Schedule of Benefits

DEDUCTIBLE PPO
MAINE

This Schedule of Benefits is a summary of your Covered Benefits. It states any Benefit Limits that apply to your Plan. Please see your Benefit Handbook for Covered Benefit details. This also lists your Member Cost Sharing amounts. 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 more than the Allowed Amount, you must pay the excess amount.

In a Medical Emergency, go to the nearest emergency facility. You can also call 911 (or other local emergency number). Your emergency room Member Cost Sharing is listed in the tables below.

Prior Approval

You must obtain Prior Approval for certain Covered Benefits. If you use a Plan Provider located within the Service Area, he/she will request Prior Approval for you. Before you seek services from a Non-Plan Provider or a Plan Provider outside the Service Area, review the list of benefits 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

You can find more information in your Benefit Handbook. Please see our website, **www.harvardpilgrim.org** or contact Member Services at **1-888-333-4742** for a detailed list of services that require Prior Approval.

Medical Necessity Guidelines

We use clinical review criteria to evaluate whether certain services or procedures are Medically Necessary for your care. To get Medical Necessity Guidelines, you or your provider may call Member Services at **1-888-333-4742** or go to **www.harvardpilgrim.org**.

Access to Lower-Priced Services

Payments you make to Non-Plan providers may be eligible to be credited to your Deductible and Out-of-Pocket Maximum.

Go to HPHConnect for more information on this program.

Covered Benefits

Your Covered Benefits are administered on a Calendar Year basis. Your Member Cost Sharing is determined by the type of service and where 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."
- services provided in a Hospital emergency room, see "Emergency Room Care."

- inpatient Hospital care, see "Hospital-Inpatient Services."
- outpatient surgical procedures, see "Surgery – Outpatient."

A service provided in your home will apply the same Member Cost Sharing as the same service provided in an office or facility. For example, for a physician visit in your home, see "Physician and Other Professional Office Visits." If you have blood drawn at home, see "Laboratory, Radiology and Other Diagnostic Services."

General Cost Sharing Features:	Member Cost Sharing:	
Coinsurance and Copayments		
	See the benefits table below	
Deductible		
– Your Plan Deductible can be met by any combination of eligible In-Network and Out-of-Network expenses.	$500 per Member per Calendar Year $1,000 per family per Calendar Year	
Important Notice: If a family Deductible applies, it can be met in one of two ways: a. If a Member of a covered family meets an individual Deductible, then that Member has no additional Deductible Member Cost Sharing responsibilities for Covered Benefits for the remainder of the Calendar Year. b. If any number of Members in a covered family collectively meets a family Deductible, then all Members in that covered family have no additional Deductible Member Cost Sharing responsibilities for Covered Benefits for the remainder of the Calendar Year.		
Deductible Rollover		
None		
Out-of-Pocket Maximum		
Includes all Member Cost Sharing Any charges above the Allowed Amount and any penalty for failure to receive Prior Approval when using Non-Plan Providers do not apply to the Out-of-Pocket Maximum	$3,000 per Member per Calendar Year $6,000 per family per Calendar Year	$6,000 per Member per Calendar Year $12,000 per family per Calendar Year
Any eligible medical expenses you incur toward the In-Network Out-of-Pocket Maximum in a Calendar Year apply to **both** the In-Network and the Out-of-Network Out-of-Pocket Maximums. Likewise, any eligible medical expenses you incur toward the Out-of-Network Out-of-Pocket Maximum in a Calendar Year apply to **both** the In-Network and the Out-of-Network Out-of-Pocket Maximums.		
Out-of-Network Penalty Payment		
Applies when the Member fails to obtain required Prior Approval for medical services or Medical Drugs from a Non-Plan Provider. Does not count toward the Deductible or Out-of-Pocket Maximum.	$500	

Benefit	In-Network Plan Providers Member Cost Sharing	Out-of-NetworkNon-Plan Providers Member Cost Sharing
Acupuncture Treatment		
– Limited to 20 visits per Calendar Year	$20 Copayment per visit	Deductible, then 20% Coinsurance

Benefit	In-Network Plan Providers Member Cost Sharing	Out-of-NetworkNon-Plan Providers Member Cost Sharing
Ambulance and Medical Transport		
Emergency ambulance transport	Deductible, then no charge	Same as In-Network
Non-emergency air ambulance transport	Deductible, then no charge	Same as In-Network
Non-emergency medical transport	Deductible, then no charge	Deductible, then 20% Coinsurance
Applied Behavior Analysis (ABA)		
Covered for the treatment of autism spectrum disorders	No Member Cost Sharing applies for your first office visit per Calendar Year with a licensed mental health professional. After the first visit, the following cost sharing applies: $20 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
Chiropractic Care		
– Limited to 40 visits per Calendar Year	$20 Copayment per visit	Deductible, then 20% Coinsurance
COVID-19 Services		
COVID-19 Testing	No charge	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 diagnostic testing, see "Laboratory, Radiology and Other Diagnostic Services."
COVID-19 Vaccines	No charge	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 diagnostic testing, see "Laboratory, Radiology and Other Diagnostic Services."

Benefit	In-Network Plan Providers Member Cost Sharing	Out-of-NetworkNon-Plan Providers Member Cost Sharing
Dental Services		
Important Notice: Coverage of Dental Services is very limited. Please see your Benefit Handbook for the details of your coverage.		
Extraction of teeth impacted in bone (performed in a Physician's office)	Deductible, then no charge	Deductible, then 20% Coinsurance
For outpatient surgical procedures, see "Surgery — Outpatient" for cost sharing details.		
Dialysis		
	Deductible, then no charge	Deductible, then 20% Coinsurance
Durable Medical Equipment		
Durable medical equipment, including orthotic devices as described in the Benefit Handbook	No charge	Deductible, then 20% Coinsurance
Blood glucose monitors, infusion devices, and insulin pumps (including supplies)	No charge	No charge
Oxygen and respiratory equipment	No charge	Deductible, then 20% Coinsurance
Early Intervention Services (for Members up to the age of 3)		
– Limited to $3,200 per Member per Calendar Year, up to a maximum of $9,600	$20 Copayment per visit	Deductible, then 20% Coinsurance
Emergency Admission		
	Deductible, then no charge	Same as In-Network
Emergency Room Care		
	$100 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 Treatment (see the Benefit Handbook for details)		
	Deductible, then no charge	Deductible, then 20% Coinsurance
Gender Affirming Services		
	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."	
Hearing Aids		
– Limited to $3,000 per hearing aid every 36 months, for each hearing impaired ear	No charge	Deductible, then 20% Coinsurance
Home Health Care		
	Deductible, then no charge	Deductible, then 20% Coinsurance

Benefit	In-Network Plan Providers Member Cost Sharing	Out-of-NetworkNon-Plan Providers Member Cost Sharing
Home Health Care (Continued)		
If services include the administration of drugs, please see the benefit for "Medical Drugs" for Member Cost Sharing details.		
Hospice – Outpatient		
	No charge	Deductible, then 20% Coinsurance
Hospital – Inpatient Services		
Acute Hospital care, including blood transfusions, and inhalation therapy	Deductible, then no charge	Deductible, then 20% Coinsurance
Inpatient maternity care	Deductible, then no charge	Deductible, then 20% Coinsurance
Inpatient routine nursery care	No charge	Deductible, then 20% Coinsurance
Inpatient rehabilitation – limited to 150 days per Calendar Year Inpatient rehabilitation and skilled nursing facility care limits are combined	Deductible, then no charge	Deductible, then 20% Coinsurance
Skilled nursing facility – limited to 150 days per Calendar Year Inpatient rehabilitation and skilled nursing facility care limits are combined	Deductible, then no charge	Deductible, then 20% Coinsurance
Laboratory, Radiology and Other Diagnostic Services (including Independent Laboratories and Freestanding Imaging Centers)		
Laboratory	Deductible, then no charge	Deductible, then 20% Coinsurance
Genetic testing	Deductible, then no charge	Deductible, then 20% Coinsurance
Radiology	Deductible, then no charge	Deductible, then 20% Coinsurance
Advanced radiology, including CT scans, PET scans, MRI, MRA and nuclear medicine services	Deductible, then no charge	Deductible, then 20% Coinsurance
Other diagnostic services	Deductible, then no charge	Deductible, then 20% Coinsurance
Low Protein Foods		
– Limited to $3,000 per Calendar Year	No charge	Deductible, then 20% Coinsurance
Maternity Care – Outpatient		
Routine outpatient prenatal and postpartum care	No charge	Deductible, then 20% Coinsurance
Routine prenatal and postpartum care is usually received and billed from the same Provider as a single or bundled service. Different Member Cost Sharing may apply to any specialized or non-routine service that is billed separately from your routine outpatient prenatal and postpartum care. For example, Member Cost Sharing for services provided by a specialist is listed under "Physician and Other Professional Office Visits" and Member Cost Sharing for an ultrasound billed as a specialized or non-routine service is listed under "Laboratory, Radiology and Other Diagnostic Services (including Independent Laboratories and Freestanding Imaging Centers)." For more information, see the "Maternity Care" benefit in your Benefit Handbook or the Preventive Services notice on our website at www.harvardpilgrim.org.		

Benefit	In-Network Plan Providers Member Cost Sharing	Out-of-NetworkNon-Plan Providers Member Cost Sharing
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 and Donor Breast Milk		
State mandated formulas and donor breast milk	Deductible, then no charge	Deductible, then 20% Coinsurance
Mental Health and Substance Use Disorder Treatment		
Inpatient Services	Deductible, then no charge	Deductible, then 20% Coinsurance
Intermediate services including Acute residential treatment, partial hospitalization and intensive outpatient programs.	Deductible, then no charge	Deductible, then 20% Coinsurance
Outpatient group therapy	No Member Cost Sharing applies for your first office visit per Calendar Year with a licensed mental health professional. After the first visit, the following cost sharing applies: $20 Copayment per visit	Deductible, then 20% Coinsurance
Mental health services in the home	No Member Cost Sharing applies for your first office visit per Calendar Year with a licensed mental health professional. After the first visit, the following cost sharing applies: $20 Copayment per visit	Deductible, then 20% Coinsurance
Outpatient treatment, including individual therapy, detoxification, and medication management	No Member Cost Sharing applies for your first office visit per Calendar Year with a licensed mental health professional. After the first visit, the following cost sharing applies: $20 Copayment per visit	Deductible, then 20% Coinsurance
Outpatient methadone maintenance	No Member Cost Sharing applies for your first week per Calendar Year with a licensed mental health professional. After the first week, the following cost sharing applies: $20 Copayment per week **Please Note:** The first week is eligible for the initial visit	Deductible, then 20% Coinsurance

Benefit	In-Network Plan Providers Member Cost Sharing	Out-of-NetworkNon-Plan Providers Member Cost Sharing
Mental Health and Substance Use Disorder Treatment (Continued)		
	Copayment waiver with a licensed mental health professional. In the case of methadone maintenance, one week will count as one visit	
Outpatient psychological testing and neuropsychological assessment	No Member Cost Sharing applies for your first office visit per Calendar Year with a licensed mental health professional. After the first visit, the following cost sharing applies: Deductible, then no charge	Deductible, then 20% Coinsurance
Outpatient telemedicine virtual visit – group therapy	No Member Cost Sharing applies for your first office visit per Calendar Year with a licensed mental health professional. After the first visit, the following cost sharing applies: $20 Copayment per visit	Deductible, then 20% Coinsurance
Outpatient telemedicine virtual visit - including individual therapy, detoxification, and medication management	No Member Cost Sharing applies for your first office visit per Calendar Year with a licensed mental health professional. After the first visit, the following cost sharing applies: $20 Copayment per visit	Deductible, then 20% Coinsurance
Observation Services		
	Deductible, then no charge	Same as In-Network
Ostomy Supplies		
	No charge	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 (including Independent Laboratories and Freestanding Imaging Centers)" for the Member Cost Sharing that applies to diagnostic services not included on this list.		

Benefit	In-Network Plan Providers Member Cost Sharing	Out-of-NetworkNon-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)		
Consultations, evaluations, Sickness and injury care	**PCP:** No Member Cost Sharing for the first visit per Calendar Year with a PCP. After the first visit, the following cost sharing applies: $20 Copayment per visit **All Other Providers:** $20 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 need sutures, please refer to office based treatments and procedures below. If you need an x-ray or have blood drawn, please refer to "Laboratory, Radiology and Other Diagnostic Services (including Independent Laboratories and Freestanding Imaging Centers)."		
Office based treatments and procedures, including but not limited to administration of injections, casting, suturing, and the application of dressings, non-routine foot care, and surgical procedures	Deductible, then no charge	Deductible, then 20% Coinsurance
Administration of allergy injections	$20 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 (even if polyp removal or other necessary medically necessary procedure is required), screening mammograms (including a second screening in the event that the initial screening is inconclusive or an abnormality is discovered), pap tests, certain labs and x-rays, voluntary sterilization for women and all FDA approved contraceptive devices. For a complete list of covered preventive services, please see the Preventive Services Notice on our website at **www.harvardpilgrim.org**. You may also get a copy of the Preventive Services Notice by calling the Member Services Department at **1-888-333-4742**. Harvard Pilgrim will add or delete services from this benefit for preventive services and tests in accordance with Federal and state guidance.		
The following additional preventive services, tests and devices: alpha-fetoprotein (AFP), fetal ultrasound, hepatitis C testing, lead level testing, prostate-specific antigen (PSA) screening, routine hemoglobin tests, group B streptococcus (GBS), routine urinalysis, blood pressure monitor, retinopathy screening, and international normalized ratio (INR) testing.	No charge	Deductible, then 20% Coinsurance
Prosthetic Devices		
Prosthetic devices (other than arms and legs)	No charge	Deductible, then 20% Coinsurance

Benefit	In-Network Plan Providers Member Cost Sharing	Out-of-NetworkNon-Plan Providers Member Cost Sharing
Prosthetic Devices (Continued)		
Prosthetic arms and legs	No charge	Deductible, then 20% Coinsurance
One additional prosthetic arm or leg for sports or recreational purposes for Members under the age of 18 .	No charge	Deductible, then 20% Coinsurance
Rehabilitation and Habilitation Services – Outpatient		
Cardiac rehabilitation	$20 Copayment per visit	Deductible, then 20% Coinsurance
Pulmonary rehabilitation therapy	$20 Copayment per visit	Deductible, then 20% Coinsurance
Occupational therapy	$20 Copayment per visit	Deductible, then 20% Coinsurance
Physical therapy	$20 Copayment per visit	Deductible, then 20% Coinsurance
Speech therapy	$20 Copayment per visit	Deductible, then 20% Coinsurance
Outpatient physical, occupational and speech therapies are covered to the extent Medically Necessary for: (1) children up to the age of three and (2) the treatment of Autism Spectrum Disorders. Outpatient physical therapy for postpartum related pelvic floor disorders is not subject to visit limits.		
Scopic Procedures - Outpatient Diagnostic and Therapeutic		
Colonoscopy, endoscopy and sigmoidoscopy	Deductible, then no charge	Deductible, then 20% Coinsurance
Surgery – Outpatient		
	Deductible, then no charge	Deductible, then 20% Coinsurance
Telemedicine Virtual Visit Services – Outpatient		
	PCP: No Member Cost Sharing for the first visits per Calendar Year with a PCP. After the first visit, the following cost sharing applies: $20 Copayment per visit **All Other Providers:** $20 Copayment per visit	Deductible, then 20% Coinsurance
For inpatient Hospital care, see "Hospital – Inpatient Services" for cost sharing details.		
Travel Reimbursement Benefit		
– Limited to $2,500 per Calendar Year See the Benefit Handbook for details	No charge	
Urgent Care Services		
Doctor on Demand	$20 Copayment per visit	
Important Note: Doctor On Demand is a specific network of providers contracted to provide virtual Urgent Care services. For more information on Doctor On Demand, including how to access them, please visit our website at **www.harvardpilgrim.org**.		
Convenience care clinic	$20 Copayment per visit	Deductible, then 20% Coinsurance

Benefit	In-Network Plan Providers Member Cost Sharing	Out-of-NetworkNon-Plan Providers Member Cost Sharing
Urgent Care Services (Continued)		
Urgent care center	$20 Copayment per visit	Deductible, then 20% Coinsurance
Hospital urgent care center	$20 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 (including Independent Laboratories and Freestanding Imaging Centers)."		
Vision Services		
Urgent eye care	**PCP:** No Member Cost Sharing for the first visit per Calendar Year with a PCP. After the first visit, the following cost sharing applies: $20 Copayment per visit **All Other Providers:** $20 Copayment per visit	Deductible, then 20% Coinsurance
Routine adult eye examinations – limited to 1 exam per Calendar Year	$20 Copayment per visit	Deductible, then 20% Coinsurance
Routine pediatric eye examinations – limited to 1 exam per Calendar Year	$20 Copayment per visit	Deductible, then 20% Coinsurance
Vision hardware for special conditions	Deductible, then no charge	Deductible, then 20% Coinsurance
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
Wigs and Scalp Hair Prostheses		
	No charge	Deductible, then 20% Coinsurance

Harvard Pilgrim Health Care

a Point32Health company

Language Assistance Services

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

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

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

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

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

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

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

Khmer (ភាសាខ្មែរ) ប្រសិនបរអ្ន កនិយាយភាសាបសងេបហ្ពិភាសាអ្ង់បលេ ស បសវាកមូ្មជំនួ យភាសា ដលែឥតលិតថ្ល លីអចរកហានសហ្រអ្ន ក។ សូ ម្ហ្មាហ្មាកាន់បលខហ្មាបលី ID តាតសាជិករស់អ្ន ក។

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

Lao (ພາສາລາວ) ກະລຸນາ ຮັບຊາບ: ຖ້າ ທ່ານເວົ້າພາສາອື່ນທີ່ຫ ນ່ ມນພາສາ ອັງິກດ, ທ່ານສາມາດໃຊ້ບໍລການ້ດ້ານພາສາໄ ດ້ ໂດຍ່ບເສຍ ຄ່າ. ກະລຸນາໂທຫາເບີ່ທ ູ່ ຍໃນ ບັດປະຈ່ າ ຕົວສະມາຊິກຂອງ ທ່ານ.

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

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

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

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

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

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

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

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General Notice About Nondiscrimination and Accessibility Requirements

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

HPHC:

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

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

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

Point32Health Civil Rights Legal Coordinator
1 Wellness Way
Canton, MA 02021-1166

866-750-2074, TTY service: 711
Fax: 617-668-2754
Email: **OCRCoordinator@point32health.org**

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

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201

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

Complaint forms are available at
www.hhs.gov/ocr/office/file/index.html

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

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General List of Exclusions
MAINE

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

Exclusion
Alternative Treatments
• Acupuncture care except when specifically listed as a Covered Benefit. • Acupuncture services that are outside the scope of standard acupuncture care. • Alternative or holistic services and all procedures, laboratories and nutritional supplements associated with such treatments. • Aromatherapy, treatment with crystals and alternative medicine. • Any of the following types of programs: Health resorts, spas, recreational programs, camps, wilderness programs (therapeutic outdoor programs), outdoor skills programs, life skills programs, therapeutic or educational boarding schools, and relaxation or lifestyle programs. • Massage therapy when performed by anyone other than a licensed physical therapist, physical therapy assistant, occupational therapist, or certified occupational therapy assistant. • Myotherapy. • Services by a naturopath that are not covered by other Plan Providers under the Plan.
Clinical Trials
Coverage is not provided for the following: • The investigational item, device, or service itself; or • For services, tests or items that are provided solely to satisfy data collection and analysis for the clinical trial and that are not used for the direct clinical management of your condition.
Dental Services
• Dental Care, except when specifically listed as a Covered Benefit. • All services of a dentist for Temporomandibular Joint Dysfunction (TMD). • Extraction of teeth, except when specifically listed as a Covered Benefit. • Pediatric dental care, except when specifically listed as a Covered Benefit.
Durable Medical Equipment and Prosthetic Devices
• Any devices or special equipment needed for sports or occupational purposes except when specifically listed as a covered benefit. • 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 diseases. • 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 diseases.
Maternity Services
• Routine pre-natal and post-partum care when you are traveling outside the Service Area. • Planned home births. • Services provided by a doula
Mental Health Care
• Biofeedback. • Educational services or testing, except services covered under the benefit for Early Intervention Services. No benefits are provided: (1) for educational services intended to enhance educational achievement; or (2) to resolve problems of school performance. • Sensory integrative praxis tests. • 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.

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

Exclusion
Physical Appearance
• Cosmetic Services, including drugs, devices, treatments and procedures, except for (1) Cosmetic Services that are incidental to the correction of Physical Functional Impairment, (2) reconstructive surgery to repair or restore appearance damaged by an Accidental Injury, (3) post-mastectomy care and (4) gender affirming procedures and related services. • Electrolysis or laser hair removal, except for what is Medically Necessary as part of gender affirming services. • Hair removal or restoration, including, but not limited to, 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. • Treatments and procedures related to appearance including but not limited to, abdominoplasty; chemical peels; collagen injections; dermabrasion; implantations (e.g. cheek, calf, pectoral, gluteal); lip reduction/enhancement; panniculectomy; removal of redundant skin; and silicone injections (e.g. for breast enlargement), except for what is Medically Necessary as part of gender affirming services or another Covered Benefit. • Treatment for skin wrinkles and skin tags or any treatment to improve the appearance of the skin. • Treatment for spider veins. • Wigs and scalp hair prostheses, except when specifically listed as a Covered Benefit • Wigs and scalp hair prostheses when hair loss is due to male pattern baldness, female pattern baldness, or natural or premature aging.
Procedures and Treatments
• Care by a chiropractor outside the scope of standard chiropractic practice, including but not limited to, surgery, prescription or dispensing of drugs or medications, internal examinations, obstetrical practice, or treatment of infections and diagnostic testing for chiropractic care other than an initial X-ray. • Commercial diet plans, weight loss programs and any services in connection with such plans or programs. **Please note**: Your employer may participate in other wellness and health improvement incentive programs offered by Harvard Pilgrim. Please review all your Plan documents for the amount of incentives, if any, available under your Plan. • If a service is listed as requiring that it be provided at a Center of Excellence, no coverage will be provided under this Handbook if that service is received from a Provider that has not been designated as a Center of Excellence. • Nutritional or cosmetic therapy using vitamins, minerals or elements, and other nutrition-based therapy. Examples include supplements, electrolytes, and foods of any kind (including high protein foods and low carbohydrate foods). • Services for Members who are donors for non-members, except as described under Human Organ Transplant Services. • Testing for central auditory processing. • Group diabetes training, educational programs or camps.
Providers
• Charges for services which were provided after the date on which your membership ends, except as required by Maine law. • Charges for any products or services, including, but not limited to, professional fees, medical equipment, drugs, and Hospital or other facility charges, that are related to any care that is not a Covered Benefit. • Charges for missed appointments. • Concierge service fees. (See the Plan's Benefit Handbook for more information.) • Follow-up care after an emergency room visit, unless provided or arranged by a Plan Provider and/or arranged by your PCP or Direct Health Care Provider when required under your Plan. • 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
• Services for a surrogate or gestational carrier who is not a Member of the Plan. • 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, except when specifically listed as a Covered Benefit. • Reversal of voluntary sterilization (including any services for infertility related to voluntary sterilization or its reversal). • Sperm collection, freezing and storage except when infertility treatment is specifically listed as a Covered Benefit. • Sperm identification when not Medically Necessary (e.g., gender identification). • The following fees: wait list fees, non-medical costs, shipping and handling charges etc. • Voluntary sterilization, including tubal ligation and vasectomy, except when specifically listed as a Covered Benefit. • Voluntary termination of pregnancy, unless necessary to preserve the life or health of a Member or unless it is specifically listed as a Covered Benefit.

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Exclusion
Services Provided Under Another Plan
• Costs for any services for which you are entitled to treatment at government expense, including military service connected disabilities. • Costs for services covered by third party liability, other insurance coverage, and which are required to be covered by a Workers' Compensation plan or an Employer under state or federal law, unless a notice of controversy has been filed with the Workers' Compensation Board contesting the work-relatedness of the claimant's condition and no decision has been made by the Board.
Telemedicine
• Telemedicine services involving e-mail, or fax. • Telemedicine services involving audio-only telephone, except where telemedicine is technologically unavailable at a scheduled time and is medically appropriate for the corresponding covered health services. • Provider fees for technical costs for the provision of telemedicine services.
Types of Care
• Custodial Care. • Rest or domiciliary care. • All institutional charges over the semi-private room rate, except when a private room is Medically Necessary. • Pain management programs or clinics. • Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, and diversion or general motivation. • Private duty nursing. • Sports medicine clinics. • Vocational rehabilitation, or vocational evaluations on job adaptability, job placement, or therapy to restore function for a specific occupation.
Vision and Hearing
• Eyeglasses, contact lenses and fittings, except as listed in the Plan's *Benefit Handbook* and any associated Riders. • Over the counter hearing aids • Refractive eye surgery, including, but not limited to, lasik surgery, orthokeratology and lens implantation for the correction of naturally occurring myopia, hyperopia and astigmatism. • Routine eye examinations, except when specifically listed as a Covered Benefit.
All Other Exclusions
• Any service or supply furnished in connection with a non-Covered Benefit. • Any service, supply or medication when there is a less intensive Covered Benefit or most cost-effective alternative that can be safely and effectively provided. • Any service, supply or medication, including physical examinations and testing, required by a third party that is not otherwise Medically Necessary (examples of a third party are an employer, an insurance company, a school, a camp, or court). • Any service or supply (with the exception of contact lenses) purchased from the internet. • Beauty or barber service. • Cost of organs that are sold rather then donated to recipients • Any drug or other product obtained at an outpatient pharmacy, except for pharmacy supplies covered under the benefit for diabetes services, unless your Plan includes outpatient pharmacy coverage. • Diabetes equipment replacements when solely due to manufacturer warranty expiration. • Digital therapeutics when not Medically Necessary. • Donated or banked breast milk. • Food or nutritional supplements, including, but not limited to, FDA-approved medical foods obtained by prescription, except as required by law and prescribed for Members who meet HPHC policies for enteral tube feedings. • Guest services. • Medical equipment, devices or supplies except as listed in this Benefit Handbook. • Medical services that are provided to Members who are confined or committed to jail, house of correction, or prison, or custodial facility of the Department of Youth Services. • Services for non-Members. • Services for which no charge would be made in the absence of insurance. • Services for which no coverage is provided in the Plan's Benefit Handbook, Schedule of Benefits, or Prescription Drug Brochure. • Services that are not Medically Necessary. • Services your PCP or a Plan Provider has not provided, arranged or approved except as described in the Plan's *Benefit Handbook*. • Taxes or governmental assessments on services or supplies. • Transportation other than by ambulance. • Air conditioners, air purifiers and filters, dehumidifiers and humidifiers. • Car seats. • Chairs, bath chairs, feeding chairs, toddler chairs, chair lifts, recliners. • Electric scooters. • Exercise equipment. • Home modifications including but not limited to elevators, handrails and ramps. • Hot tubs, jacuzzis, saunas or whirlpools. • Mattresses. • Medical alert systems. • Motorized beds. • Pillows. • Power-operated vehicles. • Stair lifts and stair glides. • Strollers. • Safety equipment. • Vehicle modifications including but not limited to van lifts. • Telephone. • Television.

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