

# Schedule of Benefits

## HPHC Insurance Company, Inc.

### BEST BUY HSA PPO

### MASSACHUSETTS

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.

#### **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](http://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](http://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](http://www.harvardpilgrim.org) or by calling the Member Services Department at **1-888-333-4742**.

#### **Covered Benefits**

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

Your Member Cost Sharing will depend upon the type of service provided and the location the service is provided in, as listed in this Schedule of Benefits. For example, for services provided in a physician's office, see "Physician and Other Professional Office Visits." For services provided in a

hospital emergency room, see "Emergency Room Care." For inpatient hospital care, see "Hospital – Inpatient Services," and for outpatient surgical procedures, please see "Surgery - Outpatient."

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

General Cost Sharing Features:	In-Network Member Cost Sharing:	Out-of-Network Member Cost Sharing:
<b>Coinsurance and Copayments</b>		
See the benefits table below		
<b>Deductible</b>		
The following Deductibles apply to all services except where specifically noted below.	\$2,500 for Individual Coverage per Plan Year \$5,000 for Family Coverage per Plan Year	\$4,000 for Individual Coverage per Plan Year \$8,000 for Family Coverage per Plan Year
Any eligible medical expenses you incur toward the In-Network Deductible in a Plan Year applies to <b>both</b> the In-Network and the Out-of-Network Deductibles. Likewise, any eligible medical expenses you incur toward the Out-of-Network Deductible in a Plan Year applies to <b>both</b> the In-Network and the Out-of-Network Deductibles.		
<b>Important Notice:</b> If you have Individual Coverage, the Individual Coverage Deductible applies (the Family Coverage Deductible will never apply). If you have Family Coverage, the Family Coverage Deductible may be met by any combination of covered family Members (the Individual Coverage Deductible will never apply). Once a Deductible is met, coverage by the Plan is subject to any other Member Cost Sharing that may apply.		
<b>Out-of-Pocket Maximum</b>		
Includes all Member Cost Sharing except: – Any charges above the Allowed Amount and any penalty for failure to receive Prior Approval when using Non-Plan Providers	\$4,000 for Individual Coverage per Plan Year \$8,000 for Family Coverage per Plan Year	\$5,000 for Individual Coverage per Plan Year \$10,000 for Family Coverage per Plan Year
Any eligible medical expenses you incur toward the In-Network Out-of-Pocket Maximum in a Plan Year applies to <b>both</b> the In-Network and the Out-of-Network Out-of-Pocket Maximum. Likewise, any eligible medical expenses you incur toward the Out-of-Network Out-of-Pocket Maximum in a Plan Year applies to <b>both</b> the In-Network and the Out-of-Network Out-of-Pocket Maximum.		
<b>Important Notice:</b> If you have Individual Coverage, the Individual Coverage Out-of-Pocket Maximum applies (the Family Coverage Out-of-Pocket Maximum will never apply). If you have Family Coverage, the Out-of-Pocket Maximum may be met by any combination of covered family Members. The individual Out-of-Pocket Maximum does not apply. Once the Out-of-Pocket Maximum has been reached, no additional Member Cost Sharing will be applied for the remainder of the Plan Year.		
<b>Out-of-Network Penalty Payment</b>		
Applies when the Member fails to obtain required Prior Approval for medical services or Medical Drugs from a Non-Plan Provider. Does not count toward the Deductible or Out-of-Pocket Maximum	\$500	

**BEST BUY HSA PPO - MASSACHUSETTS**

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

<b>Benefit</b>	<b>In-Network Plan Providers Member Cost Sharing</b>	<b>Out-of-Network Non-Plan Providers Member Cost Sharing</b>
<b>Emergency Admission</b>		
	Deductible, then no charge	Same as In-Network
<b>Emergency Room Care</b>		
	Deductible, then \$150 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.		
<b>Fertility Treatment (see the Benefit Handbook for details)</b>		
	Deductible, then no charge	Deductible, then 20% Coinsurance
<b>Hearing Aids</b>		
– Limited to \$2,000 per hearing aid every 36 months, for each hearing impaired ear	Deductible, then no charge	Deductible, then 20% Coinsurance
<b>Home Health Care</b>		
	Deductible, then no charge	Deductible, then 20% Coinsurance
If services include the administration of drugs, please see the benefit for "Medical Drugs" for Member Cost Sharing details.		
<b>Hospice - Outpatient</b>		
	Deductible, then no charge	Deductible, then 20% Coinsurance
<b>Hospital – Inpatient Services</b>		
Acute hospital care	Deductible, then no charge	Deductible, then 20% Coinsurance
Inpatient maternity care	Deductible, then no charge	Deductible, then 20% Coinsurance
Inpatient routine nursery care	No charge	20% Coinsurance
Inpatient rehabilitation – limited to 60 days per Plan Year	Deductible, then no charge	Deductible, then 20% Coinsurance
Skilled nursing facility – limited to 100 days per Plan Year	Deductible, then no charge	Deductible, then 20% Coinsurance
<b>Infertility Treatment (see the Benefit Handbook for details)</b>		
	Deductible, then no charge	Deductible, then 20% Coinsurance
<b>Laboratory, Radiology and Other Diagnostic Services</b>		
Laboratory	Deductible, then no charge	Deductible, then 20% Coinsurance
Genetic testing	Deductible, then no charge	Deductible, then 20% Coinsurance
Radiology	Deductible, then 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
<b>Laboratory, Radiology and Other Diagnostic Services (Continued)</b>		
Advanced radiology, including CT scans, PET scans, MRI, MRA and nuclear medicine services	Deductible, then no charge	Deductible, then 20% Coinsurance
Other diagnostic services	Deductible, then no charge	Deductible, then 20% Coinsurance
<b>Low Protein Foods</b>		
– Limited to \$5,000 per Plan Year	Deductible, then no charge	Deductible, then 20% Coinsurance
<b>Maternity Care - Outpatient</b>		
Routine outpatient prenatal and postpartum care	No charge	20% Coinsurance
<p>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.” For more information, see the “Maternity Care” benefit in your Benefit Handbook or the Preventive Services notice on our website at <a href="http://www.harvardpilgrim.org">www.harvardpilgrim.org</a>.</p>		
<b>Medical Drugs (drugs that cannot be self-administered)</b>		
Medical drugs received in a physician's office or other outpatient facility	Deductible, then no charge	Deductible, then 20% Coinsurance
Medical drugs received in the home	Deductible, then no charge	Deductible, then 20% Coinsurance
<p>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.</p>		
<b>Medical Formulas</b>		
	Deductible, then no charge	Deductible, then 20% Coinsurance
<b>Mental Health and Substance Use Disorder Treatment</b>		
Inpatient services	Deductible, then no charge	Deductible, then 20% Coinsurance
Intermediate care services	Deductible, then no charge	Deductible, then 20% Coinsurance
<p>Annual mental health wellness examination performed by a licensed mental health professional.</p> <p><b>Please Note:</b> Your annual mental health wellness examination may also be</p>	No charge	Deductible, then 20% Coinsurance

<b>Benefit</b>	<b>In-Network Plan Providers Member Cost Sharing</b>	<b>Out-of-Network Non-Plan Providers Member Cost Sharing</b>
<b>Mental Health and Substance Use Disorder Treatment (Continued)</b>		
provided by a PCP as part of your annual routine examination for preventive care.		
Outpatient group therapy	Deductible, then no charge	Deductible, then 20% Coinsurance
Outpatient individual therapy	Deductible, then no charge	Deductible, then 20% Coinsurance
Outpatient treatment, including outpatient detoxification and medication management	Deductible, then no charge	Deductible, then 20% Coinsurance
Outpatient methadone maintenance	Deductible, then no charge	Deductible, then 20% Coinsurance
Outpatient services provided by a recovery coach, as required by law	Deductible, then no charge	Deductible, then 20% Coinsurance
Outpatient psychological testing and neuropsychological assessment	Deductible, then no charge	Deductible, then 20% Coinsurance
Outpatient telemedicine virtual visit – group therapy	Deductible, then no charge	Deductible, then 20% Coinsurance
Outpatient telemedicine virtual visit services – including individual therapy, detoxification, and medication management	Deductible, then no charge	Deductible, then 20% Coinsurance
<b>Observation Services</b>		
	Deductible, then no charge	Same as In-Network
<b>Ostomy Supplies</b>		
	Deductible, then no charge	Deductible, then 20% Coinsurance
<b>Physician and Other Professional Office Visits (This includes all covered Plan Providers unless otherwise listed in this Schedule of Benefits.)</b>		
Routine examinations for preventive care, including immunizations	No charge	20% Coinsurance
Not all <b>In-Network</b> 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 <a href="http://www.harvardpilgrim.org">www.harvardpilgrim.org</a> . 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	Deductible, then no charge	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 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	Deductible, then no charge	Deductible, then 20% Coinsurance

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<b>Benefit</b>	<b>In-Network Plan Providers Member Cost Sharing</b>	<b>Out-of-Network Non-Plan Providers Member Cost Sharing</b>
<b>Physician and Other Professional Office Visits (This includes all covered Plan Providers unless otherwise listed in this Schedule of Benefits.) (Continued)</b>		
of dressings, genetic counseling, non-routine foot care, and surgical procedures		
Administration of allergy injections	Deductible, then no charge	Deductible, then 20% Coinsurance
<b>Preventive Services and Tests</b>		
	No charge	20% Coinsurance
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 <a href="http://www.harvardpilgrim.org">www.harvardpilgrim.org</a> . 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	20% Coinsurance
<b>Prosthetic Devices</b>		
	Deductible, then no charge	Deductible, then 20% Coinsurance
<b>Rehabilitation and Habilitation Services - Outpatient</b>		
Cardiac rehabilitation	Deductible, then no charge	Deductible, then 20% Coinsurance
Pulmonary rehabilitation therapy	Deductible, then no charge	Deductible, then 20% Coinsurance
Speech-language and hearing services	Deductible, then no charge	Deductible, then 20% Coinsurance
Occupational therapy – limited to 60 visits per Plan Year Limits combined with physical therapy.	Deductible, then no charge	Deductible, then 20% Coinsurance
Physical therapy – limited to 60 visits per Plan Year Limits combined with occupational therapy.	Deductible, then no charge	Deductible, then 20% 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.		

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<b>Benefit</b>	<b>In-Network Plan Providers Member Cost Sharing</b>	<b>Out-of-Network Non-Plan Providers Member Cost Sharing</b>
<b>Scopic Procedures - Outpatient Diagnostic and Therapeutic</b>		
Colonoscopy, endoscopy and sigmoidoscopy	Deductible, then no charge	Deductible, then 20% Coinsurance
<b>Spinal Manipulative Therapy (including care by a chiropractor)</b>		
	Deductible, then no charge	Deductible, then 20% Coinsurance
<b>Surgery – Outpatient</b>		
	Deductible, then no charge	Deductible, then 20% Coinsurance
<b>Telemedicine Virtual Visit Services - Outpatient</b>		
	Deductible, then no charge	Deductible, then 20% Coinsurance
For inpatient hospital care, see “Hospital — Inpatient Services” for cost sharing details.		
<b>Travel Reimbursement Benefit</b>		
– Limited to \$2,500 per Plan Year See the Benefit Handbook for details	Deductible, then no charge	
<b>Urgent Care Services</b>		
Doctor On Demand	Deductible, then no charge	
<b>Important Note:</b> 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 <a href="http://www.harvardpilgrim.org">www.harvardpilgrim.org</a> .		
Convenience care clinic	Deductible, then no charge	Deductible, then 20% Coinsurance
Urgent care center	Deductible, then no charge	Deductible, then 20% Coinsurance
Hospital urgent care center	Deductible, then no charge	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.”		
<b>Vision Services</b>		
Routine eye examinations – limited to 1 exam per Plan Year	No charge	Deductible, then 20% Coinsurance
Vision hardware for special conditions	Deductible, then no charge	Deductible, then 20% Coinsurance
<b>Voluntary Sterilization in a Physician’s Office</b>		
	Deductible, then no charge	Deductible, then 20% Coinsurance
<b>Voluntary Termination of Pregnancy</b>		
	Deductible, then no charge	Deductible, then 20% Coinsurance
<b>Wigs and Scalp Hair Protheses as required by law</b>		
– Limited to \$350 per Plan Year (see the Benefit Handbook for details)	Deductible, then no charge	Deductible, then 20% 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 હિત્ર વિચારો, 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 èd pou lang ki disponib gratis pou ou. Tanpri rele nimewo ki sou kat ID manm ou a.

**Hindi (हिंदी)** ध्यान दें: अगर आप अंग्रेजी के अलावा कोई दूसरी भाषा बोलते हैं, तो भाषा सहायता सेवाएं आपके 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 គន្លឹយាយភាសាបសដេប្រាំពីភាសាអង់បល: ស បសវាភមុមជំនួ យភាសា ដលៃឥតលិឥតថល: លំអាច: ភាសាសហ្មារ: អ្នក ។ សូ មុប្រាំកាន់បលឧប្រាំលី ID ភាគសាជីក: រស្មុន 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 ທ່ານເວົ້າພາສາອື່ນທີ່ບໍ່ ມ່ພາສາ ອັງກິດ, ທ່ານສາມາດໃຊ້ບໍລິການບໍ່ຕາມພາສາໄ ັ ໂດຍບໍ່ເສຍ ອ່າ. ກະລຸນາໃຫ້ທ່ານເບິ່ງ ຍ່ໃນ ບັດປະຈໍາ ຕົວສະມາຊິກຂອງ ທ່ານ.

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

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

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

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

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

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

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

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# General Notice About Nondiscrimination and Accessibility Requirements

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

## HPHC:

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

If you need these services, contact our Civil Rights Compliance Officer (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](mailto: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](http://www.hhs.gov/ocr/office/file/index.html)

## General List of Exclusions

### HPHC Insurance Company, 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
<p><b>Alternative Treatments</b></p> <ul style="list-style-type: none"> <li>• Acupuncture care, except when specifically listed as a Covered Benefit.</li> <li>• Acupuncture services that are outside the scope of standard acupuncture care.</li> <li>• Alternative, holistic or naturopathic services and all procedures, laboratories and nutritional supplements associated with such treatments, except when specifically listed as a Covered Benefit.</li> <li>• Aromatherapy, treatment with crystals and alternative medicine.</li> <li>• 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).</li> <li>• Massage therapy.</li> <li>• Myotherapy.</li> </ul>
<p><b>Dental Services</b></p> <ul style="list-style-type: none"> <li>• Dental Care, except when specifically listed as a Covered Benefit.</li> <li>• Temporomandibular Joint Dysfunction (TMD) care, except as described in the Plan's <i>Benefit Handbook</i>.</li> <li>• Extraction of teeth, except when specifically listed as a Covered Benefit.</li> <li>• Pediatric dental care, except when specifically listed as a Covered Benefit.</li> <li>• Dentures</li> </ul>
<p><b>Durable Medical Equipment and Prosthetic Devices</b></p> <ul style="list-style-type: none"> <li>• Any devices or special equipment needed for sports or occupational purposes.</li> <li>• Any home adaptations, including, but not limited to home improvements and home adaptation equipment.</li> <li>• Non-durable medical equipment, unless used as part of the treatment at a medical facility or as part of approved home health care services.</li> <li>• Repair or replacement of durable medical equipment or prosthetic devices as a result of loss, negligence, willful damage, or theft.</li> </ul>
<p><b>Experimental, Unproven, or Investigational Services</b></p> <ul style="list-style-type: none"> <li>• Any products or services, including, but not limited to, drugs, devices, treatments, procedures, and diagnostic tests that are Experimental, Unproven, or Investigational.</li> </ul>
<p><b>Foot Care</b></p> <ul style="list-style-type: none"> <li>• Foot orthotics, except for the treatment of severe diabetic foot disease or systemic circulatory disease.</li> <li>• 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.</li> </ul>
<p><b>Maternity Services</b></p> <ul style="list-style-type: none"> <li>• Planned home births.</li> <li>• Services provided by a doula.</li> <li>• If you are covered under an HMO plan, routine pre-natal and post-partum care when you are traveling outside the Service Area.</li> </ul>

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.
- Applied Behavior Analysis (ABA) for treatment of Down syndrome, except when specifically listed as a Covered Benefit.
- 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.

### 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, except when specifically listed as a Covered Benefit.
- 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:** 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).
- 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.

<b>Exclusion</b>
<p><b>Providers</b></p> <ul style="list-style-type: none"> <li>• Charges for services which were provided after the date on which your membership ends.</li> <li>• 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.</li> <li>• Charges for missed appointments.</li> <li>• Concierge service fees. (See the Plan's <i>Benefit Handbook</i> for more information.)</li> <li>• Follow-up care after an emergency room visit, unless provided by a Plan Provider and/or arranged by your PCP when required under your Plan.</li> <li>• Inpatient charges after your hospital discharge.</li> <li>• Provider's charge to file a claim or to transcribe or copy your medical records.</li> <li>• Services or supplies provided by: (1) anyone related to you by blood, marriage or adoption, or (2) anyone who ordinarily lives with you.</li> </ul>
<p><b>Reproduction</b></p> <ul style="list-style-type: none"> <li>• Any form of Surrogacy or services for a gestational carrier other than covered maternity services.</li> <li>• Any reproductive related services or drugs for Members who are not medically infertile, except when specifically listed as a Covered Benefit.</li> <li>• Infertility treatment, fertility treatment and birth control drugs, implants and devices, except when specifically listed as a Covered Benefit.</li> <li>• Infertility drugs if a Member is not in a Plan authorized cycle of infertility treatment.</li> <li>• Infertility drugs, if infertility services are not a Covered Benefit.</li> <li>• Infertility drugs that must be purchased at an outpatient pharmacy, unless your Plan includes outpatient pharmacy coverage.</li> <li>• Infertility treatment for Members who are not medically infertile, except as otherwise listed in this Benefit Handbook.</li> <li>• Intrauterine Insemination (IUI) services provided in the home.</li> <li>• Reversal of voluntary sterilization (including any services for infertility related to voluntary sterilization or its reversal).</li> <li>• Sperm collection, freezing and storage except as described in the Plan's <i>Benefit Handbook</i>.</li> <li>• Sperm identification when not Medically Necessary (e.g., gender identification).</li> <li>• The following fees: wait list fees, non-medical costs, shipping and handling charges etc.</li> <li>• Voluntary sterilization, including tubal ligation and vasectomy, except when specifically listed as a Covered Benefit.</li> <li>• Voluntary termination of pregnancy, except when specifically listed as a Covered Benefit.</li> </ul>
<p><b>Services Provided Under Another Plan</b></p> <ul style="list-style-type: none"> <li>• Costs for any services for which you are entitled to treatment at government expense, including military service connected disabilities.</li> <li>• Costs for services for which payment is required to be made by a Workers' Compensation plan or an Employer under state or federal law.</li> </ul>
<p><b>Telemedicine Services</b></p> <ul style="list-style-type: none"> <li>• Telemedicine services involving e-mail or fax.</li> <li>• Provider fees for technical costs for the provision of telemedicine services.</li> </ul>
<p><b>Types of Care</b></p> <ul style="list-style-type: none"> <li>• Custodial Care.</li> <li>• Recovery programs including rest or domiciliary care, sober houses, transitional support services, and therapeutic communities.</li> <li>• All institutional charges over the semi-private room rate, except when a private room is Medically Necessary.</li> <li>• Pain management programs or clinics.</li> <li>• Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, and diversion or general motivation.</li> <li>• Private duty nursing.</li> <li>• Sports medicine clinics.</li> <li>• Vocational rehabilitation, or vocational evaluations on job adaptability, job placement, or therapy to restore function for a specific occupation.</li> </ul>
<p><b>Vision and Hearing</b></p> <ul style="list-style-type: none"> <li>• Eyeglasses, contact lenses and fittings, except when specifically listed as a Covered Benefit.</li> <li>• Hearing aids, except when specifically listed as a Covered Benefit.</li> <li>• Hearing aid batteries, and any device used by individuals with hearing impairment to communicate over the telephone or internet, such as TTY or TDD.</li> <li>• Over the counter hearing aids.</li> <li>• Refractive eye surgery, including, but not limited to, lasik surgery, orthokeratology and lens implantation for the correction of naturally occurring myopia, hyperopia and astigmatism.</li> <li>• Routine eye examinations, except when specifically listed as a Covered Benefit.</li> </ul>

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

## 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, including physical examinations and testing, required by a third party that is not otherwise Medically Necessary (examples of a third party are an employer, an insurance company, a school, a camp, or court). • Beauty or barber service. • Cost of organs that are sold rather than donated to recipients. • Diabetes equipment replacements when solely due to manufacturer warranty expiration. • Digital therapeutics when not Medically Necessary. • Donated or banked breast milk, except when specifically listed as a Covered Benefit. • 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 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 when specifically listed as a Covered Benefit. • 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. • Services your PCP or a Plan Provider has not provided, arranged or approved when required under your Plan. • Taxes or governmental assessments on services or supplies. • Transportation, except for emergency ambulance transport, and non-emergency medical transport needed for transfer between hospitals or other covered health care facilities or from a covered facility to your home when Medically Necessary 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.

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