Schedule of Benefits

Harvard Pilgrim Health Care of New England, Inc.

ELEVATEHEALTH℠ BRONZE 5750
NEW HAMPSHIRE

IMPORTANT INFORMATION: This policy reflects the known requirements for compliance under The Affordable Care Act as passed on March 23, 2010. As additional guidance is forthcoming from the U.S. Department of Health and Human Services, and the New Hampshire Insurance Department, those changes will be incorporated into your health insurance policy.

Coverage under this Plan is under the jurisdiction of the New Hampshire Insurance Commissioner.

This Policy does not include pediatric dental services. Pediatric dental coverage is included in some health plans, but can also be purchased as a stand-alone product. Please contact your insurance carrier or producer, or seek assistance through Healthcare.gov, if you wish to purchase pediatric dental coverage or a stand-alone dental services product.

You have thirty (30) days from receipt of this Policy to review this document. If you are not satisfied for any reason with the Policy, you have the right to return the Policy to Harvard Pilgrim and have your premium returned.

This Schedule of Benefits states any Benefit Limits and 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.

In a Medical Emergency you should go to the nearest emergency facility or call 911 or other local emergency access number. A Referral from your PCP is not needed. Your emergency room Member Cost Sharing is listed in the tables below.

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 **http://www.harvardpilgrim.org** or by calling **1-888-888-4742 ext. 38723**.

Copayment Levels

There are two types of 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 midwives; and nurse practitioners.

Level 2 applies to most outpatient 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.

Your Plan may have other Copayment amounts. Please see the benefit table below for specific Copayment requirements.

American Indian/Alaskan Natives

Please Note: If you purchased your coverage through New Hampshire's Federally Operated Health Insurance Marketplace and it has determined that you are eligible to enroll in this plan as an American Indian or Alaskan Native, you are exempt from any Member Cost Sharing requirements when Covered Benefits are received by and Indian Health Service (IHS), Indian Tribe, Tribal Organization, or Urban Indian Organization (UIO) or through referral under contract health services. There is no Member Cost Sharing responsibility for American Indians or Alaskan Natives when Covered Benefits are provided by one of these providers.

Covered Benefits

Your Covered Benefits are administered on a Calendar Year basis. 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 doctor'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."

General Cost Sharing Features:	Member Cost Sharing:
Coinsurance and Copayments	
	See the benefits table below
Deductible	
	$5,750 per Member per Calendar Year $11,500 per family per Calendar Year
Deductible Rollover	
None	
Out-of-Pocket Maximum	
Includes all Member Cost Sharing	$7,000 per Member per Calendar Year $14,000 per family per Calendar Year

Benefit	Member Cost Sharing
Acupuncture Treatment for Injury or Illness	
– Limited to 20 visits per Calendar Year yes an	Deductible, then 40% Coinsurance

Benefit	Member Cost Sharing
Ambulance Transport	
Emergency ambulance transport	Deductible, then 40% Coinsurance
Non-emergency ambulance transport	Deductible, then 40% Coinsurance
Autism Spectrum Disorders Treatment	
Applied behavior analysis	No charge for the first 4 Mental Health and Drug and Alcohol Rehabilitation visits per Member (up to 8 office visits per family) Deductible, then 40% Coinsurance for all subsequent office visits.
Chemotherapy and Radiation Therapy	
Chemotherapy	Deductible, then no charge
Radiation therapy	Deductible, then no charge
Chiropractic Care	
– Limited to 12 visits per Calendar Year	Level 1: $40 Copayment per visit **Note:** The above Copayment will only apply to the first 4 medical office visits per Member (up to 8 office visits per family). Deductible, then 40% Coinsurance for all subsequent office visits.
Dental Services	
Extraction of teeth impacted in bone	Not covered
Outpatient surgery expenses for dental care	Your Member Cost Sharing will depend upon the types of services provided, as listed in this Schedule of Benefits. For example, for services provided by a physician, see "Physician and Other Professional Office Visits." For day surgery, see "Surgery – Outpatient."
If you purchased this Plan through New Hampshire's Federally Operated Health Insurance Marketplace, you may have other coverage under a separate dental plan.	
Dialysis	
Dialysis services	Deductible, then no charge
Durable Medical Equipment	
Durable medical equipment	Deductible, then 40% Coinsurance
Blood glucose monitors, infusion devices and insulin pumps (including supplies)	No charge
Oxygen and respiratory equipment	No charge
Early Intervention	
– Limited to 40 visits per Member per Calendar Year	Deductible, then 40% Coinsurance
Emergency Room Care	
	Deductible, then $300 Copayment per visit
This Copayment is waived if admitted to the hospital directly from the emergency room.	
Hearing Aids	
– Limited to 1 hearing aid per hearing impaired ear as Medically Necessary	Deductible, then 40% Coinsurance

Benefit	Member Cost Sharing
Home Health Care	
	Deductible, then no charge
If services include the administration of drugs, please see the benefit for "Medical Drugs" for Member Cost Sharing details.	
Hospice – Outpatient	
	Deductible, then no charge
Hospital – Inpatient Services	
Acute hospital care	Deductible, then 40% Coinsurance
Inpatient maternity care	Deductible, then 40% Coinsurance
Inpatient routine nursery care	No charge
Inpatient rehabilitation –limited to 100 days per Calendar Year	Deductible, then 40% Coinsurance
Skilled nursing facility – limited to 100 days per Calendar Year	Deductible, then 40% Coinsurance
Infertility Services and Treatments	
Diagnostic services for infertility including: consultation, evaluation and laboratory tests	Your Member Cost Sharing will depend upon the types of services provided, as listed in this Schedule of Benefits. For example, for services provided by a physician, see "Physician and Other Professional Office Visits.
Infertility treatment (see the Benefit Handbook for details)	Not covered
Laboratory and Radiology Services	
Laboratory	Deductible, then 40% Coinsurance
X-rays	Deductible, then 40% Coinsurance
Advanced radiology, including CT scans, MRI, MRA and nuclear medicine services	Deductible, then 40% Coinsurance
Low Protein Foods	
	Deductible, then 40% Coinsurance
Maternity Care – Outpatient	
Routine outpatient prenatal and postpartum care	No charge
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 and Radiology Services."	
Medical Drugs (drugs that cannot be self-administered)	
Medical drugs received in a doctor's office or other outpatient facility	Deductible, then 40% Coinsurance
Medical drugs received in the home	Deductible, then 40% Coinsurance
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 under the Prescription Drug section in this Schedule of Benefits.	
Medical Formulas	
	Deductible, then no charge

Benefit	Member Cost Sharing
Mental Health and Drug and Alcohol Rehabilitation Services	
Inpatient Services	Deductible, then no charge
Partial Hospitalization Services	Deductible, then no charge
Outpatient group therapy	No charge for the first 4 Mental Health and Drug and Alcohol Rehabilitation visits per Member (up to 8 office visits per family) Deductible, then 40% Coinsurance for all subsequent office visits.
Outpatient treatment, including individual therapy, detoxification and medication management	No charge for the first 4 Mental Health and Drug and Alcohol Rehabilitation visits per Member (up to 8 office visits per family) Deductible, then 40% Coinsurance for all subsequent office visits.
Outpatient methadone maintenance	No charge for the first 4 Mental Health and Drug and Alcohol Rehabilitation visits per Member (up to 8 office visits per family) Deductible, then 40% Coinsurance for all subsequent office visits. Please Note: In the case of methadone maintenance, one week of treatment will count as one visit
Outpatient psychological testing	No charge for the first 4 Mental Health and Drug and Alcohol Rehabilitation visits per Member (up to 8 office visits per family) Deductible, then 40% Coinsurance for all subsequent office visits.
eVisits	No charge
Ostomy Supplies	
	Deductible, then 40% 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
Not all services you receive during your routine exam are covered at no charge. Only preventive services designated under the Patient Protection and Affordable Care Act (PPACA) are covered at no charge. Other services not included under PPACA may be subject to additional cost sharing. For the current list of preventive services covered at no charge under PPACA, please see the Preventive Services notice on our website at **www.harvardpilgrim.org**. Please see "Laboratory and Radiology Services," for the Member Cost Sharing that applies to diagnostic services not included on this list.	
Consultations, evaluations, sickness and injury care	Level 1: $40 Copayment per visit Level 2: $100 Copayment per visit **Note:** The above Copayments will only apply to the first 4 medical office visits per Member (up to 8 office visits per family). Deductible, then 40% Coinsurance for all subsequent office visits.

Benefit	Member Cost Sharing
Physician and Other Professional Office Visits (This includes all covered Plan Providers unless otherwise listed in this Schedule of Benefits) (Continued)	
eVisits	No charge
Office based treatment and procedures including but not limited to casting, suturing and the application of dressings, non-routine foot care, and surgical procedures	Deductible, then 40% Coinsurance
Administration of allergy injections	Deductible, then $5 Copayment per visit
Preventive Services and Tests	
	No charge
Under federal law, many preventive services and tests are covered with no Member Cost Sharing, including preventive colonoscopies, certain labs and x-rays, voluntary sterilization for women and all FDA approved contraceptive devices. For a complete list of covered preventive services, please see the Preventive Services notice on our website at **www.harvardpilgrim.org**. You may also get a copy of the Preventive Services notice by calling the Member Services Department at **1–888–333–4742**. Harvard Pilgrim will add or delete services from this benefit for preventive services and tests in accordance with Federal guidance.	
Prosthetic Devices	
	Deductible, then 40% Coinsurance
Rehabilitation and Habilitation Services - Outpatient	
Cardiac rehabilitation Pulmonary rehabilitation therapy	Deductible, then 40% Coinsurance
Rehabilitation Services – Occupational therapy – limited to 20 visits per Calendar Year – Physical therapy – limited to 20 visits per Calendar Year – Speech therapy – limited to 20 visits per Calendar Year **Habilitation Services** – Occupational therapy – limited to 20 visits per Calendar Year – Physical therapy – limited to 20 visits per Calendar Year – Speech therapy – limited to 20 visits per Calendar Year	Level 1: $40 Copayment per visit **Note:** The above Copayment will only apply to the first 4 medical office visits per Member (up to 8 office visits per family). Deductible, then 40% Coinsurance for all subsequent office visits.
Outpatient physical, occupational and speech therapies are covered without limits to the extent Medically Necessary for children under the age of three.	
Scopic Procedures - Outpatient Diagnostic and Therapeutic	
Colonoscopy, endoscopy and sigmoidoscopy – Outpatient hospital facility	Deductible, then 40% Coinsurance
– Freestanding ambulatory surgery center	Deductible, then 40% Coinsurance
Surgery – Outpatient	
Outpatient hospital facility	Deductible, then 40% Coinsurance
Freestanding ambulatory surgery center	Deductible, then 40% Coinsurance

Benefit	Member Cost Sharing
Telemedicine	
Outpatient and inpatient telemedicine services	Your Member Cost Sharing will depend upon the types of services provided, as listed in this Schedule of Benefits. For example, for services provided by a physician, see "Physician and Other Professional Office Visits." For inpatient hospital care, see "Hospital – Inpatient Services."
Urgent Care Services	
Convenience care clinic	Level 1: $40 Copayment per visit for the first 4 medical office visits per Member (up to 8 office visits per family) Deductible, then 40% Coinsurance for all subsequent office visits.
Urgent care clinic	Level 2: $100 Copayment per visit for the first 4 medical office visits per Member (up to 8 office visits per family) Deductible, then 40% Coinsurance for all subsequent office visits.
Hospital urgent care clinic	Deductible, then $125 Copayment per visit
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 and Radiology Services."	
Vision Services	
Routine adult eye examinations – limited to 1 exam every 2 Calendar Years	Deductible, then 40% Coinsurance
Routine pediatric eye examinations (including a contact lens fitting) – limited to 1 exam per Calendar Year	Deductible, then 40% Coinsurance
Vision hardware for special conditions	Deductible, then no charge
Your Plan also includes coverage for pediatric vision hardware. Please see the additional Pediatric Vision section later in this Schedule of Benefits for more information.	
Voluntary Sterilization – in a Physician's Office	
	Deductible, then 40% 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 "Office based treatments and procedures." For inpatient hospital care, see "Hospital – Inpatient Services."
Wigs and Scalp Hair Prostheses as required by law	
See the Benefit Handbook for details	Deductible, then 40% Coinsurance

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Pediatric VisionCare

Dependents under the age of 19 are eligible for coverage of prescription eyeglasses or contact lenses. Each Dependent under the age of 19 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 $100 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. 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 $100 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.

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.

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 Vision Care member reimbursement form. You can obtain this form by visiting our website at**www.harvardpilgrim.org** or by calling the Member Services Department at **1–888–333–4742** 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 Vision Care member reimbursement form.
3. Attach the copy of an itemized bill to the form, showing proof of payment. Make a copy of the form for your records.
4. Mail the original form, together with the bill and proof of payment to:

   HPHC Claims
   P.O. Box 699183
   Quincy, MA 02269–9183

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

WHERE TO CALL WITH QUESTIONS

If you have any questions about your Pediatric Vision Care benefit, including how to receive reimbursement or eyewear discounts, please contact the Member Services Department at **1-888-333-4742**. 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

VALUE PRESCRIPTION DRUG BENEFIT

Benefit:	Member Cost Sharing:
Your pharmacy Member Cost Sharing for up to a 30-day supply at a retail pharmacy is:	
Tier 1:	$20 Copayment per prescription or prescription refill
Tier 2:	Deductible, then 20% Coinsurance subject to a maximum Coinsurance amount of $400 per prescription or prescription refill
Tier 3:	Deductible, then 30% Coinsurance subject to a maximum Coinsurance amount of $500 per prescription or prescription refill
Tier 4:	Deductible, then 40% Coinsurance subject to a maximum Coinsurance amount of $600 per prescription or prescription refill
Your pharmacy Member Cost Sharing for up to a 90-day supply of maintenance medications at a retail pharmacy is:	
Tier 1:	$60 Copayment per prescription or prescription refill
Tier 2:	Deductible, then 20% Coinsurance subject to a maximum Coinsurance amount of $1,200 per prescription or prescription refill
Tier 3:	Deductible, then 30% Coinsurance subject to a maximum Coinsurance amount of $1,500 per prescription or prescription refill
Tier 4:	Deductible, then 40% Coinsurance subject to a maximum Coinsurance amount of $1,800 per prescription or prescription refill
Your pharmacy Member Cost Sharing for up to a 90-day supply of maintenance medications through the Plan's mail service prescription drug program is:	
Tier 1:	$40 Copayment per prescription or prescription refill
Tier 2:	Deductible, then 20% Coinsurance subject to a maximum Coinsurance amount of $800 per prescription or prescription refill
Tier 3:	Deductible, then 30% Coinsurance subject to a maximum Coinsurance amount of $1,000 per prescription or prescription refill
Tier 4:	Deductible, then 40% Coinsurance subject to a maximum Coinsurance amount of $1,200 per prescription or prescription refill

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, including tier definitions.

Harvard Pilgrim Health Care

Language Assistance Services

Español (Spanish) ATENCIÓN: Si usted habla español, servicios de asistencia lingüística, de forma gratuita, están a su disposición. Llame al 1-888-333-4742 (TTY: 711).

Português (Portuguese) ATENÇÃO: Se você fala português, encontram-se disponíveis serviços linguísticos gratuitos. Ligue para 1-888-333-4742 (TTY: 711).

Kreyòl Ayisyen (French Creole) ATANSYON: Si nou palé Kreyòl Ayisyen, gen asistans pou sèvis ki disponib nan lang nou pou gratis. Rele 1-888-333-4742 (TTY: 711).

繁體中文 (Traditional Chinese) 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-888-333-4742（TTY：711）。

Tiếng Việt (Vietnamese) CHÚ Ý: Nếu quí vị nói Tiếng Việt, dịch vụ thông dịch của chúng tôi sẵn sàng phục vụ quí vị miễn phí. Gọi số 1-888-333-4742 (TTY: 711).

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

العربية (Arabic)

إنتباه: إذا أنت تتكلم اللُّغةِ **العربية** ، خَدَمات اَلْمُساعَدة اَللُّغَوية مُتَوفرة لك مَجانا. ً **إتصل على 1 888-333-4742** (TTY: 711)

ខ្មែរ (Cambodian) ប្រសុំជូនដំណឹង៖ បើអ្នកនិយាយភាសាខ្មែរ, យើងមានសេវាកម្មបកប្រែ ជូនលោកអ្នកដោយឥតគិតថ្លៃ។ ចូរ ទូរស័ព្ទ 1-888-333-4742 (TTY: 711)។

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

Italiano (Italian) ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-888-333-4742 (TTY: 711).

한국어 (Korean) '알림': 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-888-333-4742 (TTY: 711) 번으로 전화해 주십시오.

ελληνικά (Greek) ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, υπάρχουν στη διάθεσή σας δωρεάν υπηρεσίες γλωσσικής υποστήριξης. Καλέστε 1-888-333-4742 (TTY: 711).

Polski (Polish) UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-888-333-4742 (TTY: 711).

हिंदी (Hindi) ध्यान दीजिए: अगर आप हिंदी बोलते हैं तो आपके लिये भाषाकी सहायता मुफ्त में उपलब्ध है. जानकारी के लिये फोन करे. 1-888-333-4742 (TTY: 711)

ગુજરાતી (Gujarati) ધ્યાન આપો : જો તમે ગુજરાતી બોલતા હો તો આપને માટે ભાષાકીય સહાય તદ્દન મફત ઉપલબ્ધ છે. વિશેષ માહિતી માટે ફોન કરો. 1-888-333-4742 (TTY: 711)

ພາສາລາວ (Lao) ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-888-333-4742 (TTY: 711).

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

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General Notice About Nondiscrimination and Accessibility Requirements

Harvard Pilgrim Health Care complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Harvard Pilgrim Health Care does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

Harvard Pilgrim Health Care:

- 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 Harvard Pilgrim Health Care 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) 750-2074, TTY service: 711, Fax: (617) 509-3085, Email: civil_rights@harvardpilgrim.org. You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, the Civil Rights Compliance Officer is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
(800) 368-1019, (800) 537-7697 (TTY)

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

NEW HAMPSHIRE HMO
General List of Exclusions

The following list identifies services that are generally excluded from Harvard Pilgrim HMO 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
Alternative Treatments	
	1. Acupuncture services that are outside the scope of standard acupuncture care. 2. Alternative or holistic services and all procedures, laboratories and nutritional supplements associated with such treatments. 3. Aromatherapy, treatment with crystals and alternative medicine. 4. Health resorts, spas, recreational programs, camps, wilderness programs (therapeutic outdoor programs), outdoor skills programs, relaxation or lifestyle programs, including any services provided in conjunction with, or as part of such types of programs. 5. Massage therapy when performed by anyone other than a licensed physical therapist, physical therapy assistant, occupational therapist, or certified occupational therapy assistant. 6. Myotherapy. 7. Services by a Naturopath that are not covered by other Providers under the Plan.
Dental Services	
	1. Dental Care, except the specific dental services listed in the Benefit Handbook and Schedule of Benefits. 2. Extraction of teeth. 3. For Temporomandibular Joint Dysfunction (TMD), all services of a dentist and fixed or removable appliances that involve movement or repositioning of teeth, repair of teeth (fillings), or prosthetics (crowns, bridges, dentures), except those services that are specifically listed under the TMD benefit or other benefits in the Benefit Handbook and Schedule of Benefits. 4. Pediatric dental care, except when specifically listed as a Covered Benefit in this Schedule of Benefits.
Durable Medical Equipment and Prosthetic Devices	
	1. Any devices or special equipment needed for sports or occupational purposes. 2. Any home adaptations, including, but not limited to home improvements and home adaptation equipment. 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. 4. Repair or replacement of durable medical equipment or prosthetic devices as a result of loss, negligence, willful damage, or theft.

Exclusion	Description
Experimental, Unproven or Investigational Services	
	1. Any products or services, including, but not limited to, drugs, devices, treatments, procedures, and diagnostic tests that are Experimental, Unproven, or Investigational.
Foot Care	
	1. Foot orthotics, except for the treatment of severe diabetic foot disease 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.
Gender Reassignment Surgery	
	1. Face-lifting. 2. Lip reduction/enhancement. 3. Blepharoplasty. 4. Laryngoplasty, or other voice modification surgery. 5. Facial implants or injections. 6. Silicone injections of the breast. 7. Liposuction. 8. Electrolysis, hair removal, or hair transplantation. 9. Collagen injections. 10. Removal of redundant skin. 11. Reversal of gender reassignment surgery and all related drugs and procedures.
Maternity Services	
	1. Delivery outside the Service Area after the 37th week of pregnancy, or after you have been told that you are at risk for early delivery. 2. Routine pre-natal and post-partum care when you are traveling outside the Service Area.
Mental Health Care	
	1. Biofeedback. 2. Educational services or testing. No benefits are provided: (1) for educational services intended to enhance educational achievement; (2) to resolve problems of school performance; or (3) to treat learning disabilities. 3. Sensory integrative praxis tests. 4. Mental health care that is (1) provided to Members who are confined or committed to a jail, house of correction, prison, or custodial facility of the Department of Youth Services; or (2) provided by the Department of Mental Health. 5. Services or supplies for the diagnosis or treatment of mental health and drug and alcohol rehabilitation services that, in the reasonable judgment of the Behavioral Health Access Center, are any of the following: • Not consistent with prevailing national standards of clinical practice for the treatment of such conditions.

Exclusion	Description
Mental Health Care (Continued)	
	• Not consistent with prevailing professional research demonstrating that the services or supplies will have a measurable and beneficial health outcome. • Typically do not result in outcomes demonstrably better than other available treatment alternatives that are less intensive or more cost effective.
Physical Appearance	
	1. Cosmetic Services, including drugs, devices, treatments and procedures, except for (1) Cosmetic Services that are incidental to the correction of Physical Functional Impairment, (2) restorative surgery to repair or restore appearance damaged by an accidental injury, and (3) post-mastectomy care. 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 or any treatment to improve the appearance of the skin. 7. Treatment for spider veins. 8. Wigs, except as required by law
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. 2. Commercial diet plans, weight loss programs and any services in connection with such plans or programs. 3. If a service is listed as requiring that it be provided at a Center of Excellence, no coverage will be provided if that service is received from a Provider that has not been designated as a Center of Excellence. 4. 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). 5. Physical examinations and testing for insurance, licensing or employment. 6. Services for Members who are donors for non-members, except as described under Human Organ Transplant Services. 7. Testing for central auditory processing. 8. Group diabetes training, educational programs or camps.

Exclusion	Description
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 Benefit Handbook for more information.) 5. Follow-up care after an emergency room visit, unless provided or arranged by your PCP. 6. Inpatient charges after your hospital discharge. 7. Provider's charge to file a claim or to transcribe or copy your medical records. 8. 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. Infertility drugs. 2. Infertility treatment including, but not limited to, therapeutic donor insemination, including related sperm procurement and banking; donor egg procedures, including related egg and inseminated egg procurement, processing and banking; assisted hatching; gamete intrafallopian transfer (GIFT); intra-cytoplasmic sperm injection (ICSI); intra-uterine insemination (IUI); in-vitro fertilization (IVF); zygote intrafallopian transfer (ZIFT); preimplantation genetic diagnosis (PGD); microsurgical epididiymal sperm aspiration (MESA); and testicular sperm extraction (TESE). 3. Any form of Surrogacy or services for a gestational carrier. 4. Reversal of voluntary sterilization (including any services for infertility related to voluntary sterilization or its reversal). 5. The following fees: wait list fees, non-medical costs, shipping and handling charges, etc.
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.
Telemedicine	
	1. Telemedicine services involving fax, texting, or audio-only telephone. 2. Provider fees for technical costs for the provision of telemedicine services.

Exclusion	Description
Types of Care	
	1. Custodial Care. 2. Rest or domiciliary care. 3. All institutional charges over the semi-private room rate, except when a private room is Medically Necessary. 4. Pain management programs or clinics. 5. Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, and diversion or general motivation. 6. Private duty nursing. 7. Sports medicine clinics. 8. Vocational rehabilitation, or vocational evaluations on job adaptability, job placement, or therapy to restore function for a specific occupation.
Vision and Hearing	
	1. Eyeglasses, contact lenses and fittings, except as listed in the Benefit Handbook and this Schedule of Benefits. 2. Deluxe or designer frames. 3. Hearing aid batteries, cords, and individual or group auditory training devices and any instrument or device used by a public utility in providing telephone or other communication services. 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.
All Other Exclusions	
	1. Any service or supply furnished in connection with a non-Covered Benefit. 2. Beauty or barber service. 3. Any drug or other product obtained at an outpatient pharmacy, except for pharmacy supplies covered under the benefit for diabetes services, unless your Plan includes outpatient pharmacy coverage. 4. Food or nutritional supplements, including, but not limited to, FDA-approved medical foods obtained by prescription, except as required by law. 5. Guest services. 6. Services for non-Members. 7. Services for which no charge would be made in the absence of insurance. 8. Services for which no coverage is provided in this Benefit Handbook, this Schedule of Benefits, or Prescription Drug Brochure. 9. Services that are not Medically Necessary. 10. Services your PCP or a Plan Provider has not provided, arranged or approved except as described in the Benefit Handbook. 11. Taxes or governmental assessments on services or supplies. 12. Transportation other than by ambulance. 13. The following products and services:

Exclusion	Description
All Other Exclusions (Continued)	
	• Air conditioners, air purifiers and filters, dehumidifiers and humidifiers. • Car seats. • Chairs, bath chairs, feeding chairs, toddler chairs, chair lifts, recliners. • Electric scooters. • Exercise equipment. • Home modifications including but not limited to elevators, handrails and ramps. • Hot tubs, jacuzzis, saunas or whirlpools. • Mattresses. • Medical alert systems. • Motorized beds. • Pillows. • Power-operated vehicles. • Stair lifts and stair glides. • Strollers. • Safety equipment. • Vehicle modifications including but not limited to van lifts. • Telephone. • Television.