Schedule of Benefits

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CODE: H2F **DATE:** 11/1/11

HPHC Insurance Company, Inc.

THE BEST BUY PPO
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 US 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 summarizes your Benefits under the HPHC Insurance Company PPO (the Plan) and states the Member Cost Sharing amounts that you must pay for Covered Benefits. However, it is only a summary of your benefits. Please see your Benefit Handbook and Prescription Drug Brochure (if you have the Plan's outpatient pharmacy coverage) for detailed information on benefits covered by the Plan and the terms and conditions of coverage.

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. When using Plan Providers, coverage is based on the contracted rate between HPHC and the Provider.
- **Out-of-Network** coverage applies when you use a Non-Plan Provider for Covered Benefits. When using Non-Plan Providers, the Plan pays only a percentage of the cost of the care you receive up to the Usual, Customary and Reasonable Charges for the service. In most cases, this will be higher than the HPHC contracted rate. If a Non-Plan Provider charges any amount in excess of the Usual, Customary and Reasonable Charge, you are responsible for the excess amount. Please refer to section I.F. Member Cost Sharing in your Benefit Handbook for additional information about Out-of-Network Charges in Excess of the Usual, Customary and Reasonable Charge.

You always have coverage for care in a Medical Emergency. 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 below under the heading "Emergency Room Care."

Member Responsibility for Notification and Prior Approval

Members must contact HPHC for coverage of a number of services. These are listed below.

Mental Health and Drug and Alcohol Rehabilitation Services. Prior Approval must be obtained before receiving mental health and drug and alcohol rehabilitation services from both Plan and Non-Plan Providers. To obtain Prior Approval for mental health and drug and alcohol rehabilitation services, you should call the Behavioral Health Access Center at **1-888-777-4742**. Prior Approval must be obtained before receiving certain mental health and drug and alcohol rehabilitation services from Non-Plan Providers. Please refer to our internet site, **www.harvardpilgrim.org**, or contact the Member Services Department at **1-888-333-4742** for a list of services. To obtain Prior Approval for mental health and drug and alcohol rehabilitation services, please call the Behavioral Health Access Center at **1-888-777-4742**.

Medical Services. Members are required to notify HPHC before the start of any planned inpatient admission to a Non-Plan medical facility. Members are also required to obtain Prior Approval from HPHC for certain services. Before you receive services from a Non-Plan Provider, please refer to our Internet site, **www.harvardpilgrim.org**, or contact the Member Services Department at **1-888-333-4742** for a list of Out-of-Network services that require Prior Approval. If you do not provide notification or obtain Prior Approval when required, you will be responsible

for paying the Penalty amount stated in this Schedule of Benefits in addition to any applicable Member Cost Sharing. No coverage will be provided if HPHC determines that the service is not Medically Necessary, and you will be responsible for the entire cost of the service.

Emergency Care. You do not need to contact HPHC before receiving care in a Medical Emergency. In the event of an emergency hospital admission to a Non-Plan Provider, you must notify HPHC within 48 hours of the admission, unless notification is not possible because of your condition. If notice is given to HPHC by an attending emergency physician, no further notification is required. However, if notification is not received when the Member's condition permits it, the Member is responsible for the Penalty amount stated in this Schedule of Benefits. Please call **1-800-708-4414** to notify us of an emergency admission to a Non-Plan facility.

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 applicable to a service or procedure for which coverage is requested. Clinical review criteria may be obtained by calling **1-888-888-4742 ext. 38723**.

DEDUCTIBLE

A Deductible is a specific dollar amount that is payable by the Member for Covered Benefits received each calendar year before any benefits subject to the Deductible are payable by the Plan. If a family Deductible applies, it is met when any combination of Members in a covered family incur expenses for services to which the Deductible applies.

Not all services under this Plan are subject to the Deductible. You may have different Deductibles that apply to different Covered Benefits under your Plan. Deductible amounts are incurred as of the date of service. Your Plan Deductible amounts are listed below.

Your Plan has both an individual Deductible and a family Deductible. However, please note that a Family Deductible only applies if you have Family Coverage. Unless a family Deductible applies, you are responsible for the individual Deductible for covered services each calendar year. If you are a Member with a family Deductible, your Deductible can be satisfied in one of two ways:

a. If a Member of a covered family meets an individual Deductible, then services for that Member that are subject to that Deductible are covered by the Plan for the remainder of the calendar year.

b. If any number of Members in a covered family collectively meet the family Deductible, then all Members of the covered family receive coverage for services subject to that Deductible for the remainder of the calendar year.

Your Plan has separate Deductibles that apply to your In-Network and Out-of-Network benefits. You must meet the In-Network Deductible before In-Network services are covered by the Plan. You must meet the Out-of-Network Deductible before Out-of-Network services are covered by the Plan.

Any eligible expenses you incur toward the Deductible in a calendar year apply to **both** the In-Network and the Out-of-Network Deductibles. Once you meet the In-Network Deductible, which is usually the lower of the two, you may begin to receive coverage for In-Network services. If you later meet the Out-of-Network Deductible you may also receive coverage for Out-of-Network services.

Once a Deductible is met, coverage by the Plan is subject to any other Member Cost Sharing that may apply.

Your Covered Benefits are administered on a calendar year basis.

General Cost Sharing Features:	Member Cost Sharing:
In-Network Coinsurance and Copayments	
	See Covered Benefits below
Out-of-Network Coinsurance and Copayments	
	See Covered Benefits below
In-Network Deductible	
	$1,000 per Member per calendar year $3,000 per family per calendar year
Out-of-Network Deductible	
	$1,500 per Member per calendar year $4,500 per family per calendar year
In-Network Durable Medical Equipment Deductible	
	$100 per Member per calendar year
Out-of-Pocket Maximum	
– Includes all Member Cost Sharing except charges for outpatient prescription drugs. Any charges above the Usual, Customary and Reasonable Charge and any penalty for failure to receive Prior Approval when using Non-Plan Providers do not apply to the Out-of-Pocket Maximum.	$3,000 per Member per calendar year $9,000 per family per calendar year
Out-of-Network Penalty Payment for failure to obtain Prior Approval	
You must notify HPHC in advance of any planned inpatient admission to a Non-Plan Medical Facility. You are also required to obtain Prior Approval from HPHC before receiving certain services from a Non-Plan Provider. If you do not provide notification or get Prior Approval for these services, you are responsible for 50% of the benefit that would have otherwise been payable or $500 whichever 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 see section *I.G. NOTIFICATION AND PRIOR APPROVAL* in your handbook for more information.	
Deductible Rollover	
– Your Plan has a Deductible Rollover that applies to any Deductible amount that is incurred for services during the last 3 months of the calendar year and is applied toward the Deductible requirement for the next year.	

Benefit	In-Network Plan Providers Member Cost Sharing	Out-of-Network Non-Plan Providers Member Cost Sharing
Ambulance Transport		
– Emergency ambulance transport	Deductible, then no charge	Same as In-Network
– Non-emergency ambulance transport	Deductible, then no charge	Deductible, then 30% Coinsurance

Benefit	In-Network Plan Providers Member Cost Sharing	Out-of-Network Non-Plan Providers Member Cost Sharing
Autism Spectrum Disorders Treatment		
– Applied behavior analysis – limited to $36,000 per calendar year for Members through the age of 12 and $27,000 for Members age 13 to age 21	$15 Copayment per visit	Deductible, then 30% Coinsurance
– All other benefits are covered as stated in this Schedule of Benefits	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 Services." For services provided by a speech therapist, physical therapist and occupational therapist see "Rehabilitation Therapy – Outpatient."	
Bariatric Surgery		
	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 Services." For inpatient hospital care, see "Hospital – Inpatient Services."	
Chiropractic Care		
– Limited to 12 visits per calendar year	$15 Copayment per visit	Deductible, then 30% Coinsurance
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 by a physician, see "Physician and Other Professional Services." For inpatient hospital care, see "Hospital – Inpatient Services."	
Dental Services		
– Accidental injury 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 in a dentist's office, see "Physician and Other Professional Services." For services provided in a hospital emergency room, see "Emergency Room Care."	
– 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 Services." For day surgery, see "Surgery –Outpatient."	
Diabetes Services and Supplies		
– Self management and training/diabetic eye examinations/foot care	$15 Copayment per visit	Deductible, then 30% Coinsurance
– Diabetes equipment and supplies Member Cost Sharing does not apply to blood glucose monitors or insulin pumps (including supplies) and infusion devices.	Durable Medical Equipment Deductible, then 20% Coinsurance	Deductible, then 30% Coinsurance

Benefit	In-Network Plan Providers Member Cost Sharing	Out-of-Network Non-Plan Providers Member Cost Sharing
Diabetes Services and Supplies (Continued)		
– Pharmacy supplies	Subject to the applicable pharmacy Member Cost Sharing listed on your ID Card. If your Plan does not include coverage for outpatient prescription drugs, then coverage is subject to the lower of the pharmacy's retail price or a Copayment of $5 for Tier 1 drugs or supplies, $10 for Tier 2 drugs or supplies and $25 for Tier 3 drugs or supplies.	Subject to the applicable pharmacy Member Cost Sharing listed on your ID Card. If your Plan does not include coverage for outpatient prescription drugs, then coverage is subject to the lower of the pharmacy's retail price or a Copayment of $5 for Tier 1 drugs or supplies, $10 for Tier 2 drugs or supplies and $25 for Tier 3 drugs or supplies.
For information on the drug tiers, please visit our website at **www.harvardpilgrim.org/ members** and select "pharmacy/drug tier look up" contact the Member Services Department at **1-888-333-4742**.		
Dialysis		
– Dialysis services	$15 Copayment per visit	Deductible, then 30% Coinsurance
– Installation of home equipment is covered up to $300 in a Member's lifetime	No charge	Deductible, then 30% Coinsurance
Durable Medical Equipment and Prosthetic Devices		
Member Cost Share does not apply to the following: – Respiratory equipment (including oxygen)	Durable Medical Equipment Deductible, then 20% Coinsurance	Deductible, then 30% Coinsurance
Early Intervention		
– Limited to $3,200 per calendar year, up to $9,600 per lifetime	$15 Copayment per visit	Deductible, then 30% Coinsurance
Emergency Admission		
	Deductible, then no charge	Same as In-Network
Emergency Room Care		
	$100 Copayment per visit This Copayment is waived if admitted to the hospital directly from the emergency room.	Same as In-Network
Family Planning Services		
	$15 Copayment per visit	Deductible, then 30% Coinsurance
Hearing Aids		
– Limited to $1,500 per hearing aid every 60 months, for each hearing impaired ear	No charge	Deductible, then 30% Coinsurance
Home Health Care		
	No charge	Deductible, then 20% Coinsurance

Benefit	In-Network Plan Providers Member Cost Sharing	Out-of-Network Non-Plan Providers Member Cost Sharing
Hospice Services		
	No charge for outpatient services For inpatient hospital care, see "Hospital – Inpatient Services."	Your Member Cost Sharing will depend upon the types of services provided, as listed in this Schedule of Benefits. For example, for services provided by a physician, see "Physician and Other Professional Services." For inpatient hospital care, see "Hospital – Inpatient Services."
Hospital – Inpatient Services		
	Deductible, then no charge	Deductible, then 30% Coinsurance
House Calls		
	$15 Copayment per visit	Deductible, then 30% Coinsurance
Human Organ Transplant Services		
	Your Member Cost Sharing will depend upon the types of services provided, as listed in this Schedule of Benefits. For example, for services provided by a physician, see "Physician and Other Professional Services." For inpatient hospital care, see "Hospital – Inpatient Services."	
Infertility Services		
The Plan covers the following diagnostic services for infertility: – Consultation – Evaluation – Laboratory tests **Please Note:** The Plan does not cover infertility treatment.	$15 Copayment per visit	Deductible, then 30% Coinsurance
Laboratory and Radiology Services		
– Laboratory and x-rays	No charge	Deductible, then 30% Coinsurance
– High end radiology (CT scans, PET scans, MRI and MRA, and nuclear medicine services) No Member Cost Sharing applies to certain preventive care services. See "Preventive Services and Tests," below.	Deductible, then no charge	Deductible, then 30% Coinsurance
Low Protein Foods		
– Limited to $1,800 per Member per calendar year	No charge	Deductible, then 30% Coinsurance
Maternity Care		
– Routine outpatient prenatal and postpartum care	No charge	Deductible, then 30% Coinsurance

Benefit	In-Network Plan Providers Member Cost Sharing	Out-of-Network Non-Plan Providers Member Cost Sharing
Maternity Care (Continued)		
– Preventive services and screenings including: counseling about alcohol and tobacco use, services to promote breastfeeding, routine urinalysis and screenings for the following: asymptomatic bacteriuria; hepatitis B infection; HIV and screenings for STDs (chlamydia, gonorrhea and syphilis); iron deficiency anemia; and Rh (D) incompatibility. Please see "Preventive Services and Tests," below, for additional services and tests covered with no Member Cost Sharing.	No charge	Deductible, then 30% Coinsurance
Please Note: 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, for services provided by another physician or specialist, see "Physician and Other Professional Services" for your applicable Member Cost Sharing. Please see your Benefit Handbook for more information on maternity care.		
– Routine nursery care for the newborn, including prophylactic medication to prevent gonorrhea and screenings for the following: hearing loss; congenital hypothyroidism; phenylketonuria (PKU); and sickle cell disease	No charge	Deductible, then 30% Coinsurance
– Hospital inpatient services	Deductible, then no charge	Deductible, then 30% Coinsurance
Medical Formulas		
	No charge	Deductible, then 30% Coinsurance
Mental Health and Drug and Alcohol Rehabilitation Services		
Inpatient Services		
– Mental health services – Drug and alcohol rehabilitation services – Detoxification services	No charge	30% Coinsurance
Partial Hospitalization Services		
– Partial hospitalization services	No charge	30% Coinsurance
Outpatient Services		
– Mental health services	Individual therapy: $15 Copayment per visit Group therapy: $10 Copayment per visit	30% Coinsurance

Benefit	In-Network Plan Providers Member Cost Sharing	Out-of-Network Non-Plan Providers Member Cost Sharing
Mental Health and Drug and Alcohol Rehabilitation Services (Continued)		
– Drug and alcohol rehabilitation services	Individual therapy: $15 Copayment per visit Group therapy: $10 Copayment per visit	30% Coinsurance
– Detoxification services	$15 Copayment per visit	30% Coinsurance
– Medication management	$15 Copayment per visit	30% Coinsurance
– Psychological testing	$15 Copayment per visit	Deductible, then 30% Coinsurance
Ostomy Supplies		
	Durable Medical Equipment Deductible, then 20% Coinsurance	Deductible, then 30% Coinsurance
Physician and Other Professional Services (This includes all covered medical professionals unless otherwise stated in this Schedule of Benefits)		
– Routine examinations for preventive care, including immunizations No Member Cost Sharing applies to certain preventive care services see "Preventive Services and Tests," below.	No charge	Deductible, then 30% Coinsurance
– Sickness and injury care	$15 Copayment per visit	Deductible, then 30% Coinsurance
– Administration of allergy injections	$5 Copayment per visit	Deductible, then 30% Coinsurance
Preventive Services and Tests		
Limited to the following select preventive laboratory and pathology tests and screenings as defined by federal law:	No charge	Deductible, then 30% Coinsurance
– Abdominal aortic aneurysm screening (for males 65-75 one time only, if ever smoked) – Alcohol misuse screening and counseling (primary care visits only) – Aspirin for the prevention of heart disease (primary care counseling only) – Autism screening (for children at 18 and 24 months of age – primary care visits only) – Behavioral assessments (developmental surveillance, for children of all ages – primary care visits only)	– Cervical cancer screening, including pap smears – Cholesterol screening (for adults only) – Colorectal cancer screening, including colonoscopy, sigmoidoscopy and fecal occult blood test – Dental caries prevention - oral fluoride (for children to age 5 only) Note: Coverage for fluoride is only provided if your Plan includes outpatient pharmacy coverage. – Depression screening (primary care visits only) – Diabetes screenings – Diet counseling	– HIV screening – Immunizations , including flu shots (for children and adults as appropriate) – Iron deficiency prevention (primary care counseling for children age 6 to 12 months only) – Lead screening (for children at risk) – Microalbuminuria test – Obesity screening – Osteoporosis screening (to begin at age 60 for women at increased risk) – Ovarian cancer susceptibility screening – Sexually transmitted diseases STDs - screenings and counseling

<table>
<tr><th>Benefit</th><th>In-Network
Plan Providers
Member Cost Sharing</th><th>Out-of-Network
Non-Plan Providers
Member Cost Sharing</th></tr>
<tr><td colspan="3">Preventive Services and Tests (Continued)</td></tr>
<tr><td>– Blood pressure screening
– Breast cancer chemoprevention counseling (only for women at high risk for Breast Cancer and low risk for adverse effects of chemoprevention)
– Breast cancer screening, including mammograms and counseling for genetic susceptibility screening</td><td>– Dyslipidemia screening (for children at high risk for higher lipid levels)
– Folic acid supplements (women planning or capable of pregnancy only)
Note: Coverage for folic acid is only provided if your Plan includes outpatient pharmacy coverage.
– Hemoglobin A1c
– Hepatitis B testing</td><td>– Tobacco use counseling (primary care visits only)
– Total cholesterol tests
– Tuberculosis skin testing
– Vision screening (children to age 5 only)
Please see the Maternity Care benefit for additional services and tests covered with no Member Cost Sharing.</td></tr>
<tr><td colspan="3">Under federal law the list of preventive services and tests covered above may change periodically based on the recommendations of the following agencies:
a. Grade “A” and “B” recommendations of the United States Preventive Services Task Force;
b. With respect to immunizations, the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention; and
c. With respect to services for woman, infants, children and adolescents, the Health Resources and Services Administration.
Information on the recommendations of these agencies may be found on the web site of the US Department of Health and Human Services at: http://www.healthcare.gov/center/regulations/prevention/recommendations.html.
Harvard Pilgrim will add or delete services from this benefit for preventive services and tests in accordance with changes in the recommendations of the agencies listed above. You can find a list of the current recommendations for preventive care on Harvard Pilgrim’s web site at www.harvardpilgrim.org.</td></tr>
<tr><td colspan="3">Reconstructive Surgery</td></tr>
<tr><td></td><td colspan="2">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 Services.” For inpatient hospital care, see “Hospital – Inpatient Services.”</td></tr>
<tr><td colspan="3">Rehabilitation Hospital Care</td></tr>
<tr><td>– Limited to 100 days per calendar year
– Day limits combined with Skilled Nursing Facility Care Services</td><td>Deductible, then no charge</td><td>Deductible, then 30% Coinsurance</td></tr>
<tr><td colspan="3">Rehabilitation Therapy - Outpatient</td></tr>
<tr><td>– Cardiac Rehabilitation
– Pulmonary Rehabilitation Therapy
– Speech Therapy — limited to 25 visits per condition
– Physical and occupational therapy - limited to 25 visits combined per condition</td><td>$15 Copayment per visit</td><td>Deductible, then 30% Coinsurance</td></tr>
</table>

Benefit	In-Network Plan Providers Member Cost Sharing	Out-of-Network Non-Plan Providers Member Cost Sharing
Scopic Procedures - Outpatient Diagnostic and Therapeutic		
– Colonoscopy, endoscopy and sigmoidoscopy No Member Cost Sharing applies to certain preventive care services. See "Preventive Services and Tests," listed above.	No charge	Deductible, then 30% Coinsurance
Skilled Nursing Facility Care Services		
– Limited to 100 days per calendar year – Day limits combined with Rehabilitation Hospital Care	Deductible, then no charge	Deductible, then 30% Coinsurance
Surgery — Outpatient		
	Deductible, then no charge	Deductible, then 30% Coinsurance
Telemedicine		
– Outpatient and Inpatient Telemedicine services	Your Member Cost Sharing will depend upon the types of services provided, as listed in this Schedule of Benefits. For example, for services provided by a physician, see "Physician and Other Professional Services." For inpatient hospital care, see "Hospital – Inpatient Services."	
Temporomandibular Joint Dysfunction Services (medical treatment only)		
	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 Services." For inpatient hospital care, see "Hospital – Inpatient Services."	
Urgent Care Center Services		
	$50 Copayment per visit	$50 Copayment per visit
Vision Services		
– Routine eye examinations limited to 1 per calendar year	$15 Copayment per visit	Deductible, then 30% Coinsurance
– Vision hardware for special conditions (see your Benefit Handbook for details)	No charge	Deductible, then 30% Coinsurance
Wigs and Scalp Hair Prostheses as required by law		
	Durable Medical Equipment Deductible, then 20% Coinsurance	Deductible, then 30% Coinsurance

Exclusions

The exclusions headings in this section are intended to group together services, treatments, items, or supplies that fall into a similar category. Actual exclusions appear underneath the headings. A heading does not create, define, modify, limit or expand an exclusion.

The services listed in the table below are not covered by the Plan:

Exclusion	Description
1. Alternative Treatments	
	1. Acupuncture services, except when specifically listed as a Covered Benefit (please see your Schedule of Benefits). 2. Acupuncture services that are outside the scope of standard acupuncture treatment, except when specifically listed as a Covered Benefit (please see your Schedule of Benefits), including services for preventive, maintenance, or wellness care, thermography, hair analysis, heavy metal screening or mineral studies, massage or soft-tissue techniques, diagnostic services, x-rays or services related to menstrual cramps. 3. Alternative, holistic or naturopathic services and all procedures, laboratories and nutritional supplements associated with such treatments. 4. Aromatherapy, treatment with crystals and alternative medicine. 5. Health resorts, spas, recreational programs, camps, wilderness programs, outdoor skills programs, relaxation or lifestyle programs, including any services provided in conjunction with, or as part of such types of programs. 6. Massage therapy when performed by anyone other than a licensed physical therapist, physical therapy assistant, occupational therapist, or certified occupational therapy assistant. 7. Myotherapy.
2. Dental Services	
	1. Dental Care, except the specific dental services listed in this Benefit Handbook and your Schedule of Benefits. 2. All services of a dentist for Temporomandibular Joint Dysfunction (TMD). 3. Extraction of teeth, except when specifically listed as a Covered Benefit (please see your Schedule of Benefits). 4. Preventive dental care for children, except when specifically listed as a Covered Benefit (please see your Schedule of Benefits). 5. Dentures.
3. Durable Medical Equipment and Prosthetic Devices	
	1. Any devices or special equipment needed for sports or occupational purposes. 2. Any home adaptations, including, but not limited to home improvements and home adaptation equipment. 3. Myoelectric and bionic arms and legs, except when specifically listed as a Covered Benefit. (Please see your Schedule of Benefits). 4. Non-durable medical equipment, unless used as part of the treatment at a medical facility or as part of approved home health care services. 5. Repair or replacement of durable medical equipment or prosthetic devices as a result of loss, negligence, willful damage, or theft.
4. Experimental, Unproven or Investigational Services	
	1. Any products or services, including, but not limited to, drugs, devices, treatments, procedures, and diagnostic tests that are Experimental, Unproven, or Investigational.

Exclusion	Description
5. Foot Care	
	1. Foot orthotics, except for the treatment of severe diabetic foot disease or when specifically listed as a Covered Benefit. (Please see your Schedule of Benefits). 2. Routine foot care. Examples include nail trimming, cutting or debriding and the cutting or removal of corns and calluses. This exclusion does not apply to preventive foot care for Members with diabetes.
6. Mental Health Care	
	1. Biofeedback. 2. Educational services or testing, except services covered under the benefit for Early Intervention Services. No benefits are provided: (1) for educational services intended to enhance educational achievement; (2) to resolve problems of school performance; or (3) to treat learning disabilities. 3. Methadone maintenance. 4. Sensory integrative praxis tests. 5. 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. 6. 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. 7. Services or supplies for the diagnosis or treatment of mental health and drug and alcohol rehabilitation services that, in the reasonable judgment of the Behavioral Health Access Center, are any of the following: • Not consistent with prevailing national standards of clinical practice for the treatment of such conditions. • 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.
7. Physical Appearance	
	1. Cosmetic Services, including drugs, devices, treatments and procedures, except for (1) Cosmetic Services that are incidental to the correction of Physical Functional Impairment, (2) restorative surgery to repair or restore appearance damaged by an accidental injury, and (3) post-mastectomy care. 2. Hair removal or restoration, including, but not limited to, electrolysis, laser treatment, transplantation or drug therapy. 3. Liposuction or removal of fat deposits considered undesirable. 4. Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures). 5. Skin abrasion procedures performed as a treatment for acne. 6. Treatment for skin wrinkles or any treatment to improve the appearance of the skin. 7. Treatment for spider veins. 8. Wigs, except as required by law or when specifically listed as a Covered Benefit (please see your Schedule of Benefits).

Exclusion	Description
8. Procedures and Treatments	
	1. Chiropractic care, except when specifically listed as a Covered Benefit (please see your Schedule of Benefits). 2. 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. 3. Commercial diet plans, weight loss programs and any services in connection with such plans or programs. 4. Gender reassignment surgery and all related drugs and procedures. 5. If a service is listed as requiring that it be provided at a Center of Excellence, no In-Network coverage will be provided under the Benefit Handbook if that service is received from a Provider that has not been designated as a Center of Excellence. Please see the Handbook section "Centers of Excellence" for more information. 6. Nutritional or cosmetic therapy using vitamins, minerals or elements, and other nutrition-based therapy. Examples include supplements, electrolytes, and foods of any kind (including high protein foods and low carbohydrate foods). 7. Physical examinations and testing for insurance, licensing or employment. 8. Services for Members who are donors for non-members, except as described under Human Organ Transplant Services. 9. Testing for central auditory processing. 10. Group diabetes training, educational programs or camps.
9. Providers	
	1. Charges for services which were provided after the date on which your membership ends. 2. Charges for any products or services, including, but not limited to, professional fees, medical equipment, drugs, and hospital or other facility charges, that are related to any care that is not a Covered Benefit under the Benefit Handbook. 3. Charges for missed appointments. 4. Concierge service fees. (See Benefit Handbook section *"Provider Fees for Special Services"* for more information.) 5. Inpatient charges after your hospital discharge. 6. Provider's charge to file a claim or to transcribe or copy your medical records. 7. Services or supplies provided by: (1) anyone related to you by blood, marriage or adoption, or (2) anyone who ordinarily lives with you.
10. Reproduction	
	1. Any form of Surrogacy or services for a gestational carrier. 2. Birth control drugs, implants and devices that must be purchased at an outpatient pharmacy, unless your Plan includes outpatient pharmacy coverage. 3. Infertility drugs if a member is not in a Plan authorized cycle of infertility treatment. 4. Infertility drugs, if infertility services are not a Covered Benefit. 5. Infertility drugs that must be purchased at an outpatient pharmacy, unless your Plan includes outpatient pharmacy coverage. 6. Infertility treatment for Members who are not medically infertile. 7. Infertility treatment, except when specifically listed as a Covered Benefit (please see your Schedule of Benefits), including, but not limited to, therapeutic donor insemination, including related sperm procurement and

Exclusion	Description
10. Reproduction (Continued)	
	banking, donor egg procedures, including related egg and inseminated egg procurement, processing and banking, assisted hatching, gamete intrafallopian transfer (GIFT), intra-cytoplasmic sperm injection (ICSI), intra-uterine insemination (IUI), in-vitro fertilization (IVF), zygote intrafallopian transfer (ZIFT), preimplantation genetic diagnosis (PGD), miscrosurgical epididiymal sperm aspiration (MESA) and testicular sperm extraction (TESE). 8. Reversal of voluntary sterilization (including any services for infertility related to voluntary sterilization or its reversal). 9. Sperm collection, freezing and storage except as described in Benefit Handbook section *"Covered Benefits"*, *Infertility Services and Treatment*.when infertility treatment is listed as a covered benefit (please see your Schedule of Benefits). 10. Sperm identification when not Medically Necessary (e.g., gender identification). 11. The following fees; wait list fees, non-medical costs, shipping and handling charges etc. 12. Voluntary sterilization, including tubal ligation and vasectomy, except when specifically listed as a Covered Benefit (please see your Schedule of Benefits). 13. Voluntary termination of pregnancy, except when specifically listed as a Covered Benefit (please see your Schedule of Benefits). 14. Voluntary termination of pregnancy, unless the life of the mother is in danger.
11. Services Provided Under Another Plan	
	1. Costs for any services for which you are entitled to treatment at government expense, including military service connected disabilities. 2. Costs for services for which payment is required to be made by a Workers' Compensation plan or an Employer under state or federal law.
12. Telemedicine	
	1. Telemonitoring, telemedicine services involving e-mail, fax, or audio-only telephone, telemedicine services involving stored images forwarded for future consultation, i.e. "store and forward" telecommunication.
13. Types of Care	
	1. Custodial Care. 2. Rest or domiciliary care. 3. All institutional charges over the semi-private room rate, except when a private room is Medically Necessary. 4. Home health care services that extend beyond care on a short-term intermittent basis. 5. Pain management programs or clinics. 6. Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, and diversion or general motivation. 7. Private duty nursing. 8. Sports medicine clinics. 9. Vocational rehabilitation, or vocational evaluations on job adaptability, job placement, or therapy to restore function for a specific occupation.

Exclusion	Description
14. Vision and Hearing	
	1. Eyeglasses, contact lenses and fittings, except as listed in this Benefit Handbook. 2. 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. 3. Refractive eye surgery, including, but not limited to, lasik surgery, orthokeratology and lens implantation for the correction of myopia, hyperopia and astigmatism. 4. Routine eye examinations, except when specifically listed as a Covered Benefit (please see your Schedule of Benefits).
15. All Other Exclusions	
	1. Any service or supply furnished in connection with a non-Covered Benefit. 2. Beauty or barber service. 3. Any drug or other product obtained at an outpatient pharmacy, except for pharmacy supplies covered under the benefit for diabetes services, unless your Plan includes outpatient pharmacy coverage. 4. Food or nutritional supplements, including, but not limited to, FDA-approved medical foods obtained by prescription, except as required by law. 5. Guest services. 6. Services for non-Members. 7. Services for which no charge would be made in the absence of insurance. 8. Services for which no coverage is provided in this Benefit Handbook, or Schedule of Benefits or Prescription Drug Brochure (if your Plan includes outpatient pharmacy coverage) . 9. Services that are not Medically Necessary. 10. Services your PCP or a Plan Provider has not provided, arranged or approved except as described in the Handbook sections *"Your PCP Manages Your Health Care"* and *"Using Plan Providers"*. 11. Taxes or governmental assessments on services or supplies. 12. Transportation other than by ambulance. 13. The following products and 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.

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