Harvard Pilgrim Health Care

Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services
PPO 2500 - Flex

Coverage Period: 12/01/2024 — 11/30/2025
Coverage for: Individual + Family | Plan Type: PPO

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/public/eoc?pdid=PD0000201318**. 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?	In-Network: $2,500 member / $5,000 family Out-of-Network: $5,000 member / $10,000 family Benefits are administered on a Plan Year basis.	Generally, you must pay all of the costs from **providers** up to the **deductible** amount before this plan begins to pay. If you have other family members on the **plan**, each family member must meet their own individual **deductible** until the total amount of **deductible** expenses paid by all family members meets the overall family **deductible**.
Are there services covered before you meet your deductible?	Yes. **Prescription drugs**, **emergency room care**, and the following In-Network services: **preventive care**, **provider** office visits, services from Flex **Providers**, and Non-hospital based imaging, **Rehabilitation services** and **Habilitation services** are covered before you meet your **deductible**.	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?	In-Network: $7,000 member / $14,000 family Out-of-Network: $14,000 member / $28,000 family	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 limits** 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?	Pediatric Dental Care, premiums, balance-billing charges, penalties for failure to obtain preauthorization for services, 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?	No.	You can see the specialist you choose without a referral.

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: $25 copay/ visit; deductible does not apply	20% coinsurance	$0 copay for first visit
	Specialist visit	Level 1: $25 copay/ visit; deductible does not apply Level 2: $50 copay/ visit; deductible does not apply	20% coinsurance	None
	Preventive care/ screening/ immunization	No charge; deductible does not apply	20% coinsurance	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: $50 copay/ visit Laboratory: Flex Providers: No charge; deductible does not apply Other Plan Providers: $45 copay/ visit	X-rays: 20% coinsurance Laboratory: 20% coinsurance	None
	Imaging (CT/PET scans, MRIs)	Non-Hospital Based: $200 copay/ procedure; deductible does not apply Hospital Based: $300 copay/ procedure	20% coinsurance	Out-of-Network preauthorization required. $500 penalty if not obtained
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at **www.harvardpilgrim.org/ 2024Value5T**.	Generic drugs	30-Day Retail Tier 1: $5 copay/ prescription; deductible does not apply 90-Day Mail Tier 1: $10 copay/ prescription; deductible does not apply 30-Day Retail Tier 2: $30 copay/ prescription; deductible does not apply 90-Day Mail Tier 2: $60 copay/ prescription; deductible does not apply	Not covered	Value formulary - covers a limited list; not all drugs are covered. You pay retail price for Out of Network pharmacy drugs and are reimbursed minus applicable cost sharing. Covered only outside of service area.
	Preferred brand drugs	30-Day Retail Tier 3: $60 copay/ prescription; deductible does not apply 90-Day Mail Tier 3: $120 copay/ prescription; deductible does not apply	Not covered	
	Non-preferred brand drugs	30-Day Retail Tier 4: $100 copay/ prescription; deductible does not apply 90-Day Mail Tier 4: $300 copay/ prescription; deductible does not apply	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)	
	Specialty drugs	30-Day Retail Tier 4: $100 copay/ prescription; deductible does not apply 90-Day Mail Tier 4: $300 copay/ prescription; deductible does not apply 30-Day Retail Tier 5: 20% coinsurance up to $250; deductible does not apply 90-Day Mail Tier 5: 20% coinsurance up to $750; deductible does not apply	Not covered	Some drugs must be obtained through a Specialty Pharmacy.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Flex Providers: $50 copay/ visit; deductible does not apply Other Plan Providers: $300 copay/ visit	20% coinsurance	Out-of-Network preauthorization required. $500 penalty if not obtained
	Physician/surgeon fees	Flex Providers: No charge; deductible does not apply Other Plan Providers: No charge; deductible does not apply	20% coinsurance	
If you need immediate medical attention	Emergency room care	$300 copay/ visit; deductible does not apply		None
	Emergency medical transportation	No charge		None
	Urgent care	Urgent care center: $50 copay/ visit; deductible does not apply	Urgent care center: 20% coinsurance	Cost sharing may vary based on Urgent Care location.
If you have a hospital stay	Facility fee (e.g., hospital room)	$250 copay/ admit	20% coinsurance	Out-of-Network preauthorization required. $500 penalty if not obtained
	Physician/surgeon fee	No charge	20% coinsurance	

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 mental health, behavioral health, or substance abuse services	Outpatient services	$25 copay/ visit; deductible does not apply	20% coinsurance	$0 copay for first outpatient mental health/substance abuse visit
	Inpatient services	$250 copay/ admit	20% coinsurance	Out-of-Network preauthorization required. $500 penalty if not obtained
If you are pregnant	Office visits	$25 copay/ visit; deductible does not apply	20% coinsurance	Cost sharing does not apply for preventive services.
	Childbirth/delivery professional services	No charge	20% coinsurance	
	Childbirth/delivery facility services	$250 copay/ admit	20% coinsurance	
If you need help recovering or have other special health needs	Home health care	No charge	20% coinsurance	None
	Rehabilitation services Habilitation services	Physical Therapy: Non-hospital based: $25 copay/ visit; deductible does not apply Hospital based: $50 copay/ visit Occupational Therapy: Non-hospital based: $25 copay/ visit; deductible does not apply Hospital based: $50 copay/ visit Speech Therapy: Non-hospital based: $25 copay/ visit; deductible does not apply Hospital based: $50 copay/ visit	Physical Therapy: 20% coinsurance Occupational Therapy: 20% coinsurance Speech Therapy: 20% coinsurance	Physical & Occupational Therapy - 60 combined visits/ Plan Year Out-of-Network preauthorization required. $500 penalty if not obtained
	Skilled nursing care	$250 copay/ admit	20% coinsurance	- 100 days/ Plan Year

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)	
	Durable medical equipment	20% coinsurance	20% coinsurance	- 1 synthetic monofilament wig/ Plan Year Out-of-Network preauthorization required. $500 penalty if not obtained
	Hospice services	No charge	20% coinsurance	For inpatient see "If you have a hospital stay"
If your child needs dental or eye care	Children's eye exam	$25 copay/ visit; deductible does not apply	20% coinsurance	1 exam/Plan Year
	Children's glasses	Reimbursed first $50, then 50% of covered charges; deductible does not apply		Frames & lenses OR contacts every 12 months up to end of month child turns 19
	Children's dental check-up	No charge; deductible does not apply	20% coinsurance; deductible does not apply	- 2 exams/ 12 months up to end of month child turns 19

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.)

- Cosmetic Surgery
- Dental Care (Adult)
- Long-Term Care
- Private-duty nursing
- Routine foot care (except for diabetes or systemic circulatory diseases)
- Services that are not Medically Necessary

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.)

- Abortion
- Acupuncture
- Bariatric surgery
- Chiropractic Care
- Hearing Aids - $2,000/ hearing aid every 36 months/ impaired ear up to age 22
- Infertility Treatment
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult) - 1 exam/ Plan Year
- Weight Loss Programs - 3 months of Weight Watchers traditional OR at Work/ Plan 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, Center 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

Health Care for All
30 Winter Street, Suite 1004
Boston, MA 02108
1-800-272-4232
http://www.hcfama.org/helpline

Massachusetts Division of Insurance
1000 Washington Street, Suite 810
Boston, MA 02118–6200
1-617-521-7794

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**.

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**.

Language Access Services:

Para obtener asistencia en Español, llame al **1–888–333–4742**.

SM SM SM SM SM SM SM SM SM, SM SM SM SM SM SM SM **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 (deductibles, copayments 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) copayment	$250
■ Other copayment	$0
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	$400
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$2,900**

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) copayment	$250
■ Other copayment	$0
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	$50
Copayments	$1,800
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$1,850**

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) copayment	$250
■ Other copayment	$50
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	$1,500
Copayments	$500
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,000**

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).

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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).

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(TTY: 711)

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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. 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.

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General Notice About Nondiscrimination and Accessibility Requirements

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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.

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(TTY: 711)

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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, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-888-333-4742 (TTY: 711).

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

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

(Continued)

General Notice About Nondiscrimination and Accessibility Requirements

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

HPHC:

- 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.

PPO 2500 - Flex

MASSACHUSETTS

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

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

In-Network coverage applies when you use a Plan Provider for Covered Benefits.

Out-of-Network coverage applies when you use a Non-Plan Provider for Covered Benefits. If a Non-Plan Provider charges any amount in excess of the Allowed Amount, you are responsible for the excess amount.

In a Medical Emergency, you should go to the nearest emergency facility or call 911 or other local emergency access number. Your emergency room Member Cost Sharing is listed in the tables below.

Prior Approval

Prior Approval is required for certain benefits. Before you receive services from a Non-Plan Provider or a Plan Provider outside the Service Area, please refer to our website, **www.harvardpilgrim.org** or contact the Member Services Department at **1-888-333-4742** if you are covered under an Employer Group plan or **1-877-907-4742** if you are covered under an Individual Member plan for the complete listing of services that require Prior Approval. To obtain Prior Approval please call:

- **1–800–708–4414** for medical services
- **1–888–333–4742** for Medical Drugs
- **1–800–708–4414** for mental health and substance use disorder treatment

More information about Prior Approval can be found on our website, **www.harvardpilgrim.org** and in your Benefit Handbook.

Medical Necessity Guidelines

We use clinical review criteria to evaluate whether certain services or procedures are Medically Necessary for a Member's care. Members or their practitioners may obtain a copy of our Medical Necessity Guidelines on our website at **www.harvardpilgrim.org** or by calling the Member Services Department at **1-888-333-4742** if you are covered under an Employer Group plan or **1-877-907-4742** if you are covered under an Individual Member plan.

Flex Providers

This Plan includes Flex Providers. A Flex Provider is a Plan Provider who provides certain outpatient services with lower Member Cost Sharing. When you receive these Covered Benefits from a Flex Provider you will pay a lower Member Cost Sharing amount than if you received the same Covered Benefit from a provider that is not listed as a Flex Provider. The table below identifies the outpatient services which may be obtained from a Flex Provider and the applicable Member Cost Sharing.

The Plan's Provider Directory lists all Plan Providers including those providers listed as a Flex Provider. You can access the Provider Directory at **www.harvardpilgrim.org.** You may also obtain a paper copy free of charge by calling the Member Services Department.

Office Visit Cost Sharing Levels

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

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

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

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 Plan Year basis. If you are covered under an Individual Member Plan, your Plan Year begins on January 1. If you are covered under an Employer Group Plan, your Plan Year begins on your Employer's Anniversary Date. Please see your Benefit Handbook for more details. If you do not know your Employer's Anniversary Date, please contact your Employer's benefits office or call the Member Services Department at **1-888-333-4742.**

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

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

General Cost Sharing Features:	In-Network Member Cost Sharing:	Out-of-Network Member Cost Sharing:
Coinsurance and Copayments		
	See the benefits table below	
Deductible		
The following Deductibles apply to all services except where specifically noted below.	$2,500 per Member per Plan Year $5,000 per family per Plan Year	$5,000 per Member per Plan Year $10,000 per family per Plan Year
Out-of-Pocket Maximum		
Includes all Member Cost Sharing except: – Member Cost Sharing for Pediatric Dental Care, if applicable (if your Plan includes a pediatric dental rider, coverage for pediatric dental services has a separate Out-of-Pocket	$7,000 per Member per Plan Year $14,000 per family per Plan Year	$14,000 per Member per Plan Year $28,000 per family per Plan Year

General Cost Sharing Features:	In-Network Member Cost Sharing:	Out-of-Network Member Cost Sharing:
Maximum) – Any charges above the Allowed Amount and any penalty for failure to receive Prior Approval when using Non-Plan Providers		
Out-of-Network Penalty Payment		
Applies when the Member fails to obtain required Prior Approval for services from a Non-Plan Provider. Does not count toward the Deductible or Out-of-Pocket Maximum	$500	

Benefit:	In-Network Plan Providers Member Cost Sharing:	Out-of-Network Non-Plan Providers Member Cost Sharing:
Acupuncture Treatment for Injury or Illness		
	$50 Copayment per visit	Deductible, then 20% Coinsurance
Ambulance and Medical Transport		
Emergency ambulance transport	Deductible, then no charge	Same as In-Network
Non-emergency Ambulance Air transport	Deductible, then no charge	Same as In-Network
Non-emergency medical transport	Deductible, then no charge	Deductible, then 20% Coinsurance
Autism Spectrum Disorders Treatment		
Applied behavior analysis	No charge for the first mental health visit per Member. After the first visit, the following cost sharing applies: $25 Copayment per visit	Deductible, then 20% Coinsurance
Chemotherapy and Radiation Therapy		
Chemotherapy	Deductible, then no charge	Deductible, then 20% Coinsurance
Radiation therapy	Deductible, then no charge	Deductible, then 20% Coinsurance
Dental Services		
Important Notice: Coverage of Dental Care is very limited. Please see your Benefit Handbook for the details of your coverage.		
Extraction of teeth impacted in bone (performed in a physician's office)	Deductible, then no charge	Deductible, then 20% Coinsurance
If your Plan provides coverage for pediatric dental services, please see your pediatric dental rider for coverage information.		
Dialysis		
	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:
Durable Medical Equipment		
Durable medical equipment	Deductible, then 20% Coinsurance	Deductible, then 20% Coinsurance
Blood glucose monitors, infusion devices, and insulin pumps (including supplies)	Deductible, then no charge	Deductible, then 20% Coinsurance
Oxygen and respiratory equipment	No charge	Deductible, then 20% Coinsurance
Early Intervention Services		
	No charge	No charge
The Plan does not cover the family participation fee required by the Massachusetts Department of Public Health.		
Emergency Admission		
	Deductible, then $250 Copayment per admission	Same as In-Network
Emergency Room Care		
	$300 Copayment per visit	Same as In-Network
This Copayment is waived if you are (1) transferred to either Observation Services or Outpatient Surgery or (2) admitted to the hospital directly from the emergency room. Please see "Hospital - Inpatient Services," "Observation Services," or "Surgery – Outpatient" for the Member Cost Sharing that applies to these benefits.		
Fertility Services (see the Benefit Handbook for details)		
	Your Member Cost Sharing will depend upon where the service is provided, as listed in this Schedule of Benefits. For example, for services provided by a physician, see "Physician and Other Professional Office Visits." For inpatient hospital care, see "Hospital – Inpatient Services."	
Hearing Aids (for Members up to the age of 22)		
– Limited to $2,000 per hearing aid every 36 months, for each hearing impaired ear	Deductible, then 20% Coinsurance	Deductible, then 20% Coinsurance
Home Health Care		
	Deductible, then no charge	Deductible, then 20% Coinsurance
If services include the administration of drugs, please see the benefit for "Medical Drugs" for Member Cost Sharing details.		
Hospice – Outpatient		
	Deductible, then no charge	Deductible, then 20% Coinsurance
Hospital – Inpatient Services		
Acute hospital care	Deductible, then $250 Copayment per admission	Deductible, then 20% Coinsurance
Inpatient maternity care	Deductible, then $250 Copayment per admission	Deductible, then 20% Coinsurance
Inpatient routine nursery care	No charge	Deductible, then 20% Coinsurance
Inpatient rehabilitation – Limited to 60 days per Plan Year	Deductible, then $250 Copayment per admission	Deductible, then 20% Coinsurance

Benefit:	In-Network Plan Providers Member Cost Sharing:	Out-of-Network Non-Plan Providers Member Cost Sharing:
Skilled nursing facility – Limited to 100 days per Plan Year	Deductible, then $250 Copayment per admission	Deductible, then 20% Coinsurance
Infertility Services and Treatments (see the Benefit Handbook for details)		
	Your Member Cost Sharing will depend upon where the service is provided, as listed in this Schedule of Benefits. For example, for services provided by a physician, see "Physician and Other Professional Office Visits." For inpatient hospital care, see "Hospital – Inpatient Services."	
Laboratory, Radiology and Other Diagnostic Services		
Laboratory	**Flex Providers** No charge **Other Plan Providers** Deductible, then $45 Copayment per visit	Deductible, then 20% Coinsurance
Genetic testing	Deductible, then $45 Copayment per visit	Deductible, then 20% Coinsurance
Radiology	Deductible, then $50 Copayment per visit	Deductible, then 20% Coinsurance
Advanced radiology, including CT scans, PET scans, MRI, MRA and nuclear medicine services	**In a physician's office or non-hospital affiliated facility** $200 Copayment per procedure **In a hospital or hospital affiliated facility** Deductible, then $300 Copayment per procedure	Deductible, then 20% Coinsurance
Other diagnostic services	Deductible, then $45 Copayment per visit	Deductible, then 20% Coinsurance
Low Protein Foods		
	Deductible, then no charge	Deductible, then 20% Coinsurance
Maternity Care - Outpatient		
Childbirth classes – Limited to 1 initial childbirth course or 1 refresher course per pregnancy (see the Benefit Handbook for details)	No charge	
Routine outpatient prenatal and postpartum care	No charge The Deductible does not apply to prenatal and postpartum care provided in a physician's office. All other care is covered as stated in this Schedule of Benefits.	Deductible, then 20% Coinsurance

Benefit:	In-Network Plan Providers Member Cost Sharing:	Out-of-Network Non-Plan Providers Member Cost Sharing:
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."		
Medical Drugs (drugs that cannot be self-administered)		
Medical drugs received in a physician's office or other outpatient facility	Deductible, then no charge	Deductible, then 20% Coinsurance
Medical drugs received in the home	Deductible, then no charge	Deductible, then 20% Coinsurance
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		
	Deductible, then no charge	Deductible, then 20% Coinsurance
Mental Health and Substance Use Disorder Treatment		
Inpatient services	Deductible, then $250 Copayment per admission	Deductible, then 20% Coinsurance
Intermediate care services	Deductible, then no charge	Deductible, then 20% Coinsurance
Annual mental health wellness examination performed by a licensed mental health professional **Please Note:** Your annual mental health wellness examination may also be provided by a PCP as part of your annual routine examination for preventive care.	No charge	Deductible, then 20% Coinsurance
Outpatient group therapy	No charge for the first mental health visit per Member. After the first visit, the following cost sharing applies: $10 Copayment per visit	Deductible, then 20% Coinsurance
Outpatient treatment, including individual therapy, outpatient detoxification and medication management	No charge for the first mental health visit per Member. After the first visit, the following cost sharing applies: $25 Copayment per visit	Deductible, then 20% Coinsurance
Outpatient methadone maintenance	No charge	Deductible, then 20% Coinsurance
Outpatient psychological testing and neuropsychological assessment	No charge for the first mental health visit per Member. After the first visit, the following cost sharing applies: $25 Copayment per visit	Deductible, then 20% Coinsurance

Benefit:	In-Network Plan Providers Member Cost Sharing:	Out-of-Network Non-Plan Providers Member Cost Sharing:
Outpatient telemedicine virtual visit – group therapy	No charge for the first mental health visit per Member. After the first visit, the following cost sharing applies: $10 Copayment per visit	Deductible, then 20% Coinsurance
Outpatient telemedicine virtual visit – including individual therapy, detoxification, and medication management	No charge for the first mental health visit per Member. After the first visit, the following cost sharing applies: $25 Copayment per visit	Deductible, then 20% Coinsurance
Observation Services		
	Deductible, then $250 Copayment per observation stay	Same as In-Network
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, including immunizations	No charge	Deductible, then 20% Coinsurance
Not all **In-Network** services you receive during your routine exam are covered at no charge. Only preventive services designated under the Patient Protection and Affordable Care Act (PPACA) are covered at no charge. Other services not included under PPACA may be subject to additional cost sharing. For the current list of preventive services covered at no charge under PPACA, please see the Preventive Services Notice on our website at **www.harvardpilgrim.org.** Please see "Laboratory, Radiology and Other Diagnostic Services" for the Member Cost Sharing that applies to diagnostic services not included on this list.		
Consultations, evaluations, sickness and injury care	**PCP:** No charge for the first PCP visit per Member. After the first visit, the following cost sharing applies: **Level 1:** $25 Copayment per visit **All Other Providers:** **Level 1:** $25 Copayment per visit **Level 2:** $50 Copayment per visit	Deductible, then 20% Coinsurance
Cost sharing level varies depending on the type of provider. Please refer to the beginning of this Schedule of Benefits to determine which cost sharing level applies. Additional Member Cost Sharing may apply. Please refer to the specific benefit in this Schedule of Benefits. For example, if you need sutures, please refer to office based treatments and procedures below. If you need an x-ray or have blood drawn, please refer to "Laboratory, Radiology and Other Diagnostic Services."		

Benefit:	In-Network Plan Providers Member Cost Sharing:	Out-of-Network Non-Plan Providers Member Cost Sharing:
Office based treatments and procedures, including, but not limited to administration of injections, casting, suturing and the application of dressings, genetic counseling, non-routine foot care, and surgical procedures	Deductible, then no charge	Deductible, then 20% Coinsurance
Administration of allergy injections	$10 Copayment per visit	Deductible, then 20% Coinsurance
Preventive Services and Tests		
	No charge	Deductible, then 20% Coinsurance
Under federal and state law, many preventive services and tests are covered with no Member Cost Sharing, including preventive colonoscopies, certain labs and x-rays, voluntary sterilization for women, and all FDA approved contraceptive devices. For a complete list of covered preventive services, please see the Preventive Services Notice on our website at **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** if you are covered under an Employer Group plan or **1-877-907-4742** if you are covered under an Individual Member plan. Harvard Pilgrim will add or delete services from this benefit for preventive services and tests in accordance with federal and state guidance.		
The following additional preventive services, tests and devices: alpha-fetoprotein (AFP), fetal ultrasound, hepatitis C testing, lead level testing, prostate-specific antigen (PSA) screening, routine hemoglobin tests, group B streptococcus (GBS), routine urinalysis, blood pressure monitor, retinopathy screening, and international normalized ratio (INR) testing.	No charge	Deductible, then 20% Coinsurance
Prosthetic Devices		
	Deductible, then 20% Coinsurance	Deductible, then 20% Coinsurance
Rehabilitation and Habilitation Services - Outpatient		
Cardiac rehabilitation	$50 Copayment per visit	Deductible, then 20% Coinsurance
Pulmonary rehabilitation therapy	$50 Copayment per visit	Deductible, then 20% Coinsurance
Speech-language and hearing services	**In a physician's office or non-hospital affiliated facility** $25 Copayment per visit **In a hospital or hospital affiliated facility** Deductible, then $50 Copayment per visit	Deductible, then 20% Coinsurance

Benefit:	In-Network Plan Providers Member Cost Sharing:	Out-of-Network Non-Plan Providers Member Cost Sharing:
Occupational therapy – Rehabilitation Services – limited to 60 visits per Plan Year – Habilitation Services – limited to 60 visits per Plan Year Limits combined with physical therapy	**In a physician's office or non-hospital affiliated facility** $25 Copayment per visit **In a hospital or hospital affiliated facility** Deductible, then $50 Copayment per visit	Deductible, then 20% Coinsurance
Physical therapy – Rehabilitation Services – limited to 60 visits per Plan Year – Habilitation Services – limited to 60 visits per Plan Year Limits combined with occupational therapy	**In a physician's office or non-hospital affiliated facility** $25 Copayment per visit **In a hospital or hospital affiliated facility** Deductible, then $50 Copayment per visit	Deductible, then 20% Coinsurance
Outpatient physical and occupational therapy is not subject to the limit listed above and is covered to the extent Medically Necessary for: (1) children up to the age of three and (2) the treatment of Autism Spectrum Disorders.		
Scopic Procedures - Outpatient Diagnostic and Therapeutic		
Colonoscopy, endoscopy and sigmoidoscopy	**Flex Providers** $50 Copayment per visit **Other Plan Providers** Deductible, then $300 Copayment per visit	Deductible, then 20% Coinsurance
The lower Flex cost sharing listed above applies to services provided by Flex Providers only. Additional Member Cost Sharing may apply to services billed from other Providers. For example, if you have surgery with a Flex provider, but that provider sends a specimen out for pathology, please refer to "Laboratory, Radiology and Other Diagnostic Services" to determine the cost sharing applicable to diagnostic services.		
Spinal Manipulative Therapy (including care by a chiropractor)		
	$50 Copayment per visit	Deductible, then 20% Coinsurance
Surgery – Outpatient		
	Flex Providers $50 Copayment per visit **Other Plan Providers** Deductible, then $300 Copayment per visit	Deductible, then 20% Coinsurance
The lower Flex cost sharing listed above applies to services provided by Flex Providers only. Additional Member Cost Sharing may apply to services billed from other Providers. For example, if you have surgery with a Flex provider, but that provider sends a specimen out for pathology, please refer to "Laboratory, Radiology and Other Diagnostic Services" to determine the cost sharing applicable to diagnostic services.		

Benefit:	In-Network Plan Providers Member Cost Sharing:	Out-of-Network Non-Plan Providers Member Cost Sharing:
Telemedicine Virtual Visit Services - Outpatient		
	PCP: No charge for the first PCP visit per Member. After the first visit, the following cost sharing applies: **Level 1:** $25 Copayment per visit **All Other Providers:** **Level 1:** $25 Copayment per visit **Level 2:** $50 Copayment per visit	Deductible, then 20% Coinsurance
For inpatient hospital care, see "Hospital – Inpatient Services" for cost sharing details.		
Urgent Care Services		
Doctor On Demand	No charge	
Important Note: Doctor On Demand is a specific network of providers contracted to provide virtual Urgent Care services. For more information on Doctor On Demand, including how to access them, please visit our website at **www.harvardpilgrim.org.**		
Convenience care clinic	$25 Copayment per visit	Deductible, then 20% Coinsurance
Urgent care center	$50 Copayment per visit	Deductible, then 20% Coinsurance
Hospital urgent care center	$50 Copayment per visit	Deductible, then 20% Coinsurance
Additional Member Cost Sharing may apply. Please refer to the specific benefit in this Schedule of Benefits. For example, if you have an x-ray or have blood drawn, please refer to "Laboratory, Radiology and Other Diagnostic Services."		
Vision Services		
Routine eye examinations – Limited to 1 exam per Plan Year	$25 Copayment per visit	Deductible, then 20% Coinsurance
Vision hardware for special conditions	Deductible, then no charge	Deductible, then 20% Coinsurance
Your Plan also includes coverage for pediatric vision hardware. Please see the additional Pediatric Vision section later in this Schedule of Benefits for more information.		
Voluntary Sterilization in a Physician's Office		
	Deductible, then no charge	Deductible, then 20% Coinsurance
Voluntary Termination of Pregnancy		
	No charge	Deductible, then 20% Coinsurance

Benefit:	In-Network Plan Providers Member Cost Sharing:	Out-of-Network Non-Plan Providers Member Cost Sharing:
Wellness Reimbursement Benefits (see the Benefit Handbook for Details)		
Fitness – Coverage is provided for up to 2 Members per calendar year for membership in a qualified fitness facility, health club or fitness center **or** costs paid toward a fitness tracker as follows: • One Member is covered for reimbursement of the cost of one month of individual or family membership per calendar year **or** is covered for reimbursement of fitness membership costs and/or fitness tracker costs up to a combined maximum of $150 per calendar year.* • A second Member is covered for reimbursement of fitness membership costs and/or fitness tracker costs up to a combined maximum of $150 per calendar year.	No charge	
*If a Member receives reimbursement for one month of individual or family fitness membership which is less than $150, then the difference may be applied toward the cost of the Member's fitness tracker. If the cost of one month of individual or family fitness membership is greater than $150, then the 1 month is covered in full and there is no further coverage available for that Member.		
Weight management programs – Coverage provided for 3 months of membership at WW (Weight Watchers) digital, traditional meetings **or** Weight Watchers at Work programs per calendar year	No charge	
Wigs and Scalp Hair Prostheses as required by law		
– Limited to 1 synthetic monofilament wig per Plan Year (see the Benefit Handbook for details)	Deductible, then 20% Coinsurance	Deductible, then 20% Coinsurance

Pediatric VisionCare

Dependents up to the age of 19 are eligible for coverage of prescription eyeglasses or contact lenses. Coverage under this benefit terminates at the end of the month in which the Dependent turns 19. Each Dependent is eligible for coverage every 12 months for *either* (A) prescription eyeglass frames and lenses or (B) prescription contact lenses, as described below:

(A) PRESCRIPTION EYEGLASS FRAMES AND LENSES

The Plan will reimburse you for the purchase of one pair of Standard or Basic prescription eyeglass frames and lenses up to the following amounts:

The Plan will reimburse you for the first $50 you pay toward covered prescription eyeglass frames and lenses. Thereafter, the Plan will reimburse you 50% of your remaining covered charges. Standard or Basic lenses are limited to glass or plastic single vision lenses, conventional bifocal lenses, conventional trifocal lenses and lenticular lenses. Coverage is excluded for lenses larger than 55mm and upgrades such as tints, scratch proofing and progressive lenses. Coverage is also excluded for deluxe and designer eyeglass frames.

(B) PRESCRIPTION CONTACT LENSES

The Plan will reimburse you for the purchase of your first order of prescription contact lenses up to the following amounts:

The Plan will reimburse you for the first $50 you pay toward your first order of covered prescription contact lenses. Thereafter, the Plan will reimburse you 50% of your remaining covered charges. Reimbursement for disposable contact lenses is limited to a 6 month supply.

In addition to the Covered Benefits described above, Dependents up to the age of 19 are also eligible for the following:

(C) MEDICALLY NECESSARY CONTACT LENSES

Contact lenses may be determined to be Medically Necessary and appropriate in the treatment of patients affected by certain conditions. In general, contact lenses may be Medically Necessary and appropriate when the use of contact lenses, in lieu of eyeglasses, will result in significantly better visual and/or improved binocular function, including avoidance of diplopia or suppression. Contact lenses may be determined to be Medically Necessary in the treatment of the following conditions: keratoconus, pathological myopia, aphakia, anisometropia, aniseikonia, aniridia, corneal disorders, post-traumatic disorders, irregular astigmatism.

Medically necessary contact lenses are dispensed in lieu of other eyewear.

The Plan will reimburse you for the first $50 you pay toward Medically Necessary contact lenses. Thereafter, the Plan will reimburse you 50% of your remaining covered charges.

(D) LOW VISION SERVICES

Low vision is a significant loss of vision but not total blindness. Ophthalmologists and optometrists specializing in low vision care can evaluate and prescribe optical devices, and provide training and instruction to maximize the remaining usable vision for our members with low vision. Covered low vision services will include (1) one comprehensive low vision evaluation every 5 years; (2) Medically Necessary visual aids such as high-power eyeglasses, magnifiers and telescopes; and (3) follow-up examinations as Medically Necessary.

See "Physician and Other Professional Office Visits" for your Member Cost Sharing that applies to consultations and evaluations. The Plan will reimburse you for the first $50 you pay toward visual aids as described above. Thereafter, the Plan will reimburse you 50% of your remaining covered charges for visual aids.

OUT-OF-POCKET MAXIMUM

All Member Cost Sharing under this benefit applies toward your annual Out-of-Pocket Maximum. Please see the General Cost Sharing Table at the beginning of this Schedule of Benefits for the Out-of-Pocket Maximum amount that applies to your plan.

WHERE TO PURCHASE EYEWEAR WITH YOUR PEDIATRIC VISION CARE BENEFIT

You can purchase your eyewear from any vision hardware provider with a valid prescription from your doctor. Only contact lenses may be purchased from an internet provider. Simply pay out-of-pocket and submit to the Plan for reimbursement.

HOW TO RECEIVE REIMBURSEMENT FOR THE PEDIATRIC VISION CARE BENEFIT

To receive reimbursement for prescription eyeglasses and frames or prescription contact lenses that you have paid for, you must follow these simple steps:

1. Complete a member reimbursement form. You may obtain the reimbursement form on our website, **www.harvardpilgrim.org** or by calling the Member Services Department at **1–888–333–4742** if you are covered under an Employer Group plan or **1–877–907–4742** if you are covered under an Individual Member plan. For TTY service, please call **711**. A representative will be happy to assist you.
2. Each Member must use a separate member reimbursement form.
3. Attach the copy of an itemized bill to the form, showing proof of payment. Make a copy of the form for your records.
4. Mail the original form, together with the bill and proof of payment to:
   HPHC Claims
   P.O. Box 699183
   Quincy, MA 02269 - 9183

We will reimburse you for your payment of covered eyeglasses or contact lenses as described above. The reimbursement is applied AFTER application of discounts, coupons or other offers. Please allow 30 days to receive your reimbursement.

WHERE TO CALL WITH QUESTIONS

If you have any questions about your Pediatric Vision Care benefit, including how to receive reimbursement or eyewear discounts, please contact the Member Services Department at **1-888-333-4742** if you are covered under an Employer Group plan or **1–877–907–4742** if you are covered under an Individual Member plan. This telephone number is also listed on your ID card. If you are deaf or hearing impaired, call **711** for TTY service. A representative will be happy to assist you.

EXCLUSIONS

- Expenses incurred prior to your effective date
- Colored contact lenses, special effect contact lenses
- Deluxe or designer frames
- Eyeglass or contact lens supplies
- Lost or broken lenses or frames, unless the Member has reached his/her normal interval for service
- Non-prescription or plano lenses
- Plain or prescription sunglasses, no-line bifocals, blended lenses or oversize lenses
- Safety glasses and accompanying frames
- Spectacle lens styles, materials, treatments or add ons

- Sunglasses and accompanying frames
- Two pairs of glasses in lieu of bifocals
- Vision hardware (with the exception of contact lenses) purchased from an internet provider

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 اللُغة العربية ، خَدَمات المُساعَدة اللُغوية 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 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, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-888-333-4742 (TTY: 711).

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

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

(Continued)

General Notice About Nondiscrimination and Accessibility Requirements

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

HPHC:

- 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. | MASSACHUSETTS

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

Exclusion
Alternative Treatments
• Acupuncture care, except when specifically listed as a Covered Benefit. • Acupuncture services that are outside the scope of standard acupuncture care. • Alternative, holistic or naturopathic services and all procedures, laboratories and nutritional supplements associated with such treatments, except when specifically listed as a Covered Benefit. • Aromatherapy, treatment with crystals and alternative medicine. • Any of the following types of programs: Health resorts, spas, recreational programs, camps, outdoor skills programs, therapeutic or educational boarding schools, educational programs for children in residential care, self-help programs, life skills programs, relaxation or lifestyle programs, and wilderness programs (therapeutic outdoor programs). • Massage therapy. • Myotherapy.
Dental Services
• Dental Care, except when specifically listed as a Covered Benefit. • Temporomandibular Joint Dysfunction (TMD) care, except as described in the Plan's *Benefit Handbook*. • Extraction of teeth, except when specifically listed as a Covered Benefit. • Pediatric dental care, except when specifically listed as a Covered Benefit.
Durable Medical Equipment and Prosthetic Devices
• Any devices or special equipment needed for sports or occupational purposes. • Any home adaptations, including, but not limited to home improvements and home adaptation equipment. • Non-durable medical equipment, unless used as part of the treatment at a medical facility or as part of approved home health care services. • Repair or replacement of durable medical equipment or prosthetic devices as a result of loss, negligence, willful damage, or theft.
Experimental, Unproven or Investigational Services
• Any products or services, including, but not limited to, drugs, devices, treatments, procedures, and diagnostic tests that are Experimental, Unproven, or Investigational.
Foot Care
• Foot orthotics, except for the treatment of severe diabetic foot disease or systemic circulatory disease. • Routine foot care. Examples include nail trimming, cutting or debriding and the cutting or removal of corns and calluses. This exclusion does not apply to preventive foot care for Members diagnosed with diabetes or systemic circulatory disease.
Maternity Services
• Planned home births. • Services provided by a doula.
Mental Health and Substance Use Disorder Treatment
• Educational services or testing, except services covered under the benefit for Early Intervention Services. No benefits are provided (1) for educational services intended to enhance educational achievement or developmental functioning, (2) to resolve problems of school performance, (3) for driver alcohol education, or (4) for community reinforcement approach and assertive continuing care. • Any of the following types of programs: programs in which the patient has a pre-defined duration of care without the Plan's ability to conduct concurrent determinations of continued medical necessity, programs that only provide meetings or activities not based on individualized treatment plans, programs that focus solely on interpersonal or other skills rather than directed toward symptom reduction and functional recovery related to specific mental health disorders, and tuition based programs that offer educational, vocational, recreational, or personal developmental activities. • Sensory integrative praxis tests. • Services for any condition with only a "Z Code" designation in the Diagnostic and Statistical Manual of Mental Disorders, which means that the condition is not attributable to a mental disorder. • Mental health and substance

Exclusion
use disorder treatment that is (1) provided to Members who are confined or committed to a jail, house of correction, prison, or custodial facility of the Department of Youth Services; or (2) provided by the Department of Mental Health. • Services or supplies for the diagnosis or treatment of mental health and substance use disorders that, in the reasonable judgment of the Behavioral Health Access Center, are any of the following: not consistent with prevailing national standards of clinical practice for the treatment of such conditions; not consistent with prevailing professional research demonstrating that the services or supplies will have a measurable and beneficial health outcome; typically do not result in outcomes demonstrably better than other available treatment alternatives that are less intensive or more cost effective. • Services related to autism spectrum disorders provided under an individualized education program (IEP), including any services provided under an IEP that are delivered by school personnel or any services provided under an IEP purchased from a contractor or vendor.
Physical Appearance
• Cosmetic Services, including drugs, devices, treatments and procedures, except for (1) Cosmetic Services that are incidental to the correction of Physical Functional Impairment, (2) restorative surgery to repair or restore appearance damaged by an accidental injury, and (3) post-mastectomy care. • Hair removal or restoration, including, but not limited to, electrolysis, laser treatment, transplantation or drug therapy. • Liposuction or removal of fat deposits considered undesirable. • Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures). • Skin abrasion procedures performed as a treatment for acne. • Treatment for skin wrinkles and skin tags or any treatment to improve the appearance of the skin. • Treatment for spider veins. • Wigs and scalp hair prostheses when hair loss is due to male pattern baldness, female pattern baldness, or natural or premature aging.
Procedures and Treatments
• Care by a chiropractor outside the scope of standard chiropractic practice, including but not limited to, surgery, prescription or dispensing of drugs or medications, internal examinations, obstetrical practice, or treatment of infections and diagnostic testing for chiropractic care other than an initial X-ray. • Spinal manipulative therapy (including care by a chiropractor), except when specifically listed as a Covered Benefit. • Commercial diet plans, weight loss programs and any services in connection with such plans or programs. **Please note**: If you have coverage through an employer group plan, your employer may participate in other wellness and health improvement incentive programs offered by Harvard Pilgrim. Please review all your Plan documents for the amount of incentives, if any, available under your Plan. • Gender affirming services including reassignment surgery and all related drugs and procedures for self-insured groups, except when specifically listed as a Covered Benefit. • If a service is listed as requiring that it be provided at a Center of Excellence, no In-Network coverage will be provided if that service is received from a provider that has not been designated as a Center of Excellence. • Nutritional or cosmetic therapy using vitamins, minerals or elements, and other nutrition-based therapy. Examples include supplements, electrolytes, and foods of any kind (including high protein foods and low carbohydrate foods). • Physical examinations and testing for insurance, licensing or employment. • Services for Members who are donors for non-members, except as described under Human Organ Transplant Services. • Testing for central auditory processing. • Group diabetes training, educational programs or camps.
Providers
• Charges for services which were provided after the date on which your membership ends. • Charges for any products or services, including, but not limited to, professional fees, medical equipment, drugs, and hospital or other facility charges, that are related to any care that is not a Covered Benefit. • Charges for missed appointments. • Concierge service fees. (See the Plan's *Benefit Handbook* for more information.) • Inpatient charges after your hospital discharge. • Provider's charge to file a claim or to transcribe or copy your medical records. • Services or supplies provided by: (1) anyone related to you by blood, marriage or adoption, or (2) anyone who ordinarily lives with you.
Reproduction
• Any form of Surrogacy or services for a gestational carrier other than covered maternity services. • Infertility drugs if a Member is not in a Plan authorized cycle of infertility treatment. • Infertility drugs, if infertility services are not a Covered Benefit. • Infertility drugs that must be purchased at an outpatient pharmacy, unless your Plan includes outpatient pharmacy coverage. • Infertility treatment for Members who are not medically infertile. • Infertility treatment and birth control drugs, implants and devices, except when specifically listed as a Covered Benefit. • Reversal of voluntary sterilization (including any services for infertility related to voluntary sterilization or its reversal). • Sperm collection, freezing and

Exclusion
storage except as described in the Plan's *Benefit Handbook*. • Sperm identification when not Medically Necessary (e.g., gender identification). • The following fees: wait list fees, non-medical costs, shipping and handling charges etc. • Voluntary sterilization, including tubal ligation and vasectomy, except when specifically listed as a Covered Benefit. • Voluntary termination of pregnancy, except when specifically listed as a Covered Benefit.
Services Provided Under Another Plan
• Costs for any services for which you are entitled to treatment at government expense, including military service connected disabilities. • Costs for services for which payment is required to be made by a Workers' Compensation plan or an Employer under state or federal law.
Telemedicine Services
• Telemedicine services involving e-mail or fax. • Provider fees for technical costs for the provision of telemedicine services.
Types of Care
• Recovery programs including rest or domiciliary care, sober houses, transitional support services, and therapeutic communities. • All institutional charges over the semi-private room rate, except when a private room is Medically Necessary. • Pain management programs or clinics. • Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, and diversion or general motivation. • Private duty nursing. • Sports medicine clinics. • Vocational rehabilitation, or vocational evaluations on job adaptability, job placement, or therapy to restore function for a specific occupation.
Vision and Hearing
• Eyeglasses, contact lenses and fittings, except when specifically listed as a Covered Benefit. • Hearing aids, except when specifically listed as a Covered Benefit. • Hearing aid batteries, and any device used by individuals with hearing impairment to communicate over the telephone or internet, such as TTY or TDD. • Over the counter hearing aids. • Refractive eye surgery, including, but not limited to, lasik surgery, orthokeratology and lens implantation for the correction of naturally occurring myopia, hyperopia and astigmatism. • Routine eye examinations, except when specifically listed as a Covered Benefit.
All Other Exclusions
• Any service or supply furnished in connection with a non-Covered Benefit. • Any service or supply (with the exception of contact lenses) purchased from the internet. • Any service, supply or medication when there is a less intensive Covered Benefit or more cost-effective alternative that can be safely and effectively provided. • Any service, supply or medication that is required by a third party that is not otherwise Medically Necessary (examples of a third party are an employer, an insurance company, a school or court). • Beauty or barber service. • Diabetes equipment replacements when solely due to manufacturer warranty expiration. • Donated or banked breast milk. • Externally powered exoskeleton assistive devices and orthoses. • Food or nutritional supplements, including, but not limited to, FDA-approved medical foods obtained by prescription, except as required by law and prescribed for Members who meet HPHC policies for enteral tube feedings. • Guest services. • Medical equipment, devices or supplies except as described in the Plan's *Benefit Handbook*. • Medical services that are provided to Members who are confined or committed to jail, house of correction, prison, or custodial facility of the Department of Youth Services. • Reimbursement for travel expenses, except as described in the Plan's *Benefit Handbook*. Excluded services include but are not limited to: Alcohol and Tobacco; Childcare expenses; Entertainment; Expenses for anyone other than you and your companion; First class, business class and other luxury transportation services; Lodging other than at a hotel or motel; Lost wages; Meals; Personal care and hygiene items; Telephone calls; Tips and gratuities. • Services for non-Members. • Services for which no charge would be made in the absence of insurance. • Services for which no coverage is provided in the Plan's *Benefit Handbook*, this Schedule of Benefits, or the Prescription Drug Brochure (if applicable). • Services provided under an individualized education program (IEP), including any services provided under an IEP that are delivered by school personnel or any services provided under an IEP purchased from a contractor or vendor. • Services that are not Medically Necessary. • Taxes or governmental assessments on services or supplies. • Transportation, except for emergency ambulance transport, and non-emergency medical transport needed for transfer between hospitals or other covered health care facilities or from a covered facility to your home when Medically Necessary. • Air conditioners, air purifiers and filters, dehumidifiers and humidifiers. • Car seats. • Chairs, bath chairs, feeding chairs, toddler chairs, chair lifts, recliners. • Electric scooters. • Exercise equipment. • Home modifications including but not limited to elevators, handrails and ramps. • Hot tubs, jacuzzis, saunas or whirlpools. • Mattresses. • Medical alert systems. • Motorized beds. • Pillows. • Power-operated vehicles. • Stair lifts and stair glides. • Strollers. •

Exclusion
Safety equipment. • Vehicle modifications including but not limited to van lifts. • Telephone. • Television.

Prescription Drug Coverage

VALUE 5 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:** $5 Copayment per prescription or prescription refill **Up to a 90-day supply:** $15 Copayment per prescription or prescription refill	$10 Copayment per prescription or prescription refill
Tier 2	**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 3	**Up to a 30-day supply:** $60 Copayment per prescription or prescription refill **Up to a 90-day supply:** $180 Copayment per prescription or prescription refill	$120 Copayment per prescription or prescription refill
Tier 4	**Up to a 30-day supply:** $100 Copayment per prescription or prescription refill **Up to a 90-day supply:** $300 Copayment per prescription or prescription refill	$300 Copayment per prescription or prescription refill
Tier 5	**Up to a 30-day supply:** 20% Coinsurance* up to a maximum Coinsurance of $250 per prescription or refill **Up to a 90-day supply:** 20% Coinsurance* up to a maximum Coinsurance of $750 per prescription or refill	20% Coinsurance* up to a maximum Coinsurance of $750 per prescription or refill

*Coinsurance is based on the full cost of the medication, up to a maximum dollar amount for each prescription. The full cost will be the lower of the participating pharmacy's retail price or the price of the medication at Harvard Pilgrim's discount rate.

Harvard Pilgrim Health Care

Your plan has an annual out-of-pocket maximum, which is listed on the Schedule of Benefits. 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/2024Value5T** 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.