

# Schedule of Benefits

## HPHC Insurance Company, Inc.

### BEST BUY PPO - LP

### NEW HAMPSHIRE

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

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

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 you use a Plan Provider for Covered Benefits.

**Out-of-Network** coverage applies when you use a Non-Plan Provider for Covered Benefits. If a Non-Plan Provider charges any amount in excess of the Allowed Amount, you are responsible for the excess amount.

In a Medical Emergency you should go to the nearest emergency facility or call 911 or other local emergency number. Your emergency room Member Cost Sharing is listed in the tables below.

### **Prior Approval**

Prior Approval is required for certain benefits. Before you receive services from a Non-Plan Provider or a Plan Provider outside the Service Area, please refer our website, [www.harvardpilgrim.org](http://www.harvardpilgrim.org) or contact the Member Services Department at **1-888-333-4742** for the complete listing of services that require Prior Approval. To obtain Prior Approval please call:

- **1-800-708-4414** for medical services
- **1-844-387-1435** for Medical Drugs
- **1-888-777-4742** for mental health and substance use disorder treatment

More information about Prior Approval can be found on our website, [www.harvardpilgrim.org](http://www.harvardpilgrim.org) and in your Benefit Handbook.

### **Clinical Review Criteria**

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

### **Select LP Providers**

HPHC has designated certain facilities as Select LP Providers. These providers were chosen based on their cost efficiency and render the same quality of service at a lower cost than other Plan Providers in the network. When you receive certain services from a Select LP Provider, your

Member out-of-pocket costs will be less than if you received the same services from providers that are not Select LP Providers. The tables set forth below identify the outpatient services which may be obtained from Select LP Providers and list the Member Cost Sharing for those services when provided by a Select LP Provider or other Plan Provider.

The Plan’s Provider Directory lists all Plan Providers including those providers that are Select LP Providers. You can access the Provider Directory at [www.harvardpilgrim.org](http://www.harvardpilgrim.org). You may also obtain a paper copy of the directory, free of charge by calling the Member Services Department at **1-888-333-4742**.

HPHC establishes its list of Select LP Providers in January of each year. HPHC will not remove providers from its Select LP Provider List during January through the following December of each year. HPHC may also add Select LP Providers to its list any time during the year.

**Copayment Levels**

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

Level 1 applies to covered outpatient professional services from the following types of providers: all Primary Care Providers (PCPs); obstetricians and gynecologists; Licensed Mental Health Professionals; certified midwives; and nurse practitioners.

Level 2 applies to most outpatient specialty care.

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

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

**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.”

General Cost Sharing Features:	In-Network Member Cost Sharing:	Out-of-Network Member Cost Sharing:
<b>Coinsurance and Copayments</b>		
	See the benefits table below	
<b>Deductible</b>		
	\$3,000 per Member per Calendar Year \$6,000 per family per Calendar Year	\$4,000 per Member per Calendar Year \$12,000 per family per Calendar Year
Any eligible medical expenses you incur toward the In-Network Deductible in a Calendar Year applies to <b>both</b> the In-Network and the Out-of-Network Deductibles. Likewise, any eligible medical expenses you incur toward the Out-of-Network Deductible in a Calendar Year applies to <b>both</b> the In-Network and the Out-of-Network Deductibles.		

<b>General Cost Sharing Features:</b>	<b>In-Network Member Cost Sharing:</b>	<b>Out-of-Network Member Cost Sharing:</b>
<b>Deductible Rollover</b>		
None		
<b>Durable Medical Equipment and Prosthetic Devices Deductible</b>		
		\$100 per Member per Calendar Year
<b>Out-of-Pocket Maximum</b>		
Includes all In-Network and Out-of-Network Member Cost Sharing except: – Any charges above the Allowed Amount and any penalty for failure to receive Prior Approval when using Non-Plan Providers	\$6,500 per Member per Calendar Year \$13,000 per family per Calendar Year	
<b>Out-of-Network Penalty Payment for failure to obtain Prior Approval</b>		
Certain Out-of-Network services require Prior Approval as described earlier in this Schedule of Benefits. If you do not obtain Prior Approval for these services, you are responsible for 50% of the benefit that would have otherwise been payable or \$500 which ever is less. This Penalty charge is in addition to any Member Cost Sharing amounts and does not count toward the Deductible or Out-of-Pocket Maximum. Please refer to your Benefit Handbook for more information on the Prior Approval Program.		

<b>Benefit</b>	<b>In-Network Plan Providers Member Cost Sharing</b>	<b>Out-of-Network Non-Plan Providers Member Cost Sharing</b>
<b>Acupuncture Treatment for Injury or Illness</b>		
– Limited to 20 visits per Calendar Year	Level 1: \$25 Copayment per visit	Deductible, then 20% Coinsurance
<b>Ambulance Transport</b>		
Emergency ambulance transport	Deductible, then no charge	Same as In-Network
Non-emergency ambulance transport	Deductible, then no charge	Deductible, then 20% Coinsurance
<b>Autism Spectrum Disorders Treatment</b>		
Applied behavior analysis	Level 1: \$25 Copayment per visit	Deductible, then 20% Coinsurance
<b>Chemotherapy and Radiation Therapy</b>		
Chemotherapy	No charge	Deductible, then 20% Coinsurance
Radiation therapy	No charge	Deductible, then 20% Coinsurance
<b>Chiropractic Care</b>		
– Limited to 12 visits per Calendar Year	Level 1: \$25 Copayment per visit	Deductible, then 20% Coinsurance
<b>Dental Services</b>		
<b>Important Notice:</b> Coverage of Dental Care is very limited. Please see your Benefit Handbook for the details of your coverage.		
Extraction of teeth impacted in bone (performed in a physician's office)	Not covered	Not covered

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<b>Benefit</b>	<b>In-Network Plan Providers Member Cost Sharing</b>	<b>Out-of-Network Non-Plan Providers Member Cost Sharing</b>
<b>Dental Services (Continued)</b>		
Preventive dental care for children	Not covered	Not covered
Outpatient surgery expenses for dental care	Your Member Cost Sharing will depend upon the types of services provided, as listed in this Schedule of Benefits. For example, for services provided by a physician, see "Physician and Other Professional Office Visits." For day surgery, see "Surgery – Outpatient."	
<b>Dialysis</b>		
	Deductible, then no charge	Deductible, then 20% Coinsurance
<b>Durable Medical Equipment</b>		
Durable medical equipment	Durable Medical Equipment and Prosthetic Devices Deductible, then 20% Coinsurance	Deductible, then 20% Coinsurance
Blood glucose monitors, infusion devices and insulin pumps (including supplies)	No charge	No charge
Oxygen and respiratory equipment	No charge	Deductible, then 20% Coinsurance
<b>Early Intervention</b>		
– Limited to \$3,200 per Member per Calendar Year, up to \$9,600 per lifetime	Level 1: \$25 Copayment per visit	Deductible, then 20% Coinsurance
<b>Emergency Admission</b>		
	Deductible, then no charge	Same as In-Network
<b>Emergency Room Care</b>		
	Deductible, then \$250 Copayment per visit	Same as In-Network
This Copayment is waived if admitted to the hospital directly from the emergency room.		
<b>Hearing Aids</b>		
– Limited to \$1,500 per hearing aid every 60 months, for each hearing impaired ear	No charge	Deductible, then 20% Coinsurance
<b>Home Health Care</b>		
	No charge	Deductible, then 20% Coinsurance
If services include the administration of drugs, please see the benefit for "Medical Drugs" for Member Cost Sharing details.		
<b>Hospice – Outpatient</b>		
	No charge	Deductible, then 20% Coinsurance
<b>Hospital – Inpatient Services</b>		
Acute hospital care	Deductible, then no charge	Deductible, then 20% Coinsurance
Inpatient maternity care	Deductible, then no charge	Deductible, then 20% Coinsurance

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<b>Benefit</b>	<b>In-Network Plan Providers Member Cost Sharing</b>	<b>Out-of-Network Non-Plan Providers Member Cost Sharing</b>
<b>Hospital – Inpatient Services (Continued)</b>		
Inpatient routine nursery care	No charge	Deductible, then 20% Coinsurance
Inpatient rehabilitation – limited to 100 days per Calendar Year Day limits combined with skilled nursing facility care	Deductible, then no charge	Deductible, then 20% Coinsurance
Skilled nursing facility – limited to 100 days per Calendar Year Day limits combined with inpatient rehabilitation care	Deductible, then no charge	Deductible, then 20% Coinsurance
<b>Infertility Services and Treatments</b>		
Diagnostic services for infertility including: consultation, evaluation and laboratory tests	Your Member Cost Sharing will depend upon the types of services provided, as listed in this Schedule of Benefits. For example, for services provided by a physician, see “Physician and Other Professional Office Visits.” For inpatient hospital care, see “Hospital – Inpatient Services.”	
Infertility treatment (see the Benefit Handbook for details)	Deductible, then no charge	Deductible, then 20% Coinsurance
<b>Laboratory, Radiology and Other Diagnostic Services</b>		
Laboratory	<b>Select LP Providers</b> No charge <b>Other Plan Providers</b> No charge	Deductible, then 20% Coinsurance
Genetic Testing	No charge	Deductible, then 20% Coinsurance
Radiology	No charge	Deductible, then 20% Coinsurance
Advanced radiology, including CT scans, PET scans, MRI, MRA and nuclear medicine services	Deductible, then no charge	Deductible, then 20% Coinsurance
Other diagnostic services	No charge	Deductible, then 20% Coinsurance
<b>Low Protein Foods</b>		
– Limited to \$1,800 per Member per Calendar Year	No charge	Deductible, then 20% Coinsurance
<b>Maternity Care – Outpatient</b>		
Routine outpatient prenatal and postpartum care	No charge	Deductible, then 20% Coinsurance
Routine prenatal and postpartum care is usually received and billed from the same Provider as a single or bundled service. Different Member Cost Sharing may apply to any specialized or non-routine service that is billed separately from your routine outpatient prenatal and postpartum care. For example, Member Cost Sharing for services provided by a specialist is listed under “Physician and Other Professional Office Visits” and Member Cost Sharing for an ultrasound billed as a specialized or non-routine service is listed under “Laboratory, Radiology and Other Diagnostic Services.”		
<b>Medical Drugs (drugs that cannot be self-administered)</b>		
Medical drugs received in a physician’s office or other outpatient facility	Deductible, then no charge	Deductible, then 20% Coinsurance

<b>Benefit</b>	<b>In-Network Plan Providers Member Cost Sharing</b>	<b>Out-of-Network Non-Plan Providers Member Cost Sharing</b>
<b>Medical Drugs (drugs that cannot be self-administered) (Continued)</b>		
Medical drugs received in the home	Deductible, then no charge	Deductible, then 20% Coinsurance
Some Medical Drugs may be supplied by a specialty pharmacy. When Medical Drugs are supplied by a speciality pharmacy, the Member Cost Sharing listed above will apply.		
<b>Medical Formulas</b>		
	No charge	Deductible, then 20% Coinsurance
<b>Mental Health and Substance Use Disorder Treatments</b>		
Inpatient services	Deductible, then no charge	Deductible, then 20% Coinsurance
Partial hospitalization services	No charge	20% Coinsurance
Outpatient group therapy	\$10 Copayment per visit	20% Coinsurance
Outpatient treatment including individual therapy, detoxification, and medication management	Level 1: \$25 Copayment per visit	20% Coinsurance
Outpatient methadone maintenance	\$25 Copayment per week	20% Coinsurance
Outpatient psychological testing	Level 1: \$25 Copayment per visit	Deductible, then 20% Coinsurance
eVisits	No charge	20% Coinsurance
<b>Observation Services</b>		
	Deductible, then no charge	Same as In-Network
<b>Ostomy Supplies</b>		
	Durable Medical Equipment and Prosthetic Devices Deductible, then 20% Coinsurance	Deductible, then 20% Coinsurance
<b>Physician and Other Professional Office Visits (This includes all covered Providers unless otherwise listed in this Schedule of Benefits)</b>		
Routine examinations for preventive care, including immunizations	No charge	Deductible, then 20% Coinsurance
Not all In-Network services you receive during your routine exam are covered at no charge. Only preventive services designated under the Patient Protection and Affordable Care Act (PPACA) are covered at no charge. Other services not included under PPACA may be subject to additional cost sharing. For the current list of preventive services covered at no charge under PPACA, please see the Preventive Services notice on our website at <a href="http://www.harvardpilgrim.org">www.harvardpilgrim.org</a> . Please see "Laboratory, Radiology and Other Diagnostic Services" for the Member Cost Sharing that applies to diagnostic services not included on this list.		
Consultations, evaluations, sickness and injury care	Level 1: \$25 Copayment per visit Level 2: \$50 Copayment per visit	Deductible, then 20% Coinsurance
Additional Member Cost Sharing may apply. Please refer to the specific benefit in this Schedule of Benefits. For example, if you 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."		

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Benefit	In-Network Plan Providers Member Cost Sharing	Out-of-Network Non-Plan Providers Member Cost Sharing
<b>Physician and Other Professional Office Visits (This includes all covered Providers unless otherwise listed in this Schedule of Benefits) (Continued)</b>		
Office based treatments and procedures including but not limited to: casting, suturing and the application of dressings, non-routine foot care, and surgical procedures	Deductible, then no charge	Deductible, then 20% Coinsurance
Administration of allergy injections	\$5 Copayment per visit	Deductible, then 20% Coinsurance
eVisits	No charge	Deductible, then 20% Coinsurance
<b>Preventive Services and Tests</b>		
	No charge	Deductible, then 20% Coinsurance
Under federal law, many preventive services and tests are covered with no Member Cost Sharing, including preventive colonoscopies, certain labs and x-rays, voluntary sterilization for women and all FDA approved contraceptive devices. For a complete list of covered preventive services, please see the Preventive Services Notice on our website at <a href="http://www.harvardpilgrim.org">www.harvardpilgrim.org</a> . You may also get a copy of the Preventive Services Notice by calling the Member Services Department at <b>1-888-333-4742</b> . Harvard Pilgrim will add or delete services from this benefit for preventive services and tests in accordance with Federal guidance.		
<b>Prosthetic Devices</b>		
	Durable Medical Equipment and Prosthetic Devices Deductible, then 20% Coinsurance	Deductible, then 20% Coinsurance
<b>Rehabilitation and Habilitation Services – Outpatient</b>		
Cardiac rehabilitation Pulmonary rehabilitation therapy	Level 1: \$25 Copayment per visit Level 2: \$50 Copayment per visit	Deductible, then 20% Coinsurance
Occupational, physical and speech therapy – limited to 60 visits combined per Calendar Year	Level 2: \$50 Copayment per visit	Deductible, then 20% Coinsurance
<b>Please Note:</b> Outpatient physical, occupational and speech therapies are covered without limits to the extent Medically Necessary for children under the age of three.		
<b>Scopic Procedures - Outpatient Diagnostic and Therapeutic</b>		
Colonoscopy, endoscopy and sigmoidoscopy	<b>Select LP Providers</b> \$100 Copayment per visit <b>Other Plan Providers</b> Deductible, then no charge	Deductible, then 20% Coinsurance
<b>Surgery – Outpatient</b>		
	<b>Select LP Providers</b> \$100 Copayment per visit <b>Other Plan Providers</b> Deductible, then no charge	Deductible, then 20% Coinsurance

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<b>Benefit</b>	<b>In-Network Plan Providers Member Cost Sharing</b>	<b>Out-of-Network Non-Plan Providers Member Cost Sharing</b>
<b>Telemedicine Virtual Visit Services – Outpatient</b>		
	Level 1: \$25 Copayment per visit Level 2: \$50 Copayment per visit	Deductible, then 20% Coinsurance
For inpatient hospital care, see “Hospital – Inpatient Services” for cost sharing details.		
<b>Urgent Care Services</b>		
Convenience care clinic	Level 1: \$25 Copayment per visit	Deductible, then 20% Coinsurance
Urgent care center	\$50 Copayment per visit	Deductible, then 20% Coinsurance
Hospital urgent care center	Deductible, then \$50 Copayment per visit	Same as In-Network
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.”		
<b>Vision Services</b>		
Routine eye examinations – limited to 1 exam per Calendar Year	Level 1: \$25 Copayment per visit	Deductible, then 20% Coinsurance
Vision hardware for special conditions	No charge	Deductible, then 20% Coinsurance
<b>Voluntary Sterilization – in a Physician’s Office</b>		
	Deductible, then no charge	Deductible, then 20% Coinsurance
<b>Voluntary Termination of Pregnancy</b>		
	Your Member Cost Sharing will depend upon where the service is provided, as listed in this Schedule of Benefits. For example, for a service provided in an outpatient surgical center, see “Surgery– Outpatient.” For services provided by a physician, see “Office based treatments and procedures.” For inpatient hospital care, see “Hospital – Inpatient Services.”	
<b>Wigs and Scalp Hair Protheses as required by law</b>		
See the Benefit Handbook for details	Durable Medical Equipment and Prosthetic Devices Deductible, then 20% Coinsurance	Deductible, then 20% Coinsurance



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

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

**العربية (Arabic)**

انتباه: إذا أنت تتكلم اللغة العربية، خدمات المساعدة اللغوية متوفرة لك مجاناً. إتصل على 1 888-333-4742 (TTY: 711)

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

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

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

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

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

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

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

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

**ພາສາລາວ (Lao)** ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ຈະມີມີ້ພ້ອມໃຫ້ທ່ານ. ໂທສ 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 Connecticut, Harvard Pilgrim Health Care of New England and HPHC Insurance Company.

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

HPHC:

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

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

If you believe that HPHC has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with: Civil Rights Compliance Officer, 93 Worcester St, Wellesley, MA 02481, (866) 750-2074, TTY service: 711, Fax: (617) 509-3085, Email: [civil\\_rights@harvardpilgrim.org](mailto:civil_rights@harvardpilgrim.org). You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, the Civil Rights Compliance Officer is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

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

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



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.

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## General List of Exclusions

### HPHC Insurance Company, Inc. | NEW HAMPSHIRE

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
<p><b>Alternative Treatments</b></p> <ul style="list-style-type: none"> <li>• Acupuncture care except when specifically listed as a Covered Benefit.</li> <li>• Acupuncture services that are outside the scope of standard acupuncture care.</li> <li>• Alternative or holistic services and all procedures, laboratories and nutritional supplements associated with such treatments.</li> <li>• Aromatherapy, treatment with crystals and alternative medicine.</li> <li>• Any of the following types of programs: Health resorts, spas, recreational programs, camps, outdoor skills programs, therapeutic or educational boarding schools, relaxation or lifestyle programs and wilderness programs (therapeutic outdoor programs).</li> <li>• Massage therapy when performed by anyone other than a licensed physical therapist, physical therapy assistant, occupational therapist, or certified occupational therapy assistant.</li> <li>• Myotherapy.</li> <li>• Services by a Naturopath that are not covered by other Providers under the Plan.</li> </ul>
<p><b>Dental Services</b></p> <ul style="list-style-type: none"> <li>• Dental Care, except when specifically listed as a Covered Benefit.</li> <li>• All services of a dentist for Temporomandibular Joint Dysfunction (TMD).</li> <li>• Extraction of teeth, except when specifically listed as a Covered Benefit.</li> <li>• Pediatric dental care, except when specifically listed as a Covered Benefit.</li> </ul>
<p><b>Durable Medical Equipment and Prosthetic Devices</b></p> <ul style="list-style-type: none"> <li>• Any devices or special equipment needed for sports or occupational purposes.</li> <li>• Any home adaptations, including, but not limited to home improvements and home adaptation equipment.</li> <li>• Non-durable medical equipment, unless used as part of the treatment at a medical facility or as part of approved home health care services.</li> <li>• Repair or replacement of durable medical equipment or prosthetic devices as a result of loss, negligence, willful damage, or theft.</li> </ul>
<p><b>Experimental, Unproven or Investigational Services</b></p> <ul style="list-style-type: none"> <li>• Any products or services, including, but not limited to, drugs, devices, treatments, procedures, and diagnostic tests that are Experimental, Unproven, or Investigational.</li> </ul>
<p><b>Foot Care</b></p> <ul style="list-style-type: none"> <li>• Foot orthotics, except for the treatment of severe diabetic foot disease.</li> <li>• 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.</li> </ul>
<p><b>Mental Health Care</b></p> <ul style="list-style-type: none"> <li>• Biofeedback.</li> <li>• 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; (2) to resolve problems of school performance; or (3) to treat learning disabilities.</li> <li>• Methadone maintenance, except when specifically listed as a Covered Benefit.</li> <li>• Sensory integrative praxis tests.</li> <li>• Services for any condition with only a "V Code" designation in the Diagnostic and Statistical Manual of Mental Disorders, which means that the condition is not attributable to a mental disorder.</li> <li>• Mental health care that is (1) provided to Members who are confined or committed to a jail, house of correction, or prison, or (2) provided by the Department of Youth Services or the Department of Mental Health.</li> <li>• 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;</li> </ul>

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## Exclusion

### Physical Appearance

- Cosmetic Services, including drugs, devices, treatments and procedures, except for (1) Cosmetic Services that are incidental to the correction of Physical Functional Impairment, (2) restorative surgery to repair or restore appearance damaged by an accidental injury, and (3) post-mastectomy care.
- Hair removal or restoration, including, but not limited to, electrolysis, laser treatment, transplantation or drug therapy.
- Liposuction or removal of fat deposits considered undesirable.
- Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures).
- Skin abrasion procedures performed as a treatment for acne.
- Treatment for skin wrinkles and skin tags or any treatment to improve the appearance of the skin.
- Treatment for spider veins.
- Wigs, except as required by law.

### Procedures and Treatments

- Chiropractic care, except when specifically listed as a Covered Benefit.
- 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.
- Commercial diet plans, weight loss programs and any services in connection with such plans or programs. **Please note:** Your employer may participate in other wellness and health improvement incentive programs offered by Harvard Pilgrim. Please review all your Plan documents for the amount of incentives, if any, available under your Plan.
- If a service is listed as requiring that it be provided at a Center of Excellence, no In-Network coverage will be provided if that service is received from a Provider that has not been designated as a Center of Excellence.
- Nutritional or cosmetic therapy using vitamins, minerals or elements, and other nutrition-based therapy. Examples include cosmeceuticals, electrolytes, and foods of any kind (including high protein foods and low carbohydrate foods).
- Physical examinations and testing for insurance, licensing or employment.
- Services for Members who are donors for non-members, except as described under Human Organ Transplant Services.
- Testing for central auditory processing.
- Group diabetes training, educational programs or camps.

### Providers

- Charges for services which were provided after the date on which your membership ends.
- Charges for any products or services, including, but not limited to, professional fees, medical equipment, drugs, and hospital or other facility charges, that are related to any care that is not a Covered Benefit.
- Charges for missed appointments.
- Concierge service fees. (See the 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.

### Reproduction

- Any form of Surrogacy or services for a gestational carrier.
- Infertility drugs if a Member is not in a Plan authorized cycle of infertility treatment.
- Infertility drugs, if infertility services are not a Covered Benefit.
- Infertility drugs that must be purchased at an outpatient pharmacy, unless your Plan includes outpatient pharmacy coverage.
- Infertility treatment for Members who are not medically infertile.
- Infertility treatment except when specifically listed as a Covered Benefit.
- Reversal of voluntary sterilization (including any services for infertility related to voluntary sterilization or its reversal).
- Sperm collection, freezing and storage except as described in Section III. Covered Benefits, "Infertility Services and Treatments."
- 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 either: 1) the life of the mother is in danger, or 2) voluntary termination of pregnancy is specifically listed as a Covered Benefit.

### Services Provided Under Another Plan

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

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<b>Exclusion</b>
<b>Telemedicine</b>
<ul style="list-style-type: none"> <li>• Telemedicine services involving fax, texting, or audio-only telephone.</li> <li>• Provider fees for technical costs for the provision of telemedicine services.</li> </ul>
<b>Transgender Health Services</b>
<ul style="list-style-type: none"> <li>• Abdominoplasty.</li> <li>• Chemical peels.</li> <li>• Collagen injections.</li> <li>• Dermabrasion.</li> <li>• Electrolysis or laser hair removal (for all indications, except when required pre-operatively for genital surgery).</li> <li>• Hair transplantation.</li> <li>• Implantations (e.g. cheek, calf, pectoral, gluteal).</li> <li>• Lip reduction/enhancement.</li> <li>• Liposuction.</li> <li>• Panniculectomy.</li> <li>• Reimbursement for travel expenses.</li> <li>• Removal of redundant skin.</li> <li>• Reversal of transgender health services and all related drugs and procedures.</li> <li>• Silicone injections (e.g. for breast enlargement).</li> <li>• Transgender health services and all related drugs and procedures for self-insured groups, unless covered under a separate rider.</li> <li>• Voice modification therapy/surgery.</li> </ul>
<b>Types of Care</b>
<ul style="list-style-type: none"> <li>• Custodial Care.</li> <li>• Rest or domiciliary care.</li> <li>• All institutional charges over the semi-private room rate, except when a private room is Medically Necessary.</li> <li>• Pain management programs or clinics.</li> <li>• Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, and diversion or general motivation.</li> <li>• Private duty nursing.</li> <li>• Sports medicine clinics.</li> <li>• Vocational rehabilitation, or vocational evaluations on job adaptability, job placement, or therapy to restore function for a specific occupation.</li> </ul>
<b>Vision and Hearing</b>
<ul style="list-style-type: none"> <li>• Eyeglasses, contact lenses and fittings, except when specifically listed as a Covered Benefit.</li> <li>• Hearing aid batteries, cords, and individual or group auditory training devices and any instrument or device used by a public utility in providing telephone or other communication services.</li> <li>• Refractive eye surgery, including, but not limited to, lasik surgery, orthokeratology and lens implantation for the correction of naturally occurring myopia, hyperopia and astigmatism.</li> <li>• Routine eye examinations, except when specifically listed as a Covered Benefit.</li> </ul>
<b>All Other Exclusions</b>
<ul style="list-style-type: none"> <li>• Any service or supply furnished in connection with a non-Covered Benefit.</li> <li>• Any service or supply (with the exception of contact lenses) purchased from the internet.</li> <li>• Beauty or barber service.</li> <li>• 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.</li> <li>• Diabetes equipment replacements when solely due to manufacturer warranty expiration.</li> <li>• Donated or banked breast milk.</li> <li>• 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.</li> <li>• Guest services.</li> <li>• Medical services that are provided to Members who are confined or committed to jail, house of correction, or prison, or (2) provided by the Department of Youth Services.</li> <li>• Services for non-Members.</li> <li>• Services for which no charge would be made in the absence of insurance.</li> <li>• Services for which no coverage is provided in the Plan's Benefit Handbook, Schedule of Benefits or Prescription Drug Brochure (if applicable).</li> <li>• Services that are not Medically Necessary.</li> <li>• Services your PCP or a Plan Provider has not provided, arranged or approved except as described in the Benefit Handbook.</li> <li>• Taxes or governmental assessments on services or supplies.</li> <li>• Transportation other than by ambulance.</li> <li>• Air conditioners, air purifiers and filters, dehumidifiers and humidifiers.</li> <li>• Car seats.</li> <li>• Chairs, bath chairs, feeding chairs, toddler chairs, chair lifts, recliners.</li> <li>• Electric scooters.</li> <li>• Exercise equipment.</li> <li>• Home modifications including but not limited to elevators, handrails and ramps.</li> <li>• Hot tubs, jacuzzis, saunas or whirlpools.</li> <li>• Mattresses.</li> <li>• Medical alert systems.</li> <li>• Motorized beds.</li> <li>• Pillows.</li> <li>• Power-operated vehicles.</li> <li>• Stair lifts and stair glides.</li> <li>• Strollers.</li> <li>• Safety equipment.</li> <li>• Vehicle modifications including but not limited to van lifts.</li> <li>• Telephone.</li> <li>• Television.</li> </ul>

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