Schedule of Benefits

HPHC Insurance Company, Inc.

THE BEST BUY HSA PPO 3500
CONNECTICUT

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 access number. Your emergency room Member Cost Sharing is listed in the tables below.

Prior Approval

Prior Approval is required for certain benefits. Before you receive services from a Non-Plan Provider or a Plan Provider outside the Service Area, please refer to our website, **www.harvardpilgrim.org** or contact the Member Services Department at **1-888-333-4742** 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** and in your Benefit Handbook.

Clinical Review Criteria

We use clinical review criteria to evaluate whether certain services or procedures are Medically Necessary for a Member's care. Members or their practitioners may obtain a copy of our clinical review criteria on our website at **www.harvardpilgrim.org** or by calling **1-888-888-4742 ext. 38723**.

Covered Benefits

Your Covered Benefits are administered on a Plan Year basis. Your Plan Year begins on your Employer's Anniversary Date. If you do not know your Employer's Anniversary Date, please contact your Employer's benefits office or call the Member Services Department at **1-888-333-4742**. Your Member Cost Sharing will depend upon the type of service provided and the location the service is provided in, as listed in this Schedule of Benefits. For example, for services provided in a physician's office, see "Physician and Other Professional Office Visits." For services provided in a hospital emergency room, see "Emergency Room Care," and for outpatient surgical procedures, please see "Surgery – Outpatient."

Covered Benefits – Your Covered Benefits are administered on a Plan Year basis. Your Plan Year begins on your Employer's Anniversary Date. If you do not know your Employer's Anniversary Date, please contact your Employer's benefits office or call the Member Services Department at **1-888-333-4742**. Your Member Cost Sharing will depend upon the type of service provided and the location the service is provided in, as listed in this Schedule of Benefits. For example, for services provided in a physician's office, see "Physician and Other Professional Office Visits." For services provided in a hospital emergency room, see "Emergency Room Care," and for outpatient surgical procedures, please see "Surgery – Outpatient."

General Cost Sharing Features:	In-Network Member Cost Sharing:	Out-of-Network Member Cost Sharing:
Coinsurance and Copayments		
	See the benefits table below	
Deductible		
The In-Network and Out-of-Network Deductibles are separate and cannot be combined.	$3,500 for Individual Coverage per Plan Year $7,000 for Family Coverage per Plan Year	$7,000 for Individual Coverage per Plan Year $14,000 for Family Coverage per Plan Year
Important Notice: If you have Family Coverage, the Deductible may be met by any combination of covered family Members. The individual Deductible does not apply. Once a Deductible is met, coverage by the Plan is subject to any other Member Cost Sharing that may apply.		
Out-of-Pocket Maximum		
Includes all Member Cost Sharing. The In-Network and Out-of-Network limits are separate and do not apply toward each other.	$4,500 for Individual Coverage per Plan Year $9,000 for Family Coverage per Plan Year – with a $4,500 separate individual Out-of-Pocket Maximum per Plan Year	$9,000 for Individual Coverage per Plan Year $18,000 for Family Coverage per Plan Year – with a $9,000 separate individual Out-of-Pocket Maximum per Plan Year The following charges are excluded from the Out-of-Pocket Maximum: – Any charges above the Allowed Amount – Any penalty for failure to receive Prior Approval when using Non-Plan Providers
Important Notice: If your Plan has a combined Family Out-of-Pocket Maximum with a separate individual Out-of-Pocket Maximum, the Out-of-Pocket Maximum can be satisfied in one of two ways a. If a Member of a covered family meets the individual separate Out-of-Pocket Maximum, then that Member has no additional Member Cost Sharing for the remainder of the Plan Year. b. If any number of Members in a covered family collectively meet the combined family Out-of-Pocket Maximum, then all Members of the covered family have no additional Member Cost Sharing for the remainder of the Plan Year. No one family member may contribute more than the individual separate Out-of-Pocket Maximum amount to the family Out-of-Pocket Maximum.		

General Cost Sharing Features:	In-Network Member Cost Sharing:	Out-of-Network Member Cost Sharing:
Out-of-Network Penalty Payment		
	None	The lesser of $500 or 50% of the benefit that would have otherwise been payable. This Penalty Payment is in addition to any Member Cost Sharing amounts and does not apply toward the Deductible or Out-of-Pocket Maximum.

Benefit	In-Network Plan Providers Member Cost Sharing	Out-of-Network Non-Plan Providers Member Cost Sharing
Acupuncture Treatment for Injury or Illness		
– Limited to 20 visits per Plan Year	Deductible, then 10% Coinsurance	Deductible, then 50% Coinsurance
Ambulance Transport		
Emergency ambulance transport	Deductible, then 10% Coinsurance	Same as In-Network
Non-emergency ambulance transport	Deductible, then 10% Coinsurance	Deductible, then 50% Coinsurance
Autism Spectrum Disorders Treatment		
Applied behavior analysis	Deductible, then 10% Coinsurance	Deductible, then 50% Coinsurance
Bariatric Surgery		
	Not covered	
Chemotherapy and Radiation Therapy		
	Deductible, then 10% Coinsurance	Deductible, then 50% Coinsurance
Please refer to the online Provider Directory at **www.harvardpilgrim.org** to determine if a facility is a non-hospital facility (ambulatory surgical center).		
Chiropractic Care		
– Limited to 20 visits per Plan Year	Deductible, then 10% Coinsurance	Deductible, then 50% Coinsurance
Dental Services		
Important Notice: Benefits for Dental Care under this medical Plan are very limited. Please see your Benefit Handbook for the details of your Dental Coverage.		
Extraction of teeth impacted in bone (performed in a physician's office)	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 dentist's office, see "Physician and Other Professional Office Visits."	

Benefit	In-Network Plan Providers Member Cost Sharing	Out-of-Network Non-Plan Providers Member Cost Sharing
Dialysis		
	Deductible, then 10% Coinsurance	Deductible, then 50% Coinsurance
Durable Medical Equipment		
Durable medical equipment	Deductible, then 10% Coinsurance	Deductible, then 50% Coinsurance
Blood glucose monitors, infusion devices, and insulin pumps (including supplies)	Deductible, then 10% Coinsurance	Deductible, then 50% Coinsurance
Oxygen and respiratory equipment	Deductible, then 10% Coinsurance	Deductible, then 50% Coinsurance
Hearing aids – limited to 1 hearing aid per hearing impaired ear every 24 months	Deductible, then 10% Coinsurance	Deductible, then 50% Coinsurance
Early Intervention Services (for Members up to the age of 3)		
	Deductible, then no charge	Deductible, then 50% Coinsurance
Emergency Admissions		
	Deductible, then 10% Coinsurance	Same as In-Network
Emergency Room Care		
	Deductible, then 10% Coinsurance	Same as In-Network
Home Health Care		
– Limited to 100 visits per Plan Year	Deductible, then 10% Coinsurance	Deductible, then 25% Coinsurance
Hospice - Outpatient		
	Deductible, then 10% Coinsurance	Deductible, then 50% Coinsurance
Hospital – Inpatient Services		
Acute hospital care	Deductible, then 10% Coinsurance	Deductible, then 50% Coinsurance
Bundled payment services for total hip and knee replacement All surgical and follow-up care within 90 days of surgery including: office visits, laboratory and radiology, hospital inpatient, inpatient rehabilitation, skilled nursing facility, home health care and rehabilitative/habilitative care.	Deductible, then 10% Coinsurance	Deductible, then 50% Coinsurance
Inpatient maternity care	Deductible, then 10% Coinsurance	Deductible, then 50% Coinsurance

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Benefit	In-Network Plan Providers Member Cost Sharing		Out-of-Network Non-Plan Providers Member Cost Sharing
Hospital – Inpatient Services (Continued)			
Inpatient routine nursery care	No charge		Deductible, then 50% Coinsurance
Inpatient rehabilitation care and Skilled Nursing Facility care combined – limited to 90 days per Plan Year	Deductible, then 10% Coinsurance		Deductible, then 50% Coinsurance
Human Organ Transplant Recipient – Transportation, Lodging, and Meal Expenses			
No coverage is provided under this Plan for transportation, lodging and meal expenses in connection with human organ transplants. **Please Note:** Your plan does provide coverage for Medically Necessary human organ transplants. Please see the benefit for Human Organ Transplant Services in your Benefit Handbook for details. However, transportation, lodging and meal expenses are not covered.	Not covered		Not covered
Infertility Services and Treatments (see the Benefit Handbook for details including cycle and age limits)			
	Your Member Cost Sharing will depend upon where the service is provided, as listed in this Schedule of Benefits. For example, for services provided by a physician, see "Physician and Other Professional Office Visits." For inpatient hospital care, see "Hospital – Inpatient Services."		
Laboratory, Radiology and Other Diagnostic Services			
Laboratory	**In a hospital or hospital affiliated facility:** Deductible, then 10% Coinsurance	**In a physician's office or non-hospital affiliated facility:** Deductible, then 10% Coinsurance	Deductible, then 50% Coinsurance
X-rays and radiology Please see your Benefit Handbook for information on applicable Member Cost Sharing for mammograms.	Deductible, then 10% Coinsurance		Deductible, then 50% Coinsurance
Genetic testing	Deductible, then 10% Coinsurance		Deductible, then 50% Coinsurance
Breast ultrasound screenings Please see your Benefit Handbook for information on applicable Member Cost Sharing for breast ultrasounds.	Deductible, then no charge		Deductible, then 50% Coinsurance

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Benefit	In-Network Plan Providers Member Cost Sharing		Out-of-Network Non-Plan Providers Member Cost Sharing
Laboratory, Radiology and Other Diagnostic Services (Continued)			
Advanced radiology including: CT scans, PET scans, MRA, MRI and nuclear medicine services. Please see your Benefit Handbook for information on applicable Member Cost Sharing for breast MRIs.	**In a hospital or hospital affiliated facility:** Deductible, then 10% Coinsurance	**In a physician's office or non – hospital affiliated facility:** Deductible, then 10% Coinsurance	Deductible, then 50% Coinsurance
Please refer to the online Provider Directory at **www.harvardpilgrim.org** to determine if a facility is a non-hospital facility (ambulatory surgical center).			
Other diagnostic services	Deductible, then 10% Coinsurance		Deductible, then 50% Coinsurance
Low Protein Foods and Special Formulas			
Special formulas	Deductible, then 20% Coinsurance up to a maximum of $250 per 30 day supply		Deductible, then 50% Coinsurance
Low protein foods	Deductible, then 20% Coinsurance up to a maximum of $250 per 30 day supply		Deductible, then 50% Coinsurance
Maternity Care – Outpatient Services			
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."			
Mental Health and Substance Use Disorder Treatment			
Inpatient acute hospitalization	Deductible, then 10% Coinsurance		Deductible, then 50% Coinsurance
Acute residential treatment (including detoxification)	Deductible, then 10% Coinsurance		Deductible, then 50% Coinsurance
Intensive outpatient programs, crisis stabilization, in-home family stabilization, partial hospitalization and day treatment programs	Deductible, then 10% Coinsurance		Deductible, then 50% Coinsurance
Outpatient group and individual therapy	Deductible, then 10% Coinsurance		Deductible, then 50% Coinsurance
Outpatient methadone maintenance	Deductible, then 10% Coinsurance		Deductible, then 50% Coinsurance
Outpatient detoxification, medication management, psychological testing and neuropsychological assessment	Deductible, then 10% Coinsurance		Deductible, then 50% Coinsurance
Observation Services			
	Deductible, then 10% Coinsurance		Same as In-Network
Ostomy Supplies			
	Deductible, then 10% Coinsurance		Deductible, then 50% Coinsurance

Benefit	In-Network Plan Providers Member Cost Sharing		Out-of-Network Non-Plan Providers Member Cost Sharing
Physician and Other Professional Office Visits (This includes all covered Providers unless otherwise listed in this Schedule of Benefits.)			
Routine examinations for preventive care, including immunizations	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" for the Member Cost Sharing that applies to diagnostic services not included on this list.			
Consultations, evaluations and sickness and injury care	**PCP - office visits:** Deductible, then 10% Coinsurance	**Specialist - office visits:** Deductible, then 10% Coinsurance	Deductible, then 50% Coinsurance
Additional Member Cost Sharing may apply to related services when a Member presents at a different site of service. 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."			
Office based treatments and procedures including, but not limited to: administration of anesthesia, administration of injections and medications, casting, suturing and the application of dressings, allergy treatments, pain management, diagnostic services and testing, diabetic foot care, hearing tests, sleep studies and office surgical procedures.	**PCP - office visits:** Deductible, then 10% Coinsurance	**Specialist - office visits:** Deductible, then 10% Coinsurance	Deductible, then 50% Coinsurance
Administration of allergy injections	Deductible, then 10% Coinsurance		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, and certain labs and x-rays. For a complete list of covered preventive services, please see the Preventive Services Notice on our website at **www.harvardpilgrim.org**. You may also get a copy of the Preventive Services Notice by calling the Member Services Department at **1–888–333–4742**. Harvard Pilgrim will add or delete services from this benefit for preventive services and tests in accordance with Federal guidance.			
Prosthetic Devices			
Prosthetic devices (other than arms and legs)	Deductible, then 10% Coinsurance		Deductible, then 50% Coinsurance
Prosthetic arms and legs	Deductible, then 10% Coinsurance		Deductible, then 50% Coinsurance

Benefit	In-Network Plan Providers Member Cost Sharing		Out-of-Network Non-Plan Providers Member Cost Sharing
Rehabilitation and Habilitation Services - Outpatient			
Cardiac rehabilitation Pulmonary rehabilitation therapy	Deductible, then 10% Coinsurance		Deductible, then 50% Coinsurance
Physical and occupational therapies–limited to 40 visits per Plan Year Visit limits for physical therapy, occupational therapy, and speech therapy are combined.	**In a hospital or hospital affiliated facility:** Deductible, then 10% Coinsurance	**In a physician's office or non-hospital affiliated facility:** Deductible, then 10% Coinsurance	Deductible, then 50% Coinsurance
Speech therapy – limited to 40 visits per Plan Year Visit limits for physical therapy, occupational therapy, and speech therapy are combined.	**In a hospital or hospital affiliated facility:** Deductible, then 10% Coinsurance	**In a physician's office or non-hospital affiliated facility:** Deductible, then 10% Coinsurance	Deductible, then 50% Coinsurance
Outpatient physical, occupational and speech therapies are covered to the extent Medically Necessary for: (1) children under the age of three and (2) the treatment of Autism Spectrum Disorders. No visit limits apply to these services.			
Scopic Procedures - Outpatient Diagnostic and Therapeutic			
Colonoscopy, endoscopy and sigmoidoscopy	**In a hospital or hospital affiliated facility:** Deductible, then 10% Coinsurance	**In a physician's office or non – hospital affiliated facility:** Deductible, then 10% Coinsurance	Deductible, then 50% Coinsurance
Please refer to the online Provider Directory at **www.harvardpilgrim.org** to determine if a facility is a non—hospital surgical facility (ambulatory surgical center).			
Surgery – Outpatient			
	In a hospital or hospital affiliated facility: Deductible, then 10% Coinsurance	**In a physician's office or non – hospital affiliated facility:** Deductible, then 10% Coinsurance	Deductible, then 50% Coinsurance
Please refer to the online Provider Directory at **www.harvardpilgrim.org** to determine if a facility is a non—hospital surgical facility (ambulatory surgical center).			
Telemedicine Virtual Visit Services – Outpatient			
	PCP - office visits: Deductible, then 10% Coinsurance	**Specialist - office visits:** Deductible, then 10% Coinsurance	Deductible, then 50% Coinsurance
For inpatient hospital care, see "Hospital – Inpatient Services."			

Benefit	In-Network Plan Providers Member Cost Sharing	Out-of-Network Non-Plan Providers Member Cost Sharing
Urgent Care Services		
Walk-in retail health clinic (convenience care clinic)	Deductible, then 10% Coinsurance	Deductible, then 50% Coinsurance
Urgent care center	Deductible, then 10% Coinsurance	Deductible, then 50% Coinsurance
Hospital urgent care center	Deductible, then 10% Coinsurance	Deductible, then 50% Coinsurance
Additional Member Cost Sharing may apply to related services when a Member presents at a different site of service. Please refer to the specific benefit in this Schedule of Benefits. For example, if you have an x-ray or have blood drawn, please refer to "Laboratory, Radiology and Other Diagnostic Services".		
Vision Services		
Routine eye examinations – limited to 1 exam per Plan Year	No charge	Deductible, then 50% Coinsurance
Voluntary Sterilization in a Physician's Office		
	Deductible, then 10% Coinsurance **Please Note:** No In-Network Member Cost Sharing applies to voluntary sterilization for women.	Deductible, then 50% Coinsurance
Voluntary Termination of Pregnancy – Outpatient		
	Deductible, then 10% Coinsurance	Deductible, then 50% Coinsurance
Wigs and Scalp Hair Prostheses		
– Limited to 1 wig per Member per Plan Year. See the Benefit Handbook for details.	Deductible, then 10% Coinsurance	Deductible, then 50% 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 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 اللغة **العربية**، خدمات المساعدة اللغوية متوفرة لك مجانا. **إتصل على 1 888-333-4742**
(TTY: 711)

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

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

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

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

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

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

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

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

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

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

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. 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. | CONNECTICUT

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, 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.
Clinical Trials
No coverage is provided for the investigational product or service that is the subject of a clinical trial; or• 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 when specifically listed as a Covered Benefit. • All Services of a dentist for Temporomandibular Joint Dysfunction (TMD). • Extraction of teeth, except when specifically listed as a Covered Benefit. • Dentures.
Durable Medical Equipment and Prosthetic Devices
• Any devices or special equipment needed for sports or occupational purposes. • 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 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.
Maternity Services
• Planned home births.

Exclusion
Mental Health Care
• Biofeedback. • Educational services or testing (unless required under state or federal law). 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. • Sensory integrative praxis tests. • Services or supplies for the diagnosis or treatment of mental health and substance use disorder treatment that, in the reasonable judgment of the Behavioral Health Access Center, are any of the following: not consistent with prevailing national standards of clinical practice for the treatment of such conditions; not consistent with prevailing professional research demonstrating that the services or supplies will have a measurable and beneficial health outcome; typically do not result in outcomes demonstrably better than other available treatment alternatives that are less intensive or more cost effective. • Services related to autism spectrum disorders provided under an individualized education program (IEP), including any services provided under an IEP that are delivered by school personnel or any services provided under an IEP purchased from a contractor or vendor. • Services for the following conditions: mental retardation; learning disorders; motor skills disorders; communication disorders; caffeine-related disorders; relational problems; and other conditions not defined as mental disorders in the most recent edition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders.
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
• Bariatric surgery, except when specifically listed as a Covered Benefit. Please see your Schedule of Benefits to determine if your Plan provides coverage for this 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 other than an 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. • Any foods or nutritional therapies of any kind including the use of vitamins, minerals or elements, and other nutrition-based therapy, except when specifically listed as a Covered Benefit under your plan. Examples include supplements, electrolytes, and foods of any kind (including high protein foods and low carbohydrate foods). • Physical examinations and testing for insurance, licensing or employment. • Services for Members who are donors for non-members, except as described under Human Organ Transplant Services. • Testing for central auditory processing. • Group diabetes 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 under your Handbook. • 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.

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Exclusion
Reproduction
• Any form of Surrogacy or services for a gestational carrier other than covered Maternity Services. • Infertility drugs if a Member is not in a Plan authorized cycle of infertility treatment. • Infertility drugs, if infertility services are not a Covered Benefit. This exclusion may only apply when coverage is provided by a qualified religious organization, as allowed by law. Please see your Schedule of Benefits to determine if your Plan excludes this benefit • Infertility treatment for Members who are not medically infertile. • Infertility treatment. This exclusion may only apply when coverage is provided by a qualified religious organization, as allowed by law. Please see your Schedule of Benefits to determine if your Plan excludes this benefit. • Birth control drugs, implants and devices, except when specifically listed as a Covered Benefit. • Reversal of voluntary sterilization (including any services for infertility related to voluntary sterilization or its reversal). • Sperm collection, freezing and storage except as described in section , *"Infertility Services and Treatment"*. • Sperm identification when not Medically Necessary (e.g., gender identification). • The following fees: wait list fees, non-medical costs, shipping and handling charges, etc. • Tubal ligation. This exclusion may only apply when coverage is provided by a qualified religious organization, as allowed by law. Please see your Schedule of Benefits to determine if your Plan excludes this benefit. • Vasectomy. This exclusion may only apply when coverage is provided by a qualified religious organization, as allowed by law. Please see your Schedule of Benefits to determine if your Plan excludes this benefit. • Voluntary termination of pregnancy, unless the life of the mother is in danger. This exclusion may only apply when coverage is provided by a qualified religious organization, as allowed by law.
Services Provided Under Another Plan
• Costs for any services for which you are entitled to treatment at government expense, including military service connected disabilities, except where services are obtained in the Connecticut Veterans' Home. • To the extent permissible under Connecticut law, costs for services for which payment is required to be made by a Workers' Compensation plan or an Employer under state or federal law.
Telemedicine
• Telemedicine services involving fax, texting, or audio-only telephone. • Provider fees for technical costs for the provision of telemedicine services.
Transgender Health Services
• Abdominoplasty. • Chemical peels. • Collagen injections. • Dermabrasion. • Electrolysis or laser hair removal (for all indications, except when required pre-operatively for genital surgery). • Hair transplantation. • Implantations (e.g. cheek, calf, pectoral, gluteal). • Liposuction. • Lip reduction/enhancement. • Panniculectomy. • Removal of redundant skin. • Reversal of transgender health services and all related drugs and procedures. • Silicone injections (e.g. for breast enlargement). • Voice modification therapy/surgery. • Reimbursement for travel expenses.
Travel Expenses
• Transportation other than by ambulance, except when transportation is covered for a transplant recipient and his or her companion (please see the benefit for Human Organ Transplant Recipient - Transportation, Lodging and Meal Expenses). • Any expenses related to travel including transportation, lodging and meal expenses, except as listed in this Benefit Handbook. • Travel expenses for a transplant recipient and companion except as listed in the Covered Benefits section and the Benefit Handbook. This includes, but is not limited to, alcoholic beverages, car maintenance, vehicle insurance, flight insurance, cards, stationary, stamps, clothing, dry cleaning, entertainment, flowers, household products, household utilities, kennel services, laundry services, security deposits, toiletries, phone bills and/or cellular expenses, extended stay expenses, outside of the time period for transportation, and other expenses that have not been pre-approved. • Any expenses for anyone other than the transplant recipient and the designated traveling companion. • Local transportation costs while at a transplant facility. • Rental car costs.

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Exclusion
Types of Care
• Custodial Care.(unless required under state or federal law) • Rest or domiciliary care. • All institutional charges over the semi-private room rate, except when a private room is Medically Necessary. • Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, and diversion or general motivation. • Private duty nursing, except when specifically listed as a Covered Benefit. Please see your Schedule of Benefits to determine if your Plan provides coverage for this benefit. • 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
• Adult routine eye exams, except when listed as a Covered Benefit. • Eyeglasses, contact lenses and fittings except when specifically listed as a Covered Benefit. • 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 service or supply furnished in connection with a non-Covered Benefit. • Beauty or barber service. • Donated or banked breast milk. • Food or nutritional supplements, including, but not limited to, FDA-approved medical foods obtained by prescription, except as required by law. • Services for non-Members. • Services for which no charge would be made in the absence of insurance. • Services for which no coverage is provided in the Benefit Handbook, this Schedule of Benefits, or Prescription Drug Brochure. • Services that are not Medically Necessary (unless required under state or federal law). • Services provided by a non-Plan Provider except as described in your Handbook • Taxes or governmental assessments on services or supplies. • Air conditioners, air purifiers and filters, dehumidifiers and humidifiers. • Any service or supply (with the exception of contact lenses) purchased from the internet. • Car seats. • Chairs, bath chairs, feeding chairs, toddler chairs, chair lifts, recliners. • Diabetes equipment replacements when solely due to manufacturer warranty expiration. • 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. • 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. • Motorized beds. • Pillows. • Power-operated vehicles. • Stair lifts and stair glides. • Strollers. • Safety equipment. • Vehicle modifications including but not limited to van lifts. • Charges for telephone, television or internet.

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