Harvard Pilgrim Health Care

a Point32Health company

Member Guide

Your Health Plan Highlights

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Dear Member,

At Harvard Pilgrim, we're not just your health plan provider; we are your health care partner.

That's why we offer flexible health plans with robust local and national provider networks, preventive care programs, digital tools for added convenience and inclusive family-focused benefits.

We encourage you to use this member guide as a self-service tool to assist you toward better health and to maximize the benefits of your health plan.

Your member guide will give you an overview of:

- Medical services
- Behavioral health services
- Chronic condition management
- Wellness programs
- Exclusive discounts and many other great perks

Activate and use your secure member account to learn more and see your own specific health plan coverage and costs.

Visit **harvardpilgrim.org** for more information, resources and access to your secure member account.

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Digital Tools & More

Secure Member Account and Mobile App

Log in or activate your secure online account or download the Harvard Pilgrim mobile app[1] to access your health plan benefits information.

harvardpilgrim.org/create

Find a Provider or Hospital

Log in to your secure account to find a provider near you:

- Search for providers or hospitals by name or location, based on your plan
- Find providers accepting new patients
- View providers by specialty such as behavioral health, pediatrics and more

Estimate My Cost

Log in to your secure account to estimate your out-of-pocket costs and get quality care from a provider that will save you money.

Reduce My Costs

Connect with a nurse at **855-772-8366** to help you shop for a wide range of outpatient tests and procedures, including lab work and diagnostic imaging, and earn cash rewards when you select high-quality, cost-effective providers.[2]

Telehealth Provided by Doctor On Demand

Set up your account online to access a Doctor On Demand provider 24/7, by phone or mobile app worldwide[3] for everyday care and confidential therapy. Physicians can also order your prescription[4] at your local pharmacy when medically necessary.

doctorondemand.com/harvard-pilgrim

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Whole-person Care

Our integrated approach to care allows us to help you improve both your physical and mental well-being for the best outcome.[5]

Broad Network of Providers

You have access to high-quality care through our network of medical and behavioral health care providers. Our network covers New England and extends nationwide, offering both inpatient and outpatient services.

Behavioral Health Programs and Services

We offer innovative behavioral health programs and services for children, adolescents and adults including:

- Virtual therapy and medication management services available 7 days/week to support your mental health and well-being. Services including stress management, support for anxiety and depression and more.
- Quick and easy access to specialized providers offering services including advanced neurological therapies for children with autism spectrum disorder and other developmental differences, and outpatient mental health clinics that focus on delivering timely access to high-quality psychiatry and therapy services.

Behavioral Health Service Navigation

Our specially trained service navigation team helps you find specific resources and care, locate providers, and access innovative tools and services.

Condition Management Programs

Our licensed care managers work with you, your doctor and other health care providers to support your health with a variety of programs including care coordination, complex care, addiction recovery, transition to home, emergency department readmission diversion, supportive care, post facility discharge and peer support.

Substance Use Treatment Services

Services are available through multiple network providers. Members are supported after inpatient treatment by our internal addiction recovery care management team.

For more information about Behavioral Health services call the phone number on the back of your member ID card or visit:

harvardpilgrim.org/behavioral-health

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Understand Your Pharmacy Benefits

OptumRx provides Harvard Pilgrim members with retail, mail order and specialty pharmacy services, allowing you to have one manager for all pharmacy needs.

Log in to Your Secure Member Account to Look Up Your Prescriptions

We cover thousands of medications, but if your current prescription isn't on our list, talk to your doctor about switching to one that is covered.

Prescription Cost-sharing

The amount (copayment, deductible or coinsurance) you'll be responsible for paying, depends on your plan. The medications covered under your plan are organized into different tiers. Refer to your prescription drug plan documents for specific cost-sharing details and a description of the tiers.

Check if Your Prescription Has Special Requirements

If there is a "PA," "STPA," "QL" or "SP" after any of your prescriptions, talk to your provider.

Plan Ahead if You Take Maintenance Medication

Maintenance medications are prescriptions taken regularly for ongoing conditions, such as high blood pressure or diabetes. Check your medication expiration date, refill amount and coverage by logging into your secure online account.

Save Money With Mail Order Service

Mail order service provides the convenience of home delivery instead of going to a retail pharmacy. On some plans, your medication may be less expensive if you buy a 90-day supply through this service.

For more information about pharmacy benefits:

harvardpilgrim.org/member-rx

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Know Your Care Options

Health care isn't one-size-fits-all. Knowing where to seek care for your situation can save you time and money. As a Harvard Pilgrim member, you and your dependents have access to a variety of options:

When to See Your Primary Care Provider (PCP)

For annual checkups and physicals, as well as non-urgent needs such as preventive screenings and immunizations, your PCP is best suited to coordinate your care. They may also offer virtual health care services for even greater convenience.

When to Use Virtual Care, Through Doctor On Demand

You can request a virtual visit with a U.S.-based doctor 24/7 for non-emergency conditions such as upper respiratory infection, upset stomach or skin rash using live video or voice call with your smartphone, tablet or computer. You can also access confidential therapy and build an ongoing relationship with the provider of your choice.

When to Go to a Retail Clinic

Retail clinics, such as CVS MinuteClinic® and Walgreens Healthcare Clinic, are a good option when you're experiencing mild symptoms such as an ear infection or skin conditions like poison ivy, and you want a health professional to check it out without an appointment.

When to Visit an Urgent Care Center

You can visit an urgent care center without an appointment for situations that need immediate treatment but are not considered life-threatening, such as minor burns or cuts that may require stitches.

When to Visit the Emergency Room

If you think you're having a medical emergency and your life is in danger, call 911 or go to the nearest emergency room. Examples include severe chest or abdominal pain or serious injury.

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Condition Management

If you are looking for support with a health concern or condition, our team of care managers are here to help coordinate care to your specific needs. This service is included in your Harvard Pilgrim plan at no additional cost.

Our team is here to provide confidential support if:

- Your doctor says you need surgery
- You or someone you love has been diagnosed with diabetes, asthma, heart disease, depression or another chronic condition
- You're considering getting pregnant or you just found out you're pregnant
- You need help managing your medications
- You want to make lifestyle changes such as weight loss and increased physical activity

We will coordinate with your providers to be sure your care plan and services are effective and supportive of your individual needs.

Call us at **866-750-2068** to get the conversation started.

Our Care Team is available Monday-Friday, from 8:30 a.m.-5 p.m.

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Wellness Discounts & Perks

At Harvard Pilgrim, we want to help you reach your wellness goals through discounts on nutrition, mind and body, fitness, vision and other services related to improving overall health.

For more details on the different programs and services available, visit:

harvardpilgrim.org/discounts

Start Living Well Today

Visit **harvardpilgrim.org/livingwellportal** and click "Harvard Pilgrim Member Login." If you don't have an account, choose "Create a secure member account." Once logged in, select "Get Started" on the Health & Wellness tile.

- Take your Well-being Assessment
- Earn points toward rewards
- Participate in monthly challenges and activities to build healthy habits

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Family & Maternal Health

If you're thinking of starting a family, currently pregnant, a new parent, or seeking assistance with adoption or surrogacy, we are here to help you and your covered family members.

- Fertility information and services
- Pregnancy coverage and care
- Pregnancy and mental health
- Early parenthood assistance
- Parenting resources

Learn more:

harvardpilgrim.org/parenting

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Stay Connected & Informed

While your secure member account provides detailed information on your specific health plan coverage and costs, we also offer many other ways to keep you informed.

Member Newsletter

Our member newsletter shares current health topics and benefit highlights, including tips to manage your health, fun recipes, discounts on wellness services, new programs and much more. It's delivered to your email inbox and posted on our website.

Text Messaging

Our text messaging service is your personalized connection to your health plan. Get reminders and notifications about flu shots, as well as updates on exclusive member discounts and perks.

Email Messages

Receive valuable information about your benefits, discounts and perks, and new programs that support your health and well-being.

Harvardpilgrim.org

Our website is a great place to learn more about the resources, wellness options, condition management programs and additional member benefits that keep you and your family healthy. You can also find doctors, access your secure account, and stay up to date with our latest news.

Social Media

Follow our social channels to keep up with the latest news, tips and stories.

How to Stay in the Know

Check your secure member account to be sure we have your current email address and mobile number, and we'll ensure you stay informed.

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Key Terms

Coinsurance

This is a fixed percentage of costs that you pay for covered services. For example, if you have a plan with coinsurance, you may have to pay 20% of a provider's bill for your care, while Harvard Pilgrim pays 80%. Coinsurance is usually something you pay after you have paid an annual deductible.

Copayments

A fixed dollar amount that you pay for a covered medical service, prescription or medication.

Cost-sharing

Your out-of-pocket costs for services included within your health plan including copayments, deductibles and coinsurance.

Deductible

The amount you owe or pay out-of-pocket during a coverage period (usually one year) for covered health care services before your plan begins to pay.

In-Network

Generally, this describes coverage for care that POS and PPO members receive from participating providers in the Harvard Pilgrim network. In-network coverage typically costs less than out-of-network coverage.

Non-Covered (NC)

Medications that are not currently covered by Harvard Pilgrim.

Out-of-Network

Out-of-network coverage applies only to POS and PPO plans. Harvard Pilgrim will cover care that POS and PPO members receive from non-participating providers, but it usually costs more than in-network coverage.

Out-of-Pocket Maximum

This is a limit on the total amount of cost-sharing you have to pay annually for covered services. This generally includes copayments, coinsurance and deductibles. After you meet your out-of-pocket maximum, Harvard Pilgrim will pay all additional covered health care costs.

Premium

This is the monthly cost of your health insurance coverage.

Prior Authorization (PA)

The need for your provider to tell us why it is medically necessary for you to receive a covered medication or service.

Quantity Limitation (QL)

The quantity limit for a medication that can be purchased at any one time. A common QL is a 30-day supply.

Tier

Medical plans often place providers and hospitals in different categories, or tiers, with different cost-sharing amounts. Typically, you'll save money when you see Tier 1 providers.

For details and more key terms, go to:

harvardpilgrim.org/keyterms

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Important Information About Your Plan

The following information refers to plans offered by Harvard Pilgrim Health Care and its affiliates ("Harvard Pilgrim").

When You Need Care

If your doctor admits you to a hospital for a test, surgery or other procedure, including admission for surgical day care, hospital representatives are responsible for notifying Harvard Pilgrim on your behalf. There are a few procedures that require Harvard Pilgrim's authorization, and your doctor is aware of the procedures they must discuss with us before they take place.

To find out where our participating doctors admit patients, visit our online directory at **harvardpilgrim.org**. Or you can call one of the phone numbers at the end of this document to have one of our representatives assist you.

Harvard Pilgrim requires prior authorization (prospective review of medical necessity and clinical appropriateness) for selected medications, procedures, services and items. The prior authorization process is used to verify member eligibility and facilitate the appropriate utilization of these elective, non-urgent services. Visit **harvardpilgrim.org** to see Prior Authorization for Care details.

When you're in the hospital, Harvard Pilgrim's nurse care managers are available to work with your doctors and other providers to ensure that you receive the care you need. They may evaluate the quality and appropriateness of the services you receive, and when you no longer need hospital care, will work with your medical team to coordinate the services you need in an appropriate clinical setting (e.g., at home, or in a skilled nursing or rehabilitation facility).

In situations where Harvard Pilgrim was not notified of services (e.g., when a member was unable to give insurance information to providers), a post-service review may be completed to evaluate proper use of services or to identify quality of care issues.

Appeals

You may file a complaint about a coverage decision or appeal that decision with Harvard Pilgrim. For details, see your Benefit Handbook.

To access your Benefit Handbook online, log into your secure online account on **harvardpilgrim.org**, click on More Tasks from your Member Dashboard and select View My Plan Documents under Documents. For assistance, call Member Services at **888-333-4742**.

Member Confidentiality

Harvard Pilgrim values individuals' privacy rights and is committed to safeguarding protected health information (PHI) and personal information (PI). To support this commitment, Harvard Pilgrim has established a number of Privacy and Security policies, including those describing the administration of its privacy and security programs, requirements for staff training, and permitted uses and disclosures of PHI and PI. We may collect, use and disclose financial and medical information about you when doing business with you or with others. We do this in accordance with our privacy policies and applicable state and federal laws. Harvard Pilgrim also requires its business partners who administer health care coverage to you on our behalf to protect your information in accordance with applicable state and federal laws.

Visit **harvardpilgrim.org** or call us for a copy of Harvard Pilgrim's Notice of Privacy Practices.

Members: **888-333-4742**
Non-members: **800-848-9995**
TTY: **711**

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Additional Benefit Details

[1] Estimating costs and some other features are not available on the mobile app.

[2] Your health plan may require a referral and/or prior authorization before you receive services from a cost-effective provider. To ensure the services will be covered, please refer to your plan documents or contact Harvard Pilgrim at **888-333-4742**. For Maine-based members of a small group employer whose plans include a Health Savings Account (HSA), these additional services are included in the Reduce My Costs program: physical therapy and occupational therapy. For more information, please visit **harvardpilgrim.org/reducemycosts/maine**. Cash rewards come in an e-gift card format that is emailed directly to the member. Rewards are offered on services that meet minimum savings threshold. Rewards are considered taxable income; please consult with your tax advisor. Massachusetts members may receive a maximum of $500 in Reduce My Costs rewards per member per calendar year.

[3] This excludes U.S. territories (Puerto Rico, Guam, U.S. Virgin Islands) and certain other countries (e.g., nations on the U.S. Sanctions List).

[4] Physicians will not order prescriptions for patients calling from outside the U.S. and they do not provide Schedule I-IV DEA controlled substances and may elect not to treat or prescribe other medications based on what is clinically appropriate.

[5] If you are experiencing a crisis or emergency, you should always call 911 or go to the nearest emergency facility right away.

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:

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 (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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Language Assistance Services

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

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

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

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

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

Hindi (हिंदी) ध्यान दें: अगर आप अंग्रेजी के अलावा कोई दूसरी भाषा बोलते हैं, तो भाषा सहायता सेवाएं आपके ललए ननःशुल्क उपलब्ध हैं। कृपया अपने सदस्य आईडी काडड 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) បុរសិនបរអុន កនិយាយភាសាបសងេបហ្ាពីភាសាអុង់បលេ ស បសវាកមុ្មជំនួ យភាសា ដលែឥតលិតថ្លេ លឹអាចរកហានសហ្ារអុន ក។ សូ មុ្ហាហ្កាន់បលខហាបលី ID កាតសាជិកររស់អុន 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 ທ່ານເວົ້າພາສາອື່ນີ່ທ່ໍບແ ່ນພາສາ ອັງກດ, ທ່ານສາມາດໃຊ້ບໍລການ້ດ້ານພາສາໄ ດ້ ໂດຍ່ໍບເສຍ ຄ່າ. ກະລຸນາໂທຫາເບີ່ທ່ ຢ່ໃນ 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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Contact Us

Member Services

888-333-4742 (TTY: 711)
Mon., Tues. & Thurs. 8am - 6pm
Wed. 10am - 6pm
Fri. 8am - 5:30pm

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Medical Coverage & Cost-Sharing Guide

HMO

With this plan, you will need to receive care from medical professionals and hospitals that participate in Harvard Pilgrim's provider network, except in a medical emergency. Otherwise, you will be responsible for paying all charges.

- **In-network coverage only**
- **PCP required**
- **Referrals needed for most specialists**
- **Co-payments for most office visits**

A primary care provider (PCP) is key to good health

A PCP is the doctor, nurse practitioner or other qualified medical professional you see for annual checkups and for treatment when you're sick or injured.

- Because this plan requires you to have a PCP, we will assign one to you automatically if we don't have one on file for you or if you don't select one when you enroll.
- You and each of your dependents can choose different PCPs from our network of participating providers.
- Find a PCP or see if your current provider is in our network at **harvardpilgrim.org/providerdirectory**

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Getting care with the HMO plan

Routine and preventive care*

There's no extra charge for routine annual exams with your PCP and many preventive tests and services. Other tests and services your PCP orders may require cost-sharing.

Specialty care

You will need your PCP's referral before your plan will cover most kinds of specialty care (e.g., dermatology, physical therapy, etc.). Certain types of visits (e.g., routine eye exams and OB-GYN care) do not require referrals.

Hospital care

You will need a referral from your PCP or specialist for any tests, surgery or treatment you receive at a participating hospital, except in a medical emergency. If you are admitted to the hospital from the emergency room, call your PCP to arrange for any follow-up care you may need.

Behavioral health care**

Your plan covers in-person visits with thousands of participating licensed clinicians; you do not need a referral. Virtual visits via smartphone, tablet or computer are also available.

Care when you're traveling

Your plan covers emergency care if you get sick or injured anywhere in the world.

Acupuncture and chiropractic treatments

Acupuncture and chiropractic benefits are included without referrals on most plans.

Urgent and emergency care

If you have a non-life-threatening illness or injury and your doctor's office is closed, you have a variety of options for getting care. Of course, if you think you're having a medical emergency, go to the emergency room or call 911. Learn more about your care options at **harvardpilgrim.org/urgentcareoptions**

*Preventive services that fall under the federal Affordable Care Act.
**Not all employer-sponsored plans offer behavioral health benefits through Harvard Pilgrim.

Cost-sharing overview

No cost-sharing:
Routine & preventive care*

- Annual checkup with your PCP
- Preventive screenings and tests
- Immunizations, including flu shots
- Routine prenatal and postpartum visits

Cost-sharing may apply:
PCP and specialist visits, diagnostic tests & services, hospital services

- Visits to your provider when you're sick or injured
- Diagnostic screenings and tests outside of preventive care
- X-rays, CT scans and MRIs
- Inpatient and outpatient hospital care
- Emergency room visits
- Prescription drugs**

What you pay for services

Cost-sharing is the portion you pay for specific services like office visits, X-rays and prescriptions.** Copayments, deductibles and coinsurance are examples of cost-sharing.

Coinsurance: A fixed percentage of costs you pay for covered services. For example, you may have to pay 20% of a provider's bill for your care, while Harvard Pilgrim pays 80%. Coinsurance is usually something you pay after you have paid your full annual deductible.

Copayment: A flat dollar amount you pay for certain services on your plan. You may have different copayments for different services (e.g., primary care visits, specialist visits and prescription drugs). Copayments are normally due when you have your appointment or pick up prescriptions at the pharmacy.

Deductible: A set amount of money you pay out of your own pocket for certain covered services. If you have a $2,000 annual deductible, for example, you will have to pay $2,000 worth of charges before Harvard Pilgrim helps pay. Copayments and coinsurance do not count toward your deductible.

Out-of-pocket maximum: A limit on the total amount of cost-sharing you pay annually for covered services. This generally includes copayments, deductibles and coinsurance. After you meet your out-of-pocket maximum, Harvard Pilgrim will pay all additional covered health care costs.

See the Schedule of Benefits for more details on your coverage and cost-sharing amounts.

Learn more at harvardpilgrim.org or call member services at 888-333-4742

* Preventive services that fall under the federal Affordable Care Act.
** Not all employer-sponsored plans offer Harvard Pilgrim prescription drug benefits.

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

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Premium 4-Tier

Prescription Drug Coverage

Tier 1 $	Low-cost generic drugs and certain over-the-counter medications	**Tier 2** $$	High-cost generic drugs and selected brand-name drugs	**Tier 3** $$$	Brand-name drugs without generic equivalents and some high-cost generic drugs	**Tier 4** $$$$	Drugs not in Tiers 1, 2 or 3 (nonpreferred brands and highest-cost generics)

Your Drug Coverage

What is covered?

- Most generic drugs
- Select brand-name drugs without generic equivalents
- Certain over-the-counter medications

What is not covered?

- Most brand-name drugs with generic equivalents
- Cosmetic drugs
- Some brand-name and higher-cost generic drugs

Are there limitations on certain drugs?

Yes, we may limit the quantity of some drugs we cover. For example, you may be able to receive only a certain number of pills or doses.

Do some drugs require prior authorization?

Yes, certain drugs do require prior authorization. This process helps us ensure that you are using the most effective and safe medications for your health conditions. Your prescriber must request prior authorization on your behalf.

Can I request an exception?

Yes. If you need a drug that we either don't cover or limit, you or your provider can ask us for an exception. For details, visit **harvardpilgrim.org/rx**. Choose the year and then **Premium 4-Tier** for information on exceptions.

What is step therapy?

Step therapy is a process that requires you to first try one drug for a medical condition before we cover another drug for that condition. For example, if Drug A and Drug B both treat the same medical condition, we may require you to try Drug A first. If Drug A does not work, then we will cover Drug B.*

How can I learn more?

Use our online Prescription Drug List to find out which drugs we cover. It will show you which ones have quantity limits or require prior authorization or step therapy. Visit **harvardpilgrim.org/rx**, choose the year and then **Premium 4-Tier** to find out how your drugs are covered.

What kinds of over-the-counter medications are available in Tier 1?

Tier 1 includes certain cough, cold and allergy medicines; skin treatments (dermatology); stomach medicines (gastrointestinal); pain relievers; and eye preparations (ophthalmic).

How can I get an over-the-counter medication covered under my prescription drug benefit?

Visit **harvardpilgrim.org/rx** and choose the year and then **Premium 4-Tier**. Use the Prescription Drug Lookup to find out which over-the-counter medications are included in Tier 1. Ask your provider to write a prescription for the generic version and have it filled at a participating pharmacy.

*If you have already tried Drug A or are unable to try Drug A, an exception may be granted.

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Filling Your Prescriptions

Where can I get my prescriptions filled?

You can get your prescriptions filled at any of the more than 68,000 retail pharmacies that belong to our national participating pharmacy network. To confirm whether your pharmacy is in the network, visit **harvardpilgrim.org/rx,** choose the year and then **Premium 4-Tier** to find participating pharmacies.

Can I get a 90-day supply?

If you take maintenance medications (i.e., ones you take continually for conditions such as heart disease, diabetes or depression), you can get a 90-day supply from many retail pharmacies or through our mail order program. Although most maintenance medications are appropriate for mail order, we may exclude drugs from the program for clinical reasons or to prevent potential waste.

To learn more, visit **harvardpilgrim.org/rx**, choose the year and then **Premium 4-Tier** for details. Depending on your coverage, your cost sharing may be lower when you get these drugs through the mail order program.

What if I take specialty medications?

If you take medications for conditions such as hepatitis C, multiple sclerosis or rheumatoid arthritis, your provider must order your prescriptions through our designated specialty pharmacy. Visit **harvardpilgrim.org/rx** for information on our specialty pharmacy program, choose the year and then **Premium 4-Tier** for details.

What do I pay for my medications?

Depending on your plan, your payments — also called "cost sharing" — may include a combination of copayments, coinsurance and a deductible. Refer to the Prescription Drug Coverage insert or Schedule of Benefits to find out what you will pay when you pick up prescriptions at the pharmacy.

If you have questions about your prescription drugs, please speak with your doctor.

Learn more at harvardpilgrim.org/rx or call 888-333-4742 TTY: 711.

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

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Harvard Pilgrim Health Care

Coverage for Over-the-Counter Medications

Your health plan includes coverage for certain generic over-the-counter (OTC) medications. This means cost savings on the essentials in your medicine cabinet.

Here's how it works:

- Use the online lookup tool at **harvardpilgrim.org/rx** to see which OTC medications you take are covered.
- Ask your provider to write a prescription for the covered medication, for up to a 90-day supply.
- Bring the prescription to any in-network pharmacy* so that the pharmacist can give you the proper medication.
- You pay Tier 1 cost sharing instead of the retail price. If you have an HSA plan, you pay either our discounted rate or the retail cost, whichever is lower, until you meet your deductible, and then Tier 1 cost sharing applies.

There's another advantage: because your provider will be giving you a prescription for the OTC medications you take, your medical records will have a more complete medication history.

Below are the types of OTC medications that are covered along with a complete listing by medication:

Type of Therapy	Purpose
Cough, cold, allergy	› Antitussive (cough suppressant) › Expectorant › Nasal decongestant › Antihistamine › Nasal spray
Dermatology	› Anti-fungal › Poison ivy
Eyes (ophthalmic)	› Dry eye › Allergy
Gastrointestinal	› Anti-parasite › H2 blocker (antacid) › Laxative
Pain	› Anti-inflammatory

*Visit harvardpilgrim.org/rx to find in-network pharmacy locations near you.

Covered Over-the-Counter Generic Medications

- When using the lookup tool for your plan's formulary, search by the generic name shown here.
- Only the generic versions of the product names are covered.
- Keep in mind that multiple store brands are available as generic drugs.

Type of Therapy	Medication Brand Name	Generic Name
Cough, cold, allergy	Benadryl tabs, liquid	Diphenhydramine
	Claritin tabs, syrup	Loratadine
	Dextromethorphan liquid, syrup	Guaifenesin
	Nasalcrom nasal spray	Cromolyn
	Ocean 0.65% nasal spray	Saline
	Robitussin syrup, liquid	Phenylephrine tablet
	Sudafed tabs, liquid	Pseudoephedrine
	Zyrtec tabs, solution	Cetirizine
Dermatology	Clotrimazole cream, vaginal cream	Clotrimazole
	Hydrocortisone cream, gel, lotion, ointment, solution (various name brands)	Hydrocortisone
	Miconazole cream, vaginal cream and suppository	Miconazole
	Tolnaftate cream, solution, aerosol	Tolnaftate
Eyes (ophthalmic)	Artificial tears (various name brands)	Artificial tears
	Zaditor OTC 0.025%	Ketotifen
Gastrointestinal	Citrate of Magnesium solution	Magnesium citrate
	Dulcolax tabs, suppositories	Bisacodyl
	Fleet Enema	Sodium phosphate
	Metamucil powder	Psyllium
	Miralax powder	Polyethylene glycol 3350
	Pepcid tabs	Famotidine
	Senna 8.6mg tabs	Senna, sennosides
	Tagamet tabs	Cimetidine
Pain	Ibuprofen 100mg/5mL suspension	Ibuprofen

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

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Wellness Reimbursement

Get reimbursed for fees you pay toward wellness activities — up to $300

What Qualifies for Reimbursement?

- Membership fees to gyms or fitness facilities
- Virtual fitness class subscriptions
- Studios or facilities that offer membership or tuition
- Select nutrition programs
- Select mindfulness meditation programs
- Cardiovascular and strength training equipment
- Seasonal town, club or school athletic fees

Studios and Facilities That Qualify for Reimbursement Include:

- Dance
- Gymnastics
- Swimming
- Martial arts
- Yoga
- Pilates
- Zumba
- Aerobic/group classes
- Spinning classes
- Kickboxing
- CrossFit
- Strength training
- Tennis
- Indoor rock climbing
- Personal training (taught by a certified instructor)

Qualified Nutrition Programs Include:

- PlateJoy
- MyPlate Calorie Counter
- Wondr
- Noom
- Eat Right Now
- Weight Watchers
- Savory Living
- My Fitness Pal
- Lose It!
- EatLove
- Stronger U
- The Dinner Daily

Qualified Mindfulness Programs Include:

- Calm
- Ten Percent Happier
- Headspace
- The Mindfulness App
- Meditation Studio
- Insight Timer

Up to two covered members on a family plan can be reimbursed for up to $150 each, for a maximum reimbursement of $300. Any combination of subscriber, spouse or dependent is eligible for reimbursement. For plans with one covered member, the maximum reimbursement amount is $150 per calendar year.*

How Do I Get Reimbursed?

It's simple. Pay up to four months of your membership, subscription fees, or after purchase of qualified cardiovascular or strength training equipment.

After four months of Harvard Pilgrim membership, you can complete the Wellness Reimbursement Form online or by mail. Go to **harvardpilgrim.org/reimbursement**.

Either click on the link to submit your request online or complete the paper form and mail to the address on the form, along with a copy of your receipts.

What Does Not Qualify for Reimbursement?

- Health club initiation fees
- Fees for country clubs, social clubs and spas
- Nutrition and mindfulness programs not selected by Harvard Pilgrim
- Road race fees, sneakers, athletic wear and non-cardiovascular and non-strength training equipment
- Fitness apparel and footwear

When Can I Submit My Request?

You can request reimbursement:

- Starting May 1 of the current calendar year, and after you've been enrolled in a Harvard Pilgrim plan for four continuous months.
- After four months of membership or subscription
- Once per calendar year, submitted by March 31 of the following year

How Long Will it Take to be Reimbursed?

Once you submit your request, reimbursement takes up to eight weeks. We'll send a check to the subscriber's address of record, made payable to the subscriber.

› Learn more at **harvardpilgrim.org/reimbursement** or call member services at **888-333-4742**

* Available on plans sold to fully-insured large employer groups, and ASO plans that elect this option.
Must be currently enrolled in Harvard Pilgrim at the time of reimbursement for at least four months within a calendar year. Restrictions apply.
Reimbursement may be considered taxable income. Members should consult their employer or tax advisor. Effective January 1, 2024.

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Connecting You to Whole-Person Care

An integrated approach to behavioral health

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All Harvard Pilgrim members can access a comprehensive network of medical and behavioral health care providers, along with innovative programs and services, to improve physical and mental well-being in traditional and virtual settings. Our dedicated team will guide you from the first phone call to aftercare planning, to ensure that you receive whole-person care through an integrated approach.

If you're experiencing a crisis or emergency, you should always call 911 or go to the nearest emergency facility right away.

Member cost sharing may apply for the programs listed in this brochure. Members should refer to their plan documents for specific details regarding their coverage and benefits. Harvard Pilgrim, a Point32Health company, complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. Por servicio de traducción gratuito en español, llame al número de su tarjeta de miembro. 若需免費的中文版本, 請撥打ID卡上的電話號碼。

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Behavioral Health Service Navigation

Our specially trained Service Navigators provide personalized help to find and access the care that's right for you and your dependents. They can help you:

- Navigate the complex health care system through enhanced personalized interactions
- Connect to Harvard Pilgrim's support and programs, such as care managers
- Locate providers and obtain timely behavioral health appointments
- Learn more about the innovative tools and services we offer to support your needs

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Care Management Programs

Our licensed, integrated care managers have extensive experience and will work with you and our network of providers to help you manage medical and behavioral health conditions, create an aftercare plan and connect you with a variety of resources to ensure optimal health.

Care Coordination offers assistance in finding services for members with co-existing medical and/or behavioral health conditions.

Complex Care aims to achieve optimal health and functioning through a comprehensive assessment and tailored care plan based on the member/guardian's priorities for both adults and children with complex and immediate needs.

Addiction Recovery offers information on personalized recovery plans and treatment programs for members who are taking steps towards recovery from substance use and have recently received inpatient treatment for substance use.

Transition to Home offers resources for aftercare plans to assist members who have recently been hospitalized and need help transitioning back home.

Emergency Department Readmission Diversion offers support and assistance for members who have recently visited the emergency room due to medical or behavioral health symptoms.

Supportive Care is designed to assist both adults and children in achieving their health goals. This program is available to members who do not require complex care and may have recently received other treatment, such as in the emergency room. Our care managers provide extended support for those who need additional assistance for a longer period of time. They also work in tandem with our behavioral health team to provide whole-person care for members who have medical and behavioral health needs.

Post Facility Discharge is designed to support members who have recently been discharged from an acute level of care for their behavioral health needs. Our care managers work to ensure follow-up needs are met and identify any risks for readmission, providing a smooth transition back to the community.

Peer Support provides members with access to community resources and support from a peer specialist who has personal experience with mental health issues. We also offer a peer support program for members in our Addiction Recovery program.

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Behavioral Health Programs and Services

Harvard Pilgrim offers innovative behavioral health programs and services for children, adolescents and adults. These programs are designed to provide personalized and effective care, with a focus on improving access to care and overall health outcomes.

Virtual Therapy Services

Available seven days a week to support your mental health and well-being. Our services include AbleTo, Doctor on Demand and Grow Therapy, and offer licensed coaching, talk therapy, medication management and more.

AbleTo Need help managing stress, changing unhealthy habits, improving your mood or managing your time? Harvard Pilgrim members have access to mental health support from AbleTo. These programs aim to seamlessly combine on-demand self-care tools and personalized virtual therapy sessions, helping to ensure access to a range of options from enhancing mental resilience with self-care techniques to connecting with AbleTo licensed therapists for structured guidance and access.

Visit ableto.com/harvardpilgrim to get started

Doctor On Demand licensed providers can support you and your dependents for concerns such as anxiety, depression, seasonal affective disorder, medication management or PTSD by video or phone visits. Appointments are confirmed in less than 72 hours.

Set up your account at doctorondemand.com/harvard-pilgrim

Grow Therapy[1] provides virtual and in-person outpatient therapy and medication management for a wide range of behavioral health needs. This program helps to ensure timely and personalized care for members ages 6+.

Get started at growtherapy.com

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Substance Use Treatment

Available through multiple network providers. Members are supported after inpatient treatment by our internal Addiction Recovery Care Management Team.

Better Life Partners[2] delivers integrated health care, with an integration of primary and behavioral health care, members can truly focus on all aspects of recovery from medical and emotional well-being to substance use disorder. The close relationships with local community organizations add an extra layer of support for members. Members have access to a comprehensive support team of medical experts and specialized clinicians offering key benefits including:

- **Rapid Withdrawal Relief:** Access to medication assisted therapy quickly
- **Flexible Therapy:** Choice of group or individual sessions
- **Expert Counseling:** Weekly and as-needed sessions with trained counselors
- **All-in-One Health:** Virtual and in-person primary care options
- **Easy Communication:** Reachable via phone, email or text message
- **Community Resources:** Connection to local services tailored to unique needs
- **Progress Tracking:** Regular, structured evaluations

For more information, visit betterlifepartners.com

Our Addiction Recovery Care Management Team offers information and support on personalized recovery plans and treatment programs for members who are taking steps towards recovery from substance use and have recently received inpatient treatment for substance use.

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Notes

[1] Grow Therapy Services are available across the country. Services in Rhode Island will be added soon.

[2] Better Life Partners services are available in Massachusetts, New Hampshire, Maine and Vermont.

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We strive to provide a comprehensive and integrated approach to care, supporting you and your family in achieving optimal health and well-being through a seamless, consistent and compassionate experience. Our programs reflect our commitment to health equity by removing barriers to care and ensuring that everyone has access to the quality care they deserve.

Help is just a phone call away

For assistance with accessing these innovative programs and services, please call the number on the back of your member ID card.

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Living Well Program — Enhanced Rewards

Earn up to $120 in rewards

How it works:[1]

Enroll in the Living Well℠ program and earn rewards for participating in a variety of informative, fun and interactive activities including topics such as:

- Stress management
- Healthy eating
- Financial literacy
- Self-care
- Volunteerism
- Physical activity

Subscriber rewards — Earn up to $120 in gift cards.

You'll earn rewards incrementally, so the more you participate in the program, the more rewards you earn. Subscribers can achieve up to eight levels, at $15 each, for a total of $120 in gift cards each year.

Covered dependents or employees who are not Harvard Pilgrim members can participate in a separate Core Rewards program where they can earn points towards monthly gift card drawings.

Well-being as you define it. A community, at your fingertips.

Our program is packed with tools that let you define your own vision of well-being. Here are some of the features:

- Customize to suit your goals
- Sync to your wearable device
- Connect with others for tips and advice

Our digital engagement platform is easily accessible from most devices so you can stay on top of your goals wherever you are.

› Get started at **harvardpilgrim.org/livingwellportal**

[1] Rewards are available for fully-insured commercial accounts rated as large group, with 51-999 eligible employees. Effective January 1, 2025, rewards will also be available to fully-insured small group and individual members across all of the states in which we operate: MA, NH, ME and RI. Rewards may be taxable, please consult with your tax adviser.

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Schedule of Benefits

Harvard Pilgrim Health Care, Inc.

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

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

Medical Necessity Guidelines

We use clinical review criteria to evaluate whether certain services or procedures are Medically Necessary for a Member's care. Members or their practitioners may obtain a copy of our Medical Necessity Guidelines on our website at **www.harvardpilgrim.org** or by calling the Member Services Department at **1–888–333–4742**.

Office Visit Cost Sharing Levels

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

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

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

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

Covered Benefits

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

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

General Cost Sharing Features:	Member Cost Sharing:
Coinsurance and Copayments	
	See the benefits table below
Deductible	
	$2,500 per Member per Calendar Year $5,000 per family per Calendar Year
Important Notice: If a family Deductible applies, it can be met in one of two ways: a. If a Member of a covered family meets an individual Deductible, then that Member has no additional Deductible Member Cost Sharing responsibilities for Covered Benefits for the remainder of the Calendar Year. b. If any number of Members in a covered family collectively meets a family Deductible, then all Members in that covered family have no additional Deductible Member Cost Sharing responsibilities for Covered Benefits for the remainder of the Calendar Year.	
Deductible Rollover	
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 nextCalendar Year. Deductible Rollover amounts will not apply toward the Out-of-Pocket Maximum for the next Calendar Year.	
Out-of-Pocket Maximum	
Includes all Member Cost Sharing except Member Cost Sharing for prescription drugs, which has a separate Out-of-Pocket Maximum	$4,500 per Member per Calendar Year $9,000 per family per Calendar Year

Benefit	Your Cost Sharing
Acupuncture Treatment for Injury or Illness	
– Limited to 20 visits per Calendar Year	$35 Copayment per visit
Ambulance and Medical Transport	
Emergency ambulance transport	No charge
Non-emergency medical transport	No charge
Autism Spectrum Disorders Treatment	
Applied behavior analysis	No Member Cost Sharing applies for your first office visit per Calendar Year with a licensed mental health professional. After the first visit, the following cost sharing applies: $35 Copayment per visit
Chemotherapy and Radiation Therapy	
Chemotherapy	Deductible, then 30% Coinsurance
Radiation therapy	Deductible, then 30% Coinsurance
Chiropractic Care	
	$35 Copayment per visit
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 30% Coinsurance
Dialysis	
	$50 Copayment per visit

Benefit	Your Cost Sharing
Durable Medical Equipment	
Durable medical equipment, including orthotic devices as described in the Benefit Handbook	Deductible, then 30% Coinsurance
Blood glucose monitors, infusion devices, and insulin pumps (including supplies)	No charge
Oxygen and respiratory equipment	No charge
Early Intervention Services (for Members up to the age of 3)	
– Limited to $3,200 per Member per Calendar Year, up to a maximum of $9,600	$35 Copayment per visit
Emergency Room Care	
	Deductible, then 30% Coinsurance
Fertility Treatment (see the Benefit Handbook for details)	
	Deductible, then 20% Coinsurance
Hearing Aids	
– Limited to $3,000 per hearing aid every 36 months, for each hearing impaired ear	Deductible, then 30% Coinsurance
Home Health Care	
	Deductible, then 30% Coinsurance
If services include the administration of drugs, please see the benefit for "Medical Drugs" for Member Cost Sharing details.	
Hospice – Outpatient	
	Deductible, then 30% Coinsurance
Hospital – Inpatient Services	
Acute Hospital care, including blood transfusions, and inhalation therapy	Deductible, then 30% Coinsurance
Inpatient maternity care	Deductible, then 30% Coinsurance
Inpatient routine nursery care	No charge
Inpatient rehabilitation – limited to 100 days per Calendar Year Inpatient rehabilitation and skilled nursing facility care limits are combined	Deductible, then 30% Coinsurance
Skilled nursing facility – limited to 100 days per Calendar Year Inpatient rehabilitation and skilled nursing facility care limits are combined	Deductible, then 30% Coinsurance
Laboratory, Radiology and Other Diagnostic Services (including Independent Laboratories and Freestanding Imaging Centers)	
Laboratory	Deductible, then 30% Coinsurance
Genetic testing	Deductible, then 30% Coinsurance
Radiology	Deductible, then 30% Coinsurance
Breast ultrasound screening	No charge

Benefit	Your Cost Sharing
Laboratory, Radiology and Other Diagnostic Services (including Independent Laboratories and Freestanding Imaging Centers) (Continued)	
Advanced radiology, including CT scans, PET scans, MRI, MRA and nuclear medicine services	Deductible, then 30% Coinsurance
Breast MRI screening	No charge
Other diagnostic services (including allergy testing)	Deductible, then 30% Coinsurance
Low Protein Foods	
– Limited to $3,000 per Calendar Year	No charge
Maternity Care – Outpatient	
Routine outpatient prenatal and postpartum care	No charge
Routine prenatal and postpartum care is usually received and billed from the same Provider as a single or bundled service. Different Member Cost Sharing may apply to any specialized or non-routine service that is billed separately from your routine outpatient prenatal and postpartum care. For example, Member Cost Sharing for services provided by a specialist is listed under "Physician and Other Professional Office Visits" and Member Cost Sharing for an ultrasound billed as a specialized or non-routine service is listed under "Laboratory, Radiology and Other Diagnostic Services (including Independent Laboratories and Freestanding Imaging Centers)."	
Medical Drugs (drugs that cannot be self-administered)	
Medical drugs received in a Physician's office or other outpatient facility	30% Coinsurance up to a maximum Coinsurance of $250 per day
Medical drugs received in the home	30% Coinsurance up to a maximum Coinsurance of $250 per day
Some Medical Drugs may be supplied by a specialty pharmacy. When Medical Drugs are supplied by a specialty pharmacy, the Member Cost Sharing listed above will apply.	
Medical Formulas and Donor Breast Milk	
State mandated formulas and donor breast Milk	No charge
Mental Health and Substance Use Disorder Treatment	
Inpatient Services	Deductible, then 30% Coinsurance
Partial hospitalization services	Deductible, then 30% Coinsurance
Outpatient group therapy	No Member Cost Sharing applies for your first office visit per Calendar Year with a licensed mental health professional. After the first visit, the following cost sharing applies: $10 Copayment per visit
Mental health services in the home	No Member Cost Sharing applies for your first office visit per Calendar Year with a licensed mental health professional. After the first visit, the following cost sharing applies: $35 Copayment per visit
Outpatient treatment, including individual therapy, detoxification, and medication management	No Member Cost Sharing applies for your first office visit per Calendar Year with a licensed mental health professional. After the first visit, the following cost sharing applies: $35 Copayment per visit
Outpatient methadone maintenance	No Member Cost Sharing applies for your first week per Calendar Year with a licensed mental health professional. After the first week, the following cost sharing applies:

Benefit	Your Cost Sharing
Mental Health and Substance Use Disorder Treatment (Continued)	
	$35 Copayment per week
Outpatient psychological testing and neuropsychological assessment	No Member Cost Sharing applies for your first office visit per Calendar Year with a licensed mental health professional. After the first visit, the following cost sharing applies: $35 Copayment per visit
Outpatient telemedicine virtual visit – group therapy	No Member Cost Sharing applies for your first office visit per Calendar Year with a licensed mental health professional. After the first visit, the following cost sharing applies: $10 Copayment per visit
Outpatient telemedicine virtual visit – including individual therapy, detoxification, and medication management	No Member Cost Sharing applies for your first office visit per Calendar Year with a licensed mental health professional. After the first visit, the following cost sharing applies: $35 Copayment per visit
Observation Services	
	Deductible, then 30% Coinsurance
Ostomy Supplies	
	Deductible, then 30% Coinsurance
Physician and Other Professional Office Visits (This includes all covered Plan Providers unless otherwise listed in this Schedule of Benefits.)	
Routine examinations for preventive care, including immunizations	No charge
Not all services you receive during your routine exam are covered at no charge. Only preventive services designated under the Patient Protection and Affordable Care Act (PPACA) are covered at no charge. Other services not included under PPACA may be subject to additional cost sharing. For the current list of preventive services covered at no charge under PPACA, please see the Preventive Services notice on our website at **www.harvardpilgrim.org**. Please see "Laboratory, Radiology and Other Diagnostic Services (including Independent Laboratories and Freestanding Imaging Centers)," for the Member Cost Sharing that applies to diagnostic services not included on this list.	
Consultations, evaluations, Sickness and injury care	**PCP:** No Member Cost Sharing for the first visit per Calendar Year with a PCP. After the first visit, the following cost sharing applies: Level 1: $35 Copayment per visit **All Other Providers:** Level 1: $35 Copayment per visit Level 2: $50 Copayment per visit
Additional Member Cost Sharing may apply. Please refer to the specific benefit in this Schedule of Benefits. For example, if you need sutures, please refer to office based treatments and procedures below. If you need an x-ray or have blood drawn, please refer to "Laboratory, Radiology and Other Diagnostic Services (including Independent Laboratories and Freestanding Imaging Centers)."	
Office based treatments and procedures, including but not limited to administration of injections, casting, suturing, and the application of dressings, non-routine foot care, and surgical procedures	No charge
Administration of allergy injections	$35 Copayment per visit
Preventive Services and Tests	
	No charge

Benefit	Your 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 (even if polyp removal or other necessary medically necessary procedure is required), screening mammograms (including a second screening in the event that the initial screening is inconclusive or an abnormality is discovered), pap tests, certain labs and x-rays, voluntary sterilization for women and all FDA approved contraceptive devices. For a complete list of covered preventive services, please see the Preventive Services Notice on our website at **www.harvardpilgrim.org**. You may also get a copy of the Preventive Services Notice by calling the Member Services Department at **1–888–333–4742**. Harvard Pilgrim will add or delete services from this benefit for preventive services and tests in accordance with Federal and state guidance.	
The following additional preventive services, tests and devices: alpha-fetoprotein (AFP), fetal ultrasound, hepatitis C testing, lead level testing, prostate-specific antigen (PSA) screening, routine hemoglobin tests, group B streptococcus (GBS), routine urinalysis, blood pressure monitor, retinopathy screening, and international normalized ratio (INR) testing.	No charge
Prosthetic Devices	
Prosthetic devices (other than arms and legs)	Deductible, then 30% Coinsurance
Prosthetic arms and legs	20% Coinsurance
Rehabilitation and Habilitation Services – Outpatient	
Cardiac rehabilitation	$50 Copayment per visit
Pulmonary rehabilitation therapy	$50 Copayment per visit
Occupational therapy – limited to 60 visits per Calendar Year Occupational, physical, and speech therapy limits are combined	$35 Copayment per visit
Physical therapy – limited to 60 visits per Calendar Year Occupational, physical, and speech therapy limits are combined	$35 Copayment per visit
Speech therapy – limited to 60 visits per Calendar Year Occupational, physical, and speech therapy limits are combined	$35 Copayment per visit
Outpatient physical, occupational and speech therapies are covered to the extent Medically Necessary for: (1) children up to the age of three and (2) the treatment of Autism Spectrum Disorders. Outpatient physical therapy for postpartum related pelvic floor disorders is not subject to visit limits.	
Scopic Procedures – Outpatient Diagnostic and Therapeutic	
Colonoscopy, endoscopy and sigmoidoscopy	Deductible, then 30% Coinsurance
Surgery – Outpatient	
	Deductible, then 30% Coinsurance

Benefit	Your Cost Sharing
Telemedicine Virtual Visit Services – Outpatient	
	PCP: No Member Cost Sharing for the first visit per Calendar Year with a PCP. After the first visit, the following cost sharing applies: Level 1: $35 Copayment per visit **All Other Providers:** Level 1: $35 Copayment per visit Level 2: $50 Copayment per visit
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	$35 Copayment per visit
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	$50 Copayment per visit
Urgent care center	$50 Copayment per visit
Hospital urgent care center	$50 Copayment per visit
Additional Member Cost Sharing may apply. Please refer to the specific benefit in this Schedule of Benefits. For example, if you have an x-ray or have blood drawn, please refer to "Laboratory, Radiology and Other Diagnostic Services (including Independent Laboratories and Freestanding Imaging Centers)."	
Vision Services	
Urgent eye care	**PCP:** No Member Cost Sharing for the first visit per Calendar Year with a PCP. After the first visit, the following cost sharing applies: Level 1: $35 Copayment per visit **All Other Providers:** Level 1: $35 Copayment per visit Level 2: $50 Copayment per visit
Routine adult eye examinations – limited to 1 exam per Calendar Year	$35 Copayment per visit
Routine pediatric eye examinations – limited to 1 exam per Calendar Year	$35 Copayment per visit
Vision hardware for special conditions	Deductible, then 30% Coinsurance
Voluntary Sterilization – in a Physician's Office	
	No charge
Voluntary Termination of Pregnancy – Outpatient	
	No charge
Wigs and Scalp Hair Prostheses	
– Limited to $350 per Calendar Year (see the Benefit Handbook for details)	Deductible, then 30% 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).

العربية (Arabic)
إنتباه: إذا أنت تتكلم اللُّغة العربية ، خدمات المساعدة اللُّغوية متوفرة لك مجانا. ً إتصل على **1 888-333-4742**
(TTY: 711)

ខ្មែរ (Cambodian) ប្រសិនជាអ្នកនិយាយភាសាខ្មែរ, បើអ្នកនិយាយភាសាខ្មែរ, យើងមានសេវាកម្មបកប្រែ ជូនលោកអ្នកដោយឥតគិតថ្លៃ។ ចូរ ទូរស័ព្ទ 1-888-333-4742 (TTY: 711)។

Français (French) ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-888-333-4742 (ATS: 711).

Italiano (Italian) ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-888-333-4742 (TTY: 711).

한국어 (Korean) '알림': 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-888-333-4742 (TTY: 711) 번으로 전화해 주십시오.

Ελληνικά (Greek) ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, υπάρχουν στη διάθεσή σας δωρεάν υπηρεσίες γλωσσικής υποστήριξης. Καλέστε 1-888-333-4742 (TTY: 711).

Polski (Polish) UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-888-333-4742 (TTY: 711).

हिंदी (Hindi) ध्यान दीजिए: अगर आप हिंदी बोलते हैं तो आपके लिये भाषाकी सहायता मुफ्त में उपलब्ध है. जानकारी के लिये फोन करे. 1-888-333-4742 (TTY: 711)

ગુજરાતી (Gujarati) ધ્યાન આપો : જો તમે ગુજરાતી બોલતા હો તો આપને માટે ભાષાકીય સહાય તદ્દન મફત ઉપલબ્ધ છે. વિશેષ માહિતી માટે ફોન કરો. 1-888-333-4742 (TTY: 711)

ພາສາລາວ (Lao) ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ສັ້ງຄ່າ, 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:

- 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
Harvard Pilgrim Health Care, Inc. | MAINE

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

Exclusion
Alternative Treatments
• Acupuncture care except when specifically listed as a Covered Benefit. • Acupuncture services that are outside the scope of standard acupuncture care. • Alternative or holistic services and all procedures, laboratories and nutritional supplements associated with such treatments. • Aromatherapy, treatment with crystals and alternative medicine. • Any of the following types of programs: Health resorts, spas, recreational programs, camps, wilderness programs (therapeutic outdoor programs), outdoor skills programs, life skills programs, therapeutic or educational boarding schools, and relaxation or lifestyle programs. • Massage therapy when performed by anyone other than a licensed physical therapist, physical therapy assistant, occupational therapist, or certified occupational therapy assistant. • Myotherapy. • Services by a naturopath that are not covered by other Plan Providers under the Plan.
Clinical Trials
Coverage is not provided for the following: • The investigational item, device, or service itself; or • For services, tests or items that are provided solely to satisfy data collection and analysis for the clinical trial and that are not used for the direct clinical management of your condition.
Dental Services
• Dental Care, except when specifically listed as a Covered Benefit. • All services of a dentist for Temporomandibular Joint Dysfunction (TMD). • 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. • Routine foot care. Examples include nail trimming, cutting or debriding and the cutting or removal of corns and calluses. This exclusion does not apply to preventive foot care for Members with diabetes.
Maternity Services
• Routine pre-natal and post-partum care when you are traveling outside the Service Area. • Planned home births. • Services provided by a doula

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 Care
• Biofeedback. • Educational services or testing, except services covered under the benefit for Early Intervention Services. No benefits are provided: (1) for educational services intended to enhance educational achievement; or (2) to resolve problems of school performance. • Sensory integrative praxis tests. • 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 care 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.
Physical Appearance
• Cosmetic Services, including drugs, devices, treatments and procedures, except for (1) Cosmetic Services that are incidental to the correction of Physical Functional Impairment, (2) reconstructive surgery to repair or restore appearance damaged by an Accidental Injury, 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, except when specifically listed as a Covered Benefit..
Procedures and Treatments
• Gender reassignment surgery and all related drugs and procedures, except when specifically listed as a Covered Benefit. • Care by a chiropractor outside the scope of standard chiropractic practice, including but not limited to, surgery, prescription or dispensing of drugs or medications, internal examinations, obstetrical practice, or treatment of infections and diagnostic testing for chiropractic care other than an initial X-ray. • Commercial diet plans, weight loss programs and any services in connection with such plans or programs. **Please note**: Your employer may participate in other wellness and health improvement incentive programs offered by Harvard Pilgrim. Please review all your Plan documents for the amount of incentives, if any, available under your Plan. • If a service is listed as requiring that it be provided at a Center of Excellence, no coverage will be provided under this Handbook if that service is received from a Provider that has not been designated as a Center of Excellence. • Nutritional or cosmetic therapy using vitamins, minerals or elements, and other nutrition-based therapy. Examples include supplements, electrolytes, and foods of any kind (including high protein foods and low carbohydrate foods). • Physical examinations and testing for insurance, licensing or employment. • Services for Members who are donors for non-members, except as described under Human Organ Transplant Services. • Testing for central auditory processing. • Group diabetes training, educational programs or camps.
Providers
• Charges for services which were provided after the date on which your membership ends, except as required by Maine law. • Charges for any products or services, including, but not limited to, professional fees, medical equipment, drugs, and Hospital or other facility charges, that are related to any care that is not a Covered Benefit. • Charges for missed appointments. • Concierge service fees. (See the Plan's Benefit Handbook for more information.) • Follow-up care after an emergency room visit, unless provided or arranged by your PCP or Direct Primary Care Provider. • Inpatient charges after your Hospital discharge. • Provider's charge to file a claim or to transcribe or copy your medical records. • Services or supplies provided by: (1) anyone related to you by blood, marriage or adoption, or (2) anyone who ordinarily lives with you.

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

Exclusion
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, 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 when infertility treatment is specifically listed as a Covered Benefit. • 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, unless necessary to preserve the life or health of a Member or unless it is 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 covered by third party liability, other insurance coverage, and which are required to be covered by a Workers' Compensation plan or an Employer under state or federal law, unless a notice of controversy has been filed with the Workers' Compensation Board contesting the work-relatedness of the claimant's condition and no decision has been made by the Board.
Telemedicine
• Telemedicine services involving e-mail, or fax. • Telemedicine services involving audio-only telephone, except where telemedicine is technologically unavailable at a scheduled time and is medically appropriate for the corresponding covered health services. • Provider fees for technical costs for the provision of telemedicine services.
Transgender Health Services
• Abdominoplasty. • Chemical peels. • Collagen injections. • Dermabrasion. • Electrolysis or laser hair removal (for all indications, except when required pre-operatively for genital surgery). • Hair transplantation. • Implantations (e.g. cheek, calf, pectoral, gluteal). • Liposuction. • Lip reduction/enhancement. • Panniculectomy. • Removal of redundant skin. • Reversal of transgender health services and all related drugs and procedures. • Silicone injections (e.g. for breast enlargement). • Transgender health services and all related drugs and procedures for self-insured groups, unless covered under a separate rider. • Voice modification therapy/surgery.
Types of Care
• Custodial Care. • Rest or domiciliary care. • All institutional charges over the semi-private room rate, except when a private room is Medically Necessary. • Pain management programs or clinics. • Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, and diversion or general motivation. • Private duty nursing. • Sports medicine clinics. • Vocational rehabilitation, or vocational evaluations on job adaptability, job placement, or therapy to restore function for a specific occupation.
Vision and Hearing
• Eyeglasses, contact lenses and fittings, except as listed in the Plan's *Benefit Handbook* and any associated Riders. • 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.

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, supply or medication when there is a less intensive Covered Benefit or most 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). • Any service or supply (with the exception of contact lenses) purchased from the internet. • Beauty or barber service. • Any drug or other product obtained at an outpatient pharmacy, except for pharmacy supplies covered under the benefit for diabetes services, unless your Plan includes outpatient pharmacy coverage. • Diabetes equipment replacements when solely due to manufacturer warranty expiration. • Donated or banked breast milk. • Food or nutritional supplements, including, but not limited to, FDA-approved medical foods obtained by prescription, except as required by law and prescribed for Members who meet HPHC policies for enteral tube feedings. • Guest services. • Medical equipment, devices or supplies except as listed in this Benefit Handbook. • Medical services that are provided to Members who are confined or committed to jail, house of correction, or prison, or custodial facility of the Department of Youth Services. • 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, Schedule of Benefits, or Prescription Drug Brochure. • Services that are not Medically Necessary. • Services your PCP or a Plan Provider has not provided, arranged or approved except as described in the Plan's *Benefit Handbook.* • Taxes or governmental assessments on services or supplies. • Transportation other than by ambulance. • 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.

Harvard Pilgrim Health Care

Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services
The Harvard Pilgrim Deductible HMO

Coverage Period: 01/01/2025 — 12/31/2025
Coverage for: Individual + Family | Plan Type: HMO

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, **www.harvardpilgrim.org/LGsampleEOC**. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other **underlined** terms, see the Glossary. You can view the Glossary at **www.healthcare.gov/sbc-glossary** or call **1-888-333-4742** to request a copy.

Important Questions	Answers	Why This Matters
What is the overall deductible?	$2,500 member/ $5,000 family Benefits are administered on a calendar year basis.	Generally you must pay all the costs up to the **deductible** amount before this **plan** begins to pay. If you have other family members on the policy, they have to meet their own individual **deductible** until the overall family **deductible** amount has been met.
Are there services covered before you meet your deductible?	Yes: **emergency medical transportation**, prescription drugs, outpatient mental health services, **preventive care**, **provider** office visits, **rehabilitation services**, **habilitation services**, routine eye exams, are covered before you meet your **deductibles**.	This **plan** covers some items and services even if you haven't yet met the **deductible** amount. But, a **copayment** or **coinsurance** may apply. For example, this **plan** covers certain **preventive services** without **cost-sharing** and before you meet your **deductible**. See a list of covered **preventive services** at **https://www.healthcare.gov/coverage/preventive-care-benefits/**
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services
What is the out–of–pocket limit for this plan?	$4,500 member/ $9,000 family Separate **out-of-pocket limit** applies to Pharmacy, see "If you need drugs to treat your illness or condition".	The **out-of-pocket limit** is the most you could pay in a year for covered services. If you have other family members in this **plan**, they have to meet their own **out-of-pocket limit** until the overall family **out-of-pocket limit** has been met.

Important Questions	Answers	Why This Matters
What is not included in the out–of–pocket limit?	Prescription drugs, premiums, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. See **https://www.harvardpilgrim.org/public/find-a-provider** or call **1-888-333-4742** for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance-billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	Yes	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Level 1: $35 copay/visit; deductible does not apply	Not covered	No copay for the first office visit/Member.
	Specialist visit	Level 1: $35 copay/visit; deductible does not apply Level 2: $50 copay/visit; deductible does not apply	Not covered	None
	Preventive care/ screening/ immunization	No charge; deductible does not apply	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have a test	Diagnostic test (x-ray, blood work)	X-rays: 30% coinsurance Laboratory: 30% coinsurance	Not covered	None
	Imaging (CT/PET scans, MRIs)	30% coinsurance	Not covered	Cost sharing may vary for certain imaging services.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at **www.harvardpilgrim.org/2025Premium4T**.	Generic drugs	30-Day Retail Tier 1: $10 copay/prescription; deductible does not apply 90-Day Mail Tier 1: $20 copay/prescription; deductible does not apply 30-Day Retail Tier 2: $20 copay/prescription; deductible does not apply 90-Day Mail Tier 2: $40 copay/prescription; deductible does not apply	Not covered	You pay retail price for Out of Network pharmacy drugs and are reimbursed minus applicable cost sharing. Covered only outside of service area. Prescription drug Out-of-Pocket Maximum: $1,000 member/ $2,000 family
	Preferred brand drugs	30-Day Retail Tier 3: $30 copay/prescription; deductible does not apply 90-Day Mail Tier 3: $60 copay/prescription; deductible does not apply	Not covered	
	Non-preferred brand drugs	30-Day Retail Tier 4: $50 copay/prescription; deductible does not apply 90-Day Mail Tier 4: $100 copay/prescription; deductible does not apply	Not covered	
	Specialty drugs	All drugs are covered in Retail Pharmacy and Mail Order Pharmacy Tiers 1 — 4	Not covered	Some drugs must be obtained through a Specialty Pharmacy.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% coinsurance	Not covered	None
	Physician/surgeon fees	30% coinsurance	Not covered	
If you need immediate medical attention	Emergency room care	30% coinsurance		None
	Emergency medical transportation	No charge; deductible does not apply		None
	Urgent care	Urgent care center: $50 copay/visit; deductible does not apply	Urgent care center: Not covered	Non-participating providers only covered outside the service area. Cost sharing may vary based on location.
If you have a hospital stay	Facility fee (e.g., hospital room)	30% coinsurance	Not covered	None
	Physician/surgeon fee	30% coinsurance	Not covered	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$35 copay/visit; deductible does not apply	Not covered	No copay for the first mental health/substance abuse visit/Member.
	Inpatient services	30% coinsurance	Not covered	None
If you are pregnant	Office visits	$35 copay/visit; deductible does not apply	Not covered	Cost sharing does not apply for preventive services (such as routine prenatal visits).
	Childbirth/delivery professional services	30% coinsurance	Not covered	
	Childbirth/delivery facility services	30% coinsurance	Not covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	30% coinsurance	Not covered	None
	Rehabilitation services Habilitation services	Physical Therapy: $35 copay/visit; deductible does not apply Occupational Therapy: $35 copay/visit; deductible does not apply Speech Therapy: $35 copay/visit; deductible does not apply	Not covered	Occupational, physical & speech therapy – 60 combined visits /calendar year
	Skilled nursing care	30% coinsurance	Not covered	100 days/calendar year combined with Inpatient Rehabilitation services.
	Durable medical equipment	30% coinsurance	Not covered	Wigs – $350/calendar year
	Hospice services	30% coinsurance	Not covered	For inpatient see "If you have a hospital stay"
If your child needs dental or eye care	Children's eye exam	$35 copay/visit; deductible does not apply	Not covered	1 exam/calendar year
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Children's glasses
- Cosmetic Surgery
- Dental Care (Adult)
- Long-Term Care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care (except for diabetes or systemic circulatory diseases)
- Services that are not Medically Necessary
- Weight Loss Programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)		
• Acupuncture - 20 visits/calendar year	• Chiropractic Care	• Infertility Treatment
• Bariatric surgery	• Hearing Aids - $3,000/aid every 36 months, for each impaired ear	• Routine eye care (Adult) – 1 exam/calendar year

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or **www.dol.gov/ebsa/healthreform**, or the Department of Health and Human Services, Centers for Consumer Information and Insurance Oversight, at **1-877-267-2323 x61565** or **www.cciio.cms.gov**, or for more information on your rights to continue coverage, you can contact the Member Service number listed on your ID card or call **1-888-333-4742**. Other coverage options may be available to you, too, including buying individual insurance coverage through the **Health Insurance Marketplace**. For more information about the **Marketplace**, visit **www.HealthCare.gov** or call **1-800-318-2596**.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your **plan** for a denial of a **claim**. This complaint is called a **grievance** or **appeal**. For more information about your rights, look at the explanation of benefits you will receive for that medical **claim**. Your **plan** documents also provide complete information on how to submit a **claim**, **appeal**, or a **grievance** for any reason to your **plan**. For more information about your rights, this notice, or assistance, contact:

HPHC Member Appeals-Member Services Department
Harvard Pilgrim Health Care, Inc.
1 Wellness Way
Canton, MA 02021-1166
Telephone: 1-888-333-4742
Fax: 1-617-509-3085

Department of Labor's Employee Benefits Security Administration
1-866-444-3272
www.dol.gov/ebsa/healthreform

Consumer for Affordable Health Care
12 Church Street, PO Box 2409
Augusta, Maine 04338-2490
1-800-965-7476
www.mainecahc.org
consumerhealth@mainecahc.org

Maine Bureau of Insurance
34 State House
Station Augusta, ME 04333
1-207-624-8475
1-800-300-5000

Does this plan meet the Minimum Value Standard? Yes

If your **plan** doesn't meet the **Minimum Value Standards**, you may be eligible for a **premium tax credit** to help you pay for a **plan** through the **Marketplace**.

Does this plan provide Minimum Essential Coverage? Yes

Minimum Essential Coverage generally includes **plans**, **health insurance** available through the **Marketplace** or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of **Minimum Essential Coverage**, you may not be eligible for the **premium tax credit**.

Language Access Services:

Para obtener asistencia en Español, llame al **1–888–333–4742**.
如果需要中文的帮助, 请拨打这个号码 **1–888–333–4742**.
De assistência em Português, por favor ligue **1–888–333–4742**.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your **providers** charge, and many other factors. Focus on the cost-sharing amounts (deductible, copayment and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby (9 months of in-network pre-natal care and a hospital delivery)	
■ The plan's overall deductible	$2,500
■ Specialist copayment	$50
■ Hospital (facility) coinsurance	30%
■ Other coinsurance	30%
This EXAMPLE event includes services like:	
Specialist office visits (*prenatal care*)	
Childbirth/Delivery Professional Services	
Childbirth/Delivery Facility Services	
Diagnostic tests (*ultrasounds and blood work*)	
Specialist visit (*anesthesia*)	
Total Example Cost	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$2,500
Copayments	$70
Coinsurance	$2,000
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$4,500**

Managing Joe's type 2 Diabetes (a year of routine in-network care of a well-controlled condition)	
■ The plan's overall deductible	$2,500
■ Specialist copayment	$50
■ Hospital (facility) coinsurance	30%
■ Other coinsurance	30%
This EXAMPLE event includes services like:	
Primary care physician office visits (*including disease education*)	
Diagnostic tests (*blood work*)	
Prescription drugs	
Durable medical equipment (*glucose meter*)	
Total Example Cost	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$100
Copayments	$1,300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$1,400**

Mia's Simple Fracture (in-network emergency room visit and follow up care)	
■ The plan's overall deductible	$2,500
■ Specialist copayment	$50
■ Hospital (facility) coinsurance	30%
■ Other coinsurance	30%
This EXAMPLE event includes services like:	
Emergency room care (*including medical supplies*)	
Diagnostic test (*x-ray*)	
Durable medical equipment (*crutches*)	
Rehabilitation services (*physical therapy*)	
Total Example Cost	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$1,100
Copayments	$200
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,300**

The plan would be responsible for the other costs of these EXAMPLE covered services.

Language Assistance Services

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

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

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

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

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

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

العربية (Arabic)

إنتباه: إذا أنت تتكلم اَللُّغة **اَلعربية** ، خَدَمات اَلمُساعَدة اَللُّغوية مُتَوفرة لك مَجانا. ً **إتصل على 1 888-333-4742**

(TTY: 711)

ខ្មែរ (Cambodian) ប្រសុំជូនដំណឹង៖ បើអ្នកនិយាយភាសាខ្មែរ, យើងមានសេវាកម្មបកប្រែ ជូនលោកអ្នកដោយឥតគិតថ្លៃ។ ចូរ ទូរស័ព្ទ 1-888-333-4742 (TTY: 711)។

Français (French) ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-888-333-4742 (ATS: 711).

Italiano (Italian) ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-888-333-4742 (TTY: 711).

한국어 (Korean) '알림': 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-888-333-4742 (TTY: 711) 번으로 전화해 주십시오.

Ελληνικά (Greek) ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, υπάρχουν στη διάθεσή σας δωρεάν υπηρεσίες γλωσσικής υποστήριξης. Καλέστε 1-888-333-4742 (TTY: 711).

Polski (Polish) UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-888-333-4742 (TTY: 711).

हिंदी (Hindi) ध्यान दीजिए: अगर आप हिंदी बोलते हैं तो आपके लिये भाषाकी सहायता मुफ्तमें उपलब्ध है. जानकारी के लिये फोन करे. 1-888-333-4742 (TTY: 711)

ગુજરાતી (Gujarati) ધ્યાન આપો : જો તમે ગુજરાતી બોલતા હો તો આપને માટે ભાષાકીય સહાય તદ્દન મફત ઉપલબ્ધ છે. વિશેષ માહિતી માટે ફોન કરો. 1-888-333-4742 (TTY: 711)

ພາສາລາວ (Lao) ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທ 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:

- 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.

Schedule of Benefits

Harvard Pilgrim Health Care, Inc.

MAINE DIFFERENCE DEDUCTIBLE HMO
MAINE

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

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

Medical Necessity Guidelines

We use clinical review criteria to evaluate whether certain services or procedures are Medically Necessary for a Member's care. Members or their practitioners may obtain a copy of our Medical Necessity Guidelines on our website at **www.harvardpilgrim.org** or by calling the Member Services Department at **1–888–333–4742**.

Office Visit Cost Sharing Levels

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

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

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

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

Covered Benefits

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

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

General Cost Sharing Features:	Member Cost Sharing:
Coinsurance and Copayments	
	See the benefits table below
Deductible	
	$3,500 per Member per Calendar Year $7,000 per family per Calendar Year
Important Notice: If a family Deductible applies, it can be met in one of two ways: a. If a Member of a covered family meets an individual Deductible, then that Member has no additional Deductible Member Cost Sharing responsibilities for Covered Benefits for the remainder of the Calendar Year. b. If any number of Members in a covered family collectively meets a family Deductible, then all Members in that covered family have no additional Deductible Member Cost Sharing responsibilities for Covered Benefits for the remainder of the Calendar Year.	
Deductible Rollover	
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 nextCalendar Year. Deductible Rollover amounts will not apply toward the Out-of-Pocket Maximum for the next Calendar Year.	
Out-of-Pocket Maximum	
Includes all Member Cost Sharing except Member Cost Sharing for prescription drugs, which has a separate Out-of-Pocket Maximum	$6,500 per Member per Calendar Year $13,000 per family per Calendar Year

Benefit	Your Cost Sharing
Acupuncture Treatment for Injury or Illness	
– Limited to 20 visits per Calendar Year	$50 Copayment per visit
Ambulance and Medical Transport	
Emergency ambulance transport	No charge
Non-emergency medical transport	No charge
Autism Spectrum Disorders Treatment	
Applied behavior analysis	No Member Cost Sharing applies for your first office visit per Calendar Year with a licensed mental health professional. After the first visit, the following cost sharing applies: $50 Copayment per visit
Chemotherapy and Radiation Therapy	
Chemotherapy	Deductible, then 30% Coinsurance
Radiation therapy	Deductible, then 30% Coinsurance
Chiropractic Care	
– Limited to 40 visits per Calendar Year	$50 Copayment per visit
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 30% Coinsurance
Dialysis	
	$65 Copayment per visit

Benefit	Your Cost Sharing
Durable Medical Equipment	
Durable medical equipment, including orthotic devices as described in the Benefit Handbook	Deductible, then 30% Coinsurance
Blood glucose monitors, infusion devices, and insulin pumps (including supplies)	No charge
Oxygen and respiratory equipment	No charge
Early Intervention Services (for Members up to the age of 3)	
– Limited to $3,200 per Member per Calendar Year, up to a maximum of $9,600	$50 Copayment per visit
Emergency Room Care	
	Deductible, then 30% Coinsurance
Fertility Treatment (see the Benefit Handbook for details)	
	Deductible, then 20% Coinsurance
Hearing Aids	
– Limited to $3,000 per hearing aid every 36 months, for each hearing impaired ear	Deductible, then 30% Coinsurance
Home Health Care	
	Deductible, then 30% Coinsurance
If services include the administration of drugs, please see the benefit for "Medical Drugs" for Member Cost Sharing details.	
Hospice – Outpatient	
	Deductible, then 30% Coinsurance
Hospital – Inpatient Services	
Acute Hospital care, including blood transfusions, and inhalation therapy	Deductible, then 30% Coinsurance
Inpatient maternity care	Deductible, then 30% Coinsurance
Inpatient routine nursery care	No charge
Inpatient rehabilitation – limited to 100 days per Calendar Year Inpatient rehabilitation and skilled nursing facility care limits are combined	Deductible, then 30% Coinsurance
Skilled nursing facility – limited to 100 days per Calendar Year Inpatient rehabilitation and skilled nursing facility care limits are combined	Deductible, then 30% Coinsurance
Laboratory, Radiology and Other Diagnostic Services (including Independent Laboratories and Freestanding Imaging Centers)	
Laboratory	Deductible, then 30% Coinsurance
Genetic testing	Deductible, then 30% Coinsurance
Radiology	Deductible, then 30% Coinsurance
Breast ultrasound screening	No charge

Benefit	Your Cost Sharing
Laboratory, Radiology and Other Diagnostic Services (including Independent Laboratories and Freestanding Imaging Centers) (Continued)	
Advanced radiology, including CT scans, PET scans, MRI, MRA and nuclear medicine services	Deductible, then 30% Coinsurance
Breast MRI screening	No charge
Other diagnostic services (including allergy testing)	Deductible, then 30% Coinsurance
Low Protein Foods	
– Limited to $3,000 per Calendar Year	No charge
Maternity Care – Outpatient	
Routine outpatient prenatal and postpartum care	No charge
Routine prenatal and postpartum care is usually received and billed from the same Provider as a single or bundled service. Different Member Cost Sharing may apply to any specialized or non-routine service that is billed separately from your routine outpatient prenatal and postpartum care. For example, Member Cost Sharing for services provided by a specialist is listed under "Physician and Other Professional Office Visits" and Member Cost Sharing for an ultrasound billed as a specialized or non-routine service is listed under "Laboratory, Radiology and Other Diagnostic Services (including Independent Laboratories and Freestanding Imaging Centers)."	
Medical Drugs (drugs that cannot be self-administered)	
Medical drugs received in a Physician's office or other outpatient facility	30% Coinsurance up to a maximum Coinsurance of $250 per day
Medical drugs received in the home	30% Coinsurance up to a maximum Coinsurance of $250 per day
Some Medical Drugs may be supplied by a specialty pharmacy. When Medical Drugs are supplied by a specialty pharmacy, the Member Cost Sharing listed above will apply.	
Medical Formulas and Donor Breast Milk	
State mandated formulas and donor breast Milk	No charge
Mental Health and Substance Use Disorder Treatment	
Inpatient Services	Deductible, then 30% Coinsurance
Partial hospitalization services	Deductible, then 30% Coinsurance
Outpatient group therapy	No Member Cost Sharing applies for your first office visit per Calendar Year with a licensed mental health professional. After the first visit, the following cost sharing applies: $10 Copayment per visit
Mental health services in the home	No Member Cost Sharing applies for your first office visit per Calendar Year with a licensed mental health professional. After the first visit, the following cost sharing applies: $50 Copayment per visit
Outpatient treatment, including individual therapy, detoxification, and medication management	No Member Cost Sharing applies for your first office visit per Calendar Year with a licensed mental health professional. After the first visit, the following cost sharing applies: $50 Copayment per visit
Outpatient methadone maintenance	No Member Cost Sharing applies for your first week per Calendar Year with a licensed mental health professional. After the first week, the following cost sharing applies:

Benefit	Your Cost Sharing
Mental Health and Substance Use Disorder Treatment (Continued)	
	$50 Copayment per week
Outpatient psychological testing and neuropsychological assessment	No Member Cost Sharing applies for your first office visit per Calendar Year with a licensed mental health professional. After the first visit, the following cost sharing applies: $50 Copayment per visit
Outpatient telemedicine virtual visit – group therapy	No Member Cost Sharing applies for your first office visit per Calendar Year with a licensed mental health professional. After the first visit, the following cost sharing applies: $10 Copayment per visit
Outpatient telemedicine virtual visit – including individual therapy, detoxification, and medication management	No Member Cost Sharing applies for your first office visit per Calendar Year with a licensed mental health professional. After the first visit, the following cost sharing applies: $50 Copayment per visit
Observation Services	
	Deductible, then 30% Coinsurance
Ostomy Supplies	
	Deductible, then 30% Coinsurance
Physician and Other Professional Office Visits (This includes all covered Plan Providers unless otherwise listed in this Schedule of Benefits.)	
Routine examinations for preventive care, including immunizations	No charge
Not all services you receive during your routine exam are covered at no charge. Only preventive services designated under the Patient Protection and Affordable Care Act (PPACA) are covered at no charge. Other services not included under PPACA may be subject to additional cost sharing. For the current list of preventive services covered at no charge under PPACA, please see the Preventive Services notice on our website at **www.harvardpilgrim.org**. Please see "Laboratory, Radiology and Other Diagnostic Services (including Independent Laboratories and Freestanding Imaging Centers)," for the Member Cost Sharing that applies to diagnostic services not included on this list.	
Consultations, evaluations, Sickness and injury care	**PCP:** No Member Cost Sharing for the first visit per Calendar Year with a PCP. After the first visit, the following cost sharing applies: Level 1: $50 Copayment per visit **All Other Providers:** Level 1: $50 Copayment per visit Level 2: $65 Copayment per visit
Additional Member Cost Sharing may apply. Please refer to the specific benefit in this Schedule of Benefits. For example, if you need sutures, please refer to office based treatments and procedures below. If you need an x-ray or have blood drawn, please refer to "Laboratory, Radiology and Other Diagnostic Services (including Independent Laboratories and Freestanding Imaging Centers)."	
Office based treatments and procedures, including but not limited to administration of injections, casting, suturing, and the application of dressings, non-routine foot care, and surgical procedures	No charge
Administration of allergy injections	$50 Copayment per visit
Preventive Services and Tests	
	No charge

Benefit	Your 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 (even if polyp removal or other necessary medically necessary procedure is required), screening mammograms (including a second screening in the event that the initial screening is inconclusive or an abnormality is discovered), pap tests, certain labs and x-rays, voluntary sterilization for women and all FDA approved contraceptive devices. For a complete list of covered preventive services, please see the Preventive Services Notice on our website at **www.harvardpilgrim.org**. You may also get a copy of the Preventive Services Notice by calling the Member Services Department at **1–888–333–4742**. Harvard Pilgrim will add or delete services from this benefit for preventive services and tests in accordance with Federal and state guidance.	
The following additional preventive services, tests and devices: alpha-fetoprotein (AFP), fetal ultrasound, hepatitis C testing, lead level testing, prostate-specific antigen (PSA) screening, routine hemoglobin tests, group B streptococcus (GBS), routine urinalysis, blood pressure monitor, retinopathy screening, and international normalized ratio (INR) testing.	No charge
Prosthetic Devices	
Prosthetic devices (other than arms and legs)	Deductible, then 30% Coinsurance
Prosthetic arms and legs	20% Coinsurance
Rehabilitation and Habilitation Services – Outpatient	
Cardiac rehabilitation	$65 Copayment per visit
Pulmonary rehabilitation therapy	$65 Copayment per visit
Occupational therapy – limited to 60 visits per Calendar Year Occupational, physical, and speech therapy limits are combined	$50 Copayment per visit
Physical therapy – limited to 60 visits per Calendar Year Occupational, physical, and speech therapy limits are combined	$50 Copayment per visit
Speech therapy – limited to 60 visits per Calendar Year Occupational, physical, and speech therapy limits are combined	$50 Copayment per visit
Outpatient physical, occupational and speech therapies are covered to the extent Medically Necessary for: (1) children up to the age of three and (2) the treatment of Autism Spectrum Disorders. Outpatient physical therapy for postpartum related pelvic floor disorders is not subject to visit limits.	
Scopic Procedures – Outpatient Diagnostic and Therapeutic	
Colonoscopy, endoscopy and sigmoidoscopy	Deductible, then 30% Coinsurance
Surgery – Outpatient	
	Deductible, then 30% Coinsurance

Benefit	Your Cost Sharing
Telemedicine Virtual Visit Services – Outpatient	
	PCP: No Member Cost Sharing for the first visit per Calendar Year with a PCP. After the first visit, the following cost sharing applies: Level 1: $50 Copayment per visit **All Other Providers:** Level 1: $50 Copayment per visit Level 2: $65 Copayment per visit
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	$50 Copayment per visit
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	$65 Copayment per visit
Urgent care center	$65 Copayment per visit
Hospital urgent care center	$65 Copayment per visit
Additional Member Cost Sharing may apply. Please refer to the specific benefit in this Schedule of Benefits. For example, if you have an x-ray or have blood drawn, please refer to "Laboratory, Radiology and Other Diagnostic Services (including Independent Laboratories and Freestanding Imaging Centers)."	
Vision Services	
Urgent eye care	**PCP:** No Member Cost Sharing for the first visit per Calendar Year with a PCP. After the first visit, the following cost sharing applies: Level 1: $50 Copayment per visit **All Other Providers:** Level 1: $50 Copayment per visit Level 2: $65 Copayment per visit
Routine adult eye examinations – limited to 1 exam per Calendar Year	$50 Copayment per visit
Routine pediatric eye examinations – limited to 1 exam per Calendar Year	$50 Copayment per visit
Vision hardware for special conditions	Deductible, then 30% Coinsurance
Voluntary Sterilization – in a Physician's Office	
	No charge
Voluntary Termination of Pregnancy – Outpatient	
	No charge
Wigs and Scalp Hair Prostheses	
– Limited to $350 per Calendar Year (see the Benefit Handbook for details)	Deductible, then 30% 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).

العربية (Arabic)
إنتباه: إذا أنت تتكلم اللُّغة العربية ، خدمات المساعدة اللُّغوية متوفرة لك مجانا. ً إتصل على **1 888-333-4742**
(TTY: 711)

ខ្មែរ (Cambodian) ប្រសិនជាអ្នកនិយាយភាសាខ្មែរ, បើអ្នកនិយាយភាសាខ្មែរ, យើងមានសេវាកម្មបកប្រែ ជូនលោកអ្នកដោយឥតគិតថ្លៃ។ ចូរ ទូរស័ព្ទ 1-888-333-4742 (TTY: 711)។

Français (French) ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-888-333-4742 (ATS: 711).

Italiano (Italian) ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-888-333-4742 (TTY: 711).

한국어 (Korean) '알림': 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-888-333-4742 (TTY: 711) 번으로 전화해 주십시오.

Ελληνικά (Greek) ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, υπάρχουν στη διάθεσή σας δωρεάν υπηρεσίες γλωσσικής υποστήριξης. Καλέστε 1-888-333-4742 (TTY: 711).

Polski (Polish) UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-888-333-4742 (TTY: 711).

हिंदी (Hindi) ध्यान दीजिए: अगर आप हिंदी बोलते हैं तो आपके लिये भाषाकी सहायता मुफ्त में उपलब्ध है. जानकारी के लिये फोन करे. 1-888-333-4742 (TTY: 711)

ગુજરાતી (Gujarati) ધ્યાન આપો : જો તમે ગુજરાતી બોલતા હો તો આપને માટે ભાષાકીય સહાય તદ્દન મફત ઉપલબ્ધ છે. વિશેષ માહિતી માટે ફોન કરો. 1-888-333-4742 (TTY: 711)

ພາສາລາວ (Lao) ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ສັ້ງຄ່າ, 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:

- 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
Harvard Pilgrim Health Care, Inc. | MAINE

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

Exclusion
Alternative Treatments
• Acupuncture care except when specifically listed as a Covered Benefit. • Acupuncture services that are outside the scope of standard acupuncture care. • Alternative or holistic services and all procedures, laboratories and nutritional supplements associated with such treatments. • Aromatherapy, treatment with crystals and alternative medicine. • Any of the following types of programs: Health resorts, spas, recreational programs, camps, wilderness programs (therapeutic outdoor programs), outdoor skills programs, life skills programs, therapeutic or educational boarding schools, and relaxation or lifestyle programs. • Massage therapy when performed by anyone other than a licensed physical therapist, physical therapy assistant, occupational therapist, or certified occupational therapy assistant. • Myotherapy. • Services by a naturopath that are not covered by other Plan Providers under the Plan.
Clinical Trials
Coverage is not provided for the following: • The investigational item, device, or service itself; or • For services, tests or items that are provided solely to satisfy data collection and analysis for the clinical trial and that are not used for the direct clinical management of your condition.
Dental Services
• Dental Care, except when specifically listed as a Covered Benefit. • All services of a dentist for Temporomandibular Joint Dysfunction (TMD). • 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. • Routine foot care. Examples include nail trimming, cutting or debriding and the cutting or removal of corns and calluses. This exclusion does not apply to preventive foot care for Members with diabetes.
Maternity Services
• Routine pre-natal and post-partum care when you are traveling outside the Service Area. • Planned home births. • Services provided by a doula

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 Care
• Biofeedback. • Educational services or testing, except services covered under the benefit for Early Intervention Services. No benefits are provided: (1) for educational services intended to enhance educational achievement; or (2) to resolve problems of school performance. • Sensory integrative praxis tests. • 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 care 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.
Physical Appearance
• Cosmetic Services, including drugs, devices, treatments and procedures, except for (1) Cosmetic Services that are incidental to the correction of Physical Functional Impairment, (2) reconstructive surgery to repair or restore appearance damaged by an Accidental Injury, 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, except when specifically listed as a Covered Benefit..
Procedures and Treatments
• Gender reassignment surgery and all related drugs and procedures, except when specifically listed as a Covered Benefit. • Care by a chiropractor outside the scope of standard chiropractic practice, including but not limited to, surgery, prescription or dispensing of drugs or medications, internal examinations, obstetrical practice, or treatment of infections and diagnostic testing for chiropractic care other than an initial X-ray. • Commercial diet plans, weight loss programs and any services in connection with such plans or programs. **Please note**: Your employer may participate in other wellness and health improvement incentive programs offered by Harvard Pilgrim. Please review all your Plan documents for the amount of incentives, if any, available under your Plan. • If a service is listed as requiring that it be provided at a Center of Excellence, no coverage will be provided under this Handbook if that service is received from a Provider that has not been designated as a Center of Excellence. • Nutritional or cosmetic therapy using vitamins, minerals or elements, and other nutrition-based therapy. Examples include supplements, electrolytes, and foods of any kind (including high protein foods and low carbohydrate foods). • Physical examinations and testing for insurance, licensing or employment. • Services for Members who are donors for non-members, except as described under Human Organ Transplant Services. • Testing for central auditory processing. • Group diabetes training, educational programs or camps.
Providers
• Charges for services which were provided after the date on which your membership ends, except as required by Maine law. • Charges for any products or services, including, but not limited to, professional fees, medical equipment, drugs, and Hospital or other facility charges, that are related to any care that is not a Covered Benefit. • Charges for missed appointments. • Concierge service fees. (See the Plan's Benefit Handbook for more information.) • Follow-up care after an emergency room visit, unless provided or arranged by your PCP or Direct Primary Care Provider. • Inpatient charges after your Hospital discharge. • Provider's charge to file a claim or to transcribe or copy your medical records. • Services or supplies provided by: (1) anyone related to you by blood, marriage or adoption, or (2) anyone who ordinarily lives with you.

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

Exclusion
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, 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 when infertility treatment is specifically listed as a Covered Benefit. • 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, unless necessary to preserve the life or health of a Member or unless it is 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 covered by third party liability, other insurance coverage, and which are required to be covered by a Workers' Compensation plan or an Employer under state or federal law, unless a notice of controversy has been filed with the Workers' Compensation Board contesting the work-relatedness of the claimant's condition and no decision has been made by the Board.
Telemedicine
• Telemedicine services involving e-mail, or fax. • Telemedicine services involving audio-only telephone, except where telemedicine is technologically unavailable at a scheduled time and is medically appropriate for the corresponding covered health services. • Provider fees for technical costs for the provision of telemedicine services.
Transgender Health Services
• Abdominoplasty. • Chemical peels. • Collagen injections. • Dermabrasion. • Electrolysis or laser hair removal (for all indications, except when required pre-operatively for genital surgery). • Hair transplantation. • Implantations (e.g. cheek, calf, pectoral, gluteal). • Liposuction. • Lip reduction/enhancement. • Panniculectomy. • Removal of redundant skin. • Reversal of transgender health services and all related drugs and procedures. • Silicone injections (e.g. for breast enlargement). • Transgender health services and all related drugs and procedures for self-insured groups, unless covered under a separate rider. • Voice modification therapy/surgery.
Types of Care
• Custodial Care. • Rest or domiciliary care. • All institutional charges over the semi-private room rate, except when a private room is Medically Necessary. • Pain management programs or clinics. • Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, and diversion or general motivation. • Private duty nursing. • Sports medicine clinics. • Vocational rehabilitation, or vocational evaluations on job adaptability, job placement, or therapy to restore function for a specific occupation.
Vision and Hearing
• Eyeglasses, contact lenses and fittings, except as listed in the Plan's *Benefit Handbook* and any associated Riders. • 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.

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, supply or medication when there is a less intensive Covered Benefit or most 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). • Any service or supply (with the exception of contact lenses) purchased from the internet. • Beauty or barber service. • Any drug or other product obtained at an outpatient pharmacy, except for pharmacy supplies covered under the benefit for diabetes services, unless your Plan includes outpatient pharmacy coverage. • Diabetes equipment replacements when solely due to manufacturer warranty expiration. • Donated or banked breast milk. • Food or nutritional supplements, including, but not limited to, FDA-approved medical foods obtained by prescription, except as required by law and prescribed for Members who meet HPHC policies for enteral tube feedings. • Guest services. • Medical equipment, devices or supplies except as listed in this Benefit Handbook. • Medical services that are provided to Members who are confined or committed to jail, house of correction, or prison, or custodial facility of the Department of Youth Services. • 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, Schedule of Benefits, or Prescription Drug Brochure. • Services that are not Medically Necessary. • Services your PCP or a Plan Provider has not provided, arranged or approved except as described in the Plan's *Benefit Handbook.* • Taxes or governmental assessments on services or supplies. • Transportation other than by ambulance. • 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.

Harvard Pilgrim Health Care

Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services
The Harvard Pilgrim Deductible HMO

Coverage Period: 01/01/2025 — 12/31/2025
Coverage for: Individual + Family | Plan Type: HMO

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, **www.harvardpilgrim.org/LGsampleEOC**. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other **underlined** terms, see the Glossary. You can view the Glossary at **www.healthcare.gov/sbc-glossary** or call **1-888-333-4742** to request a copy.

Important Questions	Answers	Why This Matters
What is the overall deductible?	$3,500 member/ $7,000 family Benefits are administered on a calendar year basis.	Generally you must pay all the costs up to the **deductible** amount before this **plan** begins to pay. If you have other family members on the policy, they have to meet their own individual **deductible** until the overall family **deductible** amount has been met.
Are there services covered before you meet your deductible?	Yes: **emergency medical transportation**, prescription drugs, outpatient mental health services, **preventive care**, **provider** office visits, **rehabilitation services**, **habilitation services**, routine eye exams, are covered before you meet your **deductibles**.	This **plan** covers some items and services even if you haven't yet met the **deductible** amount. But, a **copayment** or **coinsurance** may apply. For example, this **plan** covers certain **preventive services** without **cost-sharing** and before you meet your **deductible**. See a list of covered **preventive services** at **https://www.healthcare.gov/coverage/preventive-care-benefits/**
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services
What is the out–of–pocket limit for this plan?	$6,500 member/ $13,000 family Separate **out-of-pocket limit** applies to Pharmacy, see "If you need drugs to treat your illness or condition".	The **out-of-pocket limit** is the most you could pay in a year for covered services. If you have other family members in this **plan**, they have to meet their own **out-of-pocket limit** until the overall family **out-of-pocket limit** has been met.

Important Questions	Answers	Why This Matters
What is not included in the out–of–pocket limit?	Prescription drugs, premiums, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. See **https://www.harvardpilgrim.org/public/find-a-provider** or call **1-888-333-4742** for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance-billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	Yes	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Level 1: $50 copay/visit; deductible does not apply	Not covered	No copay for the first office visit/Member.
	Specialist visit	Level 1: $50 copay/visit; deductible does not apply Level 2: $65 copay/visit; deductible does not apply	Not covered	None
	Preventive care/ screening/ immunization	No charge; deductible does not apply	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have a test	Diagnostic test (x-ray, blood work)	X-rays: 30% coinsurance Laboratory: 30% coinsurance	Not covered	None
	Imaging (CT/PET scans, MRIs)	30% coinsurance	Not covered	Cost sharing may vary for certain imaging services.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at **www.harvardpilgrim.org/2025Premium4T**.	Generic drugs	30-Day Retail Tier 1: $10 copay/prescription; deductible does not apply 90-Day Mail Tier 1: $20 copay/prescription; deductible does not apply 30-Day Retail Tier 2: $20 copay/prescription; deductible does not apply 90-Day Mail Tier 2: $40 copay/prescription; deductible does not apply	Not covered	You pay retail price for Out of Network pharmacy drugs and are reimbursed minus applicable cost sharing. Covered only outside of service area. Prescription drug Out-of-Pocket Maximum: $1,000 member/ $2,000 family
	Preferred brand drugs	30-Day Retail Tier 3: $30 copay/prescription; deductible does not apply 90-Day Mail Tier 3: $60 copay/prescription; deductible does not apply	Not covered	
	Non-preferred brand drugs	30-Day Retail Tier 4: $50 copay/prescription; deductible does not apply 90-Day Mail Tier 4: $100 copay/prescription; deductible does not apply	Not covered	
	Specialty drugs	All drugs are covered in Retail Pharmacy and Mail Order Pharmacy Tiers 1 — 4	Not covered	Some drugs must be obtained through a Specialty Pharmacy.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% coinsurance	Not covered	None
	Physician/surgeon fees	30% coinsurance	Not covered	
If you need immediate medical attention	Emergency room care	30% coinsurance		None
	Emergency medical transportation	No charge; deductible does not apply		None
	Urgent care	Urgent care center: $65 copay/visit; deductible does not apply	Urgent care center: Not covered	Non-participating providers only covered outside the service area. Cost sharing may vary based on location.
If you have a hospital stay	Facility fee (e.g., hospital room)	30% coinsurance	Not covered	None
	Physician/surgeon fee	30% coinsurance	Not covered	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$50 copay/visit; deductible does not apply	Not covered	No copay for the first mental health/substance abuse visit/Member.
	Inpatient services	30% coinsurance	Not covered	None
If you are pregnant	Office visits	$50 copay/visit; deductible does not apply	Not covered	Cost sharing does not apply for preventive services (such as routine prenatal visits).
	Childbirth/delivery professional services	30% coinsurance	Not covered	
	Childbirth/delivery facility services	30% coinsurance	Not covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	30% coinsurance	Not covered	None
	Rehabilitation services Habilitation services	Physical Therapy: $50 copay/visit; deductible does not apply Occupational Therapy: $50 copay/visit; deductible does not apply Speech Therapy: $50 copay/visit; deductible does not apply	Not covered	Occupational, physical & speech therapy – 60 combined visits /calendar year
	Skilled nursing care	30% coinsurance	Not covered	100 days/calendar year combined with Inpatient Rehabilitation services.
	Durable medical equipment	30% coinsurance	Not covered	Wigs – $350/calendar year
	Hospice services	30% coinsurance	Not covered	For inpatient see "If you have a hospital stay"
If your child needs dental or eye care	Children's eye exam	$50 copay/visit; deductible does not apply	Not covered	1 exam/calendar year
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Children's glasses
- Cosmetic Surgery
- Dental Care (Adult)
- Long-Term Care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care (except for diabetes or systemic circulatory diseases)
- Services that are not Medically Necessary
- Weight Loss Programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)		
• Acupuncture - 20 visits/calendar year	• Chiropractic Care - 40 visits/calendar year	• Infertility Treatment
• Bariatric surgery	• Hearing Aids - $3,000/aid every 36 months, for each impaired ear	• Routine eye care (Adult) – 1 exam/calendar year

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or **www.dol.gov/ebsa/healthreform**, or the Department of Health and Human Services, Centers for Consumer Information and Insurance Oversight, at **1-877-267-2323 x61565** or **www.cciio.cms.gov**, or for more information on your rights to continue coverage, you can contact the Member Service number listed on your ID card or call **1-888-333-4742**. Other coverage options may be available to you, too, including buying individual insurance coverage through the **Health Insurance Marketplace**. For more information about the **Marketplace**, visit **www.HealthCare.gov** or call **1-800-318-2596**.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your **plan** for a denial of a **claim**. This complaint is called a **grievance** or **appeal**. For more information about your rights, look at the explanation of benefits you will receive for that medical **claim**. Your **plan** documents also provide complete information on how to submit a **claim**, **appeal**, or a **grievance** for any reason to your **plan**. For more information about your rights, this notice, or assistance, contact:

HPHC Member Appeals-Member Services Department
Harvard Pilgrim Health Care, Inc.
1 Wellness Way
Canton, MA 02021-1166
Telephone: 1-888-333-4742
Fax: 1-617-509-3085

Department of Labor's Employee Benefits Security Administration
1-866-444-3272
www.dol.gov/ebsa/healthreform

Consumer for Affordable Health Care
12 Church Street, PO Box 2409
Augusta, Maine 04338-2490
1-800-965-7476
www.mainecahc.org
consumerhealth@mainecahc.org

Maine Bureau of Insurance
34 State House
Station Augusta, ME 04333
1-207-624-8475
1-800-300-5000

Does this plan meet the Minimum Value Standard? Yes

If your **plan** doesn't meet the **Minimum Value Standards**, you may be eligible for a **premium tax credit** to help you pay for a **plan** through the **Marketplace**.

Does this plan provide Minimum Essential Coverage? Yes

Minimum Essential Coverage generally includes **plans**, **health insurance** available through the **Marketplace** or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of **Minimum Essential Coverage**, you may not be eligible for the **premium tax credit**.

Language Access Services:

Para obtener asistencia en Español, llame al **1–888–333–4742**.
如果需要中文的帮助, 请拨打这个号码 **1–888–333–4742**.
De assistência em Português, por favor ligue **1–888–333–4742**.

To see examples of how this **plan** might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your **providers** charge, and many other factors. Focus on the cost-sharing amounts (deductible, copayment and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby (9 months of in-network pre-natal care and a hospital delivery)	
■ The plan's overall deductible	$3,500
■ Specialist copayment	$65
■ Hospital (facility) coinsurance	30%
■ Other coinsurance	30%
This EXAMPLE event includes services like:	
Specialist office visits (*prenatal care*)	
Childbirth/Delivery Professional Services	
Childbirth/Delivery Facility Services	
Diagnostic tests (*ultrasounds and blood work*)	
Specialist visit (*anesthesia*)	
Total Example Cost	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$3,500
Copayments	$70
Coinsurance	$2,700
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$6,270**

Managing Joe's type 2 Diabetes (a year of routine in-network care of a well-controlled condition)	
■ The plan's overall deductible	$3,500
■ Specialist copayment	$65
■ Hospital (facility) coinsurance	30%
■ Other coinsurance	30%
This EXAMPLE event includes services like:	
Primary care physician office visits (*including disease education*)	
Diagnostic tests (*blood work*)	
Prescription drugs	
Durable medical equipment (*glucose meter*)	
Total Example Cost	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$100
Copayments	$1,400
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$1,500**

Mia's Simple Fracture (in-network emergency room visit and follow up care)	
■ The plan's overall deductible	$3,500
■ Specialist copayment	$65
■ Hospital (facility) coinsurance	30%
■ Other coinsurance	30%
This EXAMPLE event includes services like:	
Emergency room care (*including medical supplies*)	
Diagnostic test (*x-ray*)	
Durable medical equipment (*crutches*)	
Rehabilitation services (*physical therapy*)	
Total Example Cost	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$1,100
Copayments	$300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,400**

The plan would be responsible for the other costs of these EXAMPLE covered services.

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(TTY: 711)

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

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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.

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Prescription Drug Coverage

PREMIUM 4 TIER

Covered prescription medications are available at participating pharmacies.

	Retail	Mail (up to a 90-day supply)
Tier 1	**Up to a 30-day supply:** $10 Copayment per prescription or prescription refill **Up to a 90-day supply:** $30 Copayment per prescription or prescription refill	$20 Copayment per prescription or prescription refill
Tier 2	**Up to a 30-day supply:** $20 Copayment per prescription or prescription refill **Up to a 90-day supply:** $60 Copayment per prescription or prescription refill	$40 Copayment per prescription or prescription refill
Tier 3	**Up to a 30-day supply:** $30 Copayment per prescription or prescription refill **Up to a 90-day supply:** $90 Copayment per prescription or prescription refill	$60 Copayment per prescription or prescription refill
Tier 4	**Up to a 30-day supply:** $50 Copayment per prescription or prescription refill **Up to a 90-day supply:** $150 Copayment per prescription or prescription refill	$100 Copayment per prescription or prescription refill

Please Note: All infertility drugs will apply 20% Coinsurance per prescription refill. Copayments and/or Coinsurance maximums listed above (if any) will never apply. If a Deductible applies to a particular tier, you will be responsible for paying the Deductible, then 20% Coinsurance.

You may purchase up to a 90–day supply of maintenance medications from certain Maine retail pharmacies. When you obtain a 90–day prescription from one of these Maine retail pharmacies, you will pay the Mail Service Prescription Drug Program Member Cost Sharing. Although most maintenance medications are available for a 90–day supply, we may limit drugs for clinical reasons or to prevent potential waste. In addition, specialty drugs, discussed above, are not available for a 90–day supply.

Your plan has an annual Out-of-Pocket Maximum for prescription drug costs. Your Out-of-Pocket maximum Coinsurance is $1,000 per Member/$2,000 per family. Once you have reached the Out-of-Pocket Maximum

(including deductible, copayment and coinsurance amounts), your prescriptions are covered in full for the rest of the year with no other cost sharing required.

Visit **www.harvardpilgrim.org/2025Premium4T** for participating pharmacy locations and mail order details. Be sure to show your Harvard Pilgrim ID card at the pharmacy to ensure you pay the correct cost-sharing amounts.

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Washington, D.C. 20201
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