Core PPO

Schedule of Benefits

schedule of benefits

Harvard Pilgrim Health Care

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Schedule of Benefits

Harvard Pilgrim Health Care, Inc.

THE HARVARD PILGRIM BEST BUY PPO
MASSACHUSETTS

This Schedule of Benefits summarizes your benefits under The Harvard Pilgrim Best Buy PPO (the Plan) and states the Member Cost Sharing amounts that you must pay for Covered Benefits. However, it is only a summary of your benefits. Please see your Benefit Handbook and Prescription Drug Brochure (if you have the Plan's outpatient pharmacy coverage) for detailed information on benefits covered by the Plan and the terms and conditions of coverage.

There are two levels of coverage - In-Network and Out-of-Network

In-Network coverage applies when you use a Plan Provider for Covered Benefits. When using Plan Providers, coverage is based on the contracted rate between HPHC and the Provider.

Out-of-Network coverage applies when you use a Non-Plan Provider for Covered Benefits. When using Non-Plan Providers, the Plan pays only a percentage of the cost of the care you receive up to the Usual, Customary and Reasonable Charges for the service. In most cases, this will be higher than the HPHC contracted rate. If a Non-Plan Provider charges any amount in excess of the Usual, Customary and Reasonable Charge, you are responsible for the excess amount. Please refer to section I.E.6. Member Cost Sharing in your Benefit Handbook for additional information about Out-of-Network Charges in excess of the Usual, Customary and Reasonable Charge.

You always have coverage for care in a Medical Emergency. In a Medical Emergency, you should go to the nearest emergency facility or call 911 or other local emergency number. Your emergency room Member Cost Sharing is listed below under the heading "Emergency Room Care."

Member Responsibility for Notification and Prior Approval

Members must contact HPHC for coverage of a number of services. These are listed below.

Mental Health Care (Including the Treatment of Substance Abuse Disorders). Prior Approval must be obtained before receiving certain mental health services from Non-Plan Providers. This requirement also applies to treatment of substance abuse disorders. Please refer to our internet site, **www.harvardpilgrim.org**, or contact the Member Services Department at **1-888-333-4742** for a list of services. To obtain Prior Approval for mental health or substance abuse services, please call the Behavioral Health Access Center at **1-888-777-4742**.

Medical Services. Members are required to notify HPHC before the start of any planned inpatient admission to a Non-Plan Medical Facility. Members are also required to obtain Prior Approval from HPHC for certain services. Before you receive services from a Non-Plan Provider, please refer to our Internet site, **www.harvardpilgrim.org**,or contact the Member Services Department at **1-888-333-4742** for a list of Out-of-Network services that require Prior Approval. If you do not provide Notification or obtain Prior Approval when required, you will be responsible for paying the Penalty amount stated in this Schedule of Benefits in addition to any applicable Member Cost Sharing. No coverage will be provided if HPHC determines that the service is not Medically Necessary, and you will be responsible for the entire cost of the service.

Emergency Care. You do not need to contact HPHC before receiving care in a Medical Emergency. In the event of an emergency hospital admission to a Non-Plan Provider, you must notify HPHC within 48 hours of the admission, unless notification is not possible because of your condition. If notice is given to HPHC by an attending emergency physician, no further notification is required. However, if notification is not received when the Member's condition permits it, the Member is responsible for the Penalty amount stated in this Schedule of Benefits. Please call **1-800-708-4414** to notify us of an emergency admission to a Non-Plan facility.

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Clinical Review Criteria

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 clinical review criteria applicable to a service or procedure for which coverage is requested. Clinical review criteria may be obtained by calling **1-888-888-4742 ext. 38723**.

Deductible

A Deductible is a specific dollar amount that is payable by the Member for Covered Benefits received each calendar year before any benefits subject to the Deductible are payable by the Plan. If a family Deductible applies, it is met when any combination of Members in a covered family incur expenses for services to which the Deductible applies.

Your Plan has both an individual Deductible and a family Deductible. However, please note that a Family Deductible only applies if you have Family Coverage. Unless a family Deductible applies, you are responsible for the individual Deductible for covered services each calendar year. If you are a Member with a family Deductible, your Deductible can be satisfied in one of two ways:

a. If a Member of a covered family meets an individual Deductible, then services for that Member that are subject to that Deductible are covered by the Plan for the remainder of the calendar year.
b. If any number of Members in a covered family collectively meet the family Deductible, then all Members of the covered family receive coverage for services subject to that Deductible for the remainder of the calendar year.

Not all services under this Plan are subject to the Deductible. Deductible amounts are incurred as of the date of service. Your Plan Deductible amounts are listed below.

Once a Deductible is met, coverage by the Plan is subject to any other Member Cost Sharing that may apply.

SERVICES SUBJECT TO THE DEDUCTIBLE

Your Deductible applies to all Out-of-Network covered services. Your Deductible also applies to all In-Network covered services, *except* for the following:

– Examinations and consultations performed by physicians and podiatrists, including periodic routine exams for preventive care

– Early intervention services

– Family planning consultations and consultations concerning contraception

– Preventive Services and Tests as listed in this *Schedule of Benefits*

– Prenatal and postpartum care in a physician's office

– Routine nursery charges for newborn care

– Outpatient mental health care services (except psychological testing and neuropsychological assessment, to which your deductible does apply)

– Pediatric preventive dental care

– Blood glucose monitors, insulin pumps and infusion devices

– Applied behavior analysis

Please note that (1) treatments and procedures by physicians and podiatrists, and (2) psychological testing are subject to the Deductible.

Deductible payments are payable to the provider and due when billed.

Prescription Drug Deductible

If your Plan includes outpatient pharmacy coverage, your drug benefit may be subject to a separate Deductible. Payments made toward the prescription drug Deductible are not counted toward the Deductible amounts listed below. Please refer to your Prescription Drug Brochure for specific information on your prescription drug Deductible, if any.

Your Covered Benefits are administered on a calendar year basis.

General Cost Sharing Features:	Member Cost Sharing:
In-Network Coinsurance and Copayments	
	See Covered Benefits below
Out-of-Network Coinsurance and Copayments	
	See Covered Benefits below
Deductible	
– Your Plan Deductible can be met by any combination of eligible In-Network and Out-of-Network expenses.	$1,000 per Member per calendar year $2,000 per family per calendar year
Out-of-Pocket Maximum	
Includes all In-Network and Out-of-Network Member Cost Sharing except charges for durable medical equipment, prosthetic devices. Any charges above the Usual, Customary and Reasonable Charges and any penalty for failure to receive Prior Approval when using Non-Plan Providers do not apply to the Out-of-Pocket Maximum.	$5,000 per Member per calendar year $10,000 per family per calendar year
Out-of-Network Penalty Payment	
– does not count toward the Deductible or Out-of-Pocket Maximum.	$500
Deductible Rollover	
Your Plan has a Deductible Rollover that applies to any Deductible amount that is incurred for services during the last 3 months of the calendar year and is applied toward the Deductible requirement for the next year.	

Benefit	In-Network Plan Providers Member Cost Sharing	Out-of-Network Non-Plan Providers Member Cost Sharing
Ambulance Transport		
– Emergency ambulance transport	Deductible, then no charge	Same as In-Network
– Non-emergency ambulance transport	Deductible, then no charge	Deductible, then 20% Coinsurance

Benefit	In-Network Plan Providers Member Cost Sharing	Out-of-Network Non-Plan Providers Member Cost Sharing
Autism Spectrum Disorders Treatment		
Professional Services – Coverage for the treatment of Autism Spectrum Disorders is provided for all of the services otherwise covered under your Plan. However, no benefit limit applies to services for the treatment of Autism Spectrum Disorders.	Your Member cost sharing depends upon the type of service provided, as listed in this Schedule of Benefits. For example: For services provided by a physician see "Physician and Other Professional Office Visits." For services by a Licensed Mental Health Professional see "Mental Health Care (Including the Treatment of Substance Abuse Disorders)." For services by a physical therapist and occupational therapist, see "Rehabilitation Therapy - Outpatient."	
Applied Behavior Analysis – No benefit limit applies to this service.	$20 Copayment per visit	Deductible, then 20% Coinsurance
Cardiac Rehabilitation		
	Deductible, then no charge	Deductible, then 20% Coinsurance
Chemotherapy and Radiation Therapy — Outpatient		
– Chemotherapy – Radiation therapy	Deductible, then no charge	Deductible, then 20% Coinsurance
Clinical Trials for the Treatment of Cancer		
	Your Member Cost Sharing will depend upon the types of services provided, as listed in this Schedule of Benefits. For example, for services provided by a physician, see "Physician and Other Professional Office Visits." For inpatient hospital care, see "Hospital – Inpatient Services."	
Dental Services		
– Emergency Dental Care	Your Member Cost Sharing will depend upon the types of services provided, as listed in this Schedule of Benefits. For example, for services provided in a dentist's office, see "Physician and Other Professional Services." For services provided in a hospital emergency room, see "Emergency Room Care."	
– Extraction of teeth impacted in bone	Your Member Cost Sharing will depend upon the types of services provided, as listed in this Schedule of Benefits." For example, for services provided in a dentist's office, see "Physician and Other Professional Services."	
– Preventive Dental Care for children (up to the age of 13)	$20 Copayment per visit The Deductible does not apply to pediatric preventive dental care.	Deductible, then 20% Coinsurance
Important Notice: Coverage of Dental Services is very limited. Please see your Benefit Handbook for the details of your coverage.		
Diabetes Services and Supplies		
– Self management and training/diabetic eye examinations/foot care	$20 Copayment per visit	Deductible, then 20% Coinsurance

Benefit	In-Network Plan Providers Member Cost Sharing	Out-of-Network Non-Plan Providers Member Cost Sharing
Diabetes Services and Supplies (Continued)		
– Diabetes equipment and supplies	Deductible, then no charge In-Network Member Cost Sharing, including the Deductible, does not apply to blood glucose monitors or insulin pumps (including supplies) and infusion devices.	Deductible, then 20% Coinsurance Out-of-Network Member Cost Sharing, including the Deductible, does not apply to blood glucose monitors or insulin pumps (including supplies) and infusion devices.
– Pharmacy supplies	Subject to the applicable pharmacy Member Cost Sharing listed on your ID Card. If your Plan does not include coverage for outpatient prescription drugs, then coverage is subject to the lower of the pharmacy's retail price or a Copayment of $5 for Tier 1 drugs or supplies, $10 for Tier 2 drugs or supplies and $25 for Tier 3 drugs or supplies.	Subject to the applicable pharmacy Member Cost Sharing listed on your ID Card. If your Plan does not include coverage for outpatient prescription drugs, then coverage is subject to the lower of the pharmacy's retail price or a Copayment of $5 for Tier 1 drugs or supplies, $10 for Tier 2 drugs or supplies and $25 for Tier 3 drugs or supplies.
For information on the drug tiers, please visit our website at **www.harvardpilgrim.org/ members** and select "pharmacy/drug tier look up" or contact the Member Services Department at **1-888-333-4742**.		
Dialysis		
– Dialysis services	Deductible, then no charge	Deductible, then 20% Coinsurance
– Installation of home equipment is covered up to $300 in a Member's lifetime	Deductible, then no charge	Deductible, then no charge
Durable Medical Equipment		
	Deductible, then 20% Coinsurance In-Network Member Cost Sharing does not apply to the following: – Respiratory equipment – Oxygen and Oxygen equipment	Deductible, then 20% Coinsurance
Early Intervention Services		
	No charge	No charge
Emergency Admission		
	Deductible, then no charge	Same as In-Network

Benefit	In-Network Plan Providers Member Cost Sharing	Out-of-Network Non-Plan Providers Member Cost Sharing
Emergency Room Care		
	Deductible, then $125 Copayment per visit This Copayment is waived if you are admitted directly to the hospital from the emergency room.	Same as In-Network
Family Planning Services		
	$20 Copayment per visit	Deductible, then 20% Coinsurance
Home Health Care		
	Deductible, then no charge	Deductible, then 20% Coinsurance
Hospice Services		
	Your Member Cost Sharing will depend upon the types of services provided, as listed in this Schedule of Benefits. For example, for services provided by a physician, see "Physician and Other Professional Office Visits." For inpatient hospital care, see "Hospital – Inpatient Services."	
Hospital – Inpatient Services		
	Deductible, then no charge	Deductible, then 20% Coinsurance
House Calls		
	Deductible, then no charge	Deductible, then 20% Coinsurance
Human Organ Transplant Services		
	Your Member Cost Sharing will depend upon the types of services provided, as listed in this Schedule of Benefits. For example, for services provided by a physician, see "Physician and Other Professional Office Visits." For inpatient hospital care, see "Hospital – Inpatient Services."	
Hypodermic Syringes and Needles		
	Subject to the applicable pharmacy Member Cost Sharing listed on your ID Card. If your Plan does not include coverage for outpatient prescription drugs, then coverage is subject to the lower of the pharmacy's retail price or a Copayment of $5 for Tier 1 drugs or supplies, $10 for Tier 2 drugs or supplies and $25 for Tier 3 drugs or supplies.	
For information on the three drug tiers, please visit our website at **www.harvardpilgrim/org/members** and select **"pharmacy/drug tier look up"** contact the Member Services Department at **1-888-333-4742**.		
Infertility Services and Treatments (see the Benefit Handbook for details)		
	Your Member Cost Sharing will depend upon the types of services provided, as listed in this Schedule of Benefits. For example, for services provided by a physician, see "Physician and Other Professional Services." For inpatient hospital care, see "Hospital – Inpatient Services."	

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Benefit	In-Network Plan Providers Member Cost Sharing	Out-of-Network Non-Plan Providers Member Cost Sharing
Laboratory and Radiology Services		
– Laboratory and x-rays	Deductible, then no charge	Deductible, then 20% Coinsurance
High end radiology – PET scans – MRA – Nuclear medicine services	Deductible, then no charge	Deductible, then 20% Coinsurance
– CT scans – MRI	Deductible, then no charge	Deductible, then 20% Coinsurance
No Member Cost Sharing applies to certain preventive care services. See "Preventive Services and Tests," below.		
Low Protein Foods		
– Limited to $5,000 per Member per calendar year	Deductible, then no charge	Deductible, then no charge
Maternity Care		
– Routine outpatient prenatal and postpartum care	No charge	Deductible, then 20% Coinsurance
– Preventive services and screenings including: counseling about alcohol and tobacco use, services to promote breastfeeding, routine urinalysis and screenings for the following: asymptomatic bacteriuria; hepatitis B infection; HIV and screenings for STDs (chlamydia, gonorrhea and syphilis); iron deficiency anemia; and Rh (D) incompatibility.	No charge	Deductible, then 20% Coinsurance
Please see "Preventive Services and Tests," below, for additional services and tests covered with no Member Cost Sharing.		
Please Note: 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, for services provided by another physician or specialist, see "Physician and Other Professional Office Visits" for your applicable Member Cost Sharing. Please see your Benefit Handbook for more information on maternity care.		
– Routine nursery care for the newborn, including prophylactic medication to prevent gonorrhea and screenings for the following: hearing loss; congenital hypothyroidism; phenylketonuria (PKU); and sickle cell disease.	No charge The Deductible does not apply to these services.	Deductible, then 20% Coinsurance
– Hospital inpatient services	Deductible, then no charge	Deductible, then 20% Coinsurance
Medical Formulas		
	Deductible, then no charge	Deductible, then no charge
Mental Health Care (Including the Treatment of Substance Abuse Disorders)		
Please note: This Plan is subject to Federal Mental Health Parity law.		

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Benefit	In-Network Plan Providers Member Cost Sharing	Out-of-Network Non-Plan Providers Member Cost Sharing
Mental Health Care (Including the Treatment of Substance Abuse Disorders) (Continued)		
Inpatient Mental Health Care Services		
	Deductible, then no charge	Deductible, then 20% Coinsurance
Intermediate Mental Health Care Services		
– Acute residential treatment (including detoxification), crisis stabilization and in-home family stabilization – Intensive outpatient programs, partial hospitalization and day treatment programs	Deductible, then no charge	Deductible, then 20% Coinsurance
Outpatient Mental Health Care Services		
– Mental health services	Individual therapy — $20 Copayment per visit Group therapy — $10 Copayment per visit	Deductible, then 20% Coinsurance
– Detoxification services	$20 Copayment per visit	Deductible, then 20% Coinsurance
– Medication management	$20 Copayment per visit	Deductible, then 20% Coinsurance
– Psychological testing	Deductible, then no charge	Deductible, then 20% Coinsurance
Ostomy Supplies		
	Deductible, then 20% Coinsurance	Deductible, then 20% Coinsurance
Physician and Other Professional Office Visits (This includes all covered Providers unless otherwise listed in this Schedule of Benefits.)		
Routine examinations for preventive care – Routine physical examinations, annual gynecological examinations, school, camp, sports and premarital examinations	No charge The Deductible does not apply to these services.	Deductible, then 20% Coinsurance
	No Member Cost Sharing applies to certain preventive care services. See "Preventive Services and Tests," below.	
Consultations, evaluations and sickness and injury care – Examinations for illness or injury – Medication management – Consultations and evaluations with specialists – Nutritional counseling	$20 Copayment per visit	Deductible, then 20% Coinsurance

Benefit	In-Network Plan Providers Member Cost Sharing	Out-of-Network Non-Plan Providers Member Cost Sharing
Physician and Other Professional Office Visits (This includes all covered Providers unless otherwise listed in this Schedule of Benefits.) (Continued)		
Treatments and procedures, including but not limited to: – Administration of injections – Allergy treatments – Casting, suturing and the application of dressings – Chemotherapy – Radiation therapy – Pregnancy testing – Genetic counseling – Surgical procedure – Non-routine foot care	Deductible, then no charge	Deductible, then 20% Coinsurance
– Administration of allergy injections	Deductible, then no charge	Deductible, then 20% Coinsurance
Preventive Services and Tests		
Limited to the following select preventive laboratory and pathology tests and screenings as defined by federal law:	No charge	Deductible, then 20% Coinsurance
– Abdominal aortic aneurysm screening (for males 65-75 one time only, if ever smoked) – Alcohol misuse screening and counseling (primary care visits only) – Aspirin for the prevention of heart disease (primary care counseling only) **Note:** Coverage for aspirin is only provided if your Plan includes outpatient pharmacy coverage. – Autism screening (for children at 18 and 24 months of age – primary care visits only) – Behavioral assessments (developmental surveillance, for children of all ages – primary care visits only) – Blood pressure screening – Breast cancer chemoprevention counseling (only for women at high risk for	– Dental caries prevention - oral fluoride (for children to age 5 only) **Note:** Coverage for fluoride is only provided if your Plan includes outpatient pharmacy coverage. – Depression screening (primary care visits only) – Diabetes screenings – Diet counseling – Dyslipidemia screening (for children at high risk for higher lipid levels) – Folic acid supplements (women planning or capable of pregnancy only) **Note:** coverage for folic acid is only provided if your Plan includes outpatient pharmacy coverage. – Hemoglobin A1c – Hepatitis B testing – HIV screening – Immunizations , including flu shots (for children and adults as appropriate)	– Iron deficiency prevention (primary care counseling for children age 6 to 12 months only) **Note:** Coverage for iron is only provided if your Plan includes outpatient pharmacy coverage. – Lead level testing – Microalbuminuria test – Obesity screening – Osteoporosis screening (for menopausal women only) – Ovarian cancer susceptibility screening – Sexually transmitted diseases (STDs) – screenings and counseling – Tobacco use counseling (primary care visits only) – Total cholesterol tests – Tuberculosis skin testing – Vision screening (children to age 5 only) Please see the Maternity Care benefit for additional services

Benefit	In-Network Plan Providers Member Cost Sharing	Out-of-Network Non-Plan Providers Member Cost Sharing
Preventive Services and Tests (Continued)		
Breast Cancer and low risk for adverse effects of chemoprevention) – Breast cancer screening, including mammograms and genetic susceptibility screening – Cervical cancer screening, including pap smears – Cholesterol screening (for adults only) – Colorectal cancer screening, including colonoscopy, sigmoidoscopy and fecal occult blood test		and tests covered with no Member Cost Sharing.
Under federal law the list of preventive services and tests covered above may change periodically based on the recommendations of the following agencies: a. Grade "A" and "B" recommendations of the United States Preventive Services Task Force; b. With respect to immunizations, the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention; and c. With respect to services for woman, infants, children and adolescents, the Health Resources and Services Administration. Information on the recommendations of these agencies may be found on the web site of the US Department of Health and Human Services at: **http://www.healthcare.gov/center/regulations/prevention/recommendations.html**. Harvard Pilgrim will add or delete services from this benefit for preventive services and tests in accordance with changes in the recommendations of the agencies listed above. You can find a list of the current recommendations for preventive care on Harvard Pilgrim's web site at **www.harvardpilgrim.org**.		
Additional Preventive Services and Tests – Fetal ultrasound – Hepatitis C testing – Lead level testing – Prostate-specific antigen (PSA) screening – Routine hemoglobin tests	No charge	Deductible, then 20% Coinsurance
Prosthetic Devices		
	Deductible, then 20% Coinsurance	Deductible, then 20% Coinsurance
Reconstructive Surgery		
	Your Member Cost Sharing will depend upon the types of services provided, as listed in this Schedule of Benefits. For example, for services provided by a physician, see "Physician and Other Professional Services." For inpatient hospital care, see "Hospital – Inpatient Services."	

Benefit	In-Network Plan Providers Member Cost Sharing	Out-of-Network Non-Plan Providers Member Cost Sharing
Rehabilitation Hospital Care		
– Limited to 60 days per calendar year	Deductible, then no charge	Deductible, then 20% Coinsurance
Rehabilitation Therapy - Outpatient		
– Pulmonary Rehabilitation Therapy	Deductible, then no charge	Deductible, then 20% Coinsurance
– Occupational Therapy — limited to 60 visits per calendar year – Physical Therapy — limited to 60 visits per calendar year	Deductible, then no charge	Deductible, then 20% Coinsurance
Scopic Procedures - Outpatient Diagnostic and Therapeutic		
– Colonoscopy, endoscopy and sigmoidoscopy	Your Member Cost Sharing will depend upon where the service is provided as listed in this Schedule of Benefits. For example, for a service provided in an outpatient surgical center, see "Surgery– Outpatient." For services provided in a physician's office, see "Physician and Other Professional Office Visits." For inpatient hospital care, see "Hospital – Inpatient Services."	
No Member Cost Sharing applies to certain preventive care services. See "Preventive Services and Tests," listed above.		
Skilled Nursing Facility Care		
– Limited to 100 days per calendar year	Deductible, then no charge	Deductible, then 20% Coinsurance
Speech-Language and Hearing Services		
	Deductible, then no charge	Deductible, then 20% Coinsurance
Surgery — Outpatient		
	Deductible, then no charge	Deductible, then 20% Coinsurance
Temporomandibular Joint Dysfunction Services (medical treatment only)		
	Your Member Cost Sharing will depend upon where the service is provided as listed in this Schedule of Benefits. For example, for a service provided in an outpatient surgical center, see "Surgery– Outpatient." For services provided in a physician's office, see "Physician and Other Professional Office Visits." For inpatient hospital care, see "Hospital – Inpatient Services."	
Vision Services		
– Routine eye examinations limited to 1 per calendar year	$20 Copayment per visit	Deductible, then 20% Coinsurance
– Vision hardware for special conditions (see your Benefit Handbook for details)	Deductible, then no charge	Deductible, then 20% Coinsurance
Voluntary Sterilization		
	Your Member Cost Sharing will depend upon the types of services provided, as listed in this Schedule of Benefits. For example, for services provided by a physician, see "Physician and Other Professional Services." For inpatient hospital care, see "Hospital – Inpatient Services."	

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Benefit	In-Network Plan Providers Member Cost Sharing	Out-of-Network Non-Plan Providers Member Cost Sharing
Voluntary Termination of Pregnancy		
	Your Member Cost Sharing will depend upon the types of services provided, as listed in this Schedule of Benefits. For example, for a service provided in an outpatient surgical center, see "Surgery– Outpatient." For services provided by a physician, see "Physician and Other Professional Office Visits." For inpatient hospital care, see "Hospital – Inpatient Services."	
Wigs and Scalp Hair Prostheses		
When needed as a result of any form of cancer or leukemia, alopecia areata, alopecia totalis or permanent hair loss due to injury. – Limited to $350 per calendar year (see Benefit Handbook for details)	Deductible, then 20% Coinsurance	Deductible, then 20% Coinsurance

Exclusions

The exclusions headings in this section are intended to group together services, treatments, items, or supplies that fall into a similar category. Actual exclusions appear underneath the headings. A heading does not create, define, modify, limit or expand an exclusion.

The services listed in the table below are not covered by the Plan:

Exclusion	Description
Alternative Treatments	
	a. Acupuncture services, except when specifically listed as a Covered Benefit (please see your Schedule of Benefits). b. Acupuncture services that are outside the scope of standard acupuncture treatment, except when specifically listed as a Covered Benefit (please see your Schedule of Benefits), including services for preventive, maintenance, or wellness care, thermography, hair analysis, heavy metal screening or mineral studies, massage or soft-tissue techniques, diagnostic services, x-rays or services related to menstrual cramps. c. Alternative, holistic or naturopathic services and all procedures, laboratories and nutritional supplements associated with such treatments. d. Aromatherapy, treatment with crystals and alternative medicine. e. Health resorts, spas, recreational programs, camps, wilderness programs (therapeutic outdoor programs), outdoor skills programs, relaxation or lifestyle programs, including any services provided in conjunction with, or as part of such types of programs. f. Massage therapy. g. Myotherapy.
Dental Services	
	a. Dental Care, except the specific dental services listed as Covered Benefits in this Benefit Handbook and your Schedule of Benefits. b. All services of a dentist for Temporomandibular Joint Dysfunction (TMD). c. Extraction of teeth, except when specifically listed as a Covered Benefit (please see your Schedule of Benefits). d. Preventive dental care for children, except when specifically listed as a Covered Benefit (please see your Schedule of Benefits). e. Dentures.
Durable Medical Equipment and Prosthetic Devices	
	a. Any devices or special equipment needed for sports or occupational purposes. b. Any home adaptations, including, but not limited to home improvements and home adaptation equipment. c. Myoelectric and bionic arms and legs, except when specifically listed as a Covered Benefit. (Please see your Schedule of Benefits). d. Non-durable medical equipment, unless used as part of the treatment at a medical facility or as part of approved home health care services. e. Repair or replacement of durable medical equipment or prosthetic devices as a result of loss, negligence, willful damage, or theft.

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Exclusion	Description
Experimental, Unproven or Investigational Services	
	a. Any products or services, including, but not limited to, drugs, devices, treatments, procedures, and diagnostic tests that are Experimental, Unproven, or Investigational.
Foot Care	
	a. Foot orthotics, except for the treatment of severe diabetic foot disease or when specifically listed as a Covered Benefit. (Please see your Schedule of Benefits). b. 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	
	a. Planned home births.
Mental Health Care	
	a. Biofeedback. b. 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; (2) to resolve problems of school performance; or (3) to treat learning disabilities. c. Methadone maintenance. d. Sensory integrative praxis tests. e. Services for any condition with only a "V Code" designation in the Diagnostic and Statistical Manual of Mental Disorders, which means that the condition is not attributable to a mental disorder. f. 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. g. Services or supplies for the diagnosis or treatment of mental health and substance abuse 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. h. Services related to autism spectrum disorders provided under an individualized education program (IEP), including any services provided under an IEP that are delivered by school personnel or any services provided under an IEP purchased from a contractor or vendor.

Exclusion	Description
Physical Appearance	
	a. Cosmetic Services, including drugs, devices, treatments and procedures, except for (1) Cosmetic Services that are incidental to the correction of a Physical Functional Impairment, (2) restorative surgery to repair or restore appearance damaged by an accidental injury, and (3) post-mastectomy care. b. Hair removal or restoration, including, but not limited to, electrolysis, laser treatment, transplantation or drug therapy. c. Liposuction or removal of fat deposits considered undesirable. d. Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures). e. Skin abrasion procedures performed as a treatment for acne. f. Treatment for skin wrinkles or any treatment to improve the appearance of the skin. g. Treatment for spider veins.
Procedures and Treatments	
	a. 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. b. Spinal manipulative therapy (including care by a chiropractor), except when specifically listed as a Covered Benefit (please see your Schedule of Benefits). c. Commercial diet plans, weight loss programs and any services in connection with such plans or programs. d. Gender reassignment surgery and all related drugs and procedures. e. If a service is listed as requiring that it be provided at a Center of Excellence, no In-Network 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. Please see *Handbook* section *"Centers of Excellence"* for more information. f. 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). g. Physical examinations and testing for insurance, licensing or employment. h. Services for Members who are donors for non-members, except as described under Human Organ Transplant Services. i. Testing for central auditory processing. j. Group diabetes training, educational programs or camps.

Exclusion	Description
Providers	
	a. Charges for services which were provided after the date on which your membership ends. b. Charges for any products or services, including, but not limited to, professional fees, medical equipment, drugs, and hospital or other facility charges, that are related to any care that is not a Covered Benefit under this Handbook. c. Charges for missed appointments. d. Concierge service fees. (See *Handbook* section *"Provider Fees For Special Services"* for more information.) e. Inpatient charges after your hospital discharge. f. Provider's charge to file a claim or to transcribe or copy your medical records. g. Services or supplies provided by: (1) anyone related to you by blood, marriage or adoption, or (2) anyone who ordinarily lives with you.
Reproduction	
	a. Any form of Surrogacy or services for a gestational carrier. b. Birth control drugs, implants and devices that must be purchased at an outpatient pharmacy, unless your Plan includes outpatient pharmacy coverage. c. Infertility drugs if a member is not in a Plan authorized cycle of infertility treatment. d. Infertility drugs, if infertility services are not a Covered Benefit. e. Infertility drugs that must be purchased at an outpatient pharmacy, unless your Plan includes outpatient pharmacy coverage. f. Infertility treatment for Members who are not medically infertile. g. Infertility treatment and birth control drugs, implants and devices. h. Reversal of voluntary sterilization (including any services for infertility related to voluntary sterilization or its reversal). i. Sperm collection, freezing and storage except as described in the *Handbook* section *"Covered Benefits"*, *Infertility Services and Treatment*. j. Sperm identification when not Medically Necessary (e.g., gender identification). k. The following fees: wait list fees, non-medical costs, shipping and handling charges etc. l. Voluntary sterilization, including tubal ligation and vasectomy, except when specifically listed as a Covered Benefit (please see your Schedule of Benefits). m. Voluntary termination of pregnancy, except when specifically listed as a Covered Benefit (please see your Schedule of Benefits). n. Voluntary termination of pregnancy, unless the life of the mother is in danger.

Exclusion	Description
Services Provided Under Another Plan	
	a. Costs for any services for which you are entitled to treatment at government expense, including military service connected disabilities. b. Costs for services for which payment is required to be made by a Workers' Compensation plan or an Employer under state or federal law.
Types of Care	
	a. Custodial Care. b. Rest or domiciliary care. c. All institutional charges over the semi-private room rate, except when a private room is Medically Necessary. d. Home health care services that extend beyond care on a short-term intermittent basis. e. Pain management programs or clinics. f. Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, and diversion or general motivation. g. Private duty nursing. h. Sports medicine clinics. i. Vocational rehabilitation, or vocational evaluations on job adaptability, job placement, or therapy to restore function for a specific occupation.
Vision and Hearing	
	a. Eyeglasses, contact lenses and fittings, except as listed in this Benefit Handbook. b. Hearing aids, except when specifically listed as a Covered Benefit (please see your Schedule of Benefits). c. Refractive eye surgery, including, but not limited to, lasik surgery, orthokeratology and lens implantation for the correction of myopia, hyperopia and astigmatism. d. Routine eye examinations, except when specifically listed as a Covered Benefit (please see your Schedule of Benefits).
All Other Exclusions	
	a. Any service or supply furnished in connection with a non-Covered Benefit. b. Beauty or barber service. c. Any drug or other product obtained at an outpatient pharmacy, except for pharmacy supplies covered under the benefit for diabetes services and hypodermic syringes and needles, as required by Massachusetts law, unless your Plan includes outpatient pharmacy coverage. d. Food or nutritional supplements, including, but not limited to, FDA-approved medical foods obtained by prescription, except as required by law. e. Guest services. f. Services for non-Members. g. Services for which no charge would be made in the absence of insurance.

Exclusion	Description
All Other Exclusions (Continued)	
	h. Services for which no coverage is provided in this Benefit Handbook, Schedule of Benefits or Prescription Drug Brochure. i. Services that are not Medically Necessary. j. Taxes or governmental assessments on services or supplies. k. Transportation other than by ambulance. l. The following products and services: • Air conditioners, air purifiers and filters, dehumidifiers and humidifiers. • Car seats. • Chairs, bath chairs, feeding chairs, toddler chairs, chair lifts, recliners. • Electric scooters. • Exercise equipment. • Home modifications including but not limited to elevators, handrails and ramps. • Hot tubs, jacuzzis, saunas or whirlpools. • Mattresses. • Medical alert systems. • Motorized beds. • Pillows. • Power-operated vehicles. • Stair lifts and stair glides. • Strollers. • Safety equipment. • Vehicle modifications including but not limited to van lifts. • Telephone. • Television.

Prescription Drug Coverage

Covered prescription medications are available at participating pharmacies.

Your copayments for up to a 30-day supply are:

- **Tier 1:** **$15**
- **Tier 2:** **$30**
- **Tier 3:** **$55**

These copayment amounts will be shown on your Plan identification (ID) card. Bring your prescription or refill to a participating pharmacy, along with your ID card, and pay the applicable copayment.

Harvard Pilgrim's mail service prescription drug program (Maintenance medications ONLY)

If you have a condition (e.g., high blood pressure) that requires maintenance medications, you can order up to a 90-day supply of these drugs through Harvard Pilgrim's mail service prescription drug program. When you order a 90-day supply, you'll save one-third on your copayments as well as a trip to the pharmacy.

EXAMPLE: If your copayment for a medication is $15, you would need to make one trip to your pharmacy for each 30-day supply — that's three trips to the pharmacy totaling $45. With the mail service prescription drug program, your one-time cost for a 90-day supply of maintenance medications is $30.

You save $15 and have the added convenience of getting everything at once.

Your copayments for a 90-day supply are:

- **Tier 1:** **$30**
- **Tier 2:** **$60**
- **Tier 3:** **$110**

Harvard Pilgrim Health Care

Harvard Pilgrim Health Care *of New England*