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-page?pid=PD0000100769](http://www.harvardpilgrim.org/public/eoc-page?pid=PD0000100769). For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary at [www.healthcare.gov/sbc-glossary](http://www.healthcare.gov/sbc-glossary) or call 1-888-333-4742 to request a copy.

<table>
<thead>
<tr>
<th>Important Questions</th>
<th>Answers</th>
<th>Why this matters</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the overall deductible?</td>
<td>In-Network: $2,000 member / $4,000 family Out-of-Network: $4,000 member / $8,000 family Benefits are administered on a Plan Year basis.</td>
<td>Generally you must pay all the costs up to the deductible amount before this plan begins to pay. If you have other family members on the 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.</td>
</tr>
<tr>
<td>Are there services covered before you meet your deductible?</td>
<td>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.</td>
<td>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 <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>.</td>
</tr>
<tr>
<td>Are there other deductibles for specific services?</td>
<td>No.</td>
<td>You don’t have to meet deductibles for specific services</td>
</tr>
<tr>
<td>What is the out-of-pocket limit for this plan?</td>
<td>In-Network: $7,000 member / $14,000 family Out-of-Network: $14,000 member / $28,000 family</td>
<td>The out-of-pocket limit is the most you could pay in a year of covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limit until the overall family out-of-pocket limit has been met.</td>
</tr>
<tr>
<td>Important Questions</td>
<td>Answers</td>
<td>Why this matters</td>
</tr>
<tr>
<td>----------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>What is not included in the out-of-pocket limit?</td>
<td>Pediatric Dental Care, premiums, balance-billed charges, penalties for failure to obtain preauthorization for services and health care this plan doesn’t cover.</td>
<td>Even though you pay these expenses, they don’t count toward the out-of-pocket limit.</td>
</tr>
<tr>
<td>Will you pay less if you use a network provider?</td>
<td>Yes. See <a href="https://www.harvardpilgrim.org/public/find-a-provider">https://www.harvardpilgrim.org/public/find-a-provider</a> or call 1-888-333-4742 for a list of preferred providers.</td>
<td>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.</td>
</tr>
<tr>
<td>Do you need a referral to see a specialist?</td>
<td>No</td>
<td>You can see the specialist you choose without a referral.</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Network Provider (You will pay the least)</td>
<td>Out-of-Network Provider (You will pay the most)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Level 1: $25 copay/visit; deductible does not apply</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Level 1: $25 copay/visit; deductible does not apply</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Level 2: $50 copay/visit; deductible does not apply</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td></td>
<td></td>
<td>No charge; deductible does not apply</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>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.</td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>What You Will Pay</td>
<td>Limitations, Exceptions, &amp; Other Important Information</td>
</tr>
<tr>
<td>----------------------</td>
<td>-----------------------</td>
<td>-------------------</td>
<td>-------------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Network Provider (You will pay the least)</td>
<td>Out-of-Network Provider (You will pay the most)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>X-rays: $45 copay/visit</td>
<td>X-rays: 20% coinsurance</td>
</tr>
<tr>
<td>If you have a test</td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>Laboratory: Flex Providers: No charge; deductible does not apply</td>
<td>Laboratory: 20% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>Physician/Non-Hospital Based: $200 copay/visit; deductible does not apply</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Hospital Based: $300 copay/procedure</td>
<td></td>
</tr>
<tr>
<td>If you need drugs to treat your illness or condition</td>
<td>Generic drugs</td>
<td>30-Day Retail Tier 1: $5 copay/prescription; deductible does not apply</td>
<td></td>
</tr>
<tr>
<td>More information about prescription drug coverage is available at <a href="http://www.harvardpilgrim.org/2022Value5T">www.harvardpilgrim.org/2022Value5T</a>.</td>
<td></td>
<td>90-Day Mail Tier 1: $10 copay/prescription; deductible does not apply</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>30-Day Retail Tier 2: $30 copay/prescription; deductible does not apply</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>90-Day Mail Tier 2: $60 copay/prescription; deductible does not apply</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Preferred brand drugs</td>
<td>30-Day Retail Tier 3: $60 copay/prescription; deductible does not apply</td>
<td>Some generic drugs are in this tier</td>
</tr>
<tr>
<td></td>
<td></td>
<td>90-Day Mail Tier 3: $120 copay/prescription; deductible does not apply</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Non-preferred brand drugs</td>
<td>30-Day Retail Tier 4: $100 copay/prescription; deductible does not apply</td>
<td>Some drugs must be obtained through a Specialty Pharmacy</td>
</tr>
<tr>
<td></td>
<td></td>
<td>90-Day Mail Tier 4: $300 copay/prescription; deductible does not apply</td>
<td></td>
</tr>
<tr>
<td>Specialty drugs</td>
<td></td>
<td>30-Day Retail Tier 4: $100 copay/prescription; deductible does not apply</td>
<td></td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>What You Will Pay</td>
<td>Limitations, Exceptions, &amp; Other Important Information</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>---------------------------------------------------</td>
<td>-----------------------------------------------------------------------------------</td>
<td>--------------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Network Provider</strong> <em>(You will pay the least)</em></td>
<td><strong>Out-of-Network Provider</strong> <em>(You will pay the most)</em></td>
</tr>
<tr>
<td></td>
<td></td>
<td>20% <strong>coinsurance</strong> up to $250; <strong>deductible</strong> does not apply</td>
<td>20% <strong>coinsurance</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td>20% <strong>coinsurance</strong> up to $750; <strong>deductible</strong> does not apply</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>30-Day Retail Tier 5:</strong> <strong>Facility fee (e.g., ambulatory surgery center)</strong></td>
<td></td>
</tr>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>Flex <strong>Providers:</strong> $75 <strong>copay</strong>/visit; <strong>deductible</strong> does not apply</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>Other Plan <strong>Providers:</strong> $300 <strong>copay</strong>/visit</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Out-of-Network preauthorization</strong> required. <strong>$500 penalty if not obtained</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>20% <strong>coinsurance</strong></td>
<td></td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td><strong>Emergency room care</strong></td>
<td>$300 <strong>copay</strong>/visit; <strong>deductible</strong> does not apply</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td><strong>Emergency medical transportation</strong></td>
<td>No charge</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td><strong>Urgent care</strong></td>
<td>Convenience care clinic: $25 <strong>copay</strong>/visit; <strong>deductible</strong> does not apply</td>
<td><strong>Convenience care clinic:</strong> 20% <strong>coinsurance</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Urgent care center: $50 <strong>copay</strong>/visit; <strong>deductible</strong> does not apply</td>
<td><strong>Urgent care center:</strong> 20% <strong>coinsurance</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Hospital urgent care center: $50 <strong>copay</strong>/visit; <strong>deductible</strong> does not apply</td>
<td><strong>Hospital urgent care center:</strong> 20% <strong>coinsurance</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Out-of-Network preauthorization</strong> required. <strong>$500 penalty if not obtained</strong></td>
<td></td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>$250 <strong>copay</strong>/admit</td>
<td>20% <strong>coinsurance</strong></td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fee</td>
<td>No charge</td>
<td>20% <strong>coinsurance</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Out-of-Network preauthorization</strong> required. <strong>$500 penalty if not obtained</strong></td>
<td></td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>Limitations, Exceptions, &amp; Other Important Information</td>
<td></td>
</tr>
<tr>
<td>----------------------</td>
<td>-----------------------</td>
<td>------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>If you have mental health, behavioral health, or substance abuse needs</td>
<td>Outpatient services</td>
<td>$0 copay for first outpatient mental health/substance abuse visit. Out-of-Network preauthorization required. $500 penalty if not obtained.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Office visits</td>
<td>Cost sharing does not apply for preventive services.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Home health care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rehabilitation services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Habilitation services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical Therapy: Non-hospital based: $25 copay/visit; deductible does not apply</td>
<td></td>
<td>Physical &amp; Occupational Therapy - 60 combined visits/Plan Year. Out-of-Network preauthorization required. $500 penalty if not obtained.</td>
<td></td>
</tr>
<tr>
<td>Hospital based: $50 copay/visit</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>What You Will Pay</td>
<td>Limitations, Exceptions, &amp; Other Important Information</td>
</tr>
<tr>
<td>----------------------</td>
<td>-----------------------</td>
<td>-------------------</td>
<td>------------------------------------------------------</td>
</tr>
<tr>
<td>Skilled nursing care</td>
<td>$250 <strong>copay</strong>/ admit</td>
<td>20% <strong>coinsurance</strong></td>
<td>- 100 days/ Plan Year</td>
</tr>
<tr>
<td>Durable medical equipment</td>
<td>20% <strong>coinsurance</strong></td>
<td>20% <strong>coinsurance</strong></td>
<td>- 1 synthetic monofilament wig/ Plan Year</td>
</tr>
<tr>
<td>Hospice services</td>
<td>No charge</td>
<td>20% <strong>coinsurance</strong></td>
<td>For inpatient see “If you have a hospital stay”</td>
</tr>
<tr>
<td>If your child needs dental or eye care</td>
<td>Children's eye exam</td>
<td>$25 <strong>copay</strong>/ visit; <strong>deductible</strong> does not apply</td>
<td>- 1 exam/ Plan Year</td>
</tr>
<tr>
<td></td>
<td>Children's glasses</td>
<td>Reimbursed first $50, then 50% of covered charges; <strong>deductible</strong> does not apply</td>
<td>Frames &amp; lenses OR contacts every 12 months up to end of month child turns 19</td>
</tr>
<tr>
<td></td>
<td>Children's dental check-up</td>
<td>No charge; <strong>deductible</strong> does not apply</td>
<td>2 exams/ 12 months up to end of month child turns 19</td>
</tr>
</tbody>
</table>

**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.)

- Long-Term (Custodial) Care
- Most Cosmetic Surgery
- Most Dental Care (Adult)
- Private-duty nursing
- Routine foot care
- 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 U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov. 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:

<table>
<thead>
<tr>
<th>HPHC Member Appeals-Member Services Department</th>
<th>Department of Labor’s Employee Benefits Security Administration</th>
<th>Health Care for All</th>
<th>Massachusetts Division of Insurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Harvard Pilgrim Health Care, Inc.</td>
<td>1-866-444-3272</td>
<td>30 Winter Street, Suite 1004</td>
<td>1000 Washington Street, Suite 810</td>
</tr>
<tr>
<td>Canton, MA 02021-1166</td>
<td><a href="http://www.dol.gov/ebsa/healthreform">www.dol.gov/ebsa/healthreform</a></td>
<td>Boston, MA 02108</td>
<td>Boston, MA 02118–6200</td>
</tr>
<tr>
<td>Telephone: 1-888-333-4742</td>
<td></td>
<td>1-800-272-4232</td>
<td></td>
</tr>
<tr>
<td>Fax: 1-617-509-3085</td>
<td><a href="http://www.hcfama.org/helpline">http://www.hcfama.org/helpline</a></td>
<td></td>
<td>1-617-521-7794</td>
</tr>
</tbody>
</table>

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 Coverage 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.

如果需要中文的帮助，请拨打这个号码 1-888-333-4742.

De assistência em Português, por favor ligue 1-888-333-4742.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.
About these Coverage Examples:

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

<table>
<thead>
<tr>
<th>Peg is Having a Baby (9 months of in-network pre-natal care and a hospital delivery)</th>
<th>Managing Joe's type 2 Diabetes (a year of routine in-network care of a well-controlled condition)</th>
<th>Mia's Simple Fracture (in-network emergency room visit and follow up care)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>The plan's overall deductible</strong></td>
<td><strong>The plan's overall deductible</strong></td>
<td><strong>The plan's overall deductible</strong></td>
</tr>
<tr>
<td><strong>Specialist copayment</strong></td>
<td><strong>Specialist copayment</strong></td>
<td><strong>Specialist copayment</strong></td>
</tr>
<tr>
<td><strong>Hospital (facility) copayment</strong></td>
<td><strong>Hospital (facility) copayment</strong></td>
<td><strong>Hospital (facility) copayment</strong></td>
</tr>
<tr>
<td><strong>Other copayment</strong></td>
<td><strong>Other copayment</strong></td>
<td><strong>Other copayment</strong></td>
</tr>
<tr>
<td><strong>Total Example Cost</strong></td>
<td><strong>Total Example Cost</strong></td>
<td><strong>Total Example Cost</strong></td>
</tr>
<tr>
<td>$2,000</td>
<td>$2,000</td>
<td>$2,000</td>
</tr>
<tr>
<td><strong>In this example, Peg would pay:</strong></td>
<td><strong>In this example, Joe would pay:</strong></td>
<td><strong>In this example, Mia would pay:</strong></td>
</tr>
<tr>
<td><strong>Deductibles</strong></td>
<td><strong>Deductibles</strong></td>
<td><strong>Deductibles</strong></td>
</tr>
<tr>
<td>$2,000</td>
<td>$0</td>
<td>$1,500</td>
</tr>
<tr>
<td><strong>Copayments</strong></td>
<td><strong>Copayments</strong></td>
<td><strong>Copayments</strong></td>
</tr>
<tr>
<td>$400</td>
<td>$1,100</td>
<td>$500</td>
</tr>
<tr>
<td><strong>Coinsurance</strong></td>
<td><strong>Coinsurance</strong></td>
<td><strong>Coinsurance</strong></td>
</tr>
<tr>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td><strong>Total Peg would pay is</strong></td>
<td><strong>The total Joe would pay is</strong></td>
<td><strong>The total Mia would pay is</strong></td>
</tr>
<tr>
<td>$2,400</td>
<td>$1,100</td>
<td>$2,000</td>
</tr>
</tbody>
</table>

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).


Kreyòl Ayisyen (French Creole) ATANSYON: Si nou palé Kreyòl Ayisyen, gen asistans pou sevis 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）。


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

العربية (Arabic) إنّا إذا كنت تتكلم اللغة العربية، خدمات المساعدة اللغوية متوفرة لك مجاناً. اتصل على 1 888-333-4742 (TTY: 711).

កម្ពុជា (Cambodian) ប្រសិនបើប្រសិទ្ធដឹងជាកម្ពុជា, ឈ្មោះជីនអំពីសំណង់តែមួយនៃការសំរេចគ្នាជីនអំពីសំណង់។ លំបង្ហាញ 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).


(Continued)
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).

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, sex, sexual orientation, or gender identity. HPHC does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, sexual orientation, or 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, sex, sexual orientation, or 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) 509-3385, 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) 368-1099, (800) 537-7697 (TTY)


Schedule of Benefits
Harvard Pilgrim Health Care, Inc.
PPO 2000 – 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 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 1-877-907-4742 for the complete listing of services that require Prior Approval. To obtain Prior Approval please call:

- 1-800-708-4414 for medical services
- 1-844-387-1435 for Medical Drugs
- 1-888-777-4742 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.

Clinical Review Criteria

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

Office Visit Cost Sharing Levels

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.

Office visit cost sharing may include Copayments, Coinsurance, or Deductible amounts, as described throughout this Schedule of Benefits.

EFFECTIVE DATE: 01/01/2022
FORM #2760
Your Plan may have other cost sharing amounts. Please see the benefit table below for specific cost sharing requirements.

**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 at 1-877-907-4742.

**COVERED BENEFITS**

Your Covered Benefits are administered on a Plan Year basis. Your Plan Year begins on your Employer’s Anniversary Date. Please see your Benefit Handbook for more details. If you do not know your Employer’s Anniversary Date, please contact your Employer’s benefits office or call the Member Services Department at 1–877–907–4742. 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.”

<table>
<thead>
<tr>
<th>General Cost Sharing Features:</th>
<th>In-Network Plan Providers Member Cost Sharing</th>
<th>Out-of-Network Non-Plan Providers Member Cost Sharing</th>
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<tbody>
<tr>
<td>Coinsurance and Copayments</td>
<td>See covered benefits below</td>
<td></td>
</tr>
<tr>
<td><strong>Deductible</strong></td>
<td></td>
<td></td>
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<tr>
<td>The following Deductibles apply to all services except where specifically noted below</td>
<td>$2,000 per Member per Plan Year&lt;br&gt;$4,000 per family per Plan Year</td>
<td>$4,000 per Member per Plan Year&lt;br&gt;$8,000 per family per Plan Year</td>
</tr>
<tr>
<td><strong>Out-of-Pocket Maximum</strong></td>
<td></td>
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</tr>
<tr>
<td>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 Maximum)</td>
<td>$7,000 per Member per Plan Year&lt;br&gt;$14,000 per family per Plan Year</td>
<td>$14,000 per Member per Plan Year&lt;br&gt;$28,000 per family per Plan Year</td>
</tr>
<tr>
<td>General Cost Sharing Features:</td>
<td>In-Network Plan Providers Member Cost Sharing</td>
<td>Out-of-Network Non-Plan Providers Member Cost Sharing</td>
</tr>
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</tr>
<tr>
<td>Out-of-Pocket Maximum (Continued)</td>
<td></td>
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</tr>
<tr>
<td>– Any charges above the Allowed Amount and any penalty for failure to receive Prior Approval when using Non-Plan Providers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Out-of-Network Penalty Payment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>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</td>
<td>$500</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Benefit</th>
<th>In-Network Plan Providers Member Cost Sharing</th>
<th>Out-of-Network Non-Plan Providers Member Cost Sharing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acupuncture Treatment for Injury or Illness</td>
<td>$50 Copayment per visit</td>
<td>Deductible, then 20% Coinsurance</td>
</tr>
<tr>
<td>Ambulance Transport</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency ambulance transport</td>
<td>Deductible, then no charge</td>
<td>Same as In-Network</td>
</tr>
<tr>
<td>Non-emergency ambulance transport</td>
<td>Deductible, then no charge</td>
<td>Deductible, then 20% Coinsurance</td>
</tr>
<tr>
<td>Autism Spectrum Disorders Treatment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Applied Behavior Analysis</td>
<td>No charge for your first office visit per Plan Year with a licensed mental health professional. After the first visit, the following cost sharing applies: $25 Copayment per visit</td>
<td>Deductible, then 20% Coinsurance</td>
</tr>
<tr>
<td>Chemotherapy and Radiation Therapy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chemotherapy</td>
<td>Deductible, then no charge</td>
<td>Deductible, then 20% Coinsurance</td>
</tr>
<tr>
<td>Radiation therapy</td>
<td>Deductible, then no charge</td>
<td>Deductible, then 20% Coinsurance</td>
</tr>
<tr>
<td>Dental Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Important Notice: Coverage of Dental Care is very limited. Please see your Benefit Handbook for the details of your coverage.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Extraction of teeth impacted in bone (performed in a physician's office)</td>
<td>Deductible, then no charge</td>
<td>Deductible, then 20% Coinsurance</td>
</tr>
<tr>
<td>If your Plan provides coverage for pediatric dental services, please see your pediatric dental rider for coverage information.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dialysis</td>
<td>Deductible, then no charge</td>
<td>Deductible, then 20% Coinsurance</td>
</tr>
<tr>
<td>Benefit</td>
<td>In-Network Plan Providers Member Cost Sharing</td>
<td>Out-of-Network Non-Plan Providers Member Cost Sharing</td>
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<td>-------------------------------------------</td>
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<td>-----------------------------------------------------</td>
</tr>
<tr>
<td>Durable Medical Equipment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Durable medical equipment</td>
<td>Deductible, then 20% Coinsurance</td>
<td>Deductible, then 20% Coinsurance</td>
</tr>
<tr>
<td>Blood glucose monitors, infusion devices, and insulin pumps (including supplies)</td>
<td>No charge</td>
<td>No charge</td>
</tr>
<tr>
<td>Oxygen and respiratory equipment</td>
<td>No charge</td>
<td>Deductible, then 20% Coinsurance</td>
</tr>
<tr>
<td>Early Intervention Services</td>
<td>No charge</td>
<td>No charge</td>
</tr>
<tr>
<td>The Plan does not cover the family participation fee required by the Massachusetts Department of Public Health.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency Admission</td>
<td>Deductible, then $250 Copayment per admission</td>
<td>Same as In-Network</td>
</tr>
<tr>
<td>Emergency Room Care</td>
<td>$300 Copayment per visit</td>
<td>Same as In-Network</td>
</tr>
<tr>
<td>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.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hearing Aids (for Members up to the age of 22)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Limited to $2,000 per hearing aid every 36 months, per heading impaired ear</td>
<td>Deductible, then 20% Coinsurance</td>
<td>Deductible, then 20% Coinsurance</td>
</tr>
<tr>
<td>Home Health Care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If services include the administration of drugs, please see the benefit for “Medical Drugs” for Member Cost Sharing details.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospice – Outpatient</td>
<td>Deductible, then no charge</td>
<td>Deductible, then 20% Coinsurance</td>
</tr>
<tr>
<td>Hospital – Inpatient Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acute hospital care</td>
<td>Deductible, then $250 Copayment per admission</td>
<td>Deductible, then 20% Coinsurance</td>
</tr>
<tr>
<td>Inpatient maternity care</td>
<td>Deductible, then $250 Copayment per admission</td>
<td>Deductible, then 20% Coinsurance</td>
</tr>
<tr>
<td>Inpatient routine nursery care (as described in your Benefit Handbook)</td>
<td>No charge</td>
<td>Deductible, then 20% Coinsurance</td>
</tr>
<tr>
<td>Inpatient rehabilitation – limited to 60 days per Plan Year</td>
<td>Deductible, then $250 Copayment per admission</td>
<td>Deductible, then 20% Coinsurance</td>
</tr>
<tr>
<td>Skilled nursing facility – limited to 100 days per Plan Year</td>
<td>Deductible, then $250 Copayment per admission</td>
<td>Deductible, then 20% Coinsurance</td>
</tr>
<tr>
<td>Benefit</td>
<td>In-Network Plan Providers Member Cost Sharing</td>
<td>Out-of-Network Non-Plan Providers Member Cost Sharing</td>
</tr>
<tr>
<td>------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------</td>
<td>------------------------------------------------------</td>
</tr>
<tr>
<td>Infertility Services and Treatments (see the Benefit Handbook for details)</td>
<td>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.”</td>
<td></td>
</tr>
<tr>
<td>Laboratory, Radiology and Other Diagnostic Services</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| 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 $45 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                                                       |                                                                                                             |                                                      |
| Maternity Care – Outpatient                                             | Deductible, then 20% Coinsurance                                                                           | Deductible, then 20% Coinsurance                                                                       |
| Childbirth classes                                                      | No charge                                                                                                   |                                                      |
| – Limited to 1 initial childbirth course or 1 refresher course per pregnancy (see the Benefit Handbook for details) |                                                                                                             |                                                      |
| 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.” |                                                      |
| Medical Drugs (drugs that cannot be self-administered)                 | Deductible, then no charge                                                                                   | Deductible, then 20% Coinsurance                                                                       |
| Medical drugs received in a physician’s office or other outpatient facility |                                                                                                             |                                                      |

(Continued on next page)
Medical Drugs (drugs that cannot be self-administered) (Continued)

Medical drugs received in the home

<table>
<thead>
<tr>
<th>In-Network Plan Providers Member Cost Sharing</th>
<th>Out-of-Network Non-Plan Providers Member Cost Sharing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductible, then no charge</td>
<td>Deductible, then 20% Coinsurance</td>
</tr>
</tbody>
</table>

Some medical drugs received in a physician's office or outpatient facility may be provided by the Specialty Pharmacy Program under your outpatient prescription drug benefit. Your Member Cost Sharing for outpatient prescription drugs is listed on your outpatient prescription drug flyer and Summary of Benefits and Coverage. Please see the Prescription Drug Brochure for a detailed explanation of your benefits.

Medical Formulas

| Deductible, then no charge                   | Deductible, then 20% Coinsurance                     |

Mental Health and Substance Use Disorder Treatment

| Inpatient services                          | Deductible, then 20% Coinsurance                     |
| Intermediate care services                 | Deductible, then 20% Coinsurance                     |
| Outpatient group therapy                   | Deductible, then 20% Coinsurance                     |
 | No charge for your first office visit per Plan Year with a licensed mental health professional. 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

| Deductible, then no charge                   | Deductible, then 20% Coinsurance                     |

Outpatient methadone maintenance

| Deductible, then no charge                   | Deductible, then 20% Coinsurance                     |

Outpatient psychological testing and neuropsychological assessment

| Deductible, then no charge                   | Deductible, then 20% Coinsurance                     |

Outpatient telemedicine virtual visit services

| Deductible, then no charge                   | Deductible, then 20% Coinsurance                     |

Observation Services

| Deductible, then $250 Copayment per observation stay | Same as In-Network |

Ostomy Supplies

<p>| Deductible, then 20% Coinsurance | Deductible, then 20% Coinsurance |</p>
<table>
<thead>
<tr>
<th>Benefit</th>
<th>In-Network Plan Providers Member Cost Sharing</th>
<th>Out-of-Network Non-Plan Providers Member Cost Sharing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician and Other Professional Office Visits (This includes all covered Plan Providers unless otherwise listed in this Schedule of Benefits.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Routine examinations for preventive care, including immunizations</td>
<td>No charge</td>
<td>Deductible, then 20% Coinsurance</td>
</tr>
<tr>
<td>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 <a href="http://www.harvardpilgrim.org">www.harvardpilgrim.org</a>. Please see “Laboratory, Radiology and Other Diagnostic Services” for the Member Cost Sharing that applies to diagnostic services not included on this list.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Consultations, evaluations, sickness and injury care</td>
<td><strong>PCP:</strong> No charge for the first visit per Plan Year with a PCP. After the first visit, the following cost sharing applies: Level 1: $25 Copayment per visit</td>
<td>Deductible, then 20% Coinsurance</td>
</tr>
<tr>
<td></td>
<td><strong>All Other Providers:</strong> Level 1: $25 Copayment per visit</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Level 2: $50 Copayment per visit</td>
<td></td>
</tr>
<tr>
<td>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 &quot;Laboratory, Radiology and Other Diagnostic Services.&quot;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Office based treatments and procedures, including, but not limited to: administration of injections, allergy treatments, casting, suturing and the application of dressings, genetic counseling, non-routine foot care, and surgical procedures</td>
<td>Deductible, then no charge</td>
<td>Deductible, then 20% Coinsurance</td>
</tr>
<tr>
<td>Administration of allergy injections</td>
<td>Deductible, then no charge</td>
<td>Deductible, then 20% Coinsurance</td>
</tr>
<tr>
<td>Preventive Services and Tests</td>
<td>No charge</td>
<td>Deductible, then 20% Coinsurance</td>
</tr>
</tbody>
</table>
Under federal and state law, many preventive services and tests are covered with no Member Cost Sharing, including preventive colonoscopies, and 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 1-877-907-4742. Harvard Pilgrim will add or delete services from this benefit for preventive services and tests in accordance with federal and state guidance.

<table>
<thead>
<tr>
<th>Preventive Services and Tests (Continued)</th>
</tr>
</thead>
<tbody>
<tr>
<td>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.</td>
</tr>
<tr>
<td><strong>In-Network Plan Providers</strong></td>
</tr>
<tr>
<td><strong>Member Cost Sharing</strong></td>
</tr>
<tr>
<td>No charge</td>
</tr>
<tr>
<td><strong>Out-of-Network Non-Plan Providers</strong></td>
</tr>
<tr>
<td><strong>Member Cost Sharing</strong></td>
</tr>
<tr>
<td>Deductible, then 20% Coinsurance</td>
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</tbody>
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<thead>
<tr>
<th>Prosthetic Devices</th>
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<tbody>
<tr>
<td><strong>In-Network Plan Providers</strong></td>
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<tr>
<td><strong>Member Cost Sharing</strong></td>
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<tr>
<td>Deductible, then 20% Coinsurance</td>
</tr>
<tr>
<td><strong>Out-of-Network Non-Plan Providers</strong></td>
</tr>
<tr>
<td><strong>Member Cost Sharing</strong></td>
</tr>
<tr>
<td>Deductible, then 20% Coinsurance</td>
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<thead>
<tr>
<th>Rehabilitation and Habilitation Services – Outpatient</th>
</tr>
</thead>
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<tr>
<td>Cardiac rehabilitation</td>
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<tr>
<td>Pulmonary rehabilitation therapy</td>
</tr>
<tr>
<td>Speech-language and hearing services</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Occupational therapy</th>
</tr>
</thead>
<tbody>
<tr>
<td>– Rehabilitation Services limited to 60 visits per Plan Year</td>
</tr>
<tr>
<td>– Habilitation Services limited to 60 visits per Plan Year</td>
</tr>
<tr>
<td>Physical and occupational therapy limits are combined</td>
</tr>
<tr>
<td>Benefit</td>
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<tr>
<td>--------------------------------------------------</td>
</tr>
<tr>
<td>Rehabilitation and Habilitation Services – Outpatient (Continued)</td>
</tr>
<tr>
<td>Physical therapy</td>
</tr>
<tr>
<td>– Rehabilitation Services limited to 60 visits per Plan Year</td>
</tr>
<tr>
<td>– Habilitation Services limited to 60 visits per Plan Year</td>
</tr>
<tr>
<td>Physical and occupational therapy limits are combined</td>
</tr>
<tr>
<td>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.</td>
</tr>
<tr>
<td><strong>Scopic Procedures – Outpatient Diagnostic and Therapeutic</strong></td>
</tr>
<tr>
<td>Colonoscopy, endoscopy and sigmoidoscopy</td>
</tr>
<tr>
<td>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 &quot;Laboratory, Radiology and Other Diagnostic Services&quot; to determine the cost sharing applicable to diagnostic services.</td>
</tr>
<tr>
<td><strong>Spinal Manipulative Therapy (including care by a chiropractor)</strong></td>
</tr>
<tr>
<td><strong>Surgery – Outpatient</strong></td>
</tr>
<tr>
<td>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 &quot;Laboratory, Radiology and Other Diagnostic Services&quot; to determine the cost sharing applicable to diagnostic services.</td>
</tr>
<tr>
<td><strong>Telemedicine Virtual Visit Services - Outpatient</strong></td>
</tr>
<tr>
<td>Benefit</td>
</tr>
<tr>
<td>---------------------------------------------</td>
</tr>
<tr>
<td>Telemedicine Virtual Visit Services - Outpatient (Continued)</td>
</tr>
<tr>
<td>For inpatient hospital care, see “Hospital – Inpatient Services” for cost sharing details.</td>
</tr>
<tr>
<td><strong>Urgent Care Services</strong></td>
</tr>
<tr>
<td>Doctor On Demand</td>
</tr>
<tr>
<td><strong>Important Note:</strong> Doctor On Demand is a specific network of providers contracted to provide virtual Urgent Care services. For more information on Doctor On Demand, including how to access them, please visit our website at <a href="http://www.harvardpilgrim.org">www.harvardpilgrim.org</a>.</td>
</tr>
<tr>
<td>Convenience care clinic</td>
</tr>
<tr>
<td>Urgent care center</td>
</tr>
<tr>
<td>Hospital urgent care center</td>
</tr>
<tr>
<td>Additional Member Cost Sharing may apply. Please refer to the specific benefit in this Schedule of Benefit. For example, if you have an x-ray or have blood drawn, please refer to “Laboratory, Radiology and Other Diagnostic Services.”</td>
</tr>
<tr>
<td><strong>Vision Services</strong></td>
</tr>
<tr>
<td>Routine eye examinations – limited to 1 per Plan Year</td>
</tr>
<tr>
<td>Vision hardware for special conditions (see the Benefit Handbook for details)</td>
</tr>
<tr>
<td>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.</td>
</tr>
<tr>
<td><strong>Voluntary Sterilization</strong></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td><strong>Voluntary Termination of Pregnancy</strong></td>
</tr>
<tr>
<td>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.”</td>
</tr>
<tr>
<td>Benefit</td>
</tr>
<tr>
<td>---------</td>
</tr>
<tr>
<td><strong>Wellness Benefits (see the Benefit Handbook for details)</strong></td>
</tr>
<tr>
<td><strong>Fitness</strong></td>
</tr>
<tr>
<td>– Coverage is provided for up to 2 Members per calendar year for membership in a qualified fitness facility, health club or fitness center <strong>or</strong> costs paid toward a fitness tracker as follows:</td>
</tr>
<tr>
<td>– One Member is covered for reimbursement of the cost of one month of individual or family membership per calendar year <strong>or</strong> is covered for reimbursement of fitness membership costs and/or fitness tracker costs up to a combined maximum of $150 per calendar year.*</td>
</tr>
<tr>
<td>– 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.</td>
</tr>
<tr>
<td>*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.</td>
</tr>
<tr>
<td><strong>Weight management programs</strong></td>
</tr>
<tr>
<td>– Coverage provided for 3 months of membership at WW (Weight Watchers) digital, traditional meetings or Weight Watchers at Work programs per calendar year.</td>
</tr>
<tr>
<td><strong>Wigs and Scalp Hair Prostheses</strong></td>
</tr>
<tr>
<td>Limited to 1 synthetic monofilament wig per Plan Year (see the Benefit Handbook for details)</td>
</tr>
</tbody>
</table>
5-Tier Value Outpatient Prescription Drug Coverage

<table>
<thead>
<tr>
<th>Benefit:</th>
<th>Member Cost Sharing:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Your pharmacy Copayments for up to a 30-day supply are:</strong></td>
<td></td>
</tr>
<tr>
<td>Tier 1:</td>
<td>$5 Copayment per prescription or prescription refill</td>
</tr>
<tr>
<td>Tier 2:</td>
<td>$30 Copayment per prescription or prescription refill</td>
</tr>
<tr>
<td>Tier 3:</td>
<td>$60 Copayment per prescription or prescription refill</td>
</tr>
<tr>
<td>Tier 4:</td>
<td>$100 Copayment per prescription or prescription refill</td>
</tr>
<tr>
<td>Tier 5:</td>
<td>20% Coinsurance up to a maximum Coinsurance of $250 per prescription or prescription refill</td>
</tr>
<tr>
<td><strong>Your pharmacy Copayments and Coinsurance for up to a 90-day supply of maintenance medications at a retail pharmacy are:</strong></td>
<td></td>
</tr>
<tr>
<td>Tier 1:</td>
<td>$15 Copayment per prescription or prescription refill</td>
</tr>
<tr>
<td>Tier 2:</td>
<td>$90 Copayment per prescription or prescription refill</td>
</tr>
<tr>
<td>Tier 3:</td>
<td>$180 Copayment per prescription or prescription refill</td>
</tr>
<tr>
<td>Tier 4:</td>
<td>$300 Copayment per prescription or prescription refill</td>
</tr>
<tr>
<td>Tier 5:</td>
<td>20% Coinsurance up to a maximum Coinsurance of $750 per prescription or prescription refill</td>
</tr>
</tbody>
</table>

**Harvard Pilgrim’s mail service prescription drug program.**
You may purchase a 90-day supply of maintenance medications through the Plan’s Mail Service Prescription Drug Program.

| **Your mail service Copayments for a 90-day supply are:** | |
| Tier 1: | $10 Copayment per prescription or prescription refill |
| Tier 2: | $60 Copayment per prescription or prescription refill |
| Tier 3: | $120 Copayment per prescription or prescription refill |
| Tier 4: | $300 Copayment per prescription or prescription refill |
| Tier 5: | 20% Coinsurance up to a maximum Coinsurance of $750 per prescription or prescription refill |

A summary of your cost sharing amounts for your prescription drug coverage is also listed on your outpatient prescription drug flyer and Summary of Benefits and Coverage. To obtain coverage for your prescription drugs bring your prescription or refill to a participating pharmacy, along with your ID card, and pay the appropriate amount. Please refer to your Prescription Drug Brochure for detailed information about your coverage.
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 EYGLASS 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.

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 can obtain this form by visiting our website at www.harvardpilgrim.org or by calling the Member Services Department at 1-877-907-4742 to request a form. 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 1-877-907-4742. 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).


Kreyòl Ayisyen (French Creole) ATANSYON: Si nou pale Kreyòl Ayisyen, gen asistans pou sèvis ki disponb 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)。


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

العربية (Arabic) إشعار: إذا كنت تتكلم اللغة العربية، خدمات المساعدة اللغوية متوفرة. قم باتصال 1-888-333-4742 (TTY: 711).

ភាសាខ្មែរ (Cambodian) សូមសម្រេចសើរឡើងវិញ មកប្រការជាអំពីការជំនួញជីវិតរបស់អ្នក និងការជំនួញជាងអំពីការជំនួញជីវិតរបស់អ្នក តាមលេខទូរស័ព្ទ 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. Καλείτε το 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 दिएं: अगर आप हिंदी बोलते हैं तो आपके लिए भाषाई सहायता मुफ्त में उपलब्ध है। जानकारी के लिए फोन करें. 1-888-333-4742 (TTY: 711)

ગુજરાતી (Gujarati) ધ્યાન દયાલા: તમે ગુજરાતી બોલતા હોય તો આપણે આપને ભાષાની સહાય માટે મહત્ત્વની કલાકારી સેવા મળશે. આપણે આપણે માટે ફોન કરો. 1-888-333-4742 (TTY: 711)

ລາວ (Laotian) ທ່ານ/ນາງ: ຈາກການປັບປຸງພາສາລາວ, ລາວບໍ່ສາມາດຮ້າຍພາສາອັງກິດ, ຈາກເລືອກອຽງງານ, ອໍາ ຣ່າຊາບ, ສໍາລັບທ້າງຖິ່ນທີ່ການຊ່ວຍເຫຼືອ, ທ່ານ/ນາງ, ທ່ານ/ນາງ. 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).


(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. HPHC does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

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, you can file a grievance with: Civil Rights Compliance Officer, 90 Worcester St, Wellesley, MA 02481, (866) 750-2074, TTY service: 711, Fax: (617) 509-3085, Email: civil_rights@harvardpilgrim.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 510F, HHHS Building
Washington, D.C. 20201
(800) 537-7697 (TTY)


cc5389_memb_serv (05/20)
### General List of Exclusions
**HPHC Insurance Company, Inc. | MASSACHUSETTS**

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

<table>
<thead>
<tr>
<th>Exclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Alternative Treatments</strong></td>
</tr>
<tr>
<td>• Acupuncture care, except when specifically listed as a Covered Benefit. • Acupuncture services that are</td>
</tr>
<tr>
<td>outside the scope of standard acupuncture care. • Alternative, holistic or naturopathic services and</td>
</tr>
<tr>
<td>all procedures, laboratories and nutritional supplements associated with such treatments, except when</td>
</tr>
<tr>
<td>specifically listed as a Covered Benefit. • Aromatherapy, treatment with crystals and alternative medicine.</td>
</tr>
<tr>
<td>• Any of the following types of programs: Health resorts, spas, recreational programs, camps, outdoor</td>
</tr>
<tr>
<td>skills programs, therapeutic or educational boarding schools, educational programs for children in</td>
</tr>
<tr>
<td>residential care, self-help programs, life skills programs, relaxation or lifestyle programs, and</td>
</tr>
<tr>
<td>wilderness programs (therapeutic outdoor programs). • Massage therapy. • Myotherapy.</td>
</tr>
<tr>
<td><strong>Dental Services</strong></td>
</tr>
<tr>
<td>• Dental Care, except when specifically listed as a Covered Benefit. • All services of a dentist for</td>
</tr>
<tr>
<td>Temporomandibular Joint Dysfunction (TMD). • Extraction of teeth, except when specifically listed as a</td>
</tr>
<tr>
<td>Covered Benefit. • Pediatric dental care, except when specifically listed as a Covered Benefit.</td>
</tr>
<tr>
<td><strong>Durable Medical Equipment and Prosthetic Devices</strong></td>
</tr>
<tr>
<td>• Any devices or special equipment needed for sports or occupational purposes. • Any home adaptations,</td>
</tr>
<tr>
<td>including, but not limited to home improvements and home adaptation equipment. • Non-durable medical</td>
</tr>
<tr>
<td>equipment, unless used as part of the treatment at a medical facility or as part of approved home</td>
</tr>
<tr>
<td>health care services. • Repair or replacement of durable medical equipment or prosthetic devices as a</td>
</tr>
<tr>
<td>result of loss, negligence, willful damage, or theft.</td>
</tr>
<tr>
<td><strong>Experimental, Unproven or Investigational Services</strong></td>
</tr>
<tr>
<td>• Any products or services, including, but not limited to, drugs, devices, treatments, procedures, and</td>
</tr>
<tr>
<td>diagnostic tests that are Experimental, Unproven, or Investigational.</td>
</tr>
<tr>
<td><strong>Foot Care</strong></td>
</tr>
<tr>
<td>• Foot orthotics, except for the treatment of severe diabetic foot disease. • Routine foot care. Examples</td>
</tr>
<tr>
<td>include nail trimming, cutting or debriding and the cutting or removal of corns and calluses. This</td>
</tr>
<tr>
<td>exclusion does not apply to preventive foot care for Members with diabetes.</td>
</tr>
<tr>
<td><strong>Maternity Services</strong></td>
</tr>
<tr>
<td>• Planned home births.</td>
</tr>
<tr>
<td><strong>Mental Health and Substance Use Disorder Treatment</strong></td>
</tr>
<tr>
<td>• Biofeedback. • Educational services or testing, except services covered under the benefit for Early</td>
</tr>
<tr>
<td>Intervention Services. No benefits are provided (1) for educational services intended to enhance</td>
</tr>
<tr>
<td>educational achievement or developmental functioning, (2) to resolve problems of school performance,</td>
</tr>
<tr>
<td>(3) to treat learning disabilities, (4) for driver alcohol education, or (5) for community reinforcement</td>
</tr>
<tr>
<td>approach and assertive continuing care. • Any of the following types of programs: programs in which the</td>
</tr>
<tr>
<td>patient has a pre-defined duration of care without the Plan's ability to conduct concurrent determinations</td>
</tr>
<tr>
<td>of continued medical necessity, programs that only provide meetings or activities not based on individualized</td>
</tr>
<tr>
<td>treatment plans, programs that focus solely on interpersonal or other skills rather than directed toward</td>
</tr>
<tr>
<td>symptom reduction and functional recovery related to specific mental health disorders, and tuition based</td>
</tr>
<tr>
<td>programs that offer educational, vocational, recreational, or personal developmental activities. • Methadone</td>
</tr>
<tr>
<td>maintenance, except when specifically listed as a Covered Benefit. • Sensory integrative praxis tests.</td>
</tr>
<tr>
<td>• Services for any condition with only a “Z Code” designation in the Diagnostic and Statistical Manual of</td>
</tr>
<tr>
<td>Mental Disorders, which means that the condition is not attributable to a mental disorder. • Mental health</td>
</tr>
<tr>
<td>and substance use disorder treatment that is (1) provided to</td>
</tr>
</tbody>
</table>

This exclusion list is not binding and is provided exclusively for information purposes. Please see your Benefit Handbook and Schedule of Benefits.
<table>
<thead>
<tr>
<th>Exclusion</th>
</tr>
</thead>
</table>

**Mental Health and Substance Use Disorder Treatment (Continued)**

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.

<table>
<thead>
<tr>
<th>Physical Appearance</th>
</tr>
</thead>
</table>
• 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.

<table>
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<tr>
<th>Procedures and Treatments</th>
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• 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, except when specifically listed as a Covered Benefit. **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 reassignment surgery and all related drugs and procedures for self-insured groups, unless covered under a separate rider. • 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.

<table>
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<th>Providers</th>
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• 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.
### Exclusion

#### Reproduction
- Any form of Surrogacy or services for a gestational carrier other than covered maternity services.
- Infertility drugs if a Member is not in a Plan authorized cycle of infertility treatment.
- Infertility drugs, if infertility services are not a Covered Benefit.
- Infertility drugs that must be purchased at an outpatient pharmacy, unless your Plan includes outpatient pharmacy coverage.
- Infertility treatment for Members who are not medically infertile.
- Infertility treatment 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 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, unless the life of the mother is in danger or unless it is specifically listed as a Covered Benefit.

#### Services Provided Under Another Plan
- Costs for any services for which you are entitled to treatment at government expense, including military service connected disabilities.
- Costs for services 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
- Custodial 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, except when specifically listed as a Covered Benefit.
- 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.
- 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 drug or other product obtained at an outpatient pharmacy, except for pharmacy supplies covered under the benefit for diabetes services and hypodermic syringes and needles, as required by law, unless your Plan includes outpatient pharmacy coverage.
- 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.
- Beauty or barber service.
- Diabetes equipment replacements when solely due to manufacturer warranty expiration.
- Donated or banked breast milk.
- Food or nutritional supplements, including, but not limited to, FDA-approved medical foods obtained by prescription, except as required by law and prescribed for Members who meet HPHC policies for enteral tube feedings.
- Guest services.
- Medical equipment, devices or supplies except as listed in this Benefit Handbook.
- Medical services that are provided to Members who are confined or committed to jail, house of correction, 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 Benefit Handbook, this Schedule of Benefits, or Prescription Drug Brochure (if applicable).
- Services that are not Medically Necessary.
- 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.

This exclusion list is not binding and is provided exclusively for information purposes. Please see your Benefit Handbook and Schedule of Benefits.
<table>
<thead>
<tr>
<th>Exclusion</th>
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<tbody>
<tr>
<td><strong>All Other Exclusions (Continued)</strong></td>
</tr>
<tr>
<td>• 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.</td>
</tr>
</tbody>
</table>

This exclusion list is not binding and is provided exclusively for information purposes. Please see your Benefit Handbook and Schedule of Benefits.
Covered prescription medications are available at participating pharmacies.

<table>
<thead>
<tr>
<th>Tier</th>
<th>Retail</th>
<th>Mail (up to a 90-day supply)</th>
</tr>
</thead>
</table>
| Tier 1| **Up to a 30-day supply:**
  $5 Copayment
Up to a 90-day supply:
$15 Copayment | $10 Copayment |
| Tier 2| **Up to a 30-day supply:**
$30 Copayment
Up to a 90-day supply:
$90 Copayment | $60 Copayment |
| Tier 3| **Up to a 30-day supply:**
$60 Copayment
Up to a 90-day supply:
$180 Copayment | $120 Copayment |
| Tier 4| **Up to a 30-day supply:**
$100 Copayment
Up to a 90-day supply:
$300 Copayment | $300 Copayment |
| 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.

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/2023Value5T](http://www.harvardpilgrim.org/2023Value5T) 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.
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).


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 quý vị nói Tiếng Việt, dịch vụ thợ dịch của chúng tôi sẵn sàng phục vụ quý 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) إتاحة إذا كنت تتكلم اللغة العربية، خدمات المساعدة اللغوية متوفرة لك مجاناً. اتصل على 1 888-333-4742 (TTY: 711).

Бамбая (Cambodian) យោង ពួកយើងដែលមានជំនួសអនុវត្តសញ្ញាក្បៅហើយ អាចផ្តល់ជំនួសអនុវត្តសញ្ញាក្បៅរបស់អ្នកបាន 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 διαθεσίμα τα διωρείων 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 दिला: अगर आप हिंदी बोलते हैं तो आपके लिए भाषा सहायता मुफ्त में उपलब्ध है। जानकारी के लिए फोन करे 1-888-333-4742 (TTY: 711).

ગુજરાતી (Gujarati) ચેમ આપે છે: તમે ગુજરાતી બોલતા હોય તો આપને માટે ભાષાના સહાયક તથા ઉદ્યોગ મૂક ગુજરાતી ભાષામાં ફોન કરો 1-888-333-4742 (TTY: 711).

LAO (Lao) ສະຖານທະくれ: ເ长沙 ໜ່ວຍເຫຼື່ອ່ຽງພາບ, ຄາວບ່ອງເກັບເລື່ອງຮ່າງດາວ, ປຸາມປະເທດ, ໂທຣາຍຸ ບ້ານສາຍ. 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).


(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, sex, sexual orientation, or gender identity. HPHC does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, sexual orientation, or 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, sex, sexual orientation, or 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) 509-3385. 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)
