinsurance
Installation of home equipment	No charge	Deductible, then 20% Coinsurance
Durable Medical Equipment	-	
Durable medical equipment	20% Coinsurance	Deductible, then 20% Coinsurance
Blood glucose monitors, infusion devices and insulin pumps (including supplies)	No charge	Deductible, then 20% Coinsurance
Oxygen and respiratory equipment	No charge	Deductible, then 20% Coinsurance
Early Intervention Services		
	No charge	Deductible, then 20% Coinsurance
The Plan does not cover the family partic Public Health.	ipation fee required by the Mass	sachusetts Department of
Emergency Admission		
	\$350 Copayment per admission up to a maximum of 1,000 per Calendar Year	Same as In-Network
Emergency Room Care		
	\$100 Copayment per visit	Same as In-Network
This Copayment is waived if you are (1) tr or (2) admitted to the hospital directly fr Services," "Observation Services," or "Sur to these benefits.	om the emergency room. Please	see "Hospital - Inpatient
Fertility Services (see the Benefit Handbo	ook for details)	
	Not covered	

Benefit	In-Network Plan Providers Member Cost Sharing	Out-of-Network Non-Plan Providers Member Cost Sharing
Gender Affirming Surgery		
	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 a service provided in an outpatient surgical center, see "Surgery – Outpatient." For services provided in a physician's office, see "Physician and Other Professional Office Visits." For inpatient hospital care, see "Hospital – Inpatient Services."	
Hearing Aids (for Members up to the age		
	20% Coinsurance	Deductible, then 20% Coinsurance
Home Health Care		
	No charge	Deductible, then 20% Coinsurance
If services include the administration of d Cost Sharing details.	rugs, please see the benefit for "	Medical Drugs" for Member
Hospice - Outpatient		
	No charge	Deductible, then 20% Coinsurance
Hospital – Inpatient Services		
Acute hospital care	\$350 Copayment per admission up to a maximum of \$1,000 per Calendar Year	Deductible, then 20% Coinsurance
Inpatient maternity care	\$350 Copayment per admission up to a maximum of \$1,000 per Calendar Year	Deductible, then 20% Coinsurance
Inpatient routine nursery care	No charge	Deductible, then 20% Coinsurance
Inpatient rehabilitation – limited to 100 days per Calendar Year Day limits combined with skilled nursing	No charge	Deductible, then 20% Coinsurance
facility care Skilled nursing facility – limited to 100 days per Calendar Year Day limits combined with rehabilitation hospital care	No charge	Deductible, then 20% Coinsurance
Infertility Services and Treatments (see th	ne Benefit Handbook for details)	
	Your Member Cost Sharing will depend upon where the service is provided, as listed in this Schedule of Benefits. For example, for services provided by a physician, see "Physician and Other Professional Office Visits." For inpatient hospital care, see "Hospital – Inpatient Services."	
Laboratory, Radiology and Other Diagno	stic Services	
Laboratory	No charge	Deductible, then 20% Coinsurance
Genetic testing	No charge	Deductible, then 20% Coinsurance

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Benefit	In-Network Plan Providers Member Cost Sharing	Out-of-Network Non-Plan Providers Member Cost Sharing
Laboratory, Radiology and Other Diagnos	stic Services (Continued)	
Radiology	No charge	Deductible, then 20% Coinsurance
Advanced radiology, including CT scans, PET scans, MRI, MRA and nuclear medicine services	\$50 Copayment per procedure Copayments for CT scans, PET scans, MRA, MRI, and Nuclear medicine are limited to \$200 per Calendar Year	Deductible, then 20% Coinsurance
Other diagnostic services	No charge	Deductible, then 20% Coinsurance
Low Protein Foods		
	No charge	Deductible, then 20% Coinsurance
Maternity Care - Outpatient		
Routine outpatient prenatal and postpartum care	No charge	Deductible, then 20% Coinsurance
or bundled service. Different Member Cost that is billed separately from your routine Member Cost Sharing for services provided Office Visits" and when not specifically lis specialized or non-routine service is listed Medical Drugs (drugs that cannot be self	e outpatient prenatal and postpa d by a specialist is listed under "P ted above, Member Cost Sharing under "Laboratory, Radiology ar	rtum care. For example, hysician and Other Professional for an ultrasound billed as a
Medical drugs received in a physician's	No charge	Deductible, then 20%
office or other outpatient facility		Coinsurance
Medical drugs received in the home	No charge	Deductible, then 20% Coinsurance
Some Medical Drugs may be supplied by a specialty pharmacy, the Member Cost Sha		ical Drugs are supplied by a
Medical Formulas		
	No charge	Deductible, then 20% Coinsurance
Mental Health and Substance Use Disord		
Inpatient services	\$350 Copayment per admission up to a maximum of \$1,000 per Calendar Year	Deductible, then 20% Coinsurance
Intermediate care services	No charge	Deductible, then 20%
 Acute residential treatment (including detoxification), crisis stabilization and in-home family stabilization 		Coinsurance
 Intensive outpatient programs, partial hospitalization and day treatment programs 		
Annual mental health wellness examination performed by a licensed mental health professional.	No charge	Deductible, then 20% Coinsurance
Please Note: Your annual mental health wellness examination may also be		

Benefit	In-Network Plan Providers Member Cost Sharing	Out-of-Network Non-Plan Providers Member Cost Sharing
Mental Health and Substance Use Disord	er Treatment (Continued)	-
provided by a PCP as part of your annual		
routine examination for preventive care.		
Outpatient group therapy	\$10 Copayment per visit	Deductible, then 20% Coinsurance
Outpatient individual therapy	\$20 Copayment per visit	Deductible, then 20% Coinsurance
Outpatient treatment, including outpatient detoxification and medication management	\$20 Copayment per visit	Deductible, then 20% Coinsurance
Outpatient methadone maintenance	No charge	Deductible, then 20% Coinsurance
Outpatient psychological testing and neuropsychological assessment	\$20 Copayment per visit	Deductible, then 20% Coinsurance
Outpatient telemedicine virtual visit – group therapy	\$10 Copayment per visit	Deductible, then 20% Coinsurance
Outpatient telemedicine virtual visit services – including individual therapy, detoxification, and medication management	\$20 Copayment per visit	Deductible, then 20% Coinsurance
Observation Services		
	\$100 Copayment per observation stay	Same as In-Network
Ostomy Supplies	· · ·	
	No charge	Deductible, then 20% Coinsurance
Physician and Other Professional Office V listed in this Schedule of Benefits.)	isits (This includes all covered Pl	an Providers unless otherwise
Routine examinations for preventive care, including immunizations	No charge	Deductible, then 20% Coinsurance
Not all In-Network services you receive of preventive services designated under the l at no charge. Other services not included the current list of preventive services cover Services Notice on our website at www.h a Other Diagnostic Services" for the Member on this list.	Patient Protection and Affordabl under PPACA may be subject to ered at no charge under PPACA, arvardpilgrim.org. Please see "La er Cost Sharing that applies to dia	e Care Act (PPACA) are covered additional cost sharing. For please see the Preventive aboratory, Radiology and agnostic services not included
Consultations, evaluations, sickness and injury care	\$20 Copayment per visit	Deductible, then 20% Coinsurance
Additional Member Cost Sharing may app Benefits. For example, if you need suture below. If you need an x-ray or have blood Diagnostic Services."	s, please refer to office based tre	enefit in this Schedule of eatments and procedures
Office based treatments and procedures, including, but not limited to administration of injections, casting, suturing and the application of dressings, genetic counseling,	No charge	Deductible, then 20% Coinsurance

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Benefit	In-Network Plan Providers Member Cost Sharing	Out-of-Network Non-Plan Providers Member Cost Sharing
Physician and Other Professional Office listed in this Schedule of Benefits.) (Cor		lan Providers unless otherwise
non-routine foot care, and surgical procedures		
Administration of allergy injections	No charge	Deductible, then 20% Coinsurance
Preventive Services and Tests		•
	No charge	Deductible, then 20% Coinsurance
Under federal and state law, many preversion Sharing, including preventive colonoscop and all FDA approved contraceptive devi- the Preventive Services Notice on our we the Preventive Services Notice by calling Pilgrim will add or delete services from t federal and state guidance.	pies, certain labs and x-rays, volun ces. For a complete list of covered bsite at www.harvardpilgrim.org the Member Services Department	tary sterilization for women, d preventive services, please see J. You may also get a copy of t at 1–888–333–4742 . Harvard
Prosthetic Devices		
	20% Coinsurance	Deductible, then 20% Coinsurance
Rehabilitation and Habilitation Services	- Outpatient	
Cardiac rehabilitation	\$20 Copayment per visit	Deductible, then 20% Coinsurance
Pulmonary rehabilitation therapy	No charge	Deductible, then 20% Coinsurance
Speech-language and hearing services	\$20 Copayment per visit	Deductible, then 20% Coinsurance
Occupational therapy	\$20 Copayment per visit	Deductible, then 20% Coinsurance
Physical therapy	\$20 Copayment per visit	Deductible, then 20% Coinsurance
Outpatient physical and occupational th to the extent Medically Necessary for: (1 Autism Spectrum Disorders.		
Scopic Procedures - Outpatient Diagnost	tic and Therapeutic	
Colonoscopy, endoscopy and sigmoidoscopy	\$250 Copayment per visit up to a maximum of \$1,000 per Calendar Year	Deductible, then 20% Coinsurance
Spinal Manipulative Therapy (including	care by a chiropractor)	
- Limited to 12 visits per Calendar Year	\$20 Copayment per visit	Deductible, then 20% Coinsurance
Surgery – Outpatient		
	\$250 Copayment per visit up to a maximum of \$1,000 per Calendar Year	Deductible, then 20% Coinsurance
Telemedicine Virtual Visit Services - Out	patient	
	\$20 Copayment per visit	Deductible, then 20% Coinsurance
For inpatient hospital care, see "Hospital	— Inpatient Services" for cost sh	aring details.

Benefit	In-Network Plan Providers Member Cost Sharing	Out-of-Network Non-Plan Providers Member Cost Sharing
Urgent Care Services		
Doctor On Demand	\$20 Copayment per visit	
Important Note: Doctor On Demand is a s Care services. For more information on Do website at www.harvardpilgrim.org .		
Convenience care clinic	\$20 Copayment per visit	\$20 Copayment per visit
Urgent care center	\$20 Copayment per visit	\$20 Copayment per visit
Hospital urgent care center	\$20 Copayment per visit	\$20 Copayment per visit
Benefits. For example, if you have an x-ra and Other Diagnostic Services." Vision Services		
Routine eye examinations – limited to 1 exam per Calendar Year	\$20 Copayment per visit	Deductible, then 20% Coinsurance
Vision hardware for special conditions	No charge	Deductible, then 20% Coinsurance
Voluntary Sterilization in a Physician's Of	fice	
	No charge	Deductible, then 20% Coinsurance
Voluntary Termination of Pregnancy		
	No charge	Deductible, then 20% Coinsurance
Wigs and Scalp Hair Prostheses as require	ed by law	
 Limited to \$350 per Calendar Year (see the Benefit Handbook for details) 	No charge	Deductible, then 20% Coinsurance

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).

(Arabic) العربية

إنتباه: إذا أنت تتكلم اللغة العربية ، خَدَمات المُساعَدة اللَّغُوية مُتُوفرة لك مَجاتا. " إتصل على 4742-338-1888 ((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 હ્યે તો આપને માટે ભાષાકીય સહ્યય તદદન મફત ઉપલબ્ધ છે. વિશેષ માહિતી માટે ફોન કરો. 1-888-333-4742 (TTY: 711)

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

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



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

(Continued)

General Notice About Nondiscrimination and Accessibility Requirements

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

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

If you need these services, contact our Civil Rights Compliance Officer.

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

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

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



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

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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, treatment with crystals and alternative medicine.
Any of the following types of programs: Health resorts, spas, recreational programs, camps, outdoor skills programs, therapeutic or educational boarding schools, educational programs for children in residential care, self-help programs, life skills programs, relaxation or lifestyle programs, and wilderness programs (therapeutic outdoor programs).
Massage therapy.
Myotherapy.

Dental Services

• Dental Care, except when specifically listed as a Covered Benefit. • Temporomandibular Joint Dysfunction (TMD) care, except as described in the Plan's *Benefit Handbook*. • 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.

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.

Exclusion

Mental Health and Substance Use Disorder Treatment

• Educational services or testing, except services covered under the benefit for Early Intervention Services. No benefits are provided (1) for educational services intended to enhance educational achievement or developmental functioning, (2) to resolve problems of school performance, (3) for driver alcohol education, or (4) for community reinforcement approach and assertive continuing care. • 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. • Sensory integrative praxis tests. • Services for any condition with only a "Z Code" designation in the Diagnostic and Statistical Manual of Mental Disorders, which means that the condition is not attributable to a mental disorder. • Mental health and substance use disorder treatment that is (1) provided to Members who are confined or committed to a jail, house of correction, prison, or custodial facility of the Department of Youth Services; or (2) provided by the Department of Mental Health. • Services or supplies for the diagnosis or treatment of mental health and substance use disorders that, in the reasonable judgment of the Behavioral Health Access Center, are any of the following: not consistent with prevailing national standards of clinical practice for the treatment of such conditions; not consistent with prevailing professional research demonstrating that the services or supplies will have a measurable and beneficial health outcome; typically do not result in outcomes demonstrably better than other available treatment alternatives that are less intensive or more cost effective. • Services related to autism spectrum disorders 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.

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, and (3) post-mastectomy care. • Hair removal or restoration, including, but not limited to, electrolysis, laser treatment, transplantation or drug therapy. • Liposuction 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. • 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. 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. • Gender affirming services including reassignment surgery and all related drugs and procedures for self-insured groups, except when specifically listed as a Covered Benefit. • If a service is listed as requiring that it be provided at a Center of Excellence, no In-Network coverage will be provided if that service is received from a provider that has not been designated as a Center of Excellence. • Nutritional or cosmetic therapy using vitamins, minerals or elements, and other nutrition-based therapy. Examples include supplements, electrolytes, and foods of any kind (including high protein foods and low carbohydrate foods). • Physical examinations and testing for insurance, licensing or employment. • Services for Members who are donors for non-members, except as described under Human Organ Transplant Services. • Testing for central auditory processing. • Group diabetes training, educational programs or camps.

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

Exclusion

Providers

Charges for services which were provided after the date on which your membership ends.
Charges for any products or services, including, but not limited to, professional fees, medical equipment, drugs, and hospital or other facility charges, that are related to any care that is not a Covered Benefit.
Charges for missed appointments.
Concierge service fees. (See the Plan's *Benefit Handbook* for more information.)
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. • Infertility drugs if a Member is not in a Plan authorized cycle of infertility treatment. • Infertility drugs, if infertility services are not a Covered Benefit. • Infertility drugs that must be purchased at an outpatient pharmacy, unless your Plan includes outpatient pharmacy coverage. • Infertility treatment for Members who are not medically infertile. • Infertility treatment and birth control drugs, implants and devices, except when specifically listed as a Covered Benefit. • 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, except when specifically listed as a Covered Benefit. • Voluntary termination of pregnancy, except when specifically listed as a Covered Benefit.

Services Provided Under Another Plan

• Costs for any services for which you are entitled to treatment at government expense, including military service connected disabilities. • Costs for services for which payment is required to be made by a Workers' Compensation plan or an Employer under state or federal law.

Telemedicine Services

• Telemedicine services involving e-mail or fax. • Provider fees for technical costs for the provision of telemedicine services.

Types of 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. • 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 when specifically listed as a Covered Benefit.
Hearing aids, 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.

Exclusion

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. • Any service, supply or medication that is required by a third party that is not otherwise Medically Necessary (examples of a third party are an employer, an insurance company, a school or court). • Beauty or barber service. • Diabetes equipment replacements when solely due to manufacturer warranty expiration. • Donated or banked breast milk. • Externally powered exoskeleton assistive devices and orthoses. • Food or nutritional supplements, including, but not limited to, FDA-approved medical foods obtained by prescription, except as required by law and prescribed for Members who meet HPHC policies for enteral tube feedings. • Guest services. • Medical equipment, devices or supplies except as described in the Plan's Benefit Handbook. • Medical services that are provided to Members who are confined or committed to jail, house of correction, prison, or custodial facility of the Department of Youth Services. • Reimbursement for travel expenses, except as described in the Plan's Benefit Handbook. Excluded services include but are not limited to: Alcohol and tobacco; Childcare expenses; Entertainment; Expenses for anyone other than you and your companion; First class, business class and other luxury transportation services; Lodging other than at a hotel or motel; Lost wages; Meals; Personal care and hygiene items; Telephone calls; Tips and gratuities. • Services for non-Members. • Services for which no charge would be made in the absence of insurance. • Services for which no coverage is provided in the Plan's Benefit Handbook, this Schedule of Benefits, or the Prescription Drug Brochure (if applicable). Services provided under an individualized education program (IEP), including any services provided under an IEP that are delivered by school personnel or any services provided under an IEP purchased from a contractor or vendor. • Services that are not Medically Necessary. • Taxes or governmental assessments on services or supplies. • Transportation, except for emergency ambulance transport, and non-emergency medical transport needed for transfer between hospitals or other covered health care facilities or from a covered facility to your home when Medically Necessary. • Air conditioners, air purifiers and filters, dehumidifiers and humidifiers. • Car seats. • Chairs, bath chairs, feeding chairs, toddler chairs, chair lifts, recliners. • Electric scooters. • Exercise equipment. • Home modifications including but not limited to elevators, handrails and ramps. • Hot tubs, jacuzzis, saunas or whirlpools. • Mattresses. • Medical alert systems. • Motorized beds. • Pillows. • Power-operated vehicles. • Stair lifts and stair glides. • Strollers. • Safety equipment. • Vehicle modifications including but not limited to van lifts. • Telephone. • Television.

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