

Schedule of Benefits

Harvard Pilgrim Health Care, Inc.

BEST BUY PPO 2000

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**.

Office Visit Cost Sharing Levels

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

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

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

EFFECTIVE DATE: 01/01/2026

FORM #1561_17

SCHEDULE OF BENEFITS | 1

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

Covered Benefits

Your Covered Benefits are administered on a Calendar Year basis.

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

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

General Cost Sharing Features:	In-Network Member Cost Sharing:	Out-of-Network Member Cost Sharing:
Coinsurance and Copayments		
	See the benefits table below	
Deductible		
The following Deductibles apply to all services except where specifically noted below. Your Plan Deductible can be met by any combination of eligible In-Network and Out-of-Network expenses.	\$2,000 per Member per Calendar Year \$4,000 per family per Calendar Year	
Out-of-Pocket Maximum		
Includes all In-Network and Out-of-Network Member Cost Sharing except: – Any charges above the Allowed Amount and any penalty for failure to receive Prior Approval when using Non-Plan Providers	\$5,000 per Member per Calendar Year \$10,000 per family per Calendar Year	
Out-of-Network Penalty Payment		
Applies when the Member fails to obtain required Prior Approval for services from a Non-Plan Provider. Does not count toward the Deductible or Out-of-Pocket Maximum	\$500	
Deductible Rollover		
Your Plan has a Deductible Rollover. Deductible amounts that you have paid for Covered Benefits during the last 3 months of the Calendar Year will be applied toward the Deductible requirement for the next Calendar Year. Deductible Rollover amounts will apply toward the Out-of-Pocket Maximum for the next Calendar Year.		

Benefit	In-Network Plan Providers Member Cost Sharing	Out-of-Network Non-Plan Providers Member Cost Sharing
Acupuncture Treatment		
	Deductible, then 20% Coinsurance	Deductible, then 40% Coinsurance
Ambulance and Medical Transport		
Emergency ambulance transport	Deductible, then 20% Coinsurance	Same as In-Network
Non-emergency air ambulance transport	Deductible, then 20% Coinsurance	Same as In-Network
Non-emergency medical transport	Deductible, then 20% Coinsurance	Deductible, then 20% Coinsurance
Autism Spectrum Disorders Treatment		
Applied behavior analysis	\$25 Copayment per visit	Deductible, then 20% Coinsurance
Chemotherapy and Radiation Therapy		
Chemotherapy	Deductible, then 20% Coinsurance	Deductible, then 40% Coinsurance
Radiation therapy	Deductible, then 20% Coinsurance	Deductible, then 40% Coinsurance
Dental Services		
Important Notice: Coverage of Dental Care is very limited. Please see your Benefit Handbook for the details of your coverage.		
Extraction of teeth impacted in bone (performed in a physician's office)	Deductible, then 20% Coinsurance	Deductible, then 40% Coinsurance
Pediatric dental care for children (up to the age of 13) – limited to 2 preventive dental exams per Calendar Year	\$25 Copayment per visit	Deductible, then 20% Coinsurance
Dialysis		
	Deductible, then 20% Coinsurance	Deductible, then 40% Coinsurance
Durable Medical Equipment		
Durable medical equipment	Deductible, then 30% Coinsurance	Deductible, then 30% Coinsurance
Blood glucose monitors, infusion devices and insulin pumps (including supplies)	No charge	No charge
Oxygen and respiratory equipment	No charge	Deductible, then 20% Coinsurance
Early Intervention Services		
	No charge	No charge
The Plan does not cover the family participation fee required by the Massachusetts Department of Public Health.		
Emergency Admission		
	Deductible, then 20% Coinsurance	Same as In-Network

Benefit	In-Network Plan Providers Member Cost Sharing	Out-of-Network Non-Plan Providers Member Cost Sharing
Emergency Room Care		
	\$250 Copayment per visit	Same as In-Network
This Copayment is waived if you are (1) transferred to either Observation Services or Outpatient Surgery or (2) admitted to the hospital directly from the emergency room. Please see "Hospital - Inpatient Services," "Observation Services," or "Surgery – Outpatient" for the Member Cost Sharing that applies to these benefits.		
Fertility Services (see the Benefit Handbook for details)		
	Deductible, then 20% Coinsurance	Deductible, then 40% Coinsurance
Hearing Aids (for Members up to the age of 22)		
– Limited to \$2,000 per hearing aid every 36 months, for each hearing impaired ear	Deductible, then 30% Coinsurance	Deductible, then 30% Coinsurance
Home Health Care		
	Deductible, then 20% Coinsurance	Deductible, then 40% Coinsurance
If services include the administration of drugs, please see the benefit for "Medical Drugs" for Member Cost Sharing details.		
Hospice - Outpatient		
	Deductible, then 20% Coinsurance	Deductible, then 40% Coinsurance
Hospital – Inpatient Services		
Acute hospital care	Deductible, then 20% Coinsurance	Deductible, then 40% Coinsurance
Inpatient maternity care	Deductible, then 20% Coinsurance	Deductible, then 40% Coinsurance
Inpatient routine nursery care	No charge	Deductible, then 20% Coinsurance
Inpatient rehabilitation – limited to 60 days per Calendar Year	Deductible, then 20% Coinsurance	Deductible, then 40% Coinsurance
Skilled nursing facility – limited to 100 days per Calendar Year	Deductible, then 20% Coinsurance	Deductible, then 40% Coinsurance
Infertility Treatment (see the Benefit Handbook for details)		
	Deductible, then 20% Coinsurance	Deductible, then 40% Coinsurance
Laboratory, Radiology and Other Diagnostic Services		
Laboratory	\$25 Copayment per visit	Deductible, then 20% Coinsurance
Genetic testing	\$25 Copayment per visit	Deductible, then 20% Coinsurance
Radiology	\$25 Copayment per visit	Deductible, then 20% Coinsurance
Advanced radiology, including CT scans, PET scans, MRI, MRA and nuclear medicine services	\$100 Copayment per procedure	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 Diagnostic Services (Continued)		
Other diagnostic services	\$25 Copayment per visit	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
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 when not specifically listed above, Member Cost Sharing for an ultrasound billed as a specialized or non-routine service is listed under "Laboratory, Radiology and Other Diagnostic Services."		
Medical Drugs (drugs that cannot be self-administered)		
Medical drugs received in a physician's office or other outpatient facility	Deductible, then 20% Coinsurance	Deductible, then 40% Coinsurance
Medical drugs received in the home	Deductible, then 20% Coinsurance	Deductible, then 40% 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		
	No charge	Deductible, then 20% Coinsurance
Mental Health and Substance Use Disorder Treatment		
Inpatient services	Deductible, then 20% Coinsurance	Deductible, then 40% Coinsurance
Intermediate care services	No charge	Deductible, then 20% Coinsurance
Annual mental health wellness examination performed by a licensed mental health professional. Please Note: Your annual mental health wellness examination may also be provided by a PCP as part of your annual routine examination for preventive care.	No charge	Deductible, then 20% Coinsurance
Outpatient group therapy	\$10 Copayment per visit	Deductible, then 20% Coinsurance
Outpatient individual therapy	\$25 Copayment per visit	Deductible, then 20% Coinsurance
Outpatient treatment, including outpatient detoxification and medication management	\$25 Copayment per visit	Deductible, then 20% Coinsurance
Outpatient methadone maintenance	No charge	Deductible, then 20% Coinsurance
Outpatient psychological testing and neuropsychological assessment	Deductible, then 20% Coinsurance	Deductible, then 40% Coinsurance

Benefit	In-Network Plan Providers Member Cost Sharing	Out-of-Network Non-Plan Providers Member Cost Sharing
Mental Health and Substance Use Disorder Treatment (Continued)		
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	\$25 Copayment per visit	Deductible, then 20% Coinsurance
Observation Services		
	Deductible, then 20% Coinsurance	Same as In-Network
Ostomy Supplies		
	Deductible, then 20% Coinsurance	Deductible, then 40% Coinsurance
Physician and Other Professional Office Visits (This includes all covered Plan Providers unless otherwise listed in this Schedule of Benefits.)		
Routine examinations for preventive care, including immunizations	No charge	Deductible, then 20% Coinsurance
Not all In-Network services you receive during your routine exam are covered at no charge. Only preventive services designated under the Patient Protection and Affordable Care Act (PPACA) are covered at no charge. Other services not included under PPACA may be subject to additional cost sharing. For the current list of preventive services covered at no charge under PPACA, please see the Preventive Services Notice on our website at www.harvardpilgrim.org . Please see "Laboratory, Radiology and Other Diagnostic Services" for the Member Cost Sharing that applies to diagnostic services not included on this list.		
Consultations, evaluations, sickness and injury care	Level 1: \$25 Copayment per visit Level 2: \$50 Copayment per visit	Deductible, then 20% Coinsurance
Cost sharing level varies depending on the type of provider. Please refer to the beginning of this Schedule of Benefits to determine which cost sharing level applies.		
Additional Member Cost Sharing may apply. Please refer to the specific benefit in this Schedule of Benefits. For example, if you need sutures, please refer to office based treatments and procedures below. If you need an x-ray or have blood drawn, please refer to "Laboratory, Radiology and Other Diagnostic Services."		
Office based treatments and procedures, including, but not limited to administration of injections, casting, suturing and the application of dressings, genetic counseling, non-routine foot care, and surgical procedures	Deductible, then 20% Coinsurance	Deductible, then 40% Coinsurance
Administration of allergy injections	Deductible, then 20% Coinsurance	Deductible, then 40% Coinsurance
Preventive Services and Tests		
	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
Preventive Services and Tests (Continued)		
Under federal and state law, many preventive services and tests are covered with no Member Cost Sharing, including preventive colonoscopies, certain labs and x-rays, voluntary sterilization for women, and all FDA approved contraceptive devices. For a complete list of covered preventive services, please see the Preventive Services Notice on our website at www.harvardpilgrim.org . You may also get a copy of the Preventive Services Notice by calling the Member Services Department at 1-888-333-4742. Harvard Pilgrim will add or delete services from this benefit for preventive services and tests in accordance with federal and state guidance.		
The following additional preventive services, tests and devices: alpha-fetoprotein (AFP), fetal ultrasound, hepatitis C testing, lead level testing, prostate-specific antigen (PSA) screening, routine hemoglobin tests, group B streptococcus (GBS), routine urinalysis, blood pressure monitor, retinopathy screening, and international normalized ratio (INR) testing.	No charge	Deductible, then 20% Coinsurance
Prosthetic Devices		
	20% Coinsurance	Deductible, then 40% Coinsurance
Rehabilitation and Habilitation Services - Outpatient		
Cardiac rehabilitation	Deductible, then 20% Coinsurance	Deductible, then 40% Coinsurance
Pulmonary rehabilitation therapy	Deductible, then 20% Coinsurance	Deductible, then 40% Coinsurance
Speech-language and hearing services	Deductible, then 20% Coinsurance	Deductible, then 40% Coinsurance
Occupational therapy – limited to 60 visits per Calendar Year Limits combined with physical therapy.	Deductible, then 20% Coinsurance	Deductible, then 40% Coinsurance
Physical therapy – limited to 60 visits per Calendar Year Limits combined with occupational therapy.	Deductible, then 20% Coinsurance	Deductible, then 40% Coinsurance
Outpatient physical and occupational therapy is not subject to the limit listed above and is covered to the extent Medically Necessary for: (1) children up to the age of three and (2) the treatment of Autism Spectrum Disorders.		
Scopic Procedures - Outpatient Diagnostic and Therapeutic		
Colonoscopy, endoscopy and sigmoidoscopy	Deductible, then 20% Coinsurance	Deductible, then 40% Coinsurance
Spinal Manipulative Therapy (including care by a chiropractor)		
– Limited to 12 visits per Calendar Year	Deductible, then 20% Coinsurance	Deductible, then 40% Coinsurance
Surgery – Outpatient		
	Deductible, then 20% Coinsurance	Deductible, then 40% Coinsurance

Benefit	In-Network Plan Providers Member Cost Sharing	Out-of-Network Non-Plan Providers Member Cost Sharing
Telemedicine Virtual Visit Services - Outpatient		
	Level 1: \$25 Copayment per visit Level 2: \$50 Copayment per visit	Deductible, then 20% Coinsurance
For inpatient hospital care, see “Hospital — Inpatient Services” for cost sharing details.		
Travel Reimbursement Benefit		
– Limited to \$2,500 per Calendar Year See the Benefit Handbook for details	No charge	
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	\$25 Copayment per visit	Deductible, then 20% Coinsurance
Urgent care center	\$50 Copayment per visit	Deductible, then 20% Coinsurance
Hospital urgent care center	\$50 Copayment per visit	Deductible, then 20% Coinsurance
Additional Member Cost Sharing may apply. Please refer to the specific benefit in this Schedule of Benefits. For example, if you have an x-ray or have blood drawn, please refer to “Laboratory, Radiology and Other Diagnostic Services.”		
Vision Services		
Routine eye examinations – limited to 1 exam per Calendar Year	\$25 Copayment per visit	Deductible, then 20% Coinsurance
Vision hardware for special conditions	Deductible, then 20% Coinsurance	Deductible, then 40% Coinsurance
Voluntary Sterilization in a Physician’s Office		
	Deductible, then 20% Coinsurance	Deductible, then 40% Coinsurance
Voluntary Termination of Pregnancy		
	No charge	Deductible, then 20% Coinsurance
Wigs and Scalp Hair Protheses as required by law		
– Limited to \$350 per Calendar Year (see the Benefit Handbook for details)	Deductible, then 20% Coinsurance	Deductible, then 40% Coinsurance



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Language Assistance Services

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

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

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

Gujarati (ગુજરાતી) ધ્યાન આપો: જો તમે અંગ્રેજી સિવાય બીજી ભાષા બોલો છો, તો ભાષા હિતિ વિઓ, તમારા માટે મફત ઉપલબ્ધ છે. કૃપા કરીને તમારા ભિંચ આઈડી કાર્ડ પરના નંબર પર કોલ કરો.

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

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

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

Khmer (ភាសាខ្មែរ) ប្រសិនបើអ្នក គន្លឹយាយភាសាបសដ្ឋប្រវត្តិភាសាអង់បល: ស បសវត្តមុមជំនួ យភាសា ដលៃឥតលិតថ្លល: លំអាចរភាសាសហ្មាអុន ក។ សូ មុប្រវត្តិភាសាបសដ្ឋប្រវត្តិ ID ភាគសាជីករស្មុន ក។

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

Lao (ພາສາລາວ) ກະລຸນາ ຮັບຊາບ: ຖ້າ ໃຫມເວົ້າພາສາອື່ນທີ່ບໍ່ ແມ່ນພາສາ ອັງກິດ, ໃຫມສາມາດໃຊ້ບໍລິການພາສາໄ ໂດຍບໍ່ເສຍ ຄ່າ. ກະລຸນາໂທຫາເບີຢູ່ ຢູ່ໃນ ບັດປະຈຳ ຕົວສະມາຊິກຂອງ ໃຫມ.

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

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

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

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

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

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

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

Continued on next page

General Notice About Nondiscrimination and Accessibility Requirements

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

HPHC:

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

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

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

Point32Health Civil Rights Legal Coordinator

1 Wellness Way
Canton, MA 02021-1166

866-750-2074, TTY service: 711

Fax: 617-668-2754

Email: OCRCoordinator@point32health.org

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

U.S. Department of Health and Human Services

200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201

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

Complaint forms are available at

www.hhs.gov/ocr/office/file/index.html

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

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General List of Exclusions

Harvard Pilgrim Health Care, Inc. | 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
<ul style="list-style-type: none"> • 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
<ul style="list-style-type: none"> • Dental Care, except when specifically listed as a Covered Benefit. • Temporomandibular Joint Dysfunction (TMD) care, except as described in the Plan's <i>Benefit Handbook</i>. • Extraction of teeth, except when specifically listed as a Covered Benefit. • Pediatric dental care, except when specifically listed as a Covered Benefit. • Dentures
Durable Medical Equipment and Prosthetic Devices
<ul style="list-style-type: none"> • 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
<ul style="list-style-type: none"> • Any products or services, including, but not limited to, drugs, devices, treatments, procedures, and diagnostic tests that are Experimental, Unproven, or Investigational.
Foot Care
<ul style="list-style-type: none"> • 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
<ul style="list-style-type: none"> • Planned home births. • Services provided by a doula.

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

Exclusion

Mental Health and Substance Use Disorder Treatment

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

Physical Appearance

- Cosmetic Services, including drugs, devices, treatments and procedures, except for (1) Cosmetic Services that are incidental to the correction of Physical Functional Impairment, (2) restorative surgery to repair or restore appearance damaged by an accidental injury, (3) post-mastectomy care, and (4) gender affirming procedures and related services.
- Electrolysis or laser hair removal, except for what is Medically Necessary as part of gender affirming services.
- Hair removal or restoration, including, but not limited to transplantation or drug therapy.
- Liposuction, except for what is Medically Necessary as part of gender affirming services, or removal of fat deposits considered undesirable.
- Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures).
- Skin abrasion procedures performed as a treatment for acne.
- Treatments and procedures related to appearance including but not limited to, 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 another Covered Benefit.
- Treatment for skin wrinkles and skin tags or any treatment to improve the appearance of the skin.
- Treatment for spider veins.
- Wigs and scalp hair prostheses when hair loss is due to male pattern baldness, female pattern baldness, or natural or premature aging.

Procedures and Treatments

- Care by a chiropractor outside the scope of standard chiropractic practice, including but not limited to, surgery, prescription or dispensing of drugs or medications, internal examinations, obstetrical practice, or treatment of infections and diagnostic testing for chiropractic care other than an initial X-ray.
- Spinal manipulative therapy (including care by a chiropractor), except when specifically listed as a Covered Benefit.
- Commercial diet plans, weight loss programs and any services in connection with such plans or programs. **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.

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Exclusion
Providers
<ul style="list-style-type: none"> • 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 <i>Benefit Handbook</i> 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
<ul style="list-style-type: none"> • Any form of Surrogacy or services for a gestational carrier other than covered maternity services. • Any reproductive related services or drugs for Members who are not medically infertile, except when specifically listed as a Covered Benefit. • 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, except as otherwise listed in this Benefit Handbook. • Intrauterine Insemination (IUI) services provided in the home. • 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 <i>Benefit Handbook</i>. • 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.
Services Provided Under Another Plan
<ul style="list-style-type: none"> • 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
<ul style="list-style-type: none"> • Telemedicine services involving e-mail or fax. • Provider fees for technical costs for the provision of telemedicine services.
Types of Care
<ul style="list-style-type: none"> • Custodial Care. • Recovery programs including rest or domiciliary care, sober houses, transitional support services, and therapeutic communities. • All institutional charges over the semi-private room rate, except when a private room is Medically Necessary. • Pain management programs or clinics. • Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, and diversion or general motivation. • 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
<ul style="list-style-type: none"> • 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.

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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, in accordance with applicable Medical Necessity Guidelines. • Any service, supply or medication that is required by a third party that is not otherwise Medically Necessary (examples of a third party are an employer, an insurance company, a school or court). • Beauty or barber service. • 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 or when specifically listed as a Covered Benefit. • Voice modification surgery, except when Medically Necessary for gender affirming services. • Air conditioners, air purifiers and filters, dehumidifiers and humidifiers. • Car seats. • Chairs, bath chairs, feeding chairs, toddler chairs, chair lifts, recliners. • Electric scooters. • Exercise equipment. • Home modifications including but not limited to elevators, handrails and ramps. • Hot tubs, jacuzzis, saunas or whirlpools. • Mattresses. • Medical alert systems. • Motorized beds. • Pillows. • Power-operated vehicles. • Stair lifts and stair glides. • Strollers. • Safety equipment. • Vehicle modifications including but not limited to van lifts. • Telephone. • Television.