Schedule of Benefits

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Harvard Pilgrim Health Care of New England, Inc.

THE HARVARD PILGRIM BEST BUY HMO
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 Harvard Pilgrim Best Buy HMO (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.

Services are covered when Medically Necessary. Subject to the exceptions listed in the section of the Benefit Handbook titled, "How The Plan Works" all services must be (1) provided or arranged by your Primary Care Provider (PCP) and (2) provided by a Plan Provider. These requirements do not apply to care needed in a Medical Emergency.

You always have coverage for care in a Medical Emergency. A Referral from your PCP is not needed. 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."

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**.

Your Covered Benefits are administered on a calendar year basis.

General Cost Sharing Features:	Member Cost Sharing:
Coinsurance and Copayments	
	See Covered Benefits below
Deductible	
	$1,000 per Member per calendar year $3,000 per family per calendar year
Deductible Rollover	
	Included
Durable Medical Equipment and Prosthetic Devices Deductible	
	$100 per Member per calendar year

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Benefit	Member Cost Sharing
Ambulance Transport	
– Emergency ambulance transport	Deductible, then no charge
– Non-emergency ambulance transport	Deductible, then no charge
Autism Spectrum Disorders Treatment	
– Applied behavior analysis — limited to $36,000 per calendar year for Members through the age of 12 and $27,000 per calendar year for Members age 13 to 21	$20 Copayment per visit
– 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	$20 Copayment per visit
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	$20 Copayment per visit

Benefit	Member Cost Sharing
Diabetes Services and Supplies (Continued)	
– Diabetes equipment and supplies Member Cost Sharing, including the Deductible, does not apply to blood glucose monitors or insulin pumps (including supplies) and infusion devices.	Durable Medical Equipment and Prosthetics Devices Deductible, then 20% Coinsurance
– Pharmacy supplies	Subject to the applicable pharmacy Member Cost Sharing listed on your ID Card and your Outpatient Prescription Drug Schedule of Benefits. 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**" or contact the Member Services Department at **1-888-333-4742**.
Dialysis	
– Dialysis services	$20 Copayment per visit
– Installation of home equipment is covered up to $300 in a Member's lifetime.	No charge
Durable Medical Equipment	
Member Cost Sharing does not apply to the following: – Respiratory equipment – Oxygen and oxygen equipment	Durable Medical Equipment and Prosthetics Devices Deductible, then 20% Coinsurance
Early Intervention	
– Limited to $3,200 per Member per calendar year up to $9,600 per lifetime	$20 Copayment per visit
Emergency Room Care	
	$100 Copayment per visit This Copayment is waived if admitted to the hospital directly from the emergency room.
Family Planning Services	
	$20 Copayment per visit
Hearing Aids	
– Limited to $1,500 per hearing aid every 60 months, for each hearing impaired ear	No charge
Home Health Care	
	No charge
Hospice Services	
	No charge for outpatient services. For inpatient hospital care, see "Hospital – Inpatient Services."

Benefit	Member Cost Sharing
Hospital – Inpatient Services	
	Deductible, then no charge
House Calls	
	$20 Copayment per visit
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.	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."
Laboratory and Radiology Services	
– Laboratory and x-rays	No charge
– 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
Low Protein Foods	
– Limited to $1,800 per Member per calendar year	No charge
Maternity Care	
– Routine outpatient prenatal and postpartum care	No charge
– 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
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,	

Benefit	Member Cost Sharing
Maternity Care (Continued) 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
– Hospital inpatient services	Deductible, then no charge
Medical Formulas	
	No charge
Mental Health and Drug and Alcohol Rehabilitation Services	
Inpatient Mental Health Services	No charge
Partial Hospitalization	No charge
Outpatient Mental Health Services	Group therapy — $10 Copayment per visit Individual therapy — $20 Copayment per visit
Medication Management	$20 Copayment per visit
Psychological Testing	$20 Copayment per visit
Inpatient Drug and Alcohol Rehabilitation Services	No charge
Partial Hospitalization	No charge
Outpatient Drug and Alcohol Rehabilitation Services	Group therapy — $10 Copayment per visit Individual therapy — $20 Copayment per visit
Inpatient Detoxification	No charge
Outpatient Detoxification	$20 Copayment per visit
Ostomy Supplies	
	Durable Medical Equipment and Prosthetics Devices Deductible, then 20% Coinsurance
Physician and Other Professional Services (This includes all covered medical professionals unless otherwise stated in this Schedule of Benefits)	
– Routine examinations and preventive care, including immunizations No Member Cost Sharing applies to certain preventive care services. See "Preventive Services and Tests," below.	No charge
– Sickness and injury care	$20 Copayment per visit
– Administration of allergy injections	$5 Copayment per visit

<table>
<tr><th>Benefit</th><th colspan="3">Member Cost Sharing</th></tr>
<tr><td colspan="4">Preventive Services and Tests</td></tr>
<tr><td colspan="2">Limited to the following select preventive laboratory and pathology tests and screenings as defined by federal law:</td><td colspan="2">No charge</td></tr>
<tr><td>– 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)
– 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>– 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
– 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>– 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 - screenings and counseling
– 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="4">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="4">Prosthetic Devices</td></tr>
<tr><td colspan="2"></td><td colspan="2">Durable Medical Equipment and Prosthetics Devices
Deductible, then 20% Coinsurance</td></tr>
</table>

Benefit	Member Cost Sharing
Reconstructive Surgery	
	Your Member Cost Sharing will depend upon the types of services provided, as listed in this Schedule of Benefits. For example, for inpatient hospital care, see "Hospital – Inpatient Services."
Rehabilitation Hospital Care	
– Limited to 100 days per calendar year – Day limits combined with Skilled Nursing Facility Care	Deductible, then no charge
Rehabilitation Therapy - Outpatient	
– Cardiac Rehabilitation – Pulmonary Rehabilitation Therapy – Speech Therapy — limited to 25 visits per condition – Physical and occupational therapy - limited to 25 visits combined per condition	$20 Copayment per visit
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.	Deductible, then no charge
Skilled Nursing Facility Care	
– Limited to 100 days per calendar year – Day limits combined with Rehabilitation Hospital Care	Deductible, then no charge
Surgery — Outpatient	
	Deductible, then no charge
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)	
	$20 Copayment per visit
Urgent Care Center Services	
	$50 Copayment per visit
Vision Services	
– Routine eye examinations — limited to 1 per calendar year	$20 Copayment per visit
– Vision hardware for special conditions (see your Benefit Handbook for details)	No charge

Benefit	Member Cost Sharing
Voluntary Sterilization	
	$20 Copayment per visit
Voluntary Termination of Pregnancy	
	$20 Copayment per visit
Wigs and Scalp Hair Prostheses as required by law	
	Durable Medical Equipment and Prosthetics Devices Deductible, then 20% 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 the 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. Maternity Services	
	1. Delivery outside the Service Area after the 37th week of pregnancy, or after you have been told that you are at risk for early delivery. 2. Routine pre-natal and post-partum care when you are traveling outside the Service Area.
7. Mental Health Care	
	1. Biofeedback. 2. Educational services or testing. No benefits are provided: (1) for educational services intended to enhance educational achievement; (2) to resolve problems of school performance; or (3) to treat learning disabilities. 3. Methadone maintenance. 4. Sensory integrative praxis tests. 5. 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. 6. 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.
8. 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
9. 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 Handbook if that service is received from a Provider that has not been designated as a Center of Excellence. Please see the Benefit Handbook 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.
10. 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 Handbook. 3. Charges for missed appointments. 4. Concierge service fees. (See the Benefit Handbook for more information.) 5. Follow-up care after an emergency room visit, unless provided or arranged by your PCP. 6. Inpatient charges after your hospital discharge. 7. Provider's charge to file a claim or to transcribe or copy your medical records. 8. Services or supplies provided by: (1) anyone related to you by blood, marriage or adoption, or (2) anyone who ordinarily lives with you.
11. 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
11. 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 the Benefit Handbook, *Infertility Services and Treatment.* 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.
12. 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.
13. 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.
14. 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
15. Vision and Hearing	
	1. Eyeglasses, contact lenses and fittings, except as listed in the 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).
16. 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 the Benefit Handbook 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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