Harvard Pilgrim Health Care

Member Guide

Find everything you need at **harvardpilgrim.org**

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Dear Member,

At Harvard Pilgrim Health Care we strongly believe in whole-person care. Our mission is to ensure that you and your loved ones have access to high-quality health care coverage and services, including medical and behavioral health services, chronic care management, wellness programs, exclusive discounts, and many other great perks. With innovative programs, we focus on enhancing physical and mental well-being whether you're connecting in person or virtually.

We encourage you to use this member guide to:

- Activate your secure member account and download our free mobile app. Your secure member account will offer details on your specific health plan coverage and costs
- Learn more about your care options
- Explore our wellness programs, including discounts and reimbursement opportunities

You can also visit **harvardpilgrim.org** for more information, resources and access to your secure member account.

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Maximize Your Health Plan: Digital Tools and More

Secure Member Account and Mobile App

Log in or activate your secure online account at **harvardpilgrim.org/create** or download the Harvard Pilgrim mobile app[1] to access your health plan benefits information.

Find a doctor or hospital

Log in to your secure account to find a convenient location near you:

- Search for doctors or hospitals by name or location
- Find doctors accepting new patients
- View doctors by specialty such as behavioral health, pediatrics and more

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Estimate My Cost

Log in to your secure account to estimate your out-of-pocket costs and get quality care from a provider that will save you money and fit into your budget.

Reduce My Costs

Connect with a nurse at **855-772-8366** when you shop for a wide range of outpatient tests and procedures, including lab work and diagnostic imaging, and earn cash rewards when you select high-quality, cost-effective providers.[2]

Telehealth provided by Doctor On Demand

Set up your account at **doctorondemand.com/harvard-pilgrim**. Access a Doctor On Demand provider 24/7, by phone or mobile app worldwide[3] for everyday care and confidential therapy. Physicians can also order your prescription[4] at your local pharmacy when medically necessary.

An Integrated Approach to Behavioral Health

Harvard Pilgrim Health Care provides several programs and services, complemented by our extensive network of providers, to support you and your loved ones. Our integrated approach to care allows us to help you improve both your physical and mental well-being for the best outcomes.[5]

Broad Network Providers

In line with our "whole-person" care approach, Harvard Pilgrim members have continuous access to high-quality comprehensive care through our expansive network of medical and behavioral health care providers. Our network covers New England and extends nationwide, offering both in-patient and out-patient services.

NEW: Behavioral health service navigation

Our specially trained service navigators provide personalized help to navigate the complex health care system, locate providers, connect to internal supports and programs, and learn more about innovative tools and services.

Care management programs

Our licensed care managers work with you and your providers to ensure optimal health and functioning through a variety of care management programs, including care coordination, complex care, addiction recovery, transition to home, emergency department readmission diversion, supportive care, post facility discharge and peer support.

Behavioral health programs and services

Harvard Pilgrim offers innovative behavioral health programs and services for children, adolescents and adults:

- Virtual therapy services are available 7 days/week: to support your mental health and well-being. Our services include AbleTo,[6] Doctor on Demand, and Valera Health[7], offering licensed coaching, talk therapy, medication management and more
- Quick and easy access to specialty providers including Cortica,[7] offering diagnostic, applied behavior analysis (ABA), occupational therapy, speech therapy and social skills under one roof. To provide rapid access appointments, we have partnered with Transformations Care Network,[7] a virtual and in-person outpatient mental health clinic.
- Substance use treatment services are also available through multiple network providers, including Spectrum Health, and members are supported after inpatient treatment by our internal addiction recovery care management team.

Help is just a phone call away. For assistance with accessing these innovative programs and services, please call the number on the back of your ID card.

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

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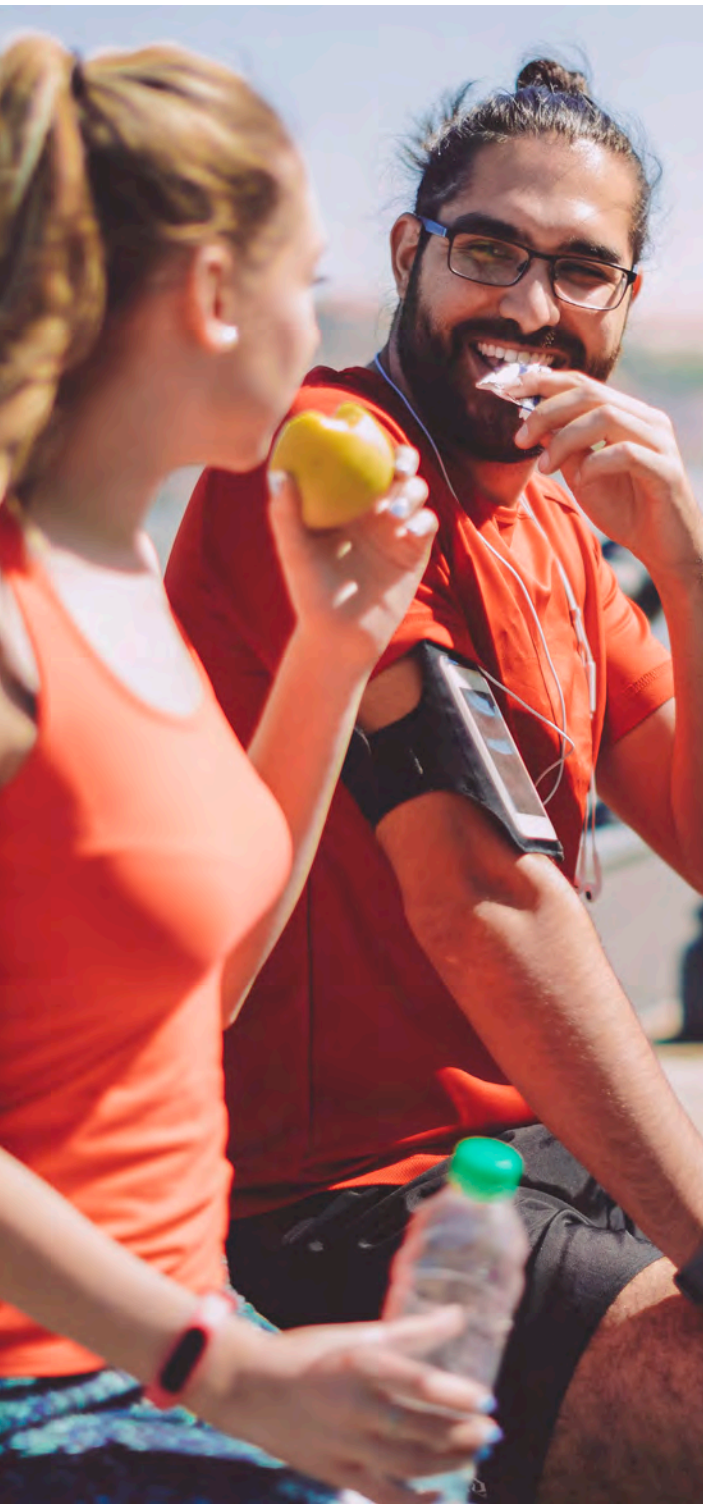
Understand Your Pharmacy Benefits

OptumRx provides Harvard Pilgrim members with retail, mail order and specialty pharmacy services, allowing you to have one pharmacy manager for all pharmacy needs.



Log in to your secure online member account to look up your prescriptions

We cover thousands of different medications, but if your current prescription isn't on our list, talk to your doctor about switching to a covered medication.

Many medications we cover have cost-sharing (copayment, deductible or coinsurance) — the amount you'll be responsible for paying, depending on your plan. The medications covered under your plan are organized into different tiers. Typically, the lower the tier, the lower your cost. Refer to your prescription drug plan documents for specific cost-sharing details and a description of the tiers.

Check if your prescription has special requirements

If there is a "PA," "STPA," "QL" or "SP" after any of your prescriptions, talk to your provider. Refer to the "Key Terms" section of this Member Guide for full "special requirements" definitions.

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Plan ahead if you take maintenance medication

Maintenance medications are drugs taken regularly for ongoing conditions, such as high blood pressure or diabetes. If you're switching from another health insurance plan to Harvard Pilgrim, make sure you have enough medication on hand to cover the transition period until your new coverage with Harvard Pilgrim begins.

Check your medication expiration date, refill amount and coverage under Harvard Pilgrim. If your medication is not covered, talk to your doctor about switching to an alternate maintenance medication that is covered.

Save money with mail order service

Mail order service provides the convenience of home delivery instead of going to a retail pharmacy. On some plans, your medication may be less expensive if you buy a 90-day supply through this service.

For more information, go to **harvardpilgrim.org/rx**

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Know Your Care Options

Health care isn't one-size-fits-all. From minor cuts to a sore throat or even a blood pressure check, knowing where to seek care for your situation can save you time and money. As a Harvard Pilgrim member, you and your dependents have access to a variety of options:

When to visit the Emergency Room

If you think you're having an emergency and your life is in danger, call 911 or go to the nearest emergency room. Common medical emergencies that should be treated in the emergency room include choking, heart attack or severe abdominal pain.

When to see your Primary Care Provider (PCP)

For non-urgent needs such as preventive screenings, checkups, immunizations or chronic conditions, your PCP knows your medical history and is best suited to coordinate your care. And, they may also offer virtual health care services for even greater convenience.

When to visit an Urgent Care Center

You can stop by an urgent care center without an appointment for conditions that need immediate treatment but are not considered life-threatening. Examples include minor burns or cuts that may require stitches.

When to go to a Retail Clinic

Retail clinics such as CVS MinuteClinic® and Walgreens Health care Clinic are a good option when you're experiencing mild symptoms such as an ear infection or skin conditions like poison ivy, and you want a health professional to check it out without an appointment.

When to use virtual care, through Doctor On Demand

You can request a virtual visit with a U.S.-based doctor 24/7 for non-emergency conditions such as upper respiratory infection, upset stomach or skin rash using live video or voice call via your smartphone, tablet or computer. You can also access confidential therapy and build an ongoing relationship with the provider of your choice.

When to reach out to our Harvard Pilgrim Care Team

Need assistance managing a chronic condition, understanding costs related to health insurance or coordinating access to quality care? Our Care Team of registered nurses, clinical social workers and certified health coaches will answer your questions, help you navigate the health care system, and support your health and wellness goals at no cost.

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Wellness Discounts and Perks

Harvard Pilgrim wants to help you reach your wellness goals with discounts on nutrition, mind and body, fitness and other services related to good health. For more information and details on the different programs and services available, visit **harvardpilgrim.org/discounts**[8]

Start Living Well Today

Log into **harvardpilgrim.org** and click "Member Login." If you don't have an account, choose "Create a secure account" to create one. Once logged in, select "Get Started" on the Health & Wellness tile.

- Take your Well-being Assessment
- Connect with a Health Coach
- Participate in monthly challenges and activities to build healthy habits
- Earn points towards rewards

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Stay Connected and Informed

While your secure member account provides detailed information on your specific health plan coverage and costs, we offer many other ways to connect you with the information you need to live healthier and save money.

Member Newsletter

Our digital member newsletter shares current health topics and benefit highlights including tips to manage your health, recipes and discounts on wellness services. It's delivered to your email inbox and posted on our public website.

Text Messaging

Our text messaging service is your personalized connection to your health plan. Get reminders and notifications about flu shots, as well as updates on exclusive member discounts and perks.

Email Messages

Receive valuable information about your benefits, discount options, new program, and health and well-being opportunities.

Website

The member section of our website is a great place to learn more about the resources, wellness options, care management programs and additional member benefits to keep you and your family healthy. Bookmark the site for easy access **harvardpilgrim.org**

Social Media

Follow our social feeds to keep up with the latest news, tips and stories.

How to get started

Check your secure member account to be sure we have your current email address and mobile telephone number, and we'll ensure you stay informed.

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Key Terms

Premium

This is the monthly cost of your health insurance coverage.

Cost-sharing

Your out-of-pocket costs for services included within your health plan including copayments, deductibles and coinsurance.

Copayments

A fixed dollar amount that you pay for a covered medical service, prescription or medication.

Deductible

The amount you owe or pay out-of-pocket during a coverage period (usually one year) for covered health care services before your plan begins to pay.

Coinsurance

This is a fixed percentage of costs that you pay for covered services. For example, if you have a plan with coinsurance, 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 an annual deductible.

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Out-of-pocket maximum

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

In-network

Generally, this describes coverage for care that POS and PPO members receive from participating providers in the Harvard Pilgrim network. In-network coverage typically costs less than out-of-network coverage. In most cases, if you have a POS plan, you need to have a referral from your primary care provider (PCP) to another participating provider in order for in-network cost-sharing to apply.

Out-of-network

Out-of-network coverage applies only to POS and PPO plans. Harvard Pilgrim will cover care that POS and PPO members receive from non-participating providers, but it usually costs more than in-network coverage. In addition, if you have a POS plan, you will — in most cases — have out-of-network coverage when you receive care for covered services from participating providers without your primary care provider's referral.

Tier

Medical plans often place providers and hospitals in different categories, or tiers, with different cost-sharing amounts. Typically, you'll save money when you see Tier 1 providers.

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Pharmacy Key Terms

Prior Authorization (PA)

The need for your provider to tell us why it is medically necessary for you to receive a covered medication or service. We consult with your doctor(s) to provide you with better health outcomes, cost savings and assure your safety. Contact the doctor who recommended the medication or service. If the doctor believes the medication or service that requires PA is necessary for your treatment, they may submit a request for coverage to Harvard Pilgrim. We'll cover the medication or service if it meets our medical necessity coverage guidelines.

Step Therapy Authorization (STPA)

An automated form of prior authorization that encourages clinically proven use of first-line therapies so that the most therapeutically appropriate and cost-effective drugs are used first, before other drugs may be covered. Some types of step therapy include requiring the use of generics before brand name drugs or preferred drugs before non-preferred brand name drugs. Check our step therapy drug list to find out which step your drug is on. If you haven't previously taken the steps we require, and your doctor believes the drug prescribed for you is necessary, your doctor may request authorization. You can check the list by visiting **harvardpilgrim.org**. Click on "Plan Details," then select "Prescription Drug Benefits."

Quantity Limitation (QL)

The quantity limit for a medication that can be purchased at any one time. A common QL is a 30-day supply, which is the maximum number of units needed for 30 days based on the prescribed daily/weekly dose. You're covered for up to the quantity posted in our covered drug list. If your doctor believes you need to take more than that quantity, the doctor may submit a request for authorization.

Designated Specialty Pharmacy (SP)

A pharmacy management program that requires members to purchase selected medications from specific sources. Once your membership is effective, log in to **harvardpilgrim.org**. Click on "Plan Details," then select "Prescription Drug Benefits," or contact our Member Services department to help you receive your medication without interruption.

Non-Covered (NC)

Medications that are not currently covered by us. If your provider feels you require this medication, your provider should contact us. They may submit a request for coverage to Harvard Pilgrim. We will cover the medication if it meets our coverage guidelines. If the request is approved, you will be covered for your prescription.

New-to-Market Drug Evaluation (NTM)

In an effort to ensure the new-to-market prescriptions that we cover are safe, effective and affordable, we delay coverage of many new drugs until a physician specialist reviews them. If your doctor feels you need a new medication, they can contact us to request coverage.

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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 **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 **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).

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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 **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.

Visit **harvardpilgrim.org** or call us for a copy of Harvard Pilgrim's Notice of Privacy Practices.

Members: 888-333-4742
Non-members: 800-848-9995
TTY: 711

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Additional Benefit Details

[1] Estimating costs and some other features are not available on the mobile app.

[2] Your health plan may require a referral and/or prior authorization before you receive services from a cost-effective provider. To ensure the services will be covered, please refer to your plan documents or contact Harvard Pilgrim at 888-333-4742. For Maine-based members of a small group employer whose plans include a Health Savings Account (HSA), these additional services are included in the Reduce My Costs program: physical therapy and occupational therapy. For more information, please visit **harvardpilgrim.org/reducemycosts/maine**. Cash rewards comes in an e-gift card format that is emailed directly to the member. Rewards are offered on services that meet minimum savings threshold. Rewards are considered taxable income; please consult with your tax advisor. Massachusetts members may receive a maximum of $500 in Reduce My Costs rewards per member per calendar year.

[3] This excludes U.S. territories (Puerto Rico, Guam, U.S. Virgin Islands) and certain other countries (e.g., nations on the U.S. Sanctions List).

[4] Physicians will not order prescriptions for patients calling from outside the U.S. and they do not provide Schedule I-IV DEA controlled substances and may elect not to treat or prescribe other medications based on what is clinically appropriate.

[5] The behavioral health programs and services including care management programs mentioned in this guide reflect availability as of November 2023. Member cost-sharing may apply. Members should refer to their plan documents for specific details regarding their coverage and benefits.

[6] AbleTo Virtual Therapy will be available to Harvard Pilgrim members with employer-sponsored coverage. Cost-sharing applies to members with high deductible plans with an HSA.

[7] Valera Health services, Transformations Care Network and Cortica autism services providers are located only in Massachusetts.

[8] This information has been provided by the vendors and has not been independently confirmed by Harvard Pilgrim Health Care.

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General Notice About Nondiscrimination and Accessibility Requirements

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

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 (see below for contact information).

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 (including pregnancy, sexual orientation, and gender identity), you can file a grievance with:

Civil Rights Compliance Officer
1 Wellness Way
Canton, MA 02021

866-750-2074, TTY service: 711,
Fax: 617-509-3085
Email: **civil.rights@point32health.org**

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

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

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

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

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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 اللُّغة **العربية**، خَدمات المُساعَدة اللُّغوية مُتوفرة لك مَجانا. **إتصل على 1 888-333-4742**
(TTY: 711)

ខ្មែរ (Cambodian) ប្រសុំជូនដំណឹង៖ បើអ្នកនិយាយភាសាខ្មែរ, ើងមានសេវាកម្មបកប្រែ ជូនលោកអ្នកដោយ តតតិតថ្លៃ។ 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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Contact Us

Member Services
888-333-4742 (TTY: 711)
Mon., Tues. & Thurs. 8 a.m. - 6 p.m.
Wed. 10 a.m. - 6 p.m.
Fri. 8 a.m. - 5:30 p.m.

Harvard Pilgrim Health Care offers interpreter services. Call 844-442-7324 (TTY: 711)

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

Harvard Pilgrim Health Care

Medical Coverage & Cost-Sharing Guide

POS

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 with your primary care physician (PCP)'s referral.

- **In-network coverage**
- **Out-of-network coverage**
- **PCP required**
- **Referrals needed for specialists to receive the in-network benefit level**

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.

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Getting care with the POS plan

Routine and preventive care*

There's no extra charge for routine annual exams with your PCP and for many preventive tests and services. Other tests and services your PCP 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, but your costs will be lower when you receive care from in-network providers with your PCP's referral.

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. Learn more about your care options at **harvardpilgrim.org/urgentcareoptions**

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 you're 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 PCP is key to good health

A PCP is the doctor, nurse practitioner or other qualified medical professional you see for annual checkups and for treatment when you're sick or injured.

- Because this plan requires you to have a PCP, we will assign one to you automatically if we don't have one on file for you or if you don't select one when you enroll.
- You and each of your dependents can choose different PCPs from our network of participating providers.
- Find a PCP or see if your current provider is in our network at **harvardpilgrim.org/providerdirectory**

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

Cost-sharing overview

No cost sharing when received in-network:
Routine & preventive care*

- Annual checkup
- Preventive screenings and tests
- Immunizations, including flu shots
- Routine prenatal and postpartum 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
- Prescription drugs**

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.

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.

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

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

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

Learn more at **harvardpilgrim.org** or call member services at **(888) 333-4742**

Harvard Pilgrim Health Care

Value 5-Tier

Prescription Drug Coverage

Tier 1	$	Low-cost generic drugs and certain 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

Your Drug Coverage

What is covered?

- Most generic drugs
- Brand-name drugs without generic equivalents
- Certain over-the-counter medications

What is not covered?

- Most 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 **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.*

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 **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 **harvardpilgrim.org/rx** and choose the year and then **Value 5-Tier**. 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.

*If you have already tried Drug A or are unable to try Drug A, an exception may be granted.

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Filling Your Prescriptions

Where can I get my prescriptions filled?

You can get your prescriptions filled at any of the more than 68,000 retail pharmacies that belong to our national participating pharmacy network. To confirm whether your pharmacy is in the network, visit **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, visit **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.

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 **harvardpilgrim.org/rx** for information on our specialty pharmacy program, choose the year and then **Value 5-Tier** for details.

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.

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

Learn more at **harvardpilgrim.org/rx** or call **888-333-4742** TTY: **711**.

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Harvard Pilgrim Health Care

Coverage for Over-the-Counter Medications

Your health plan includes coverage for certain generic over-the-counter (OTC) medications. This means cost savings on the essentials in your medicine cabinet.

Here's how it works:

- Use the online lookup tool at **harvardpilgrim.org/rx** to see which OTC medications you take are covered.
- Ask your provider to write a prescription for the covered medication, for up to a 90-day supply.
- Bring the prescription to any in-network pharmacy* so that the pharmacist can give you the proper medication.
- You pay Tier 1 cost sharing instead of the retail price. If you have an HSA plan, you pay either our discounted rate or the retail cost, whichever is lower, until you meet your deductible, and then Tier 1 cost sharing applies.

There's another advantage: because your provider will be giving you a prescription for the OTC medications you take, your medical records will have a more complete medication history.

Below are the types of OTC medications that are covered along with a complete listing by medication:

Type of Therapy	Purpose
 **Cough, cold, allergy**	› Antitussive (cough suppressant) › Expectorant › Nasal decongestant › Antihistamine › Nasal spray
 **Dermatology**	› Anti-fungal › Poison ivy
 **Eyes (ophthalmic)**	› Dry eye › Allergy
 **Gastrointestinal**	› Anti-parasite › H2 blocker (antacid) › Laxative
 **Pain**	› Anti-inflammatory

*Visit harvardpilgrim.org/rx to find in-network pharmacy locations near you.

Covered Over-the-Counter Generic Medications

- When using the lookup tool for your plan's formulary, search by the generic name shown here.
- Only the generic versions of the product names are covered.
- Keep in mind that multiple store brands are available as generic drugs.

Type of Therapy	Medication Brand Name	Generic Name
 **Cough, cold, allergy**	Benadryl tabs, liquid	Diphenhydramine
	Claritin tabs, syrup	Loratadine
	Dextromethorphan liquid, syrup	Guaifenesin
	Nasalcrom nasal spray	Cromolyn
	Ocean 0.65% nasal spray	Saline
	Robitussin syrup, liquid	Phenylephrine tablet
	Sudafed tabs, liquid	Pseudoephedrine
	Zyrtec tabs, solution	Cetirizine
 **Dermatology**	Clotrimazole cream, vaginal cream	Clotrimazole
	Hydrocortisone cream, gel, lotion, ointment, solution (various name brands)	Hydrocortisone
	Miconazole cream, vaginal cream and suppository	Miconazole
	Tolnaftate cream, solution, aerosol	Tolnaftate
 **Eyes (ophthalmic)**	Artificial tears (various name brands)	Artificial tears
	Zaditor OTC 0.025%	Ketotifen
 **Gastrointestinal**	Citrate of Magnesium solution	Magnesium citrate
	Dulcolax tabs, suppositories	Bisacodyl
	Fleet Enema	Sodium phosphate
	Metamucil powder	Psyllium
	Miralax powder	Polyethylene glycol 3350
	Pepcid tabs	Famotidine
	Senna 8.6mg tabs	Senna, sennosides
	Tagamet tabs	Cimetidine
 **Pain**	Ibuprofen 100mg/5mL suspension	Ibuprofen

Harvard Pilgrim Health Care

Whole-Person Care

A New Integrated Approach to Behavioral Health

Starting November 1, 2023, all Harvard Pilgrim members can access a comprehensive network of medical and behavioral health care providers, along with innovative programs and services[1], to improve both physical and mental well-being in traditional and virtual settings. Our dedicated team will guide you from the first phone call to aftercare planning, to ensure that you receive "whole-person" care through an integrated approach. Our goal is to provide you and your family with a seamless, consistent, and compassionate experience to achieve optimal health and well-being.

Behavioral health service navigation

Our specially trained service navigators provide personalized help to navigate the complex health care system, locate providers, connect to internal supports and programs, and learn more about innovative tools and services.

Care management programs

Our licensed care managers work with you and your providers to ensure optimal health and functioning through a variety of care management programs, including care coordination, complex care, addiction recovery, transition to home, emergency department readmission diversion, supportive care, post facility discharge and peer support.

Behavioral health programs and services

Harvard Pilgrim offers innovative behavioral health programs and services for children, adolescents, and adults:

- **Virtual therapy services** are available 7 days/week: to support your mental health and well-being. Our services include AbleTo[2], Doctor on Demand, and Valera Health[3], offering licensed coaching, talk therapy, medication management, and more
- **Quick and easy access to specialty providers** includes Cortica[3] offering diagnostic, applied behavior analysis (ABA), occupational therapy, speech therapy and social skills under one roof. And to provide rapid access appointments, we have partnered with Transformations Care Network[3], a virtual and in-person outpatient mental health clinic.
- **Substance use treatment services** are also available through multiple network providers including Spectrum Health[3] and members are supported after inpatient treatment by our internal addiction recovery care management team.

Help is just a phone call away. For assistance with accessing these innovative programs and services, please call the number on the back of your ID card.

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

[1] The behavioral health programs and services including care management programs mentioned in this flyer reflect availability as of June 2023. Member cost sharing may apply. Members should refer to their plan documents for specific details regarding their coverage and benefits.

[2] AbleTo Virtual Therapy will be available to Harvard Pilgrim members with employer-sponsored coverage. Cost share applies to members with high deductible plans with an HSA.

[3] Valera Health services, Transformations Care Network, Spectrum Health Systems and Cortica autism services providers are located only in Massachusetts.

Harvard Pilgrim Health Care

Fitness Reimbursement Form Instructions

Please read the instructions below, then fill out the Fitness Reimbursement Form on page 3.

Want your reimbursement faster? Submit your request online at **harvardpilgrim.org/fitnessreimbursement**

Getting reimbursed is easy

Please enclose copies of the following:

- ☑ Copy of your health/fitness membership agreement
- ☑ Completed Fitness Reimbursement Form
- ☑ Receipts showing that you paid for at least four months in a calendar year for membership or subscription fees (must show your name and the facility or program name). Fees must equal or exceed amounts being claimed.

Mail to:
Harvard Pilgrim Health Care
P. O. Box 9185
Quincy, MA 02269

Frequently Asked Questions

› How do I qualify for a wellness reimbursement?

- You must be eligible for fitness reimbursement through your Harvard Pilgrim plan.
- Fitness facility or other qualified fitness membership must be for at least four months in a current calendar year.
- Current Harvard Pilgrim membership must be at least four months in a calendar year and must coincide with four months of fitness membership or subscription.

› When can I submit my Fitness Reimbursement Form?

- Starting on May 1 of the current calendar year and when you have met the above-stated criteria.

› What qualifies for reimbursement?

- Full-service health/fitness facilities that have cardiovascular and strength-training equipment qualify, as well as facilities for exercising and improving physical fitness.
- Fitness studios/facilities that offer yoga, Pilates, Zumba, aerobic/group classes, indoor cycling/spinning classes, kick-boxing, CrossFit, strength training, tennis, indoor rock climbing and personal training (taught by a certified instructor).
- Virtual fitness subscriptions.
- Not eligible for reimbursement: fees you pay for group classes or personal training outside of a fitness facility/studio, and health club initiation fees or costs that you pay for instructional dance studios, country clubs, social clubs (such as ski, riding or hiking clubs), spas, gymnastics facilities, martial arts schools, pool-only facilities, road race fees, sport camps, ski passes, sports teams or leagues, and school sports athletic user fees.
- Validation is subject to approval by Harvard Pilgrim.

› How much can I claim for fitness reimbursement?*

- When eligible, up to two members on a family plan can be reimbursed for up to $150 each, for a maximum reimbursement of $300. Any combination of subscriber, spouse or dependent is eligible for reimbursement. For plans with one covered member, the maximum reimbursement amount is $150.
- Some members may be eligible for a different reimbursement amount based on their health plan.
- Small group or individual plans in MA allow up to $150 total for fitness membership fees and fitness trackers.
- Check with your employer or contact Member Services for eligibility and reimbursement amount.

› What happens after I submit the Fitness Reimbursement Form?

- Reimbursement checks will be mailed and made payable **only** to the Subscriber only at the Subscriber's address of record. No other address will be accepted. If you believe your current address is different from the address we have on file, please call the Member Services number on the back of your ID card before you submit the form.
- Please allow up to 8 weeks for processing.

* Fitness reimbursement may be considered taxable income. For tax information, consult your employer or tax advisor.

Harvard Pilgrim Health Care

Fitness Reimbursement Form

To be filled out by Harvard Pilgrim Health Care SUBSCRIBER only. Please use blue or black ink and print all information clearly.

When to submit this form

- When you are eligible for fitness reimbursement through your employer or individual plan.
- After you have been a member in qualified fitness program and Harvard Pilgrim Health Care for at least four months in a calendar year.
- Once per calendar year, submitted by March 31 of the following year, with all necessary receipts or proof of payment. Some small group and individual plans have until December 31 of the following calendar year to submit for reimbursement.
- After all sections have been completely filled out and signed by the subscriber.

Section A – Subscriber Information (person who holds coverage)

Harvard Pilgrim ID Number	Subscriber's Last Name	First Name	Middle Initial
Date of Birth (mm/dd/yyyy)			
Address	City	State	ZIP Code
Daytime Phone (area code) xxx-xxxx	Company Name (Employer)	Subscriber's Email	

Section B – Subscriber and/or Member Information for Reimbursement

Harvard Pilgrim ID Number	Last Name	First Name	Date of Birth (mm/dd/yyyy)
Harvard Pilgrim ID Number	Last Name	First Name	Date of Birth (mm/dd/yyyy)

Section C – Fitness Program Information (List all health and facility memberships that you and/or your dependent(s) are submitting for reimbursement spanning the qualifying four months.).

ATTACH DOCUMENTATION	**Calendar Year** **from:** mm/dd/yyyy **to:** mm/dd/yyyy	**Facility or Program Name**	**City, State**	**Phone Number** (area code) xxx-xxxx	**$ Amount being claimed**
	from: ___/___/___ **to:** ___/___/_____				
	from: ___/___/___ **to:** ___/___/_____				

Section D – Fitness Tracking Device Information ((List the brand – i.e., Apple Watch, Fitbit, Garmin, Nike, Samsung Gear, etc.) (NOT ALL MEMBERS ARE ELIGIBLE FOR THIS REIMBURSEMENT; see instructions on page 2)

ATTACH RECEIPT	**Purchase Date**	**Tracking Device Brand**	**$ Amount being claimed**

Total number of documents: _____ Total dollar amount being claimed : **$_____**

Section E – Subscriber Certification

I certify the information on the form and all supporting documents are complete, accurate and unaltered. I will attempt, in good faith, to regularly use my fitness services for which I am being reimbursed.

Subscriber's Signature Date (mm/dd/yyyy)

Fitness reimbursement may be considered taxable income. For tax information, consult your employer or tax advisor.

Clear Form

Harvard Pilgrim Health Care

REASONS FOR SUBMISSION (PLEASE CHECK ONE)	**QUALIFYING EVENT DATE:**_________________
☐NEW ENROLLMENT/CONTRACT ☐CHANGE TO CONTRACT ☐TERMINATE CONTRACT	☐ OPEN ENROLLMENT ☐NEW HIRE ☐COBRA ☐LOSS OF INSURANCE ☐COURT ORDER ☐BIRTH/ADOPTION ☐P/T TO F/T ☐MARRIAGE/DIVORCE ☐MOVED IN/OUT OF SERVICE AREA ☐DEATH ☐VOLUNTARY CANCELLATION

REASON FOR CHANGES (CHECK ALL THAT APPLY)

☐CHANGE COVERAGE TYPE ☐ADD DEPENDENT LISTED ☐TERMINATE DEPENDENT LISTED ☐TRANSFER/RE-ENROLL TO COBRA

☐OTHER:____

EMPLOYER/GROUP INFO (TO BE COMPLETED BY EMPLOYER)

EMPLOYER/GROUP NAME	GROUP #DIVISION	DATE OF HIRE	EFFECTIVE DATE OF COVERAGE
Uprise Partners LLC	1 7 9 0 2 3 0 0 0		

SUBSCRIBER INFORMATION

HP ID	PRODUCT:	PLAN NAME
	☐HMO ☐PPO ☒POS ☐ACCESS AMERICA	Clear Choice POS Silver 3000

SUBSCRIBER FIRST NAME	MI	LAST NAME	DOB	GENDER
				☐M ☐F

SSN	HOME PHONE	WORK PHONE	CELL PHONE	EMAIL

STREET ADDRESS (NO PO BOX)	APT #	CITY	STATE	ZIP

PRIMARY LANGUAGE (OPTIONAL)	PCP FULL NAME	PCP TOWN	CURRENT PATIENT	PCP ID #
			☐YES ☐NO	

SPOUSE INFORMATION

SPOUSE FIRST NAME	MI	LAST NAME	DOB	GENDER
				☐M ☐F

SSN	MAILING ADDRESS (IF DIFFERENT)	RELATION CODE

PCP FULL NAME	PCP TOWN	CURRENT PATIENT	PCP ID #
		☐YES ☐NO	

DEPENDENT INFORMATION

DEPENDENT FIRST NAME	MI	LAST NAME	DOB	GENDER	RELATION CODE
				☐M ☐F	

MAILING ADDRESS (IF DIFFERENT)	SSN

PCP FULL NAME	PCP TOWN	CURRENT PATIENT	PCP ID#
		☐YES ☐NO	

DEPENDENT INFORMATION

DEPENDENT FIRST NAME	MI	LAST NAME	DOB	GENDER	RELATION CODE
				☐M ☐F	

MAILING ADDRESS (IF DIFFERENT)	SSN

PCP FULL NAME	PCP TOWN	CURRENT PATIENT	PCP ID#
		☐YES ☐NO	

DEPENDENT INFORMATION

DEPENDENT FIRST NAME	MI	LAST NAME	DOB	GENDER	RELATION CODE
				☐M ☐F	

MAILING ADDRESS (IF DIFFERENT)	SSN

PCP FULL NAME	PCP TOWN	CURRENT PATIENT	PCP ID#
		☐YES ☐NO	

☐PLEASE CHECK IF USING ADDITIONAL MEMBERSHIP APPLICATIONS FOR DEPENDENT CHILDREN. BE SURE TO COMPLETE EMPLOYER AND SUBSCRIBER SECTIONS ON ADDITIONAL FORMS

OTHER INSURANCE – *IF YOU HAVE NOT COMPLETED THIS SECTION, YOU MAY RECEIVE A FOLLOW-UP QUESTIONNAIRE AND CLAIMS MAY BE DELAYED.*

ARE YOU OR ANYONE LISTED ABOVE COVERED BY ANOTHER HEALTH INSURANCE POLICY AT THE SAME TIME YOUR HPHC POLICY IS IN EFFECT? ☐YES. PLEASE COMPLETE ☐NO

NAME OF HEALTH PLAN	HEALTH PLAN ID NUMBER	EFFECTIVE DATE	NAMES OF SUBSCRIBER

MEMBERSHIP WILL BECOME EFFECTIVE UPONACCEPTANCE BYHARVARD PILGRIM. BENEFITSUNDER THE PLAN WILL BE EXPLAINED IN YOUR EVIDENCE OF COVERAGE (EOC). I UNDERSTAND THAT HARVARD PILGRIM MAY OBTAIN PERSONAL ANDMEDICAL INFORMATION TOADMINISTER THE PLAN. FOR AN EXPLANATION OF HOW WE MAY USE OR DISCLOSE PROTECTED HEALTH INFORMATION, PLEASEREAD YOUR NOTICE OF PRIVACY PRACTICES. MAINE MEMBERS: YOU UNDERSTAND THAT YOUR EOC INCLUDESA SUBROGATION PROVISION THAT PERMITS SUBROGATION PAYMENTS TO US ON A JUST AND EQUITABLE BASIS. IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE OR MISLEADING INFORMATION TOAN INSURANCE COMPLANYFOR THE PURPOSE OF DEFRAUDING THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES OR DENIAL OF INSURANCE BENEFITS.

CONNECTICUT MEMBERS: I AFFIRM THAT THE FOREGOING STATEMENTS ARE TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE AND BELIEF. I UNDERSTAND THAT THE COMPANY HAS THE RIGHT TO TERMINATE COVERAGE RETROACTIVE TO THE EFFECTIVE DATE OF COVERAGE FOR A PERIOD OF TWO YEARS FOR KNOWINGLY PROVIDING FALSE, INCOMPLETE OR MISLEADING INFORMATION HEREIN.

EMPLOYEE SIGNATURE	DATE	EMPLOYER SIGNATURE	DATE

Thank you for choosing Harvard Pilgrim Health Care.

Please read the following instructions prior to completing this enrollment/change form. This form may be used for all enrollment transactions (Adding coverage, changing coverage, terminating coverage). In order to add, change or terminate coverage you must (1) experience a qualifying event, (2) complete this enrollment, and (3) provide the completed form to your employer within the allowed timeframe or approved retroactive period.

Qualifying Events:

New Enrollment	**Contract change**	**Termination**
Open Enrollment	Open Enrollment	Open Enrollment
New hire date	Marriage/Divorce	Voluntary Cancellation
Probationary Period (if applicable)	Birth/Adoption/Court Order	Left Employment
Loss of Insurance	Loss of Insurance	Moved from Area
Employment Status Change	Loss of Employer Premium contributions	No Longer Eligible (e.g. deceased, LOA, laid off, COBRA nonpayment)

Employer Section: Your Employer must fill out this section as well as the Reason for Submission in full for any transactions that this form is used for.

Member Section: Please complete all of the employee sections of this membership application in full. Failure to do so could delay enrollment. You will receive your ID card(s) and member benefit documents after your enrollment has been fully processed. If you are adding or removing a dependent(s), just include the details about the dependent(s) that you are adding or removing off the plan.

- **Product/Plan Name:** Please be sure to fill in the correct product code for the plan you have selected. Your options are HMO, POS, PPO and Access America. If your employer offers multiple Harvard Pilgrim Plans, please indicate the Plan name as listed on the enrollment materials to help clearly differentiate the plan you are choosing. If you know the Plan MD # (MD0000016670) the number to identify the plan/product please include the information.
- **Personal Information:** In addition to yourself, please include the personal information for every dependent that will be enrolled on the Plan. ***IMPORTANT: Social security numbers (or personal tax identification number) for each member on the plan are needed to ensure that federal regulatory reporting requirements are met. Social security numbers are not displayed on the member's ID card.***
- **Primary Care Provider:** If your plan is an HMO or POS, you will need to select a primary care provider (PCP). If your plan requires one, it is important that you choose a PCP right away. Be sure to fill out this section for all members, including dependents. Write the Harvard Pilgrim PCP ID (not the phone number) and the full name of the doctor you have chosen to coordinate your health care without a PCP assignment, your in-network benefits may be limited to emergency services only. To find a PCP or lookup the PCP ID, visit www.harvardpilgrim.org, and use the doctor search feature available in the Member Section.
- **Relation Code:** Please use one of the following codes to designate the dependent's relationship to the Employee:
  - 02 Spouse/Civil Union
  - 03 Child up to age 26
  - 06 Disabled (verification required)
  - 07 Ex-spouse
  - DP Domestic Partner
  - SE Spousal Equivalent

When this application is complete: Please sign the enrollment form and provide it to your employer. Your employer will need to sign this form and will forward this application to Harvard Pilgrim Health Care for processing. If you need additional assistance completing this form or selecting a PCP, please call a member services coordinator at 1-888-333-4742.

Coverage underwritten or administered by Harvard Pilgrim Health Care. Harvard Pilgrim Health Care includes Harvard Pilgrim Health Care, Harvard Pilgrim Health Care of New England and HPHC Insurance Company.

Schedule of Benefits

Harvard Pilgrim Health Care, Inc.

Clear Choice POS Silver 3000
MAINE

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.

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

In-Network coverage applies when Covered Benefits are provided or arranged by your Primary Care Provider (PCP) in the Service Area, or provided by a Plan Provider outside of the Service Area.

Out-of-Network coverage applies when Covered Benefits are provided by a Non-Plan Provider or a provided by a Plan Provider without a Referral when a Referral is required. If a Non-Plan Provider charges any amount in excess of the Allowed Amount, you are responsible for the excess amount.

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

Prior Approval

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

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

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

Medical Necessity Guidelines

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

Office Visit Cost Sharing Levels

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

Level 1 applies to covered outpatient professional services received from the following types of providers: all Primary Care Providers (PCPs); obstetricians and gynecologists; licensed mental health professionals; certified Nurse midwives; and Nurse practitioners who bill independently.

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

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

Access to Lower-Priced Services

If you receive specific Covered Benefits from certain Non-Plan Providers located in Maine, New Hampshire, and Massachusetts, you may be able to receive credit for your payment for services provided by such Non-Plan Providers toward your Deductible and Out-of-Pocket Maximum. The specific Covered Benefits include services within the following categories:

- Physical and occupational therapy services
- Radiology and imaging services
- Laboratory services and x-rays
- Infusion therapy services

Go to HPHConnect for more information on this program.

Covered Benefits

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

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

General Cost Sharing Features:	In-Network Member Cost Sharing:	Out-of-Network Member Cost Sharing
Coinsurance and Copayments		
	See the benefits table below	
Deductible		
	$3,000 per Member per Calendar Year $6,000 per family per Calendar Year	$6,000 per Member per Calendar Year $12,000 per family per Calendar Year
Important Notice: If a family Deductible applies, it can be met in one of two ways: a. If a Member of a covered family meets an individual Deductible, then that Member has no additional Deductible Member Cost Sharing responsibilities for Covered Benefits for the remainder of the Calendar Year. b. If any number of Members in a covered family collectively meets a family Deductible, then all Members in that covered family have no additional Deductible Member Cost Sharing responsibilities for Covered Benefits for the remainder of the Calendar Year.		
Deductible Rollover		
None		

General Cost Sharing Features:	In-Network Member Cost Sharing:	Out-of-Network Member Cost Sharing
Out-of-Pocket Maximum		
Includes all Member Cost Sharing Any charges above the Allowed Amount and any penalty for failure to receive Prior Approval when using Non-Plan Providers do not apply to the Out-of-Pocket Maximum	$9,100 per Member per Calendar Year $18,200 per family per Calendar Year	$18,200 per Member per Calendar Year $36,400 per family per Calendar Year
Out-of-Network Penalty Payment		
Applies when the Member fails to obtain required Prior Approval for services from a Non-Plan Provider. Does not count toward the Deductible or Out-of-Pocket Maximum.	$500	

Benefit	In-Network Plan Providers with a proper Referral Member Cost Sharing	Out-of-Network Non-Plan Providers and Plan Providers without a Referral Member Cost Sharing
Acupuncture Treatment for Injury or Illness		
	$40 Copayment per visit	Deductible, then 50% Coinsurance
Ambulance and Medical Transport		
Emergency ambulance transport	Deductible, then 40% Coinsurance	Same as In-Network
Non-emergency air ambulance transport	Deductible, then 40% Coinsurance	Same as In-Network
Non-emergency medical transport	Deductible, then 40% Coinsurance	Deductible, then 50% Coinsurance
Autism Spectrum Disorders Treatment		
Applied behavior analysis	No Member Cost Sharing applies for your first office visit per Calendar Year with a licensed mental health professional. After the first visit, the following cost sharing applies: $40 Copayment per visit	Deductible, then 50% Coinsurance
Copayments for outpatient mental health services, including mental health services in the home, will accumulate toward the Deductible.		
Chemotherapy and Radiation Therapy		
Chemotherapy	Deductible, then 40% Coinsurance	Deductible, then 50% Coinsurance
Radiation therapy	Deductible, then 40% Coinsurance	Deductible, then 50% Coinsurance
Chiropractic Care		
	$40 Copayment per visit	Deductible, then 50% Coinsurance

Benefit	In-Network Plan Providers with a proper Referral Member Cost Sharing	Out-of-Network Non-Plan Providers and Plan Providers without a Referral Member Cost Sharing
Clinical Trials		
	Your Member Cost Sharing will depend upon the types of services provided, 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 inpatient Hospital care, see "Hospital – Inpatient Services."	
Dental Services		
Important Notice: Coverage of Dental Services is very limited. Please see your Benefit Handbook for the details of your coverage.		
Emergency Dental Care (within six months of injury or within six months of the effective date of coverage, whichever is later) Other dental services, including setting a jaw fracture and removing a tumor (but not a root cyst) General anesthesia for dentistry	Your Member Cost Sharing will depend upon the types of services provided, 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 inpatient Hospital care, see "Hospital – Inpatient Services."	
Extraction of teeth impacted in bone (performed in a Physician's office)	Deductible, then 40% Coinsurance	Deductible, then 50% Coinsurance
Dialysis		
Dialysis services, including dialysis training	Deductible, then 40% Coinsurance	Deductible, then 50% Coinsurance
Durable Medical Equipment		
Durable medical equipment, including orthotic devices as described in the Benefit Handbook	Deductible, then 40% Coinsurance	Deductible, then 50% Coinsurance
Blood glucose monitors, infusion devices, and insulin pumps (including supplies)	No charge	No charge
Oxygen and respiratory equipment	No charge	Deductible, then 50% Coinsurance
Early Intervention Services (for Members up to the age of 3)		
– Limited to 40 visits per Calendar Year	$40 Copayment per visit	Deductible, then 50% Coinsurance
Emergency Admission		
	Deductible, then 40% Coinsurance	Same as In-Network
Emergency Room Care		
	Deductible, then 40% Coinsurance	Same as In-Network
Fertility Treatment (see the Benefit Handbook for details)		
	Deductible, then 20% Coinsurance	Deductible, then 50% Coinsurance

Benefit	In-Network Plan Providers with a proper Referral Member Cost Sharing	Out-of-Network Non-Plan Providers and Plan Providers without a Referral Member Cost Sharing
Hearing Aids		
For Members up to age 19: – Limited to 1 hearing aid per hearing impaired ear every 36 months For all other Members: – Limited to $3,000 per hearing aid every 36 months, for each hearing impaired ear	Deductible, then 50% Coinsurance	Deductible, then 50% Coinsurance
Home Health Care		
Including infusion therapy and nutritional counseling	Deductible, then 40% Coinsurance	Deductible, then 50% Coinsurance
If services include the administration of drugs, please see the benefit for "Medical Drugs" for Member Cost Sharing details.		
Hospice Services		
	Deductible, then 40% Coinsurance	Deductible, then 50% Coinsurance
If inpatient services or respite care are required, please see "Hospital – Inpatient Services" for Member Cost Sharing details.		
Hospital – Inpatient Services		
Acute Hospital care, including bariatric surgery, blood transfusions, infusion therapy, inhalation therapy, organ or tissue transplants and breast reduction surgery and symptomatic varicose vein surgery	Deductible, then 40% Coinsurance	Deductible, then 50% Coinsurance
Inpatient maternity care	Deductible, then 40% Coinsurance	Deductible, then 50% Coinsurance
Inpatient routine nursery care	No charge	Deductible, then 50% Coinsurance
Inpatient rehabilitation – limited to 150 days per Calendar Year Inpatient rehabilitation and skilled nursing facility care limits are combined	Deductible, then 40% Coinsurance	Deductible, then 50% Coinsurance
Skilled nursing facility – limited to 150 days per Calendar Year Inpatient rehabilitation and skilled nursing facility care limits are combined	Deductible, then 40% Coinsurance	Deductible, then 50% Coinsurance

Benefit	In-Network Plan Providers with a proper Referral Member Cost Sharing	Out-of-Network Non-Plan Providers and Plan Providers without a Referral Member Cost Sharing
Laboratory, Radiology and Other Diagnostic Services (including Independent Laboratories and Freestanding Imaging Centers)		
Laboratory, including but not limited to human leukocyte antigen testing as described in the Benefit Handbook	**In a Physician's office or non-Hospital affiliated facility:** $15 Copayment per visit **In a Hospital or Hospital affiliated facility:** Deductible, then 40% Coinsurance	Deductible, then 50% Coinsurance
Genetic testing	Deductible, then 40% Coinsurance	Deductible, then 50% Coinsurance
Radiology	Deductible, then 40% Coinsurance	Deductible, then 50% Coinsurance
Breast ultrasound screening	No charge	Deductible, then 50% Coinsurance
Advanced radiology, including CT scans, PET scans, MRI, MRA and nuclear medicine services	**In a Physician's office or non-Hospital affiliated facility:** $250 Copayment per visit **In a Hospital or Hospital affiliated facility:** Deductible, then 40% Coinsurance	Deductible, then 50% Coinsurance
Breast MRI screening	No charge	Deductible, then 50% Coinsurance
Other diagnostic services (including allergy testing)	Deductible, then 40% Coinsurance	Deductible, then 50% Coinsurance
Low Protein Foods		
	Deductible, then 40% Coinsurance	Deductible, then 50% Coinsurance
Maternity Care – Outpatient		
Routine outpatient prenatal and postpartum care	No charge	Deductible, then 50% Coinsurance
Routine prenatal and postpartum care is usually received and billed from the same Provider as a single or bundled service. Different Member Cost Sharing may apply to any specialized or non-routine service that is billed separately from your routine outpatient prenatal and postpartum care. For example, Member Cost Sharing for services provided by a specialist is listed under "Physician and Other Professional Office Visits" and Member Cost Sharing for an ultrasound billed as a specialized or non-routine service is listed under "Laboratory, Radiology and Other Diagnostic Services (including Independent Laboratories and Freestanding Imaging Centers)."		
Medical Drugs (drugs that cannot be self-administered)		
Medical drugs, including infusion therapy, received in a Physician's office or other outpatient facility	Deductible, then 40% Coinsurance	Deductible, then 50% Coinsurance
Medical drugs, including infusion therapy, received in the home	Deductible, then 40% Coinsurance	Deductible, then 50% Coinsurance

Benefit	In-Network Plan Providers with a proper Referral Member Cost Sharing	Out-of-Network Non-Plan Providers and Plan Providers without a Referral Member Cost Sharing
Medical Drugs (drugs that cannot be self-administered) (Continued)		
Some Medical Drugs may be supplied by a specialty pharmacy. When Medical Drugs are supplied by a specialty pharmacy, the Member Cost Sharing listed above will apply.		
Medical Formulas and Donor Breast Milk		
State mandated formulas and donor breast milk	Deductible, then 40% Coinsurance	Deductible, then 50% Coinsurance
Mental Health and Substance Use Disorder Treatment		
Inpatient Services	Deductible, then 40% Coinsurance	Deductible, then 50% Coinsurance
Partial hospitalization services	Deductible, then 40% Coinsurance	Deductible, then 50% Coinsurance
Outpatient group therapy	No Member Cost Sharing applies for your first office visit per Calendar Year with a licensed mental health professional. After the first visit, the following cost sharing applies: $10 Copayment per visit	Deductible, then 50% Coinsurance
Mental health services in the home	No Member Cost Sharing applies for your first office visit per Calendar Year with a licensed mental health professional. After the first visit, the following cost sharing applies: $40 Copayment per visit	Deductible, then 50% Coinsurance
Outpatient treatment, including individual therapy, detoxification, and medication management	No Member Cost Sharing applies for your first office visit per Calendar Year with a licensed mental health professional. After the first visit, the following cost sharing applies: $40 Copayment per visit	Deductible, then 50% Coinsurance
Outpatient methadone maintenance	No charge	Deductible, then 50% Coinsurance
Outpatient psychological testing and neuropsychological assessment	No Member Cost Sharing applies for your first office visit per Calendar Year with a licensed mental health professional. After the first visit, the following cost sharing applies: $40 Copayment per visit	Deductible, then 50% Coinsurance

Benefit	In-Network Plan Providers with a proper Referral Member Cost Sharing	Out-of-Network Non-Plan Providers and Plan Providers without a Referral Member Cost Sharing
Mental Health and Substance Use Disorder Treatment (Continued)		
Outpatient telemedicine virtual visit – group therapy	No Member Cost Sharing applies for your first office visit per Calendar Year with a licensed mental health professional. After the first visit, the following cost sharing applies: $10 Copayment per visit	Deductible, then 50% Coinsurance
Outpatient telemedicine virtual visit - including individual therapy, detoxification, and medication management	No Member Cost Sharing applies for your first office visit per Calendar Year with a licensed mental health professional. After the first visit, the following cost sharing applies: $40 Copayment per visit	Deductible, then 50% Coinsurance
Copayments for outpatient mental health services, including mental health services in the home, will accumulate toward the Deductible.		
Observation Services		
	Deductible, then 40% Coinsurance	Same as In-Network
Ostomy Supplies		
	Deductible, then 40% Coinsurance	Deductible, then 50% Coinsurance
Physician and Other Professional Office Visits (This includes all covered Providers unless otherwise listed in this Schedule of Benefits.)		
Routine examinations, including annual gynecological exams, for preventive care, including immunizations and annual digital rectal exams	No charge	Deductible, then 50% Coinsurance
Not all In-Network services you receive during your routine exam are covered at no charge. Only preventive services designated under the Patient Protection and Affordable Care Act (PPACA) are covered at no charge. Other services not included under PPACA may be subject to additional cost sharing. For the current list of preventive services covered at no charge under PPACA, please see the Preventive Services Notice on our website at **www.harvardpilgrim.org**. Please see "Laboratory, Radiology and Other Diagnostic Services (including Independent Laboratories and Freestanding Imaging Centers)" for the Member Cost Sharing that applies to diagnostic services not included on this list.		

Benefit	In-Network Plan Providers with a proper Referral Member Cost Sharing	Out-of-Network Non-Plan Providers and Plan Providers without a Referral Member Cost Sharing
Physician and Other Professional Office Visits (This includes all covered Providers unless otherwise listed in this Schedule of Benefits.) (Continued)		
Consultations, evaluations, Sickness and injury care, including nutritional counseling	**PCP:** No Member Cost Sharing for the first visit per Calendar Year with a PCP. After the first visit, the following cost sharing applies: Level 1: $40 Copayment per visit **All Other Providers:** Level 1: $40 Copayment per visit Level 2: $80 Copayment per visit	Deductible, then 50% Coinsurance
Copayments for office visits with a PCP will accumulate toward the Deductible.		
Additional Member Cost Sharing may apply. Please refer to the specific benefit in this Schedule of Benefits. For example, if you need sutures, please refer to office based treatments and procedures below. If you need an x-ray or have blood drawn, please refer to "Laboratory, Radiology and Other Diagnostic Services (including Independent Laboratories and Freestanding Imaging Centers)."		
Office based treatments and procedures, including but not limited to administration of injections, casting, suturing, the application of dressings, inhalation therapy, non-routine foot care, and surgical procedures	Deductible, then 40% Coinsurance	Deductible, then 50% Coinsurance
Administration of allergy injections	$40 Copayment per visit	Deductible, then 50% Coinsurance
Preventive Services and Tests		
	No charge	Deductible, then 50% Coinsurance
Under Federal and state law, many preventive services and tests are covered with no Member Cost Sharing, including preventive colonoscopies (even if polyp removal or other necessary medically necessary procedure is required), screening mammograms (including a second screening in the event that the initial screening is inconclusive or an abnormality is discovered), pap tests, certain labs and x-rays, voluntary sterilization for women and all FDA approved contraceptive devices. For a complete list of covered preventive services, please see the Preventive Services Notice on our website at **www.harvardpilgrim.org**. You may also get a copy of the Preventive Services Notice by calling the Member Services Department at **1–888–333–4742**. Harvard Pilgrim will add or delete services from this benefit for preventive services and tests in accordance with Federal and state guidance.		
The following additional preventive services, tests and devices: alpha-fetoprotein (AFP), fetal ultrasound, hepatitis C testing, lead level testing, prostate-specific antigen (PSA) screening, routine hemoglobin tests, group B streptococcus (GBS), routine urinalysis, blood pressure monitor, retinopathy screening, and	No charge	Deductible, then 50% Coinsurance

Benefit	In-Network Plan Providers with a proper Referral Member Cost Sharing	Out-of-Network Non-Plan Providers and Plan Providers without a Referral Member Cost Sharing
Preventive Services and Tests (Continued)		
international normalized ratio (INR) testing.		
Prosthetic Devices		
Prosthetic devices (other than arms and legs)	Deductible, then 40% Coinsurance	Deductible, then 50% Coinsurance
Prosthetic arms and legs	Deductible, then 20% Coinsurance	Deductible, then 50% Coinsurance
Rehabilitation and Habilitation Services – Outpatient		
Cardiac rehabilitation – limited to 36 visits per cardiac episode	$80 Copayment per visit	Deductible, then 50% Coinsurance
Pulmonary rehabilitation therapy	$80 Copayment per visit	Deductible, then 50% Coinsurance
Occupational therapy **Rehabilitation Services (including treatment for head injuries)** – limited to 60 visits per Calendar Year **Habilitation Services (including treatment for head injuries)** – limited to 60 visits per Calendar Year Occupational, physical, and speech therapy limits are combined	$40 Copayment per visit	Deductible, then 50% Coinsurance
Physical therapy **Rehabilitation Services (including treatment for head injuries)** – limited to 60 visits per Calendar Year **Habilitation Services (including treatment for head injuries)** – limited to 60 visits per Calendar Year Occupational, physical, and speech therapy limits are combined	$40 Copayment per visit	Deductible, then 50% Coinsurance
Speech therapy **Rehabilitation Services (including treatment for head injuries)** – limited to 60 visits per Calendar Year **Habilitation Services (including treatment for head injuries)** – limited to 60 visits per Calendar Year Occupational, physical, and speech therapy limits are combined	$40 Copayment per visit	Deductible, then 50% Coinsurance
Outpatient physical, occupational and speech therapies are covered to the extent Medically Necessary for: (1) children up to the age of three and (2) the treatment of Autism Spectrum Disorders. Outpatient physical therapy for postpartum related pelvic floor disorders is not subject to visit limits.		

Benefit	In-Network Plan Providers with a proper Referral Member Cost Sharing	Out-of-Network Non-Plan Providers and Plan Providers without a Referral Member Cost Sharing
Scopic Procedures - Outpatient Diagnostic and Therapeutic		
Colonoscopy, endoscopy and sigmoidoscopy	**In a non-Hospital affiliated facility:** $300 Copayment per visit **In a Hospital or Hospital affiliated facility:** Deductible, then 40% Coinsurance	Deductible, then 50% Coinsurance
Surgery – Outpatient		
	In a non-Hospital affiliated facility: $300 Copayment per visit **In a Hospital or Hospital affiliated facility:** Deductible, then 40% Coinsurance	Deductible, then 50% Coinsurance
Telemedicine Virtual Visit Services – Outpatient		
	PCP: No Member Cost Sharing for the first visit per Calendar Year with a PCP. After the first visit, the following cost sharing applies: Level 1: $40 Copayment per visit **All Other Providers:** Level 1: $40 Copayment per visit Level 2: $80 Copayment per visit	Deductible, then 50% Coinsurance
For inpatient Hospital care, see "Hospital – Inpatient Services" for cost sharing details.		
Copayments for office visits with a PCP will accumulate toward the Deductible.		
Urgent Care Services		
Doctor on Demand	No charge	
Important Note: Doctor On Demand is a specific network of providers contracted to provide virtual Urgent Care services. For more information on Doctor On Demand, including how to access them, please visit our website at **www.harvardpilgrim.org**.		
Convenience care clinic (retail health clinic)	$40 Copayment per visit	Deductible, then 50% Coinsurance
Urgent care center	$40 Copayment per visit	Deductible, then 50% Coinsurance
Hospital urgent care center	$40 Copayment per visit	Deductible, then 50% Coinsurance
Additional Member Cost Sharing may apply. Please refer to the specific benefit in this Schedule of Benefits. For example, if you have an x-ray or have blood drawn, please refer to "Laboratory, Radiology and Other Diagnostic Services (including Independent Laboratories and Freestanding Imaging Centers)."		

Benefit	In-Network Plan Providers with a proper Referral Member Cost Sharing	Out-of-Network Non-Plan Providers and Plan Providers without a Referral Member Cost Sharing
Vision Services		
Urgent eye care	**PCP:** No Member Cost Sharing for the first visit per Calendar Year with a PCP. After the first visit, the following cost sharing applies: Level 1: $40 Copayment per visit **All Other Providers:** Level 1: $40 Copayment per visit Level 2: $80 Copayment per visit	Deductible, then 50% Coinsurance
Copayments for office visits with a PCP will accumulate toward the Deductible.		
Routine adult eye examinations – limited to 1 exam per Calendar Year	$40 Copayment per visit	Deductible, then 50% Coinsurance
Routine pediatric eye examinations – limited to 1 exam per Calendar Year	$40 Copayment per visit	Deductible, then 50% Coinsurance
Vision hardware for special conditions	Deductible, then 40% Coinsurance	Deductible, then 50% Coinsurance
Your Plan also includes coverage for pediatric vision hardware. Please see the additional Pediatric Vision section later in this Schedule of Benefits for more information.		
Voluntary Sterilization – in a Physician's Office		
	Deductible, then 40% Coinsurance	Deductible, then 50% Coinsurance
Voluntary Termination of Pregnancy – Outpatient		
	No charge	Deductible, then 50% Coinsurance

Pediatric VisionCare

Dependents up to the age of 19 are eligible for coverage of prescription eyeglasses or contact lenses. Coverage under this benefit terminates at the end of the month in which the Dependent turns 19. Each Dependent is eligible for coverage every 24 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.

OUT-OF-POCKET MAXIMUM

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

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 **1–888–333–4742** if you are covered under an Employer Group plan or **1–877-907-4742** if you are covered under an individual Member plan 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 **1-888-333-4742** if you are covered under an Employer Group plan or **1–877-907-4742** if you are covered under an individual Member plan. This telephone number is also listed on your ID card. If you are deaf or hearing impaired, call **711** for TTY service. A representative will be happy to assist you.

EXCLUSIONS

- Expenses incurred prior to your effective date
- Colored contact lenses, special effect contact lenses
- Deluxe or designer frames
- Eyeglass or contact lens supplies

- Lost or broken lenses or frames, unless the Member has reached his/her normal interval for service
- Non-prescription or plano lenses
- Plain or prescription sunglasses, no-line bifocals, blended lenses or oversize lenses
- Safety glasses and accompanying frames
- Spectacle lens styles, materials, treatments or add ons
- Sunglasses and accompanying frames
- Two pairs of glasses in lieu of bifocals
- Vision hardware (with the exception of contact lenses) purchased from an internet provider

Language Assistance Services

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

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

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

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

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

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

العربية (Arabic)
إنتباه: إذا أنت تتكلم اللُّغة العربية ، خدمات المساعدة اللُّغوية متوفرة لك مجانا. ً إتصل على **1 888-333-4742**
(TTY: 711)

ខ្មែរ (Cambodian) ប្រសិនជាអ្នកនិយាយភាសាខ្មែរ, 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, ໂດຍບໍ່ສັ້ງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-888-333-4742 (TTY: 711).

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

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

(Continued)

General Notice About Nondiscrimination and Accessibility Requirements

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

HPHC:

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

If you need these services, contact our Civil Rights Compliance Officer.

If you believe that HPHC has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex (including pregnancy, sexual orientation, and gender identity), you can file a grievance with: Civil Rights Compliance Officer, 1 Wellness Way, Canton, MA 02021-1166, (866) 750-2074, TTY service: 711, Fax: (617) 509-3085, Email: civil_rights@point32health.org. You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, the Civil Rights Compliance Officer is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

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

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

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

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General List of Exclusions
Harvard Pilgrim Health Care, Inc. | MAINE

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

Exclusion
Alternative Treatments
• Acupuncture services that are outside the scope of standard acupuncture care. • Alternative or holistic services and all procedures, laboratories and nutritional supplements associated with such treatments. • Aromatherapy, treatment with crystals and alternative medicine. • Any of the following types of programs: Health resorts, spas, recreational programs, camps, wilderness programs (therapeutic outdoor programs), outdoor skills programs, life skills programs, therapeutic or educational boarding schools, and relaxation or lifestyle programs. • Massage therapy when performed by anyone other than a licensed physical therapist, physical therapy assistant, occupational therapist, or certified occupational therapy assistant. • Myotherapy. • Services by a Naturopath that are not covered by other Providers under the Plan.
Clinical Trials
Coverage is not provided for the following: • The investigational item, device, or service itself; or • For services, tests or items that are provided solely to satisfy data collection and analysis for the clinical trial and that are not used for the direct clinical management of your condition.
Dental Services
• Dental Care, except the specific dental services listed in this Benefit Handbook, your Schedule of Benefits, and any associated Riders. • Office visits, consultations, and all related services for Temporomandibular Joint Dysfunction (TMD). • Pediatric dental care, except when specifically listed as a Covered Benefit in this Schedule of benefit or any associated Riders.
Durable Medical Equipment and Prosthetic Devices
• Any devices or special equipment needed for sports or occupational purposes with the exception of prosthetics arms and legs for Members under the age of 18. • Any home adaptations, including, but not limited to home improvements and home adaptation equipment. • Non-durable medical equipment, unless used as part of the treatment at a medical facility or as part of approved home health care services. • Repair or replacement of durable medical equipment or prosthetic devices as a result of loss, negligence, willful damage, or theft.
Experimental, Unproven or Investigational Services
• Any products or services, including, but not limited to, drugs, devices, treatments, procedures, and diagnostic tests that are Experimental, Unproven, or Investigational.
Foot Care
• Foot orthotics, except for the treatment of systemic circulatory diseases or severe diabetic foot disease. • Routine foot care. Examples include nail trimming, cutting or debriding and the cutting or removal of corns and calluses. This exclusion does not apply to preventive foot care for Members with diabetes or systemic circulatory diseases.
Maternity Services
Planned home births.

Exclusion
Mental Health Care
• Educational services or testing except services covered under the benefit for Early Intervention Services. No benefits are provided: (1) for educational services intended to enhance educational achievement or (2) to resolve problems of school performance. • Sensory integrative praxis tests. • Services for any condition with only a "Z Code" designation in the Diagnostic and Statistical Manual of Mental Disorders, which means that the condition is not attributable to a mental disorder. • Mental health 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. • Services or supplies for the diagnosis or treatment of mental health and substance use disorders that, in the reasonable judgment of the Behavioral Health Access Center, are any of the following: not consistent with prevailing national standards of clinical practice for the treatment of such conditions; not consistent with prevailing professional research demonstrating that the services or supplies will have a measurable and beneficial health outcome; typically do not result in outcomes demonstrably better than other available treatment alternatives that are less intensive or more cost effective.
Physical Appearance
• Cosmetic Services, including drugs, devices, treatments and procedures, except for (1) Cosmetic Services that are incidental to the correction of Physical Functional Impairment, (2) reconstructive surgery to repair or restore appearance damaged by an Accidental Injury, (3) post-mastectomy care, and (4) gender affirming procedures and related services. • Electrolysis or laser hair removal, except for what is Medically Necesssary as part of gender affirming services. • Hair removal or restoration, including, but not limited to, transplantation or drug therapy. • Liposuction, except for what is Medically Necessary as part of gender affirming services, or removal of fat deposits considered undesirable. • Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures). • Skin abrasion procedures performed as a treatment for acne. • Treatments and procedures related to appearance including but not limited to, abdominoplasty; chemical peels; collagen injections; dermabrasion; implantations (e.g. cheek, calf, pectoral, gluteal); lip reduction/enhancement; panniculectomy; removal of redundant skin; and silicone injections (e.g. for breast enlargement), except for what is Medically Necessary as part of gender affirming services or another Covered Benefit. • Treatment for skin wrinkles and skin tags or any treatment to improve the appearance of the skin. • Treatment for spider veins. • Wigs.
Procedures and Treatments
• Care by a chiropractor outside the scope of standard chiropractic practice, including but not limited to, surgery, prescription or dispensing of drugs or medications, internal examinations, obstetrical practice, or treatment of infections and diagnostic testing for chiropractic care other than the initial x-ray • Commercial diet plans, weight loss programs and any services in connection with such plans or programs. Please note: Your employer may participate in other wellness and health improvement incentive programs offered by Harvard Pilgrim. Please review all your Plan documents for the amount of incentives, if any, available under your Plan. • 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). • If a service received in Massachusetts, Maine, Rhode Island or New Hampshire is listed as requiring that it be provided at a Center of Excellence, no In-Network coverage will be provided under this Handbook if that service is received in Massachusetts, Maine, Rhode Island or New Hampshire from a Provider that has not been designated as a Center of Excellence. • Physical examinations and testing for insurance, licensing or employment. • Services for Members who are donors for non-members, except as described under Human Organ Transplant Services. • Testing for central auditory processing. • Group diabetes educational programs or camps.
Providers
• Charges for services which were provided after the date on which your membership ends, except as required by Maine law. • Charges for any products or services, including, but not limited to, professional fees, medical equipment, drugs, and hospital or other facility charges, that are related to any care that is not a Covered Benefit. • Charges for missed appointments. • Concierge service fees. (See the Plan's Benefit Handbook for more information.) • Inpatient charges after your Hospital discharge. • Provider's charge to file a claim or to transcribe or copy your medical records. • Services or supplies provided by: (1) anyone related to you by blood, marriage or adoption, or (2) anyone who ordinarily lives with you.

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

Exclusion
Reproduction
• Birth control drugs, implants and devices. This exclusion may apply when coverage is provided by a religious organization, as allowed by law. Please see your Schedule of Benefits to determine if your Plan provides coverage for this benefit. • Services for a surrogate or gestational carrier who is not a Member of the Plan. • Reversal of voluntary sterilization (including any services for infertility related to voluntary sterilization or its reversal). • Sperm identification when not Medically Necessary (e.g., gender identification). • The following fees: wait list fees, non-medical costs, shipping and handling charges etc. • Voluntary sterilization, including tubal ligation and vasectomy, except when specifically listed as a Covered Benefit. • Voluntary termination of pregnancy, unless the life of the mother is in danger or unless it is specifically listed as a Covered Benefit.
Services Provided Under Another Plan
• Costs for any services for which you are entitled to treatment at government expense, including military service connected disabilities. • Costs for services by third party liability, other insurance coverage, and which are required to be covered by a Workers' Compensation plan or an Employer under state or federal law, unless a notice of controversy has been filed with the Workers' Compensation Board contesting the work-relatedness of the claimant's condition and no decision has been made by the Board.
Telemedicine
• Telemedicine services involving e-mail or fax. • Telemedicine services involving audio-only telephone, except where telemedicine is technologically unavailable at a scheduled time and is medically appropriate for the corresponding covered health services. • Provider fees for technical costs for the provision of telemedicine services.
Types of Care
• Rest or domiciliary care. • All institutional charges over the semi-private room rate, except when a private room is Medically Necessary. • Pain management programs or clinics. • Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, and diversion or general motivation. • Private duty nursing. • Sports medicine clinics. • Vocational rehabilitation, or vocational evaluations on job adaptability, job placement, or therapy to restore function for a specific occupation.
Vision and Hearing
• Eyeglasses, contact lenses and fittings, except as listed in the Plan's Benefit Handbook and any associated Riders. • Over the counter hearing aids. • Refractive eye surgery, including, but not limited to, lasik surgery, orthokeratology and lens implantation for the correction of naturally occurring myopia, hyperopia and astigmatism.
All Other Exclusions
• 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. • Any service or supply furnished in connection with a non-Covered Benefit. • Any service, supply or medication when there is a less intensive Covered Benefit or most cost-effective alternative that can be safely and effectively provided. • Any service, supply or medication that is required by a third party that is not otherwise Medically Necessary (examples of a third party are an employer, an insurance company, a school or court). • Any service or supply (with the exception of contact lenses) purchased from the internet. • Beauty or barber service. • Any drug or other product obtained at an outpatient pharmacy, except for pharmacy supplies covered under the benefit for diabetes services, unless your Plan includes outpatient pharmacy coverage. • Diabetes equipment replacements when solely due to manufacturer warranty expiration. • Externally powered exoskeleton assistive devices and orthoses. • Food or nutritional supplements, including, but not limited to, FDA-approved medical foods obtained by prescription, except as required by law and prescribed for Members who meet HPHC policies for enteral tube feedings. • Guest services. • Medical equipment, devices or supplies except as listed in this Benefit Handbook. • Medical services that are provided to Members who are confined or committed to jail, house of correction, prison, or custodial facility of the Department of Youth Services.. • Reimbursement for travel expenses. • Services for non-Members. • Services for which no charge would be made in the absence of insurance. • Services for which no coverage is provided in the Plan's Benefit Handbook, Schedule of Benefits, or Prescription Drug Brochure. • Services provided under an individualized education program (IEP), including any services provided under an IEP that are delivered by school personnel or any services

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

Exclusion
All Other Exclusions (Continued)
provided under an IEP purchased from a contractor or vendor. • Services that are not Medically Necessary. • Taxes or governmental assessments on services or supplies. • Transportation, except for emergency ambulance transport, and non-emergency medical transport needed to transfer between Hospitals or other covered health care facilities or from a covered facility to your home when Medically Necessary. • Voice modification surgery, except when Medically Necessary for gender affirming services. • 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.

ID: DN0000201072
DATE: 01/01/2024

Pediatric Dental Rider - POS

Harvard Pilgrim Health Care, Inc.

(for children up to the age of 19)
MAINE

The pediatric dental rider identifies the covered dental services as described below for dependents up to the age of 19 enrolled in the POS plan (the Plan). Coverage under this rider terminates at the end of the month in which the Dependent reaches the age of 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.

A *Directory of Network Dental Providers* is available online at **https://www.harvardpilgrim.org/public/pediatric-dental-coverage**. 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 also listed 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, including any Dental Provider outside the country. You generally are required to pay more for Out-of-Network Benefits than for In-Network Benefits. Out-of-Network Benefits are paid 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 Dental 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.

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 Deductibles are calculated on a Calendar 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.

General Cost Sharing Features	In-Network	Out-of-Network
Deductible		
	Please see your medical *Schedule of Benefits*	Please see your medical *Schedule of Benefits*
Out-of-Pocket Maximum		
	Please see your medical *Schedule of Benefits*	Please see your medical *Schedule of Benefits*

Benefit Description and Limitations	In-Network Plan Providers Member Cost Sharing	Out-of-Network Non-Plan Providers Member Cost Sharing
TYPE I SERVICES: *PREVENTIVE & DIAGNOSTIC BASIC COVERED SERVICES*		
Diagnostic Services		
Intraoral Bitewing Radiographs (Bitewing X-ray) – Limited to 1 set every 6 months	No charge	20% Coinsurance
Panorex Radiographs (Full Jaw X-ray) or Complete Series Radiographs (Full Set of X-rays) – Limited to 1 film every 60 months	No charge	20% Coinsurance
Periodic Oral Evaluation (Check up Exam) – Limited to 1 every 6 months	No charge	20% Coinsurance
Preventive Services		
Dental Prophylaxis (Cleanings) – Limited to 1 every 6 months	No charge	20% Coinsurance

Benefit Description and Limitations	In-Network Plan Providers Member Cost Sharing	Out-of-Network Non-Plan Providers Member Cost Sharing
Fluoride Treatments – Limited to 2 treatments per 12 months	No charge	20% Coinsurance
Sealants (Protective Coating) – Limited to 1 sealant per tooth every 36 months	No charge	20% Coinsurance
Space Maintainers	No charge	20% Coinsurance
TYPE II SERVICES: *MINOR RESTORATIVE COVERED SERVICES*		
Minor Restorative Services, Endodontics, Periodontics, and Oral Surgery		
Amalgam Restorations (Silver Fillings)	Deductible, then 20% Coinsurance	Deductible, then 40% Coinsurance
Composite Resin Restorations (Tooth Colored Fillings) – For anterior (front) teeth only.	Deductible, then 20% Coinsurance	Deductible, then 40% Coinsurance
Endodontics (Root Canal Therapy) performed on anterior or posterior primary teeth – Limited to once per tooth per lifetime	Deductible, then 20% Coinsurance	Deductible, then 40% Coinsurance
Relining and Rebasing Dentures – Limited to relining/rebasing performed more than 6 months after the initial insertion. Limited to once per 36 months	Deductible, then 20% Coinsurance	Deductible, then 40% Coinsurance
Repairs or Adjustments to Full Dentures, Partial Dentures, Bridges, or Crowns	Deductible, then 20% Coinsurance	Deductible, then 40% Coinsurance
Scaling and Root Planing (Deep Cleanings) – Limited to once per quadrant per 24 months	Deductible, then 20% Coinsurance	Deductible, then 40% Coinsurance
Periodontal Maintenance (Gum Maintenance) – Limited to 4 times per 12 month period following completion of active periodontal therapy	Deductible, then 20% Coinsurance	Deductible, then 40% Coinsurance
Simple Extractions (Simple tooth removal)	Deductible, then 20% Coinsurance	Deductible, then 40% Coinsurance
Oral Surgery, including Surgical Extraction	Deductible, then 20% Coinsurance	Deductible, then 40% Coinsurance
Adjunctive Services		
General Services (including Emergency Treatment of dental pain) General anesthesia is covered when clinically necessary.	Deductible, then 20% Coinsurance	Deductible, then 40% Coinsurance

Benefit Description and Limitations	In-Network Plan Providers Member Cost Sharing	Out-of-Network Non-Plan Providers Member Cost Sharing
TYPE III SERVICES: ***MAJOR RESTORATIVE SERVICES***		
Inlays/Onlays/Crowns (Partial to Full Crowns) – Limited to once per tooth per 60 months. Covered only when silver fillings cannot restore the tooth	Deductible, then 50% Coinsurance	Deductible, then 50% Coinsurance
Endodontics (root canal therapy) performed on anterior teeth, bicuspids, and molars – Limited to once per tooth per lifetime	Deductible, then 50% Coinsurance	Deductible, then 50% Coinsurance
Endodontic Surgery	Deductible, then 50% Coinsurance	Deductible, then 50% Coinsurance
Fixed Prosthetics (Bridges) – Limited to 1 per tooth per 60 months	Deductible, then 50% Coinsurance	Deductible, then 50% Coinsurance
Occlusal guards for Members age 13 and older – Limited to 1 guard per 12 months	Deductible, then 50% Coinsurance	Deductible, then 50% Coinsurance
Periodontal Surgery (Gum Surgery) – Limited to 1 quadrant or site per 36 months per surgical area	Deductible, then 50% Coinsurance	Deductible, then 50% Coinsurance
Removable Prosthetics (Full or partial dentures) – Limited to 1 per 60 months.	Deductible, then 50% Coinsurance	Deductible, then 50% Coinsurance
Relining and Rebasing Dentures – Limited to relining/rebasing performed more than 6 months after the initial insertion. Limited to once per 36 months	Deductible, then 50% Coinsurance	Deductible, then 50% Coinsurance

Benefit Description and Limitations	In-Network Plan Providers Member Cost Sharing	Out-of-Network Non-Plan Providers Member Cost Sharing
Implants		
Implant Placement – Limited to once per 60 months Implant Supported Prosthetics – Limited to once per 60 months Implant Maintenance Procedures – Limited to once per 60 months Repair Implant Supported Prosthesis by Report – Limited to once per 60 months Repair Implant Abutment by Support – Limited to once per 60 months Radiographic/Surgical Implant Index by Report – Limited to once per 60 months	Deductible, then 50% Coinsurance	Deductible, then 50% Coinsurance
TYPE IV SERVICES: *ORTHODONTIA*		
Orthodontic Services 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.		

Benefit Description and Limitations	In-Network Plan Providers Member Cost Sharing	Out-of-Network Non-Plan Providers Member Cost Sharing
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. **Note:** All orthodontic treatment must be prior authorized.	Deductible, then 50% Coinsurance	Deductible, then 50% Coinsurance

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 S*ection 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, 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.

9. Drugs/medications, obtainable with or without a prescription, unless they are dispensed and utilized in the dental office during the patient visit.
10. Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue.
11. 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.
12. 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.
13. 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.
14. Charges for failure to keep a scheduled appointment without giving the dental office 24 hours notice.
15. Expenses for Dental Procedures begun prior to the Dependent becoming enrolled for coverage provided through this rider to the Policy.
16. 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.
17. 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.
18. Fixed or removable prosthodontic restoration procedures for complete oral rehabilitation or reconstruction.
19. 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.
20. Procedures related to the reconstruction of a patient's correct vertical dimension of occlusion (VDO).
21. Occlusal guards used as safety items or to affect performance primarily in sports-related activities.
22. Placement of fixed partial dentures solely for the purpose of achieving periodontal stability.
23. 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:

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 listed below 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 (proof of loss) 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:

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 up to 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 up to the age of 19 must pay for Covered Dental Services in a 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 Deductible's that you must pay for Covered Benefits in a Calendar 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 up to age 19.
- Rendered in the most cost-efficient manner and type of setting appropriate for the delivery of the Dental Service.
- 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.

Language Assistance Services

Español (Spanish) ATENCIÓN: Si usted habla español, servicios de asistencia lingüística, de forma gratuita, están a su disposición. Llame al 1-877-907-4742 (TTY: 711).

Português (Portuguese) ATENÇÃO: Se você fala português, encontram-se disponíveis serviços linguísticos gratuitos. Ligue para 1-877-907-4742 (TTY: 711).

Kreyòl Ayisyen (French Creole) ATANSYON: Si nou palé Kreyòl Ayisyen, gen asistans pou sèvis ki disponib nan lang nou pou gratis. Rele 1-877-907-4742 (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 1-877-907-4742（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 1-877-907-4742 (TTY: 711).

Русский (Russian) ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-877-907-4742 (телетайп: 711).

العربية (Arabic)
إنتباه: إذا كنت تتكلم اللغة **العربية**، خدمات المساعدة اللغوية متوفرة لك مجانا. **إتصل على 1 877-907-4742**
(TTY: 711)

ខ្មែរ (Cambodian) ប្រសូមជូនដំណឹង៖ បើអ្នកនិយាយភាសាខ្មែរ, សេវាកម្មបកប្រែ ជូនលោកអ្នកដោយឥតគិតថ្លៃ។ ចូរ ទូរស័ព្ទ 1-877-907-4742 (TTY: 711)។

Français (French) ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-877-907-4742 (ATS: 711).

Italiano (Italian) ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-877-907-4742 (TTY: 711).

한국어 (Korean) '알림': 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-877-907-4742 (TTY: 711) 번으로 전화해 주십시오.

Ελληνικά (Greek) ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, υπάρχουν στη διάθεσή σας δωρεάν υπηρεσίες γλωσσικής υποστήριξης. Καλέστε 1-877-907-4742 (TTY: 711).

Polski (Polish) UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-877-907-4742 (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. 1-877-907-4742 (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. 1-877-907-4742 (TTY: 711)

ພາສາລາວ (Lao) ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-877-907-4742 (TTY: 711).

ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call 1-877-907-4742 (TTY: 711).

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

(Continued)

General Notice About Nondiscrimination and Accessibility Requirements

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

HPHC:

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

If you need these services, contact our Civil Rights Compliance Officer.

If you believe that HPHC has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex (including pregnancy, sexual orientation, and gender identity), you can file a grievance with: Civil Rights Compliance Officer, 1 Wellness Way, Canton, MA 02021-1166, (866) 750-2074, TTY service: 711, Fax: (617) 509-3085, Email: civil_rights@point32health.org. You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, the Civil Rights Compliance Officer is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

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

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

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

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Harvard Pilgrim Health Care

Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services
Clear Choice POS Silver 3000

Coverage Period: 05/01/2024 — 04/30/2025
Coverage for: Individual + Family | Plan Type: POS

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, **www.harvardpilgrim.org/public/eoc?pdid=PD0000201398**. For general definitions of common terms, such as **allowed amount**, **balance billing**, **coinsurance**, **copayment**, **deductible**, **provider**, or other underlined terms, see the Glossary. You can view the Glossary at **www.healthcare.gov/sbc-glossary** or call **1-888-333-4742** to request a copy.

Important Questions	Answers	Why This Matters
What is the overall deductible?	Medical & **Prescription Drug Deductible**: In-Network: $3,000 member / $6,000 family Out-of-Network: $6,000 member / $12,000 family Benefits are administered on a calendar year basis.	Generally, you must pay all of the costs from **providers** up to the **deductible** amount before this plan begins to pay. If you have other family members on the **plan**, each family member must meet their own individual **deductible** until the total amount of **deductible** expenses paid by all family members meets the overall family **deductible**.
Are there services covered before you meet your deductible?	Yes. Tiers 1, 2, and 3 **prescription drugs**, and the following In-Network services: **preventive care**, **provider** office visits, **Rehabilitation services** and **Habilitation services**, Non-hospital affiliated facility day surgery, Non-hospital based laboratory and imaging are covered before you meet your **deductible**.	This **plan** covers some items and services even if you haven't yet met the **deductible** amount. But a **copayment** or **coinsurance** may apply. For example, this **plan** covers certain **preventive services** without **cost-sharing** and before you meet your **deductible**. See a list of covered preventive services at **https://www.healthcare.gov/coverage/preventive-care-benefits/**.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services.
What is the out–of–pocket limit for this plan?	In-Network: $9,100 member / $18,200 family Out-of-Network: $18,200 member / $36,400 family	The **out-of-pocket limit** is the most you could pay in a year for covered services. If you have other family members in this **plan**, they have to meet their own **out-of-pocket limits** until the overall family **out-of-pocket limit** has been met.

Important Questions	Answers	Why This Matters
What is not included in the out–of–pocket limit?	Premiums, balance-billing charges, penalties for failure to obtain preauthorization for services, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. See **https://www.harvardpilgrim.org/public/find-a-provider** or call **1-888-333-4742** for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services."
Do you need a referral to see a specialist?	Yes.	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Level 1: $40 copay/ visit; deductible does not apply	50% coinsurance	$0 copay for first visit
	Specialist visit	Level 1: $40 copay/ visit; deductible does not apply Level 2: $80 copay/ visit; deductible does not apply	50% coinsurance	None
	Preventive care/ screening/ immunization	No charge; deductible does not apply	50% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have a test	Diagnostic test (x-ray, blood work)	X-rays: 40% coinsurance Laboratory: Non-Hospital Based: $15 copay/ visit; deductible does not apply Hospital Based: 40% coinsurance	X-rays: 50% coinsurance Laboratory: 50% coinsurance	None
	Imaging (CT/PET scans, MRIs)	Non-Hospital Based: $250 copay/ visit; deductible does not apply Hospital Based: 40% coinsurance	50% coinsurance	Out-of-Network preauthorization required. $500 penalty if not obtained
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at **www.harvardpilgrim.org/ 2024Value5T**.	Generic drugs	30-Day Retail Tier 1: $15 copay/ prescription; deductible does not apply 90-Day Mail Tier 1: $30 copay/ prescription; deductible does not apply 30-Day Retail Tier 2: $25 copay/ prescription; deductible does not apply 90-Day Mail Tier 2: $50 copay/ prescription; deductible does not apply	Not covered	Value formulary - covers a limited list; not all drugs are covered. You pay retail price for Out of Network pharmacy drugs and are reimbursed minus applicable cost sharing. Covered only outside of service area.
	Preferred brand drugs	30-Day Retail Tier 3: $50 copay/ prescription; deductible does not apply 90-Day Mail Tier 3: $100 copay/ prescription; deductible does not apply	Not covered	
	Non-preferred brand drugs	30-Day Retail Tier 4: 30% coinsurance up to $300 90-Day Mail Tier 4: 30% coinsurance up to $600	Not covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Specialty drugs	30-Day Retail Tier 4: 30% coinsurance up to $300 90-Day Mail Tier 4: 30% coinsurance up to $600 30-Day Retail Tier 5: 50% coinsurance up to $600 90-Day Mail Tier 5: 50% coinsurance up to $1,200	Not covered	Some drugs must be obtained through a Specialty Pharmacy.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Non-hospital affiliated facility: $300 copay/ visit; deductible does not apply Hospital affiliated facility: 40% coinsurance	50% coinsurance	Out-of-Network preauthorization required. $500 penalty if not obtained
	Physician/surgeon fees	Non-hospital affiliated facility: No charge; deductible does not apply Hospital affiliated facility: 40% coinsurance	50% coinsurance	
If you need immediate medical attention	Emergency room care	40% coinsurance		None
	Emergency medical transportation	40% coinsurance		None
	Urgent care	Urgent care center: $40 copay/ visit; deductible does not apply	Urgent care center: 50% coinsurance	Cost sharing may vary based on Urgent Care location.
If you have a hospital stay	Facility fee (e.g., hospital room)	40% coinsurance	50% coinsurance	Out-of-Network preauthorization required. $500 penalty if not obtained
	Physician/surgeon fee	40% coinsurance	50% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$40 copay/ visit; deductible does not apply	50% coinsurance	$0 copay for first mental health/substance abuse visit
	Inpatient services	40% coinsurance	50% coinsurance	Out-of-Network preauthorization required. $500 penalty if not obtained

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you are pregnant	Office visits	$40 copay/ visit; deductible does not apply	50% coinsurance	Cost sharing does not apply for preventive services.
	Childbirth/delivery professional services	40% coinsurance	50% coinsurance	
	Childbirth/delivery facility services	40% coinsurance	50% coinsurance	
If you need help recovering or have other special health needs	Home health care	40% coinsurance	50% coinsurance	Out-of-Network preauthorization required. $500 penalty if not obtained
	Rehabilitation services Habilitation services	Physical Therapy: $40 copay/ visit; deductible does not apply Occupational Therapy: $40 copay/ visit; deductible does not apply Speech Therapy: $40 copay/ visit; deductible does not apply	Physical Therapy: 50% coinsurance Occupational Therapy: 50% coinsurance Speech Therapy: 50% coinsurance	Physical, Occupational & Speech Therapy - 60 combined visits/ calendar year Out-of-Network preauthorization required. $500 penalty if not obtained
	Skilled nursing care	40% coinsurance	50% coinsurance	- 150 days/ calendar year combined with Inpatient Rehabilitation services
	Durable medical equipment	40% coinsurance	50% coinsurance	Out-of-Network preauthorization required. $500 penalty if not obtained
	Hospice services	40% coinsurance	50% coinsurance	For inpatient see "If you have a hospital stay"
If your child needs dental or eye care	Children's eye exam	$40 copay/ visit; deductible does not apply	50% coinsurance	1 exam/calendar year
	Children's glasses	Reimbursed first $50, then 50% of covered charges; deductible does not apply		Frames & lenses OR contacts every 24 months up to end of month child turns 19
	Children's dental check-up	No charge; deductible does not apply	20% coinsurance; deductible does not apply	- 1 exam/ 6 months up to end of month child turns 19

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)		
• Cosmetic Surgery • Dental Care (Adult)	• Long-Term Care • Private-duty nursing • Routine foot care (except for diabetes or systemic circulatory diseases)	• Services that are not Medically Necessary • Weight Loss Programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)		
• Abortion • Acupuncture • Bariatric surgery • Chiropractic Care	• Hearing Aids - 1 hearing aid/ impaired ear every 36 months up to age 19 • Hearing Aids - $3,000/ impaired ear every 36 months for all other members • Infertility Treatment	• Non-emergency care when traveling outside the U.S. • Routine eye care (Adult) - 1 exam/ calendar year

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Maine Bureau of Insurance, Department of Professional and Financial Regulation, 34 State House Station, Augusta, ME 04333-0334, **(800) 300-5000**, or contact Harvard Pilgrim at the number on the back of your ID card. Other coverage options may be available to you too, including buying individual insurance coverage through the **CoverME.gov**. For more information, about the **CoverME.gov**, visit **www.CoverME.gov** or call **1-866-636-0355**.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your **plan** for a denial of a **claim**. This complaint is called a **grievance** or **appeal**. For more information about your rights, look at the explanation of benefits you will receive for that medical **claim**. Your **plan** documents also provide complete information on how to submit a **claim**, **appeal**, or a **grievance** for any reason to your **plan**. For more information about your rights, this notice, or assistance, contact:

HPHC Member Appeals-Member Services Department
Harvard Pilgrim Health Care, Inc.
1 Wellness Way
Canton, MA 02021-1166
Telephone: 1-888-333-4742
Fax: 1-617-509-3085

Department of Labor's Employee Benefits Security Administration
1-866-444-3272
www.dol.gov/ebsa/healthreform

Consumer for Affordable Health Care
12 Church Street, PO Box 2409
Augusta, Maine 04338-2490
1-800-965-7476
www.mainecahc.org
consumerhealth@mainecahc.org

Maine Bureau of Insurance
34 State House
Station Augusta, ME 04333
1-207-624-8475
1-800-300-5000

Does this plan provide Minimum Essential Coverage? Yes

Minimum Essential Coverage generally includes **plans**, **health insurance** available through the **Marketplace** or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of **Minimum Essential Coverage**, you may not be eligible for the **premium tax credit**.

Does this plan meet the Minimum Value Standard? Yes

If your **plan** doesn't meet the **Minimum Value Standards**, you may be eligible for a **premium tax credit** to help you pay for a **plan** through the **Marketplace**.

Language Access Services:

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

SM SM SM SM SM SM SM SM SM, SM SM SM SM SM SM SM **1–888–333–4742**.

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

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

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

Peg is Having a Baby (9 months of in-network pre-natal care and a hospital delivery)		Managing Joe's Type 2 Diabetes (a year of routine in-network care of a well-controlled condition)		Mia's Simple Fracture (in-network emergency room visit and follow up care)	
■ **The plan's overall deductible**	$3,000	■ **The plan's overall deductible**	$3,000	■ **The plan's overall deductible**	$3,000
■ **Specialist copayment**	$80	■ **Specialist copayment**	$80	■ **Specialist copayment**	$80
■ **Hospital (facility) coinsurance**	40%	■ **Hospital (facility) coinsurance**	40%	■ **Hospital (facility) coinsurance**	40%
■ **Other copayment**	$15	■ **Other copayment**	$15	■ **Other coinsurance**	40%
This EXAMPLE event includes services like:		**This EXAMPLE event includes services like:**		**This EXAMPLE event includes services like:**	
Specialist office visits (*prenatal care*)		Primary care physician office visits (*including disease education*)		Emergency room care (*including medical supplies*)	
Childbirth/Delivery Professional Services		Diagnostic tests (*blood work*)		Diagnostic test (*x-ray*)	
Childbirth/Delivery Facility Services		Prescription drugs		Durable medical equipment (*crutches*)	
Diagnostic tests (*ultrasounds and blood work*)		Durable medical equipment (*glucose meter*)		Rehabilitation services (*physical therapy*)	
Specialist visit (*anesthesia*)					
Total Example Cost	**$12,700**	**Total Example Cost**	**$5,600**	**Total Example Cost**	**$2,800**
In this example, Peg would pay:		**In this example, Joe would pay:**		**In this example, Mia would pay:**	
Cost Sharing		*Cost Sharing*		*Cost Sharing*	
Deductibles	$3,000	Deductibles	$0	Deductibles	$2,200
Copayments	$300	Copayments	$1,700	Copayments	$300
Coinsurance	$3,400	Coinsurance	$0	Coinsurance	$0
What isn't covered		*What isn't covered*		*What isn't covered*	
Limits or exclusions	$0	Limits or exclusions	$0	Limits or exclusions	$0
The total Peg would pay is	**$6,700**	**The total Joe would pay is**	**$1,700**	**The total Mia would pay is**	**$2,500**

The plan would be responsible for the other costs of these EXAMPLE covered services.

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(TTY: 711)

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(Continued)

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If you need these services, contact our Civil Rights Compliance Officer.

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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)

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

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Prescription Drug Coverage

VALUE 5 TIER

Covered prescription medications are available at participating pharmacies.

Covered prescription drugs are subject to your plan's Deductible (for Access America and PPO plans, covered prescriptions are subject to the In-Network Deductible). This means that you need to pay the full cost of your medications until you reach the required Deductible amount. 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. See the *Schedule of Benefits* for your plan's Deductible amount. Once you meet the Deductible for the year, you pay either a Copayment or Coinsurance.

	Retail	Mail (up to a 90-day supply)
Tier 1	**Up to a 30-day supply:** $15 Copayment per prescription or prescription refill **Up to a 90-day supply:** $45 Copayment per prescription or prescription refill	$30 Copayment per prescription or prescription refill
Tier 2	**Up to a 30-day supply:** $25 Copayment per prescription or prescription refill **Up to a 90-day supply:** $75 Copayment per prescription or prescription refill	$50 Copayment per prescription or prescription refill
Tier 3	**Up to a 30-day supply:** $50 Copayment per prescription or prescription refill **Up to a 90-day supply:** $150 Copayment per prescription or prescription refill	$100 Copayment per prescription or prescription refill
Tier 4	**Up to a 30-day supply:** Deductible, then 30% Coinsurance* up to a maximum Coinsurance of $300 per prescription or refill **Up to a 90-day supply:** Deductible, then 30% Coinsurance* up to a maximum Coinsurance of $900 per prescription or refill	Deductible, then 30% Coinsurance* up to a maximum Coinsurance of $600 per prescription or refill

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	Retail	Mail (up to a 90-day supply)
Tier 5	**Up to a 30-day supply:** Deductible, then 50% Coinsurance* up to a maximum Coinsurance of $600 per prescription or refill **Up to a 90-day supply:** Deductible, then 50% Coinsurance* up to a maximum Coinsurance of $1,800 per prescription or refill	Deductible, then 50% Coinsurance* up to a maximum Coinsurance of $1,200 per prescription or refill

*Once the Deductible is met, 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.

You may purchase up to a 90–day supply of maintenance medications from certain Maine retail pharmacies. When you obtain a 90–day prescription from one of these Maine retail pharmacies, you will pay the Mail Service Prescription Drug Program Member Cost Sharing. Although most maintenance medications are available for a 90–day supply, we may limit drugs for clinical reasons or to prevent potential waste. In addition, specialty drugs, discussed above, are not available for a 90–day supply.

Your plan has an annual out-of-pocket maximum, which is listed on the Schedule of Benefits. Once you have reached the out-of-pocket maximum (including Deductible, Copayment and Coinsurance amounts), your prescriptions are covered in full for the rest of the year with no other cost sharing required.

Visit **www.harvardpilgrim.org/2024Value5T** for participating pharmacy locations and mail order details. Be sure to show your Harvard Pilgrim ID card at the pharmacy to ensure you pay the correct cost-sharing amounts.

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