Helping you get the most out of your health insurance.

Learn about your benefits.

Enrollment Materials
Welcome to Harvard Pilgrim!

Health insurance can be complicated. At Harvard Pilgrim, we’re here to guide you on understanding your plan, getting the most value from your benefits and finding ways to better health.

This kit contains everything you need to help you understand your benefits and the programs, tools and services available to you as a Harvard Pilgrim member.

Get started with your plan

After you enroll, be sure to:

1. Register for your member account at www.harvardpilgrim.org
2. Get your electronic ID card
3. Confirm that your providers are in your plan’s network before your next appointment
4. Check to see how your prescriptions are covered

Note: Not all employer-sponsored plans include Harvard Pilgrim prescription drug benefits.
Understand your plan

Review what’s inside this kit to learn more about:

**Your medical benefits**
High-quality coverage for a range of services, including preventive care, office visits, medical emergencies, hospitalization and more.

**Prescription drug benefits**
Access to a broad range of safe, effective medications.*

**Extras that help you make the most of your plan**
Tools that help you compare costs for hundreds of medical treatments. Discounts on products and services that help you lead a healthy lifestyle. Personal health coaching and guidance to help you achieve your wellness goals.

All the information you need, all in one place
Your online member account is your go-to place for all your member benefits and information. Access plan benefits, claims status, your personal health information and more at www.harvardpilgrim.org.

Let Harvard Pilgrim guide you to a happier, healthier place.

*Not all employer-sponsored plans include Harvard Pilgrim prescription drug benefits.*
New plan. New benefits. 
Lots of questions?

Harvard Pilgrim welcomes you as a new member.

We want to make your switch to Harvard Pilgrim as easy as possible.
Know that we are here to help and support you every step of the way!

You’re switching to a new health plan, and maybe you want to know:

- How soon do you get your ID card?
- How can you confirm coverage for an upcoming appointment or procedure?
- How will your medications will be covered?

Harvard Pilgrim SmartStart will guide you through this change.

Talk to us!

Contact us at SmartStart@harvardpilgrim.org or call (866) 874-0817 for answers to your questions.

We’ll be happy to talk with you about your new benefits and put you in touch with clinical experts to discuss your medical concerns.

Get set up online.

Visit www.harvardpilgrim.org to set up your member account.

Use our New Member Welcome Guide to:

- Verify your contact information
- Select or change primary care providers
- View and print your Harvard Pilgrim ID card
- Answer a brief health questionnaire (responses will not affect coverage)
A guide to your medical coverage
Getting care with the PPO plan

With this plan, you may receive care from medical professionals and hospitals in or out of Harvard Pilgrim’s network. Your costs will be lower when you receive care from in-network providers.

**Routine and preventive care***
There’s no extra charge for routine annual exams and many preventive tests and services with in-network providers. Other tests and services your in-network provider orders may require cost sharing.

**Specialty care**
You can see specialists inside or outside of Harvard Pilgrim’s network for covered services. Referrals are not required.

**Behavioral health care****
Your plan covers in-person visits with thousands of participating licensed clinicians. Virtual visits via smartphone, tablet or computer are also available.

**Care when you’re traveling**
Your plan covers emergency care at the in-network level if you get sick or injured while traveling anywhere in the world.

**Acupuncture and chiropractic treatments**
Acupuncture and chiropractic benefits are included on most plans. Referrals are not required.

**Urgent and emergency care**
If you have a non-life-threatening illness or injury and your doctor’s office is closed, you have a variety of options for getting care. Of course, if you think you’re having a medical emergency, go to the emergency room or call 911.

<table>
<thead>
<tr>
<th>Commonly treated conditions</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Virtual visits</td>
<td>$</td>
</tr>
<tr>
<td>Real-time virtual visit with providers via smartphone, tablet or computer</td>
<td>Non-life-threatening illnesses and injuries (coughs/colds, sore/strep throat, nausea/diarrhea, etc.)</td>
</tr>
<tr>
<td>Convenience care/retail clinic</td>
<td>$$</td>
</tr>
<tr>
<td>Walk-in, convenience care or retail clinics</td>
<td>Minor illnesses and infections (bronchitis, strep throat, ear &amp; eye infections, etc.)</td>
</tr>
<tr>
<td>Urgent care center</td>
<td>$$$</td>
</tr>
<tr>
<td>Walk-in clinic for urgent care</td>
<td>Minor illnesses, injuries and infections (burns, bites, colds &amp; flu, sprains &amp; strains, etc.)</td>
</tr>
<tr>
<td>Emergency room (ER)</td>
<td>$$$$</td>
</tr>
<tr>
<td>Part of a hospital that provides immediate treatment for life-threatening illnesses and injuries</td>
<td>Medical emergencies (heart attack, stroke, choking, loss of consciousness, seizures, etc.)</td>
</tr>
</tbody>
</table>

Visit [www.harvardpilgrim.org/urgentcareoptions](http://www.harvardpilgrim.org/urgentcareoptions) for more information about these options.

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

The PPO plan gives you flexibility and choice with the providers you see and the hospitals you use.

Features

- **In-network coverage**
- **No referrals required**

- **Out-of-network coverage**

**In-network coverage**
You get in-network coverage—which typically costs less—when you receive care from participating providers. Our network is vast, with thousands of participating providers and hospitals across the country. Chances are very good that you can receive all of your care with in-network providers.

**Out-of-network coverage**
You get out-of-network coverage—which typically costs more—when you receive care from non-participating providers. Our network providers have agreed to certain charges. When you choose out-of-network providers, they can charge more than the Harvard Pilgrim allowed amount and you will be responsible for paying the difference.

A note about hospital admissions
When you’re going to be admitted to the hospital, services are covered according to what combination of providers you use. Suppose that you are being sent to a participating hospital by a non-participating doctor. In this case your hospital visit is covered at the in-network benefit level, and the doctor’s services are covered at the out-of-network benefit level.

Except in an emergency, you must notify us before a hospital admission when non-participating providers are involved. Just give Member Services a call.

A primary care provider is key to good health
A primary care provider (PCP) is the doctor, nurse practitioner or other qualified medical professional you see for annual check-ups and for treatment when you’re sick or injured.

We strongly recommend having a PCP to work with even though this plan doesn’t require you to have one. A PCP will keep a record of your care and can help you make informed decisions about your health.

You and each of your dependents can choose different PCPs from our network of participating providers.

The role of a PCP
- Provides preventive and routine medical care
- Refers you to participating medical specialists, when needed
- Knows your health history and educates you about healthy lifestyle choices

Two ways to find a PCP:
Find a PCP or see if your current provider is in our network.

Visit
www.harvardpilgrim.org/providerdirectory

Call us:
Already a member:
(888) 333-4742
Not yet a member:
(866) 874-0817
TTY: 711
Once you’re a member

Register for your member account at www.harvardpilgrim.org:
- Look up the details of your plan.
- Compare costs for tests and procedures.
- Explore different health topics and ways to be well.
- Check out ways to save with discounts on eyewear, reimbursement for fitness programs and more!

Need help?
Already a member: (888) 333-4742
Not yet a member: (866) 874-0817
TTY: 711
What you pay for services

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

**Allowed amount:** Generally, this is the maximum amount that Harvard Pilgrim will pay a provider for covered services. If you see a non-participating provider, it’s possible that the provider will charge more than the allowed amount for the care you received. In that case, you would be responsible for paying the difference between the provider’s charges and Harvard Pilgrim’s allowed amount. This is sometimes called “balance billing.”

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

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

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

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

*Not all employer-sponsored plans offer Harvard Pilgrim prescription drug benefits.

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

Here’s how your plan covers some common services.

**No cost sharing when received in-network—Routine & preventive care**
- Annual checkup
- Preventive screenings and tests
- Immunizations, including flu shots
- Routine pre-natal and post-partum visits

**Cost sharing may apply—Doctor office visits, diagnostic tests & services, hospital services**
- Visits to your provider when you’re sick or injured
- Diagnostic screenings and tests outside of preventive care
- X-rays, CT scans and MRIs
- Inpatient and outpatient hospital care
- Emergency room visits

*Preventive services that fall under the federal Affordable Care Act.

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

Costs for medical tests and procedures often vary widely with no significant difference in quality. So why pay more if you don’t have to?

With our Flex plans, you can visit select providers and pay lower out-of-pocket costs¹ for:
• Lab tests (excluding genetic testing)
• Outpatient surgery services

Depending on your plan,² you may also pay lower cost sharing for:
• MRI, CT/CAT and PET scans
• Physical, speech and occupational therapy

Visit www.harvardpilgrim.org/flexplans to learn more and to find providers who can help you save money.

Note: HMO plans require a referral from your primary care provider or specialist. See the Benefit Handbook for details. Review your Schedule of Benefits for details on cost sharing.

When you use select providers:

The deductible will not apply.¹²

You’ll pay a copayment for outpatient surgery.¹²

There is no charge for covered lab tests, excluding genetic testing.¹²

You’ll pay a copayment or coinsurance for MRI, CT and PET scans.¹²

You’ll pay a copayment or coinsurance for physical, speech and occupational therapy.¹²

¹ Members on HSA plans have to meet their annual deductible first, and then they may pay lower out-of-pocket costs.
² Different member cost sharing may apply. Check your Schedule of Benefits for details. The Schedule of Benefits governs in the event that the information in this document is different.
Your guide to prescription drug coverage

Value 5-Tier
Our 5-tier prescription drug plan helps you get the most from your coverage.

All covered medications fall into one of five tiers.

**TIER 1**
Low-cost generic drugs and certain over-the-counter (OTC) medications*

**TIER 2**
High-cost generic drugs

**TIER 3**
Preferred brand-name drugs and some high-cost generic drugs

**TIER 4**
Preferred specialty drugs and non-preferred brand-name drugs

**TIER 5**
Non-preferred specialty drugs and other high-cost brand-name and generic drugs

*Over-the-counter medication is covered under Tier 1 as of January 1, 2021.

Fact: FDA-approved generic drugs contain the same active ingredients as their brand-name counterparts.
Which tier is my drug in?

For the most up-to-date information, visit www.harvardpilgrim.org/rx. Choose the year and then “Value 5-Tier” to find out how your drugs are covered.

Do drugs ever change tiers?
The short answer—sometimes. The prescription drug market is rapidly changing, with drug costs constantly rising. When drugs do change tiers, it usually happens in January of each year. We’ll let you know in the fall about any upcoming changes to our prescription drug program.

Your drug coverage

What drugs are covered?
• Most generic drugs
• Brand-name drugs without generic equivalents
• Certain over-the-counter medications*

What drugs aren’t covered?
• Brand-name drugs with generic equivalents
• Cosmetic drugs
• Some brand-name and higher-cost generic drugs

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

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

Can I request an exception?
Yes. If you need a drug that we either don’t cover or limit, you or your provider can ask us for an exception. For details, visit www.harvardpilgrim.org/rx. Choose the year and then “Value 5-Tier” for information on exceptions.

What is step therapy?
Step therapy is a process that requires you to first try one drug for a medical condition before we cover another drug for that condition.

For example, if Drug A and Drug B both treat the same medical condition, we may require you to try Drug A first. If Drug A does not work, then we will cover Drug B. If you did not try Drug A first, then prior authorization would be required for Drug B.

How can I learn more?
Use our online Prescription Drug List to find out which drugs we cover. It will show you which ones have quantity limits or require prior authorization or step therapy. Visit www.harvardpilgrim.org/rx. Choose the year and then “Value 5-Tier” to find out how your drugs are covered.

What kinds of over-the-counter medications are available in Tier 1?*
Tier 1 includes certain cough, cold and allergy medicines; skin treatments (dermatology); stomach medicines (gastrointestinal); pain relievers; and eye preparations (ophthalmic).

How can I get an over-the-counter medication covered under my prescription drug benefit?*
Visit www.harvardpilgrim.org/rx and use the Prescription Drug Lookup to find out which over-the-counter medications are included in Tier 1. Ask your provider to write a prescription for the generic version and have it filled at a participating pharmacy.

*Over-the-counter medication is covered under Tier 1 as of January 1, 2021.
Filling your prescriptions

Where can I get my prescriptions filled?
You can get your prescriptions filled at any of 67,000 retail pharmacies that belong to our national participating pharmacy network. To confirm whether your local pharmacy is in the network, visit www.harvardpilgrim.org/rx. Choose the year and then “Value 5-Tier” to find participating pharmacies.

Can I get a 90-day supply?
If you take maintenance medications (i.e., ones you take continually for conditions such as heart disease, diabetes or depression), you can get a 90-day supply from many retail pharmacies or through our mail order program. To learn more about these options, visit www.harvardpilgrim.org/rx. Choose the year and then “Value 5-Tier” for details. Depending on your coverage, your cost sharing may be lower when you get these drugs through the mail order program or at retail pharmacies in Maine.

What if I take specialty medications?
If you take medications for conditions such as hepatitis C, multiple sclerosis or rheumatoid arthritis, your provider must order your prescriptions through our designated specialty pharmacy. Visit www.harvardpilgrim.org/rx for information on our specialty pharmacy program. Choose the year and then “Value 5-Tier” details.

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

To learn more about Harvard Pilgrim’s pharmacy program:

Visit www.harvardpilgrim.org/rx

Call

Already a member? (888) 333-4742
Not yet a member? (866) 874-0817
TTY: 711
What do I pay for my medications?

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

Copayment – A fixed dollar amount you pay for a prescription. Your copayment is typically different for each tier. Each copayment covers an individual prescription up to a 30-day supply or one refill.

Coinsurance – A fixed percentage of costs that you pay for medication. Each tier may have a different cost percentage. Your coinsurance charge will be calculated using the lower of the pharmacy’s retail price or Harvard Pilgrim’s discount price for the drugs.

Deductible – Depending on your plan, a set amount of money you pay out of your own pocket for medical services and/or prescriptions. If your prescriptions fall under a deductible, you will pay the lower of the pharmacy’s retail price or Harvard Pilgrim’s discount price for the drugs.

Out-of-pocket maximum – A limit on the total amount you pay for a year in copayments, coinsurance and deductibles. Your plan may include an out-of-pocket maximum for prescription drugs. Find out in the Prescription Drug Coverage insert or Schedule of Benefits.
Welcome to OptumRx home delivery
Once your coverage begins:

Where can I fill my prescriptions?

- **OptumRx home delivery**
  Order a 90-day supply of the medication you take regularly for less, depending on your plan. There’s no charge for standard shipping to U.S. addresses.

  Set up home delivery online, with the app or by calling OptumRx.

  Please have the following items ready:
  - Your doctor’s contact information
  - Names and strength of current medications
  - Payment information

- **Network retail pharmacies**
  Show your member ID card at any OptumRx network retail pharmacy. Visit [www.harvardpilgrim.org/rx](http://www.harvardpilgrim.org/rx), call Member Services or use the app to find network pharmacies.
About OptumRx home delivery

OptumRx® home delivery is Harvard Pilgrim’s mail order pharmacy partner. Our pharmacy care experts are committed to providing safe, easy and cost-effective ways to help you get the medication you need.
Things to do before your coverage begins

1. Set up your www.harvardpilgrim.org member account. Once logged in, click “Check drug coverage and costs” to get started with OptumRx home delivery.

2. Let your doctor know that OptumRx home delivery is your new mail order pharmacy, and check to see if you have refills remaining on your prescriptions.

3. If you are currently using another home delivery service, make sure you have at least a 1-month supply of medication on hand during the transition.

Things to do after your coverage begins

1. Log in to your www.harvardpilgrim.org member account. Click “Check drug coverage & costs” to get started with OptumRx home delivery.

2. Review your formulary
   - Find out if you need to take action before filling your first prescription.
   - Check for lower-cost options.

3. Fill your prescriptions
   - Have your member ID card ready.
   - Use home delivery for maintenance medications, refill reminders and more.
Helpful tips

**Know your plan**
Your plan may require one or more of the following before you can fill your prescription:

**Prior authorization:**
Your plan’s approval to get a medication

**Step therapy:**
Trying one or more lower-cost medications before another

**Quantity limits:**
Getting a certain amount of each prescription

**Talk to your doctor**
When you talk with your doctor, use our app to confirm coverage and costs. You can also talk about what you need to do to get your medication.

**Save money on medication**
Your formulary is a list of covered medications. The list is broken into sections called tiers (or cost level you pay).

- Choosing medications in lower tiers may save you money.
- Generic medications usually have lower cost sharing than brand-name medications. Ask your doctor if a generic is right for you.
Questions?
Once your coverage begins

Log in to your www.harvardpilgrim.org 
member account.

Open the OptumRx app.

Call (855) 258-1561. For TTY service, call 711.
Fill your prescriptions with home delivery.

How it works
1. Order a 3-month supply of your maintenance medications — ones you take regularly.
2. OptumRx® home delivery fills your order, mails it to you and lets you know when to expect your delivery.
3. Your medication arrives within 4 to 7 days of placing the order. OptumRx home delivery will notify you if there will be a delay in your order.

Four easy ways to enroll:
ePrescribe Your doctor can send an electronic prescription to OptumRx home delivery.
Online Log in to your member account at www.harvardpilgrim.org. Click “Check drug coverage & costs” to go to an OptumRx page where you can set up your mail order account.
Phone Call (855) 258-1561. For TTY service, call 711.
Mail Complete the attached order form and mail it to OptumRx, P.O. Box 2975, Mission, KS 66201.

Manage your medication home delivery on the go.
Starting January 1, 2020, order and track your prescriptions online at www.harvardpilgrim.org/rx or download and open the OptumRx app.

The benefits of home delivery
- Your medication is delivered right to your mailbox, saving you a trip to the pharmacy.
- Your maintenance medication could cost less.
- Pay nothing for standard shipping.
- Phone, text* and email reminders help you remember every dose and every refill.

OptumRx specializes in the delivery, clinical management and affordability of prescription medications and consumer health products. We are an Optum® company — a leading provider of integrated health services. Learn more at optum.com.

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FORM NO: NH_CC9265_1019
NEW PRESCRIPTION MAIL-IN ORDER FORM

1. Member and physician information — please use black or blue ink. One form per member.

   Member ID Number

   (Additional coverage, if applicable) Secondary Member ID Number

   Last Name    First Name    MI

   Delivery Address    Apt. #

   City    State    ZIP

   Phone Number with Area Code

   Date of Birth (mm/dd/yyyy)    Gender
   O M   O F

   Email

   Physician Name

   Physician Phone Number with Area Code

2. Health history

   Medication Allergies:
   O Aspirin    O Erythromycin    O Quinolones
   O None known    O Cephalosporins    O NSIDs    O Sulfas
   O Amoxicillin/Ampicillin    O Codeine    O Penicillin

   Health Conditions:
   O Asthma    O Glaucoma    O High cholesterol
   O None known    O Cancer    O Heart condition
   O Arthritis    O Diabetes    O Osteoporosis

   Over-the-counter/herbal medications taken regularly:

3. Payment and shipping information — do not send cash

   Standard delivery is included at no charge. New prescriptions should arrive within about 10 business days from the date the completed order is received. Completed refill orders should arrive within about 7 business days. OptumRx will contact you if there will be an extended delay in delivering your medications.

   You may log on to optumrx.com to see if drug pricing information is available before enclosing payment. Once shipped, medications may not be returned for a refund or adjustment.

   O Ship overnight. Add $12.50 to order amount (subject to change).
   O Check enclosed. All checks must be signed and made payable to: OptumRx.
   O Charge to my credit card on file.
   O Charge to my NEW credit card.

   New Credit Card Number

   Expiration Date (Month/Year)

   Signature: ___________________________ Date: __________

   For new prescription orders and maintenance refills, this credit card will be billed for copay/coinsurance and other such expenses related to prescription orders. By supplying my credit card number, I authorize OptumRx to maintain my credit card on file as payment method for any future charges. To modify payment selection, contact customer service at any time.

4. Mail this completed order form with your new prescription(s) to OptumRx, P.O. Box 2975, Mission, KS 66201. DO NOT STAPLE OR TAPE PRESCRIPTIONS TO THE ORDER FORM.
“I love that my plan comes with lots of extras that deliver more value and savings.”

Programs to help you be well and save money.

The individual shown is representative only. The comment is a composite of sentiments often expressed by our members.

FORM NO: NH_CC7973_0420
Once you’re a member, register for your member account at www.harvardpilgrim.org to learn more about these and other programs that bring you value.

**Be well**

**Improve your well-being**
Whether you’re seeking support for healthy eating, fitness, finances or stress management, our Living WellSM Everyday program is packed with tools that let you define your own vision of a healthier you.

Visit www.harvardpilgrim.org/livingwelleveryday

**Learn more about managing a health condition**
Our nurse care managers are available to help you manage your condition, support your care and improve your quality of life.

Visit www.harvardpilgrim.org/nursecare

**Coaching you to better health**
A Harvard Pilgrim lifestyle management coach can support, educate and motivate you on your way to better health. This service comes at no additional cost and is available to any member age 18 and older.

Visit www.harvardpilgrim.org/healthcoach

**Manage stress, increase focus and stay healthy**
Explore the basic practices of mindfulness through instructional videos and guided meditation through our Mind the Moment program.

Visit www.harvardpilgrim.org/mindthemoment

**Save money**

**Stay healthy and save with discounts on products and services**
Harvard Pilgrim members can save on a wide range of products and services to help stay healthy and active, including vision, fitness, healthy eating and much more.*

Visit www.harvardpilgrim.org/savings

**Save on tests and procedures – and earn cash rewards**
Find care at a lower-cost facility for elective outpatient medical procedures and diagnostic testing using Reduce My Costs and you’ll receive a cash reward for using the facility.

Visit www.harvardpilgrim.org/reducemystress

**Estimate your health care expenses and compare provider costs**
Get an estimate of your out-of-pocket costs before you receive care. Search for hundreds of services and procedures and compare costs for multiple providers.

Visit www.harvardpilgrim.org/estimatecosts

*The savings programs featured in this flyer are not insurance products. Rather, they are discounts for programs and services designed to help keep members healthy and active. All programs subject to change without advance notice.

Visit www.harvardpilgrim.org
Prospective members: (866) 874-0817
Current members: (888) 333-4742
TTY: 711

“Accessing behavioral health care is easy with Harvard Pilgrim.”

Whether you’re currently in treatment and/or looking for more support, your Harvard Pilgrim plan gives you lots of options.

Once your Harvard Pilgrim membership is active, you have access to a vast network* of behavioral health providers in all 50 states through our partner, United Behavioral Health (UBH).

These providers evaluate and treat general mental health conditions, such as depression and anxiety. This includes therapy — both in-person and “virtual”— and prescribing medication when appropriate and in accordance with regulatory requirements.

Read on for more. ▶
Getting started: accessing behavioral health providers

Log in to www.harvardpilgrim.org, click “Find a provider” at the top of the page and select “Behavioral Health.” Here you can also filter for “Virtual Visits” if that’s your preference for care.

If your membership is active... you can find a provider online whenever you’re ready.

Not sure if your membership is active?
Review these steps to check and be sure you’re all set.

1. **No Harvard Pilgrim ID #?**
   Call Harvard Pilgrim’s SmartStart team at (866) 874-0817 for assistance.

2. **Got your ID # and just need to set up your online account?**
   It’s easy. At www.harvardpilgrim.org, follow the simple steps after the “Member Login” prompt.

Transition of care benefits: continuing care with a non-participating provider

Once you become an active member of Harvard Pilgrim you may request authorization to continue care with a non-participating provider for a transitional period. Please be aware that authorization must be requested within 30 days of your enrollment effective date. To learn more about your transition of care benefits, please call our Behavioral Health Access Center at (888) 777-4742. Licensed care advocates are available to answer your questions and assist you.

If you are not yet active with Harvard Pilgrim, you can still call the Behavioral Health Access Center to check whether or not your current provider is in our network.

Virtual Visits: get care using your smartphone, tablet or computer

Did you know that Harvard Pilgrim’s got you covered for routine behavioral health “virtual” care? Even better, the convenience doesn’t cost you more. Find a virtual care provider at www.harvardpilgrim.org.

Another virtual option — for both routine or occasional behavioral health support — is Doctor on Demand. Get details and set up an account at www.doctorondemand.com.

These services are a convenient option for routine care and not meant for emergencies.

24/7 support

For non-emergent, routine behavioral health treatment issues, please contact your behavioral health provider. If you have more urgent questions about finding treatment or a behavioral health provider, please call the Behavioral Health Access Center at (888) 777-4742. Licensed care advocates answer calls around the clock, seven days a week.

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

Get extra support with the Sanvello mobile app

Through our partnership with United Behavioral Health you also have access to the Sanvello mobile app, another resource to help you dial down the symptoms of stress, anxiety and depression — anywhere, anytime. Use the app to track your daily mood, learn coping tools, experience guided journeys, and so much more.

Once downloaded, enter your Harvard Pilgrim ID for complimentary access to the premium version.

You can also access the app at www.liveandworkwell.com.

To browse as a guest, use access code: HPHC.

Note: Cost-sharing amounts may vary depending on your plan. As always, be sure to review your Schedule of Benefits for complete details about your benefits and coverage.
To enroll, please use the fillable, printable PDF file titled “HPHC_enrollment_form.pdf” included with this digital kit.
ID: MD0000005163

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.

**Copayment Levels**

There are two types of In-Network office visit Copayments that apply to your Plan: a lower Copayment, known as “Level 1,” and a higher Copayment known as “Level 2."

Level 1 applies to covered outpatient professional services 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 most specialty care.

If a provider is categorized as both a Level 1 provider and a Level 2 provider, Level 1 applies. For example, if a provider is both a PCP and a cardiologist, you will be responsible for a Level 1 Copayment.

EFFECTIVE DATE: 01/01/2020

FORM #2613  SCHEDULE OF BENEFITS  |  1
PPO 2000 – FLEX - MASSACHUSETTS

Your Plan may have other Copayment amounts. Please see the benefit table below for specific Copayment 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](http://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</th>
<th>Out-of-Network Non-Plan Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coinsurance and Copayments</td>
<td>Member Cost Sharing</td>
<td>Member Cost Sharing</td>
</tr>
<tr>
<td>Deductible</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>$2,000 per Member per Plan Year</td>
<td>$4,000 per Member per Plan Year</td>
</tr>
<tr>
<td></td>
<td>$4,000 per family per Plan Year</td>
<td>$8,000 per family per Plan Year</td>
</tr>
<tr>
<td>Deductible Rollover</td>
<td>None</td>
<td></td>
</tr>
</tbody>
</table>
### General Cost Sharing Features:

<table>
<thead>
<tr>
<th>Out-of-Pocket Maximum</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>Includes all Member Cost Sharing except:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>– 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>$6,500 per Member per Plan Year</td>
<td>$13,000 per Member per Plan Year</td>
</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>$13,000 per family per Plan Year</td>
<td>$26,000 per family per Plan Year</td>
</tr>
</tbody>
</table>

### Out-of-Network Penalty Payment

| Does not count toward the Deductible or Out-of-Pocket Maximum | $500 |

<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></td>
<td></td>
</tr>
<tr>
<td>Limited to 20 visits per Plan Year</td>
<td>Level 2: $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 Copayment applies for your first office visit per Plan Year with a licensed mental health professional. After the first visit, the following cost sharing applies:</td>
<td>Deductible, then 20% Coinsurance</td>
</tr>
<tr>
<td></td>
<td>Level 1: $25 Copayment per visit</td>
<td></td>
</tr>
<tr>
<td>Chemotherapy and Radiation Therapy</td>
<td></td>
<td></td>
</tr>
<tr>
<td></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>
</tbody>
</table>
### Benefit Summary

<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><strong>Dialysis</strong></td>
<td>Deductible, then no charge</td>
<td>Deductible, then 20% Coinsurance</td>
</tr>
<tr>
<td><strong>Durable Medical Equipment</strong></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><strong>Early Intervention Services</strong></td>
<td></td>
<td></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><strong>Emergency Admission</strong></td>
<td>Deductible, then $250 Copayment per admission</td>
<td>Same as In-Network</td>
</tr>
<tr>
<td><strong>Emergency Room Care</strong></td>
<td>$300 Copayment per visit</td>
<td>Same as In-Network</td>
</tr>
<tr>
<td>This Copayment is waived if admitted to the hospital directly from the emergency room.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Hearing Aids (for Members up to the age of 22)</strong></td>
<td>Deductible, then 20% Coinsurance</td>
<td>Deductible, then 20% Coinsurance</td>
</tr>
<tr>
<td>Limited to $2,000 per hearing aid every 36 months, per hearing impaired ear</td>
<td>Deductible, then 20% Coinsurance</td>
<td>Deductible, then 20% Coinsurance</td>
</tr>
<tr>
<td><strong>Home Health Care</strong></td>
<td>Deductible, then no charge</td>
<td>Deductible, then 20% Coinsurance</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><strong>Hospice – Outpatient</strong></td>
<td>Deductible, then no charge</td>
<td>Deductible, then 20% Coinsurance</td>
</tr>
<tr>
<td><strong>Hospital – Inpatient Services</strong></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>
</tbody>
</table>
### Infertility Services and Treatments (see the Benefit Handbook for details)

<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>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>
<td></td>
</tr>
</tbody>
</table>

### Laboratory, Radiology and Other Diagnostic Services

<table>
<thead>
<tr>
<th>Laboratory, Radiology and Other Diagnostic Services</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>Laboratory Flex Providers</td>
<td>Deductible, then $45 Copayment per visit</td>
<td>Deductible, then 20% Coinsurance</td>
</tr>
<tr>
<td>Other Plan Providers</td>
<td>Deductible, then $45 Copayment per visit</td>
<td>Deductible, then 20% Coinsurance</td>
</tr>
<tr>
<td>Genetic testing</td>
<td>Deductible, then $45 Copayment per visit</td>
<td>Deductible, then 20% Coinsurance</td>
</tr>
<tr>
<td>Radiology</td>
<td>Deductible, then $45 Copayment per visit</td>
<td>Deductible, then 20% Coinsurance</td>
</tr>
<tr>
<td>Advanced radiology, including CT scans, PET scans, MRI, MRA and nuclear medicine services</td>
<td>Deductible, then $45 Copayment per visit</td>
<td>Deductible, then 20% Coinsurance</td>
</tr>
<tr>
<td>Advanced radiology, including CT scans, PET scans, MRI, MRA and nuclear medicine services</td>
<td>Deductible, then $45 Copayment per visit</td>
<td>Deductible, then 20% Coinsurance</td>
</tr>
<tr>
<td>Other diagnostic services</td>
<td>Deductible, then $45 Copayment per visit</td>
<td>Deductible, then 20% Coinsurance</td>
</tr>
<tr>
<td>Low Protein Foods</td>
<td>Deductible, then 20% Coinsurance</td>
<td>Deductible, then 20% Coinsurance</td>
</tr>
<tr>
<td>Maternity Care – Outpatient</td>
<td>Deductible, then 20% Coinsurance</td>
<td>Deductible, then 20% Coinsurance</td>
</tr>
<tr>
<td>Childbirth classes</td>
<td>No charge</td>
<td></td>
</tr>
<tr>
<td>– Limited to 1 initial childbirth course or 1 refresher course per pregnancy (see the Benefit Handbook for details)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Routine outpatient prenatal and postpartum care</td>
<td>No charge</td>
<td>Deductible, then 20% Coinsurance</td>
</tr>
<tr>
<td>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.”</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical Drugs (drugs that cannot be self-administered)</td>
<td>Deductible, then no charge</td>
<td>Deductible, then 20% Coinsurance</td>
</tr>
<tr>
<td>Medical drugs received in a physician’s office or other outpatient facility</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(Continued on next page)
### Important Information

**Benefit**

<table>
<thead>
<tr>
<th>Medical Drugs (drugs that cannot be self-administered) (Continued)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>In-Network Plan Providers Member Cost Sharing</strong></td>
</tr>
<tr>
<td>Medical drugs received in the home</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**

<table>
<thead>
<tr>
<th>Inpatient services</th>
<th>Deductible, then $250 Copayment per admission</th>
<th>Deductible, then 20% Coinsurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intermediate care services</td>
<td>Deductible, then no charge</td>
<td>Deductible, then 20% Coinsurance</td>
</tr>
</tbody>
</table>

| Outpatient group therapy                             | No Copayment applies 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 | No Copayment applies for your first office visit per Plan Year with a licensed mental health professional. After the first visit, the following cost sharing applies: Level 1: $25 Copayment per visit | Deductible, then 20% Coinsurance |

<table>
<thead>
<tr>
<th>Outpatient methadone maintenance</th>
<th>No charge</th>
<th>Deductible, then 20% Coinsurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient psychological testing and neuropsychological assessment</td>
<td>Deductible, then no charge</td>
<td>Deductible, then 20% Coinsurance</td>
</tr>
</tbody>
</table>

**Observation Services**

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

**Ostomy Supplies**

| Deductible, then 20% Coinsurance | Deductible, then 20% Coinsurance |

**Physician and Other Professional Office Visits (This includes all covered Plan Providers unless otherwise listed in this Schedule of Benefits.)**

| Routine examinations for preventive care, including immunizations | No charge | Deductible, then 20% Coinsurance |
### PPO 2000 – FLEX - MASSACHUSETTS

<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.) (Continued)</td>
<td></td>
<td></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 &quot;Laboratory, Radiology and Other Diagnostic Services&quot; 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>No Copayment for the first office visit per Plan Year with your PCP. After the first visit, the following cost sharing applies: <strong>Level 1</strong>: $25 Copayment per visit <strong>Level 2</strong>: $50 Copayment per visit</td>
<td>Deductible, then 20% Coinsurance</td>
</tr>
<tr>
<td>Copayment level varies depending on the type of provider. Please refer to the beginning of this Schedule of Benefits to determine which Copayment 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, pregnancy testing, 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>
<tr>
<td>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 <a href="http://www.harvardpilgrim.org">www.harvardpilgrim.org</a>. 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.</td>
<td></td>
<td></td>
</tr>
<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</td>
<td>No charge</td>
<td>Deductible, then 20% Coinsurance</td>
</tr>
</tbody>
</table>
### Preventive Services and Tests (Continued)

- **Monitor, retinopathy screening,** and **international normalized ratio (INR) testing.**

<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>Prosthetic Devices</td>
<td>Deductible, then 20% Coinsurance</td>
<td>Deductible, then 20% Coinsurance</td>
</tr>
<tr>
<td><strong>Rehabilitation and Habilitation Services – Outpatient</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cardiac rehabilitation</td>
<td>Deductible, then Level 1: $25 Copayment per visit</td>
<td>Deductible, then 20% Coinsurance</td>
</tr>
<tr>
<td>Pulmonary rehabilitation therapy</td>
<td>Deductible, then Level 1: $25 Copayment per visit</td>
<td>Deductible, then 20% Coinsurance</td>
</tr>
<tr>
<td>Speech-language and hearing services</td>
<td>In a physician’s office or non-hospital affiliated facility $25 Copayment per visit In a hospital or hospital affiliated facility Deductible, then $50 Copayment per visit</td>
<td>Deductible, then 20% Coinsurance</td>
</tr>
<tr>
<td><strong>Rehabilitation Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical and occupational therapies – combined up to 60 visits per Plan Year Habilitation Services</td>
<td>- in a physician’s office or non-hospital affiliated facility $25 Copayment per visit - in an acute hospital or hospital affiliated facility Deductible, then $50 Copayment per visit</td>
<td>Deductible, then 20% Coinsurance</td>
</tr>
<tr>
<td>Physical and occupational therapies – combined up to 60 visits per Plan Year</td>
<td>- in a physician’s office or non-hospital affiliated facility $25 Copayment per visit - in an acute hospital or hospital affiliated facility Deductible, then $50 Copayment per visit</td>
<td>Deductible, then 20% Coinsurance</td>
</tr>
</tbody>
</table>

**Scopic Procedures – Outpatient Diagnostic and Therapeutic**

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Flex Providers Copayment per visit</th>
<th>Other Plan Providers Deductible, then Copayment per visit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Colonoscopy, endoscopy and sigmoidoscopy</td>
<td>$75</td>
<td>$300</td>
</tr>
</tbody>
</table>

**Spinal Manipulative Therapy (including care by a chiropractor)**

<table>
<thead>
<tr>
<th>Level</th>
<th>Cost Sharing</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>$50</td>
</tr>
</tbody>
</table>

**Important Information**

Outpatient physical and occupational therapy is not subject to the limit listed above and is covered to the extent Medically Necessary for: (1) children under the age of three and (2) the treatment of Autism Spectrum Disorders.

The lower Flex cost sharing listed above applies to services provided by Flex Providers only. Additional Member Cost Sharing may apply to services billed from other Providers. For example, if you have surgery with a Flex provider, but that provider sends a specimen out for pathology, please refer to “Laboratory, Radiology and Other Diagnostic Services” to determine the cost sharing applicable to diagnostic services.
### Benefit In-Network Plan Providers

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Member Cost Sharing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgery – Outpatient</td>
<td>Flex Providers $75 Copayment per visit Other Plan Providers Deductible, then $300 Copayment per visit</td>
</tr>
</tbody>
</table>

The lower Flex cost sharing listed above applies to services provided by Flex Providers only. Additional Member Cost Sharing may apply to services billed from other Providers. For example, if you have surgery with a Flex provider, but that provider sends a specimen out for pathology, please refer to “Laboratory, Radiology and Other Diagnostic Services” to determine the cost sharing applicable to diagnostic services.

### Telemedicine Virtual Visit Services - Outpatient

<table>
<thead>
<tr>
<th>Level</th>
<th>Member Cost Sharing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level 1:</td>
<td>$25 Copayment per visit</td>
</tr>
<tr>
<td>Level 2:</td>
<td>$50 Copayment per visit</td>
</tr>
</tbody>
</table>

Deductible, then 20% Coinsurance

For inpatient hospital care, see “Hospital – Inpatient Services” for cost sharing details.

### Urgent Care Services

- **Doctors On Demand**
  - No charge

**Important Note:** Doctors On Demand is a specific network of providers contracted to provide virtual Urgent Care services. For more information on Doctors On Demand, including how to access them, please visit our website at [www.harvardpilgrim.org](http://www.harvardpilgrim.org).

- **Convenience care clinic**
  - Level 1: $25 Copayment per visit
  - Deductible, then 20% Coinsurance

- **Urgent care center**
  - Level 2: $50 Copayment per visit
  - Deductible, then 20% Coinsurance

- **Hospital urgent care center**
  - Level 2: $50 Copayment per visit
  - Deductible, then 20% Coinsurance

Additional Member Cost Sharing may apply. Please refer to the specific benefit in this Schedule of Benefits. For example, if you have an x-ray or have blood drawn, please refer to “Laboratory, Radiology and Other Diagnostic Services.”

### Vision Services

- **Routine eye examinations – limited to 1 per Plan Year**
  - Level 1: $25 Copayment per visit
  - Deductible, then 20% Coinsurance

- **Vision hardware for special conditions**
  - Deductible, then no charge
  - Deductible, then 20% Coinsurance

Your Plan also includes coverage for pediatric vision hardware. Please see the additional Pediatric Vision section later in this Schedule of Benefits for more information.

### Voluntary Sterilization

- **Deductible, then no charge**
  - **Deductible, then 20% Coinsurance**

### Voluntary Termination of Pregnancy

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.”
### PPO 2000 – FLEX - MASSACHUSETTS

**Benefit**

<table>
<thead>
<tr>
<th>Wellness Benefits (see the Benefit Handbook for details)</th>
<th>In-Network Plan Providers</th>
<th>Out-of-Network Non-Plan Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fitness</td>
<td>Member Cost Sharing</td>
<td>Member Cost Sharing</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>
<td>No charge</td>
<td>No charge</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>
<td></td>
<td></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>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*If a Member receives reimbursement for one month of individual or family fitness membership which is less than $150, then the difference may be applied toward the cost of the Member’s fitness tracker. If the cost of one month of individual or family fitness membership is greater than $150, then the 1 month is covered in full and there is no further coverage available for that Member.

**Weight management programs**

- Coverage provided for 3 months of membership at Weight Watchers traditional meetings or Weight Watchers at Work programs per calendar year.

<table>
<thead>
<tr>
<th>Wigs and Scalp Hair Prostheses</th>
<th>Deductible, then 20% Coinsurance</th>
<th>Deductible, then 20% Coinsurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Limited to 1 synthetic monofilament wig per Plan Year (see the Benefit Handbook for details)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**FORM #2613**

**SCHEDULE OF BENEFITS** | 10
5-Tier Value Outpatient Prescription Drug Coverage

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

<table>
<thead>
<tr>
<th>Benefit: Your pharmacy Copayments and Coinsurance for up to a 90-day supply of maintenance medications at a retail pharmacy are:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Tier 1: $15 Copayment per prescription or prescription refill</td>
<td></td>
</tr>
<tr>
<td>Tier 2: $90 Copayment per prescription or prescription refill</td>
<td></td>
</tr>
<tr>
<td>Tier 3: $180 Copayment per prescription or prescription refill</td>
<td></td>
</tr>
<tr>
<td>Tier 4: $300 Copayment per prescription or prescription refill</td>
<td></td>
</tr>
<tr>
<td>Tier 5: 20% Coinsurance up to a maximum of $750 per prescription or prescription refill</td>
<td></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 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 under the age of 19 are eligible for coverage of prescription eyeglasses or contact lenses. Coverage under this benefit terminates at the end of the month in which the Dependent turns 19. Each Dependent is eligible for coverage every 12 months for either (A) prescription eyeglass frames and lenses or (B) prescription contact lenses, as described below:

(A) PRESCRIPTION EYEGLASS FRAMES AND LENSES

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

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

(B) PRESCRIPTION CONTACT LENSES

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

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

In addition to the Covered Benefits described above, Dependents under 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.
Getting Started
Medical Health Plan
Prescription Drug Plan
Prescription Home Delivery
Programs & Savings
Behavioral Health
Enrollment Form
Summary of Benefits
Important Information

PPO 2000 – FLEX - MASSACHUSETTS

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 sevè ki disponib nan lang pou sevè. 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 (TTY: 711).

العربية (Arabic) إشعار: إذا كنت تتكلم اللغة العربية، خدمات المساعدة اللغوية متوفرة لكم مجانيًا. تصل إلى 1-888-333-4742 (TTY: 711).

ไทย (Cambodian) จงสื่อสารให้อีกภาษาไทย, บริการแปลฟรีสำหรับผู้พิการทางการพูด. โทร 1-888-333-4742 (TTY: 711).


Italiano (Italian) ATTENZIONE: In caso la lingua parata 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 διαθέσιμα σε διάφορα μεταφραστικά υπηρεσίες για τους αγοραστές, Καλέστε το 1-888-333-4742 (TTY: 711).


हिंदी (Hindi) अनुरोध दिखाएः अगर आप हिंदी बोलते हैं तो आपके लिए भाषात्मक सहायता मुफ्त में उपलब्ध है।

अंग्रेजी के लिए कोल करें. 1-888-333-4742 (TTY: 711).

ગુજરાતી (Gujarati) અઝાદ આપો : જે તમે ગુજરાતી બોલતો હોય તે આપને ભાષાશિક સહાય તકનીકી મદદ મળી શકે છે, કોલ 1-888-333-4742 (TTY: 711).

ଓଡ଼ିଆ (Odia) ଅନୁକୋଚିତ : ଆପୁର ହନ୍ତକୁ ବଳିବା ପାଇଁ, ଭାଷାଶିକ ସହାୟୟ ରକଠାନ ଦେଇବ, କାର୍ଯ୍ୟରେ ଇଲ୍ତ୍ରକ, ଇଙ୍କେରେ ଇଲ୍ତ୍ରକ, ଇଙ୍କେରେ 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; 93 Worcester St; Wellesley, MA 02481; (617) 750-2074; TTY service: 711. Fax: (617) 509-3065; 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://oocrportal.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 S09F, HHH Building; Washington, D.C. 20201; (800) 368-1019, (800) 537-7697 (TTY).


cc6589_memb_serv (11/9)
**HPHC Insurance Company, Inc.**  
**MASSACHUSETTS PPO**  
**General List of Exclusions**

The following list identifies services that are generally excluded from Harvard Pilgrim PPO and Access America 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 Description

<table>
<thead>
<tr>
<th>Alternative Treatments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Acupuncture care except when specifically listed as a Covered Benefit.</td>
</tr>
<tr>
<td>2. Acupuncture services that are outside the scope of standard acupuncture care.</td>
</tr>
<tr>
<td>3. Alternative, holistic or naturopathic services and all procedures, laboratories and nutritional supplements associated with such treatments, except when specifically listed as a Covered Benefit. Please see your Schedule of Benefits to determine if your Plan provides coverage for these benefits.</td>
</tr>
<tr>
<td>4. Aromatherapy, treatment with crystals and alternative medicine.</td>
</tr>
<tr>
<td>5. Any of the following types of programs: Health resorts, spas, recreational programs, camps, outdoor skills programs, therapeutic or educational boarding schools, educational programs for children in residential care, self-help programs, life skills programs, relaxation or lifestyle programs, and wilderness programs (therapeutic outdoor programs).</td>
</tr>
<tr>
<td>6. Massage therapy.</td>
</tr>
<tr>
<td>7. Myotherapy.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Dental Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Dental Care, except when specifically listed as a Covered Benefit.</td>
</tr>
<tr>
<td>2. All services of a dentist for Temporomandibular Joint Dysfunction (TMD).</td>
</tr>
<tr>
<td>3. Extraction of teeth, except when specifically listed as a Covered Benefit.</td>
</tr>
<tr>
<td>4. Pediatric dental care, except when specifically listed as a Covered Benefit.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Durable Medical Equipment and Prosthetic Devices</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Any devices or special equipment needed for sports or occupational purposes.</td>
</tr>
<tr>
<td>2. Any home adaptations, including, but not limited to home improvements and home adaptation equipment.</td>
</tr>
<tr>
<td>3. Non-durable medical equipment, unless used as part of the treatment at a medical facility or as part of approved home health care services.</td>
</tr>
<tr>
<td>4. Repair or replacement of durable medical equipment or prosthetic devices as a result of loss, negligence, willful damage, or theft.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Experimental, Unproven or Investigational Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Any products or services, including, but not limited to, drugs, devices, treatments, procedures, and diagnostic tests that are Experimental, Unproven, or Investigational.</td>
</tr>
</tbody>
</table>
## Exclusions

<table>
<thead>
<tr>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Foot Care</strong></td>
</tr>
<tr>
<td>1. Foot orthotics, except for the treatment of severe diabetic foot disease.</td>
</tr>
<tr>
<td>2. Routine foot care. Examples include nail trimming, cutting or debriding and the cutting or removal of corns and calluses. This exclusion does not apply to preventive foot care for Members with diabetes.</td>
</tr>
<tr>
<td><strong>Maternity Services</strong></td>
</tr>
<tr>
<td>1. Planned home births.</td>
</tr>
<tr>
<td><strong>Mental Health and Substance Use Disorder Treatment</strong></td>
</tr>
<tr>
<td>1. Biofeedback.</td>
</tr>
<tr>
<td>2. Educational services or testing, except services covered under the benefit for Early Intervention Services. No benefits are provided (1) for educational services intended to enhance educational achievement or developmental functioning, (2) to resolve problems of school performance, (3) to treat learning disabilities, (4) for driver alcohol education, or (5) for community reinforcement approach and assertive continuing care.</td>
</tr>
<tr>
<td>3. Any of the following types of programs: programs in which the patient has a pre-defined duration of care without the Plan’s ability to conduct concurrent determinations of continued medical necessity, programs that only provide meetings or activities not based on individualized treatment plans, programs that focus solely on interpersonal or other skills rather than directed toward symptom reduction and functional recovery related to specific mental health disorders, and tuition based programs that offer educational, vocational, recreational, or personal developmental activities.</td>
</tr>
<tr>
<td>4. Methadone maintenance, except when specifically listed as a Covered Benefit.</td>
</tr>
<tr>
<td>5. Sensory integrative praxis tests.</td>
</tr>
<tr>
<td>6. Services for any condition with only a “Z Code” designation in the Diagnostic and Statistical Manual of Mental Disorders, which means that the condition is not attributable to a mental disorder.</td>
</tr>
<tr>
<td>7. Mental health and substance use disorder treatment that is (1) provided to Members who are confined or committed to a jail, house of correction, prison, or custodial facility of the Department of Youth Services; or (2) provided by the Department of Mental Health.</td>
</tr>
<tr>
<td>8. 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:</td>
</tr>
<tr>
<td>• Not consistent with prevailing national standards of clinical practice for the treatment of such conditions.</td>
</tr>
<tr>
<td>• Not consistent with prevailing professional research demonstrating that the services or supplies will have a measurable and beneficial health outcome.</td>
</tr>
<tr>
<td>• Typically do not result in outcomes demonstrably better than other available treatment alternatives that are less intensive or more cost effective.</td>
</tr>
<tr>
<td>9. 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.</td>
</tr>
</tbody>
</table>
### Exclusion Description

#### Physical Appearance

1. Cosmetic Services, including drugs, devices, treatments and procedures, except for (1) Cosmetic Services that are incidental to the correction of a Physical Functional Impairment, (2) restorative surgery to repair or restore appearance damaged by an accidental injury, and (3) post-mastectomy care.

2. Hair removal or restoration, including, but not limited to, electrolysis, laser treatment, transplantation or drug therapy.

3. Liposuction or removal of fat deposits considered undesirable.

4. Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures).

5. Skin abrasion procedures performed as a treatment for acne.

6. Treatment for skin wrinkles and skin tags or any treatment to improve the appearance of the skin.

7. Treatment for spider veins.

#### Procedures and Treatments

1. 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.

2. Spinal manipulative therapy (including care by a chiropractor), except when specifically listed as a Covered Benefit.

3. 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.

4. Gender reassignment surgery and all related drugs and procedures for self-insured groups, unless covered under a separate rider.

5. 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.

6. 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).

7. Physical examinations and testing for insurance, licensing or employment.

8. Services for Members who are donors for non-Members, except as described under Human Organ Transplant Services.


10. Group diabetes training, educational programs or camps.
## Exclusions

### Providers

1. Charges for services which were provided after the date on which your membership ends.
2. 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.
3. Charges for missed appointments.
4. Concierge service fees. (See the Plan’s Benefit Handbook for more information.)
5. Inpatient charges after your hospital discharge.
6. Provider’s charge to file a claim or to transcribe or copy your medical records.
7. Services or supplies provided by: (1) anyone related to you by blood, marriage or adoption, or (2) anyone who ordinarily lives with you.

### Reproduction

1. Any form of Surrogacy or services for a gestational carrier.
2. Infertility drugs if a Member is not in a Plan authorized cycle of infertility treatment.
3. Infertility drugs, if infertility services are not a Covered Benefit.
4. Infertility drugs that must be purchased at an outpatient pharmacy, unless your Plan includes outpatient pharmacy coverage.
5. Infertility treatment for Members who are not medically infertile.
6. Infertility treatment and birth control drugs, implants and devices, except when specifically listed as a Covered Benefit.
7. Reversal of voluntary sterilization (including any services for infertility related to voluntary sterilization or its reversal).
8. Sperm collection, freezing and storage except as described in the Plan’s Benefit Handbook.
9. Sperm identification when not Medically Necessary (e.g., gender identification).
10. The following fees: wait list fees, non-medical costs, shipping and handling charges etc.
11. Voluntary sterilization, including tubal ligation and vasectomy, except when specifically listed as a Covered Benefit.
12. 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

1. Costs for any services for which you are entitled to treatment at government expense, including military service connected disabilities.
2. Costs for services for which payment is required to be made by a Workers’ Compensation plan or an Employer under state or federal law.
## Exclusions

<table>
<thead>
<tr>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Telemedicine Services</strong></td>
</tr>
<tr>
<td>1. Telemedicine services involving e-mail, fax, texting, or audio-only telephone.</td>
</tr>
<tr>
<td>2. Provider fees for technical costs for the provision of telemedicine services.</td>
</tr>
<tr>
<td><strong>Types of Care</strong></td>
</tr>
<tr>
<td>1. Custodial Care.</td>
</tr>
<tr>
<td>2. Recovery programs including rest or domiciliary care, sober houses, transitional support services, and therapeutic communities.</td>
</tr>
<tr>
<td>3. All institutional charges over the semi-private room rate, except when a private room is Medically Necessary.</td>
</tr>
<tr>
<td>4. Pain management programs or clinics.</td>
</tr>
<tr>
<td>5. 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.</td>
</tr>
<tr>
<td>6. Private duty nursing.</td>
</tr>
<tr>
<td>7. Sports medicine clinics.</td>
</tr>
<tr>
<td>8. Vocational rehabilitation, or vocational evaluations on job adaptability, job placement, or therapy to restore function for a specific occupation.</td>
</tr>
<tr>
<td><strong>Vision and Hearing</strong></td>
</tr>
<tr>
<td>1. Eyeglasses, contact lenses and fittings, except when specifically listed as a Covered Benefit.</td>
</tr>
<tr>
<td>2. Hearing aids, except when specifically listed as a Covered Benefit.</td>
</tr>
<tr>
<td>3. Hearing aid batteries, and any device used by individuals with hearing impairment to communicate over the telephone or internet, such as TTY or TDD.</td>
</tr>
<tr>
<td>4. Refractive eye surgery, including, but not limited to, lasik surgery, orthokeratology and lens implantation for the correction of naturally occurring myopia, hyperopia and astigmatism.</td>
</tr>
<tr>
<td>5. Routine eye examinations, except when specifically listed as a Covered Benefit.</td>
</tr>
<tr>
<td><strong>All Other Exclusions</strong></td>
</tr>
<tr>
<td>1. 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.</td>
</tr>
<tr>
<td>2. Any service or supply furnished in connection with a non-Covered Benefit.</td>
</tr>
<tr>
<td>3. Any service or supply (with the exception of contact lenses) purchased from the internet.</td>
</tr>
<tr>
<td>4. Beauty or barber service.</td>
</tr>
<tr>
<td>5. Diabetes equipment replacements when solely due to manufacturer warranty expiration.</td>
</tr>
<tr>
<td>6. Donated or banked breast milk.</td>
</tr>
<tr>
<td>7. Food or nutritional supplements, including, but not limited to, FDA-approved medical foods obtained by prescription, except as required.</td>
</tr>
</tbody>
</table>
### Exclusion Description

<table>
<thead>
<tr>
<th>Exclusion</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Other Exclusions (Continued)</td>
<td>by law and prescribed for Members who meet HPHC policies for enteral tube feedings.</td>
</tr>
<tr>
<td>8. Guest services.</td>
<td></td>
</tr>
<tr>
<td>9. 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.</td>
<td></td>
</tr>
<tr>
<td>10. Services for non-Members.</td>
<td></td>
</tr>
<tr>
<td>11. Services for which no charge would be made in the absence of insurance.</td>
<td></td>
</tr>
<tr>
<td>12. Services for which no coverage is provided in the Plan’s Benefit Handbook, Schedule of Benefits or Prescription Drug Brochure (if applicable).</td>
<td></td>
</tr>
<tr>
<td>13. Services that are not Medically Necessary.</td>
<td></td>
</tr>
<tr>
<td>14. Taxes or governmental assessments on services or supplies.</td>
<td></td>
</tr>
<tr>
<td>15. Transportation other than by ambulance.</td>
<td></td>
</tr>
<tr>
<td>16. The following products and services:</td>
<td></td>
</tr>
<tr>
<td>• Air conditioners, air purifiers and filters, dehumidifiers and humidifiers.</td>
<td></td>
</tr>
<tr>
<td>• Car seats.</td>
<td></td>
</tr>
<tr>
<td>• Chairs, bath chairs, feeding chairs, toddler chairs, chair lifts, recliners.</td>
<td></td>
</tr>
<tr>
<td>• Electric scooters.</td>
<td></td>
</tr>
<tr>
<td>• Exercise equipment.</td>
<td></td>
</tr>
<tr>
<td>• Home modifications including but not limited to elevators, handrails and ramps.</td>
<td></td>
</tr>
<tr>
<td>• Hot tubs, jacuzzis, saunas or whirlpools.</td>
<td></td>
</tr>
<tr>
<td>• Mattresses.</td>
<td></td>
</tr>
<tr>
<td>• Medical alert systems.</td>
<td></td>
</tr>
<tr>
<td>• Motorized beds.</td>
<td></td>
</tr>
<tr>
<td>• Pillows.</td>
<td></td>
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<tr>
<td>• Power-operated vehicles.</td>
<td></td>
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<tr>
<td>• Stair lifts and stair glides.</td>
<td></td>
</tr>
<tr>
<td>• Strollers.</td>
<td></td>
</tr>
<tr>
<td>• Safety equipment.</td>
<td></td>
</tr>
<tr>
<td>• Vehicle modifications including but not limited to van lifts.</td>
<td></td>
</tr>
<tr>
<td>• Telephone.</td>
<td></td>
</tr>
<tr>
<td>• Television.</td>
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</tr>
</tbody>
</table>
Pediatric Dental Rider - PPO
Harvard Pilgrim Health Care, Inc.
(for children under the age of 19)
MASSACHUSETTS

The pediatric dental rider identifies the covered dental services as described below for dependents under the age of 19 enrolled in the PPO plan (the Plan). Benefits under this Rider terminate at the end of the month the Dependent turns 19.

Because this Rider is part of your Evidence of Coverage and is a legal document, we want to give you information about the document that will help you understand it. Certain capitalized words have special meanings. We have defined these words in either the Benefit Handbook in Section II: Glossary or in this Rider in Section 5: Defined Terms for Pediatric Dental Services.

When we use the words "we," "us," and "our" in this document, we are referring to Harvard Pilgrim Health Care. When we use the words "you" and "your" we are referring to people who are Dependents, as the term is defined in the Benefit Handbook in Section II: Glossary.

SECTION 1: ACCESSING PEDIATRIC DENTAL SERVICES

In-Network Benefits

These Covered Benefits apply when you choose to obtain Covered Dental Services from an In-Network Dental Provider. You generally are required to pay less to the provider than you would pay for services from an Out-of-Network provider. In-Network Benefits are determined based on the contracted fee for each Covered Dental Service. In no event, will you be required to pay an In-Network Dental Provider an amount for a Covered Dental Service in excess of the contracted fee.

In order for Covered Dental Services to be paid as In-Network Benefits, you must obtain all Covered Dental Services directly from or through an In-Network Dental Provider.

You must always verify the participation status of a provider prior to seeking services. From time to time, the participation status of a provider may change. You can verify the participation status by calling us and/or the provider. If necessary, we can provide assistance in referring you to an In-Network Dental Provider.

We will make available to you a Directory of Network Dental Providers. You can also call Customer Service at 1-800-460-0315 to determine which providers participate in the Network. The telephone number for Customer Service is on your ID card.

Out-of-Network Benefits

These Covered Benefits apply when you decide to obtain Covered Dental Services from an Out-of-Network Dental Provider. You generally are required to pay more for Out-of-Network Benefits than for In-Network Benefits. Out-of-Network Benefits are paid
PEDiatric Dental Rider - PPO - Massachusetts

at the 80th percentile of the Out-of-Network Dental Provider's charge up to the Usual, Customary and Reasonable Charge, as defined in this pediatric dental rider. As a result, you may be required to pay an Out-of-Network Dental Provider for a Covered Dental Service any amount he or she charges that is in excess of the Usual, Customary and Reasonable Charge. In addition, when you obtain Covered Dental Services from Out-of-Network Dental Providers, you must file a claim with us to be reimbursed for Eligible Dental Expenses.

Covered Dental Services

You are eligible for Covered Dental Services listed in this Rider if such Dental Services are Necessary and are provided by or under the direction of a Dental Provider.

Covered Benefits are available only for Necessary Dental Services. The fact that a Dental Provider has performed or prescribed a procedure or treatment, or the fact that it may be the only available treatment, for a dental disease does not mean that the procedure or treatment is a Covered Dental Service under this Rider.

Pre-Treatment Estimate

If the charge for a Dental Service is expected to exceed $300 or if a dental exam reveals the need for fixed bridgework, you may notify us of such treatment before treatment begins and receive a pre-treatment estimate. If you desire a pre-treatment estimate, you or your Dental Provider should send a notice to us, via claim form, within 20 calendar days of the exam. If requested, the Dental Provider must provide us with dental x-rays, study models or other information necessary to evaluate the treatment plan for purposes of benefit determination.

We will determine if the proposed treatment is a Covered Dental Service and will estimate the amount of payment. The estimate of Covered Benefits payable will be sent to the Dental Provider and will be subject to all terms, conditions and provisions of the Policy. Clinical situations that can be effectively treated by a less costly, clinically acceptable alternative procedure will be assigned a benefit based on the less costly procedure.

A pre-treatment estimate of Covered Benefits is not an agreement to pay for expenses. This procedure lets you know in advance approximately what portion of the expenses will be considered for payment.

Pre-Authorization

Pre-authorization is required for all Orthodontic Services. Speak to your Dental Provider about obtaining a pre-authorization before Orthodontic Services are rendered. You or your Dental Provider can request Pre-Authorization for these services by contacting us at 1–800–460–0315. If you do not obtain a pre-authorization, we have a right to deny your claim for failure to comply with this requirement.

If a treatment plan is not submitted, you will be responsible for payment of any dental treatment not approved by us. Clinical situations that can be effectively treated by a less costly, clinically acceptable alternative procedure will be assigned a Benefit based on the less costly procedure.

Form #1603_02
SECTION 2: BENEFITS FOR PEDIATRIC DENTAL SERVICES

Covered Benefits are provided for the Dental Services stated in this Section when such services are:

A. Necessary.
B. Provided by or under the direction of a Dental Provider.
C. The least costly clinically appropriate service. Clinical situations that can be effectively treated by a less costly, clinically appropriate alternative procedure will be covered based on the least costly procedure.
D. Not excluded as described in Section 3: Pediatric Dental Services exclusions of this Rider.

Benefits

Dental Services Deductible’s are calculated on a Calendar Year or Plan Year basis.

When Benefit limits apply, the limit stated refers to any combination of In-Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.

<table>
<thead>
<tr>
<th>General Cost Sharing Features</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dental Services Out-of-Pocket Maximum</td>
<td>$1,350 per Member</td>
<td>$2,700 per family</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Benefit Description and Limitations</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>TYPE I SERVICES: PREVENTIVE &amp; DIAGNOSTIC COVERED SERVICES</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diagnostic Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intraoral Bitewing Radiographs (Bitewing X-ray)</td>
<td>No charge</td>
<td>20% Coinsurance</td>
</tr>
<tr>
<td>– Limited to 1 set every 6 months</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Panorex Radiographs (Full Jaw X-ray) or Complete Series Radiographs (Full Set of X-rays)</td>
<td>No charge</td>
<td>20% Coinsurance</td>
</tr>
<tr>
<td>– Limited to 1 time per 36 months.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Benefit Description and Limitations

<table>
<thead>
<tr>
<th>Service Description</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><strong>TYPE I SERVICES: PREVENTIVE &amp; DIAGNOSTIC COVERED SERVICES</strong> (Continued)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Periodic Oral Evaluation (Check up Exam)</td>
<td>No charge</td>
<td>20% Coinsurance</td>
</tr>
<tr>
<td>- Limited to 2 times per 12 months. Covered as a separate Benefit only if no other service was done during the visit other than X-rays.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Preventive Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dental Prophylaxis (Cleanings)</td>
<td>No charge</td>
<td>20% Coinsurance</td>
</tr>
<tr>
<td>- Limited to 2 times per 12 months.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fluoride Treatments</td>
<td>No charge</td>
<td>20% Coinsurance</td>
</tr>
<tr>
<td>- Limited to 2 treatments per 12 months.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sealants (Protective Coating)</td>
<td>No charge</td>
<td>20% Coinsurance</td>
</tr>
<tr>
<td>- Limited to one sealant per primary or permanent first and second noncarious molars and bicuspid every consecutive 36 months.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>TYPE II SERVICES: MINOR RESTORATIVE COVERED SERVICES</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Minor Restorative Services, Endodontics, Periodontics, and Oral Surgery</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Amalgam Restorations (Silver Fillings)</td>
<td>20% Coinsurance</td>
<td>40% Coinsurance</td>
</tr>
<tr>
<td>- Limited to one restoration per member per tooth surface per year</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Composite Resin Restorations (Tooth Colored Fillings)</td>
<td>20% Coinsurance</td>
<td>40% Coinsurance</td>
</tr>
<tr>
<td>- Limited to anterior and posterior teeth</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Endodontics (Root Canal Therapy), including endodontic retreatment</td>
<td>20% Coinsurance</td>
<td>40% Coinsurance</td>
</tr>
<tr>
<td>- covered only when performed on anterior teeth, bicuspids and first and second molars.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Endodontic Surgery</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- covered only when performed on anterior teeth, bicuspids and first and second molars.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## Benefit Description and Limitations

<table>
<thead>
<tr>
<th>Service Description</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><strong>TYPE II SERVICES: MINOR RESTORATIVE COVERED SERVICES</strong> (Continued)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Periodontal Maintenance (Gum Maintenance)</td>
<td>20% Coinsurance</td>
<td>40% Coinsurance</td>
</tr>
<tr>
<td>- Limited to 4 times per 12 month period following completion of active periodontal therapy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Periodontal Surgery (Gum Surgery)</td>
<td>20% Coinsurance</td>
<td>40% Coinsurance</td>
</tr>
<tr>
<td>- Limited 1 quadrant or site per 36 months per surgical area.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Scaling and Root Planing (Deep Cleanings)</td>
<td>20% Coinsurance</td>
<td>40% Coinsurance</td>
</tr>
<tr>
<td>- Limited to once per quadrant every 36 months</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Simple Extractions (Simple tooth removal)</td>
<td>20% Coinsurance</td>
<td>40% Coinsurance</td>
</tr>
<tr>
<td>Oral Surgery, including Surgical Extraction</td>
<td>20% Coinsurance</td>
<td>40% Coinsurance</td>
</tr>
<tr>
<td>Space Maintainers</td>
<td>20% Coinsurance</td>
<td>40% Coinsurance</td>
</tr>
<tr>
<td>- Covered only when there is a premature loss of teeth that may lead to loss of arch</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adjunctive Services</td>
<td>20% Coinsurance</td>
<td>40% Coinsurance</td>
</tr>
<tr>
<td>- General Services (including Emergency Treatment of dental pain)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- General anesthesia is covered when clinically necessary.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>TYPE III SERVICES: MAJOR RESTORATIVE SERVICES</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inlays/Onlays/Crowns (Partial to Full Crowns), including repairs and recementation</td>
<td>50% Coinsurance</td>
<td>50% Coinsurance</td>
</tr>
<tr>
<td>Full-coverage composite crowns</td>
<td>50% Coinsurance</td>
<td>50% Coinsurance</td>
</tr>
<tr>
<td>- Limited to anterior primary teeth</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Occlusal Guards</td>
<td>50% Coinsurance</td>
<td>50% Coinsurance</td>
</tr>
<tr>
<td>- Limited to one guard per 12 months</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preventive resin restoration</td>
<td>50% Coinsurance</td>
<td>50% Coinsurance</td>
</tr>
<tr>
<td>- Limited to occlusal surfaces</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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**PEDIATRIC DENTAL RIDER - PPO - MASSACHUSETTS**

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**Summary of Benefits**

**DENTAL COVERAGE | 5**

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**FORM #1603_02**

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**Harvard Pilgrim Health Care**
## Benefit Description and Limitations

<table>
<thead>
<tr>
<th>Description</th>
<th>In-Network Plan</th>
<th>Out-of-Network Non-Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>TYPE III SERVICES: MAJOR RESTORATIVE SERVICES (Continued)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fixed Prosthetics (Bridges), including repairs</td>
<td>50% Coinsurance</td>
<td>50% Coinsurance</td>
</tr>
<tr>
<td>– Limited to 1 per tooth per 60 months</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Removable Prosthetics (Full or partial dentures), including repairs</td>
<td>50% Coinsurance</td>
<td>50% Coinsurance</td>
</tr>
<tr>
<td>– Limited to 1 per tooth per 60 months</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Relining and Rebasing Dentures</td>
<td>50% Coinsurance</td>
<td>50% Coinsurance</td>
</tr>
<tr>
<td>– Covered if services are performed within 6 months of the insertion of the denture. Subsequent services are covered once every 24 months.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>TYPE IV SERVICES: Orthodontia</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Orthodontic Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Covered Benefits will be paid in equal installments over the course of the entire orthodontic treatment plan as agreed upon between you and your Dental Provider, starting on the date that the orthodontic bands or appliances are first placed, or on the date a one-step orthodontic procedure is performed.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Benefits for comprehensive orthodontic treatment are approved, only in those instances that are related to an identifiable syndrome such as cleft lip and or palate, Crouzon’s syndrome, Treacher-Collins syndrome, Pierre-Robin syndrome, hemi-facial atrophy, hemi-facial hypertrophy; or other severe craniofacial deformities which result in a physically handicapping malocclusion as determined by our dental consultants. Benefits are not available for comprehensive orthodontic treatment for crowded dentitions (crooked teeth), excessive spacing between teeth, temporomandibular joint (TMJ) conditions and/or having horizontal/vertical (overjet/overbite) discrepancies.</td>
<td>50% Coinsurance</td>
<td>50% Coinsurance</td>
</tr>
<tr>
<td><strong>Note:</strong> All orthodontic treatment must be prior authorized.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
SECTION 3: PEDIATRIC DENTAL EXCLUSIONS

Except as may be specifically provided in this Rider under Section 2: Benefits for Covered Dental Services, no benefits are provided under this Rider for the following:

1. Any Dental Service or Procedure not listed as a Covered Dental Service in this Rider in Section 2: Benefits for Covered Dental Services.
2. Dental Services that are not Necessary.
3. Hospitalization or other facility charges.
4. Any Dental Procedure performed solely for cosmetic/aesthetic reasons. (Cosmetic procedures are those procedures that improve physical appearance.)
5. Reconstructive surgery, regardless of whether or not the surgery is incidental to a dental disease, Injury, or Congenital Anomaly, when the primary purpose is to improve physiological functioning of the involved part of the body.
6. Any Dental Procedure not directly associated with dental disease.
7. Any Dental Procedure not performed in a dental setting.
8. Procedures that are considered to be Experimental, Investigational or Unproven Services. This includes pharmacological regimens not accepted by the American Dental Association (ADA) Council on Dental Therapeutics. The fact that an Experimental, or Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Covered Benefits if the procedure is considered to be Experimental, Investigational or Unproven in the treatment of that particular condition.
10. Drugs/medications, obtainable with or without a prescription, unless they are dispensed and utilized in the dental office during the patient visit.
11. Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue.
12. Treatment of benign neoplasms, cysts, or other pathology involving benign lesions, except excisional removal. Treatment of malignant neoplasms or Congenital Anomalies of hard or soft tissue, including excision.
13. Replacement of complete dentures, fixed and removable partial dentures or crowns and implants, implant crowns and prosthesis if damage or breakage was directly related to provider error. This type of replacement is the responsibility of the Dental Provider. If replacement is Necessary because of patient non-compliance, the patient is liable for the cost of replacement.
14. Services related to the temporomandibular joint (TMJ), either bilateral or unilateral. Upper and lower jaw bone surgery (including that related to the temporomandibular joint). Orthognathic surgery, jaw alignment, and treatment for the temporomandibular joint.
15. Charges for failure to keep a scheduled appointment without giving the dental office 24 hours notice.
16. Expenses for Dental Procedures begun prior to the Dependent becoming enrolled for coverage provided through this Rider to the Policy.
17. Dental Services otherwise covered under the Policy, but rendered after the date individual coverage under the Policy terminates, including Dental Services for dental conditions arising prior to the date individual coverage under the Policy terminates.

18. Services rendered by a provider with the same legal residence as a Dependent or who is a member of a Dependent’s family, including spouse, brother, sister, parent or child.

19. Foreign Services are not covered unless required as a Medical Emergency.

20. Fixed or removable prosthodontic restoration procedures for complete oral rehabilitation or reconstruction.

21. Attachments to conventional removable prostheses or fixed bridgework. This includes semi-precision or precision attachments associated with partial dentures, crown or bridge abutments, full or partial overdentures, any internal attachment associated with an implant prosthesis, and any elective endodontic procedure related to a tooth or root involved in the construction of a prosthesis of this nature.

22. Procedures related to the reconstruction of a patient’s correct vertical dimension of occlusion (VDO).

23. Occlusal guards used as safety items or to affect performance primarily in sports-related activities.

24. Placement of fixed partial dentures solely for the purpose of achieving periodontal stability.

25. Acupuncture; acupressure and other forms of alternative treatment, whether or not used as anesthesia.

SECTION 4: APPEALS AND GRIEVANCES

Appeals
If you are dissatisfied with a decision on our coverage of services, you may appeal. Appeals may also be filed by a Member’s representative or a provider acting on a Member’s behalf and must be received within 180 days of the initial denial. Our staff is available to assist you in filing an appeal. If you’d like assistance, please call Customer Service at 1-800-460-0315.

To initiate your appeal, you or your representative should write a letter to us about the coverage you are requesting and why you feel it should be granted. Please be as specific as possible in your appeal request. We need all the important details in order to make a fair decision. Please send your request to the following address:

Harvard Pilgrim Health Care
Attention: Appeals
P.O. Box 30569
Salt Lake City, UT 84130–0569

You may also contact us at 1–800–460–0315 to initiate your appeal.

Grievances
If you have a complaint about your care under the Plan or about our service, we want to know about it. For all grievances, please call or write to us at:
PEDIATRIC DENTAL RIDER - PPO - MASSACHUSETTS

Harvard Pilgrim Health Care
Attention: Grievances
P.O. Box 30569
Salt Lake City, UT 84130–0569
Telephone: 1–800–460–0315

For additional information on the Appeals and Grievance process, please refer to your Benefit Handbook.

SECTION 5: CLAIMS FOR PEDIATRIC DENTAL SERVICES

When obtaining Dental Services from an Out-of-Network provider, you will be required to pay all billed charges directly to your Dental Provider. You may then seek reimbursement from us. Information about claim timelines and responsibilities in the Benefit Handbook in Section V: How to File a Claim apply to Covered Dental Services provided under this Rider, except that when you submit your claim, you must provide us with all of the information identified below.

Reimbursement for Dental Services

You are responsible for sending a request for a claim for reimbursement to our office, on a form provided by or satisfactory to us.

Claim Forms. It is not necessary to include a claim form with the proof of loss. However, the proof must include all of the following information:

• Dependent’s name and address
• Dependent’s identification number
• The name and address of the provider of the service(s)
• A diagnosis from the Dental Provider including a complete dental chart showing extractions, fillings or other dental services rendered before the charge was incurred for the claim.
• Radiographs, lab or hospital reports.
• Casts, molds or study models
• Itemized bill which includes the CPT or ADA codes or description of each charge.
• The date the dental disease began
• A statement indicating that you are or you are not enrolled for coverage under any other health or dental insurance plan or program. If you are enrolled for other coverage you must include the name of the other carrier(s).

If you would like to use a claim form, you can request one be mailed to you by calling Customer Service at 1–800–460–0315. This number is also listed on your ID Card. If you do not receive the claim form within 15 calendar days of your request, send in the proof of loss with the information stated above.

Please mail your request for reimbursement to the following address:

FORM #1603_02

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PEDIATRIC DENTAL RIDER - PPO - MASSACHUSETTS

Claims – Harvard Pilgrim Health Care
P.O. Box 30567
Salt Lake City, UT 84130–0567

Written proof of loss should be given to the Company within 90 days after the date of the loss. If it was not reasonably possible to give written proof in the time required, the company will not reduce or deny the claim for this reason. However, proof must be filed as soon as reasonably possible, but no later than 1 year after the date of service.

SECTION 6: DEFINED TERMS FOR PEDIATRIC DENTAL SERVICES

The following definitions are in addition to those listed in Section II: Glossary of the Benefit Handbook:

**Covered Dental Service** – a Dental Service or Dental Procedure for which Benefits are provided under this Rider.

**Dental Provider** - any dentist or dental practitioner who is duly licensed and qualified under the law of jurisdiction in which treatment is received to render Dental Services, perform dental surgery or administer anesthetics for dental surgery.

**Dental Service or Dental Procedures** - dental care or treatment provided by a Dental Provider to a Dependent under the age of 19 while the Policy is in effect, provided such care or treatment is recognized by us as a generally accepted form of care or treatment according to prevailing standards of dental practice.

**Dental Services Deductible** - the amount a Dependent under the age of 19 must pay for Covered Dental Services in a Plan Year or Calendar Year before we will begin paying for Covered Benefits in that year.

**Dental Services Out-of-Pocket Maximum** – a limit on the amount of Copayments, Coinsurance and Deductibles that you must pay for Covered Benefits in a Calendar Year or Plan Year.

**Eligible Dental Expenses** - Eligible Dental Expenses for Covered Dental Services, incurred while the Policy is in effect, are determined as stated below:

- For In-Network Benefits, when Covered Dental Services are received from In-Network Dental Providers, Eligible Dental Expenses are our contracted fee(s) for Covered Dental Services with that provider.

- For Out-of-Network Benefits, when Covered Dental Services are received from Out-of-Network Dental Providers, Eligible Dental Expenses are the lesser of the Usual and Customary fees, as defined below or the billed charges.

**Necessary** - Dental Services and supplies under this Rider which are determined by us through case-by-case assessments of care based on accepted dental practices to be appropriate and are all of the following:

- Necessary to meet the basic dental needs of the Dependent under age 19.

- Rendered in the most cost-efficient manner and type of setting appropriate for the delivery of the Dental Service.
PEDIATRIC DENTAL RIDER - PPO - MASSACHUSETTS

- Consistent in type, frequency and duration of treatment with scientifically based guidelines of national clinical, research, or health care coverage organizations or governmental agencies that are accepted by us.
- Consistent with the diagnosis of the condition.
- Required for reasons other than the convenience of the Dependent or his or her Dental Provider.
- Demonstrated through prevailing peer-reviewed dental literature to be either:
  - Safe and effective for treating or diagnosing the condition or sickness for which their use is proposed; or
  - Safe with promising efficacy
    - For treating a life threatening dental disease or condition.
    - Provided in a clinically controlled research setting.
    - Using a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health.

(For the purpose of this definition, the term life threatening is used to describe dental diseases or sicknesses or conditions, which are more likely than not to cause death within one year of the date of the request for treatment.)

The fact that a Dental Provider has performed or prescribed a procedure or treatment or the fact that it may be the only treatment for a particular dental disease does not mean that it is a Necessary Covered Dental Service as defined in this Rider. The definition of Necessary used in this Rider relates only to Benefits under this Rider and differs from the way in which a Dental Provider engaged in the practice of dentistry may define necessary.

Usual, Customary and Reasonable Charge - Usual, Customary and Reasonable Charge is the maximum amount that we will pay for services from Dental Providers. The Usual, Customary and Reasonable Charge is calculated using the 80th percentile of provider reimbursement for services in the same geographic area under the FAIR Health database.
PEDIATRIC DENTAL RIDER - PPO - MASSACHUSETTS

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 hỗ trợ dịch vụ chăm sóc sức khỏe miễn phí quý vị miễn phí. Gọi số 1-888-333-4742 (TTY: 711).

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


ភាសាខ្មែរ (Cambodian) សូមសារសេវាអភិបត្តិជាតិស្ត្រីសេវាក៏ប្រកួតប្រជន៍។ សរុបសេវាក៍ជាតិស្ត្រី 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).


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 διαθεσιμότητα σας δωρεάν υπηρεσίες γλωσσικής στήριξης. 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).

हिन्दी (Hindi) ध्यान दिजिए: अगर आप हिंदी बोलते हैं तो आपके लिए आपकी सहायता मुफ्त में उपलब्ध है।

ગુજરાતી (Gujarati) ધ્યાન ધરશે: તમે ગુજરાતી બોલતા હોય તો આપણે તમારી સહાયક સંસ્થાને મફત પ્રવૃત્તપતા છે. બેસ માલરની મફત લાંબાકાંકી 1-888-333-4742 (TTY: 711).

ລາວ (Lao) ເປັນຄວາມຫຼາຍ: ມັດທະຍິກ ທ່າແຫ່ງຂອງຊາຍ ລາວ ທ່ານຈະ ລາຍການຊອດພິວນ ເພບອາຄົນ ລາຍການນຳໄປທີ່ສະມາດ. ມາດ 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).


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PEDIATRIC DENTAL RIDER - PPO - MASSACHUSETTS

General Notice About Non-Discrimination 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 93 Worcester St. Wellesley, MA 02481, (866) 750-2674, TTY service: 711, Fax: (617) 509-3885, 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 S06F, HHH Building
Washington, D.C. 20201
(600) 560-1010, (800) 537-7697 (TTY)


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### Prescription Drug Coverage

**VALUE 5 TIER**

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>
<tbody>
<tr>
<td>Tier 1</td>
<td>Up to a 30-day supply: $5 Copayment</td>
<td>$10 Copayment</td>
</tr>
<tr>
<td></td>
<td>Up to a 90-day supply: $15 Copayment</td>
<td></td>
</tr>
<tr>
<td>Tier 2</td>
<td>Up to a 30-day supply: $30 Copayment</td>
<td>$60 Copayment</td>
</tr>
<tr>
<td></td>
<td>Up to a 90-day supply: $90 Copayment</td>
<td></td>
</tr>
<tr>
<td>Tier 3</td>
<td>Up to a 30-day supply: $60 Copayment</td>
<td>$120 Copayment</td>
</tr>
<tr>
<td></td>
<td>Up to a 90-day supply: $180 Copayment</td>
<td></td>
</tr>
<tr>
<td>Tier 4</td>
<td>Up to a 30-day supply: $100 Copayment</td>
<td>$300 Copayment</td>
</tr>
<tr>
<td></td>
<td>Up to a 90-day supply: $300 Copayment</td>
<td></td>
</tr>
<tr>
<td>Tier 5</td>
<td>Up to a 30-day supply: 20% Coinsurance* up to $250 maximum per prescription or refill</td>
<td>20% Coinsurance* up to $750 maximum per prescription or refill</td>
</tr>
<tr>
<td></td>
<td>Up to a 90-day supply: 20% Coinsurance* up to $750 maximum per prescription or refill</td>
<td></td>
</tr>
</tbody>
</table>

*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/2020Value5T](http://www.harvardpilgrim.org/2020Value5T) 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）。


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

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

ខ្មែរ (Cambodian) ការជួបជំនឿថែមជូនជាតិអំពីសុខភាពជាតិអំពីសុខភាព អាចផ្តល់បានទៅនឹងអ្នក 1-888-333-4742 (TTY: 711)

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

Italiano (Italian) ATTEZIONE: 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) 알려드립니다. 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 σε διάθεσή σας δωρεάν υπηρεσίες γλωσσικής υποστήριξης. Καλέστε την 1-888-333-4742 (TTY: 711).

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हिंदी (Hindi) यथार्थ वाक्य: अगर आप हिंदी बोलते हैं तो आपके लिए भाषाप्राप्ति सहायता मुफ्त में उपलब्ध है। जानकारी के लिए फोन करें: 1-888-333-4742 (TTY: 711)

GUJRATI (Gujarati) यथार्थ वाक्य: आपके लिए गुजराती भाषाप्राप्ति सहायता मुफ्त में उपलब्ध है। सहयोग के लिए फोन करें: 1-888-333-4742 (TTY: 711)

ພາສາລາວ (Laotian) ເនotta ເនotta ທ່ານ ການບໍລິການການສາມາດ, ດຽວນຶ່ງໃຫ້ບໍລິການຕ້ອງການ, ດຽວນຶ່ງທີ່ຍ່ວຍການ, ດຽວນຶ່ງທີ່ຢ່າງໃຫ້ການ. ຜູ້ອາທິດທານ: 1-888-333-4742 (TTY: 711).

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(Continued)
General Notice About Nondiscrimination and Accessibility Requirements

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U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHB Building
Washington, D.C. 20201
(800) 368-1019, (800) 537-7667 (TTY)


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Important information about your plan

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

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

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

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

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

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

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

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

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


MEMBERS: (888) 333-4742
NON-MEMBERS: (800) 848-9995
TTY: 711
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 sévis 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)。

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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).


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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)


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