Schedule of Benefits

Harvard Pilgrim Health Care, Inc.

The Harvard Pilgrim Primary Choice℠ Plan
MASSACHUSETTS

Please Note: This Plan includes a tiered Provider network. In this plan, Members pay different levels of Member Cost Sharing depending on the tier of the Provider delivering a Covered Benefit. The Primary Choice Provider Directory includes provider tiering information and is available online at **www.harvardpilgrim.org/GIC** or by calling Member Services at **1-888-333-4742**. For TTY service, please call **711**.

This Schedule of Benefits states any Benefit Limits and Member Cost Sharing amounts that you must pay for Covered Benefits. However, it is only a summary of your Covered Benefits. Please see your Benefit Handbook for details. Your Member Cost Sharing may include a Deductible, Coinsurance, and Copayments. Different Copayments apply depending on the type of Provider or the type of service. Please see the tables below for details.

You will find words in this Schedule of Benefits that have special meanings. When we use one of those words, we start it with a capital letter. Capitalized terms that are not defined in this Schedule of Benefits are defined in the Glossary in your Benefit Handbook.

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

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/GIC** or by calling **1-888-888-4742 ext. 38723**.

Tiered Providers

Most hospitals and physicians covered by the Plan are placed into one of two benefit levels or "tiers." Member Cost Sharing for these Providers depends upon the tier in which a Provider is placed. Tier 1 is the lower cost tier and Tier 2 is the higher cost tier. Only acute care hospitals, Primary Care Providers (PCPs) and medical specialists are assigned to one of two tiers. In some cases, a Provider may practice at more than one location and may have a different tier assigned to each location. Different out-of-pocket costs may apply to the same Provider based upon where you are treated by that Provider.

Certain Primary Choice Providers in specialties such as cardiology, gastroenterology and obstetrics/gynecology may also be Providers in internal medicine, pediatrics or other primary care specialties. When these Providers bill us for their services as PCPs, the applicable tiered PCP Copayment will apply. When these Providers bill us for their services as specialists, the applicable tiered specialty Copayment will apply.

Some Providers work from offices that are operated by a hospital. When services are rendered and billed from such an office, a Tier 2 Specialist Copayment will be applied. However, please contact Member Services if you received care from a physician who specializes in internal, adolescent or geriatric medicine; family and general practice; pediatrics; or a midwife, nurse practitioner or

a physician assistant in such an office to determine if you are subject to the PCP Copayment and which Tiered PCP Copayment will apply.

You can lower your out-of-pocket cost by selecting the physicians and hospitals in the lower cost tier. The tables below list the Member Cost Sharing for each type of tiered service. The Primary Choice Provider Directory lists all Plan Providers and their tier. You can access the Primary Choice Provider Directory at **www.harvardpilgrim.org/GIC**. You may also obtain a paper copy of the directory, free of charge, by calling HPHC's Member Services Department at **1–888–333–4742**.

Please Note: When you choose a PCP, it is important to consider the tier of the hospital that your PCP uses. For example, a Tier 1 PCP may admit patients to a Tier 2 Hospital. If your Tier 1 PCP were to refer you to a Tier 2 hospital, you would pay the lower out-of-pocket costs for physician services but the higher out-of-pocket costs for hospital care.

Non-Tiered Benefits

For certain Covered Benefits Member Cost Sharing is not tiered. These Covered Benefits include services provided by Primary Choice Providers in the following specialties: behavioral health; early intervention; physical, speech and occupational therapy; chiropractic; audiology; and optometry. Your Member Cost Sharing for these Covered Benefits is listed in the tables below.

IMPORTANT POINTS TO REMEMBER

Under a Tiered Network Plan, your out-of-pocket costs will vary depending on whom you see and where you go for care. Please review and consider the following when seeking care under your Primary Choice Plan:

- You can lower your out-of-pocket cost by selecting the Providers and hospitals in the lower cost tier.
- When you choose a PCP, it is important to consider the tier of the hospital that your PCP uses. For example, a Tier 1 PCP may admit patients to a Tier 2 Hospital.
- A Provider may practice at more than one location and may have a different tier assigned to each location. Different out-of-pocket costs may apply to the same Provider based upon where you are treated by that Provider.
- Some Primary Choice Providers have multiple offices and may be a Primary Choice Provider at one location, and not at another. You must check with HPHC to make sure the services you seek are covered under your Primary Choice Plan for that specific Provider at that specific location.
- Some Primary Choice Providers may be affiliated with hospitals that do not participate in the Primary Choice network. If a Primary Choice Provider refers you to a hospital that is not in the Primary Choice network, coverage will not be provided under your Primary Choice plan.

General Cost Sharing Features:	Member Cost Sharing:
Tiered Copayments	
	Tier 1 PCP Copayment: $20 per visit. Tier 2 PCP Copayment: $20 per visit. Tier 1 Specialist Copayment: $30 per visit. Tier 2 Specialist Copayment: $60 per visit.
Inpatient Hospital Copayments	
Medical care	Hospital Tier 1 Inpatient Copayment: $275 per admission Hospital Tier 2 Inpatient Copayment: $500 per admission

General Cost Sharing Features:	Member Cost Sharing:
Inpatient Hospital Copayments (Continued)	
Mental health care (including the treatment of substance use disorders)	$275 Copayment per admission
Please Note: There is an Inpatient Copayment maximum of one Medical or Mental Health Care inpatient Copayment per Member during each Quarter in a Plan Year.	
If you are readmitted to a medical hospital or mental health care hospital in a new Quarter, but within 30 calendar days of a discharge, your second Inpatient Hospital Copayment will be waived. Readmission does not have to be to the same hospital or for the same condition. This waiver is limited to a Plan Year basis. The bullets below list examples of when you can expect to pay a Inpatient Hospital Copayment and when you can expect that Copayment to be waived: • If you are admitted from March 2 until March 7, you are responsible for an Inpatient Hospital Copayment. If you are then readmitted from March 12 until March 15, the second Inpatient Hospital Copayment is waived because it is within the same Quarter as the first admission. • If you are admitted March 2 until March 7, and then readmitted April 3 until April 8, the second Inpatient Hospital Copayment is waived even though it is a new Quarter because it is within 30 calendar days of the original discharge. • If you are admitted March 2 until March 7, and then readmitted April 30 until May 2, you are responsible for the second Inpatient Hospital Copayment. The second admission occurred more than 30 days from the original discharge and it is a new Quarter. • If you are admitted June 2 until June 7, and then readmitted July 1 until July 4, you are responsible for the second Inpatient Hospital Copayment. Although the second admission occurred less than 30 days from the original discharge, it happened during a new Plan Year.	
Surgical Day Care Copayment	
	$250 Copayment per visit, up to a maximum of 4 Surgical Day Care Copayments per Member per Plan Year.
Deductible – Medical	
	$400 per Member per Plan Year $800 per family per Plan Year
Coinsurance	
	20% Coinsurance for Skilled Nursing Facility care
Out-of-Pocket Maximum	
Includes all Member Cost Sharing	$5,000 per Member per Plan Year $10,000 per family per Plan Year

Covered Benefits

Your Covered Benefits are administered on a Plan Year basis. The benefit table below is a summary of the services covered by your Plan. It also indicates your Member Cost Sharing, such as Copayment, Deductible or Coinsurance amounts. More detailed information about Covered Benefits can be found in your Benefit Handbook. 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 doctor'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 "Surgical Day Care."

Benefit	Member Cost Sharing
Ambulance Transport	
Emergency ambulance transport, including ground and/or air transportation	Deductible, then no charge
Non-emergency ambulance transport (ground only)	Deductible, then no charge
Autism Spectrum Disorders Treatment	
Applied behavior analysis	$20 Copayment per visit
Chemotherapy and Radiation Therapy	
	Deductible, then no charge
Chiropractic Care	
– Limited to 20 visits per Plan Year	$20 Copayment per visit
Dental Services	
Important Notice: Coverage of Dental Care is very limited. Please see your Benefit Handbook for the details of your coverage.	
Emergency dental care (received within 3 days of injury) Reduction of fractures and removal of cysts or tumors	Office visits: $60 Copayment per visit Hospital Inpatient Services: Hospital Tier 1: $275 Copayment per admission, then Deductible Hospital Tier 2: $500 Copayment per admission, then Deductible Surgical Day Care: $250 Copayment per visit, then Deductible
Please Note: The Covered Benefits below are **only** provided when the Member has a serious medical condition that makes it essential that he or she be admitted to a hospital as an inpatient or to a surgical day care unit or ambulatory surgical facility as an outpatient in order for the dental care to be performed safely. Serious medical	Hospital Inpatient Services: Hospital Tier 1: $275 Copayment per admission, then Deductible Hospital Tier 2: $500 Copayment per admission, then Deductible Surgical Day Care:

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Benefit	Member Cost Sharing
Dental Services (Continued)	
conditions include, but are not limited to, hemophilia and heart disease. – Removal of 7 or more permanent teeth, excision of radicular cysts involving the roots of three or more teeth, extraction of impacted teeth, and gingivectomies of two or more gum quadrants	$250 Copayment per visit, then Deductible
Diabetes Equipment and Supplies	
Diabetes equipment	Deductible, then no charge
Blood glucose monitors, insulin pumps and supplies and infusion devices	Deductible, then no charge
Diabetes equipment including needles and syringes for the administration of insulin are covered by this Plan. Insulin (other than insulin administered with an insulin pump) and other pharmacy supplies are covered under your outpatient prescription drug coverage, which is not administered by HPHC. Please see your **Express Scripts Prescription Drug Plan brochure** or call **Express Scripts** at **855–283–7679** for information on coverage of outpatient prescription drugs.	
Pharmacy supplies	See your **Express Scripts Prescription Drug Plan brochure** for cost sharing amounts.
Dialysis	
Dialysis services	Deductible, then no charge
Installation of home equipment.	Deductible, then no charge
Durable Medical Equipment	
Durable medical equipment	Deductible, then no charge
Oxygen and respiratory equipment	Deductible, then no charge
Early Intervention Services	
	No charge
The Plan does not cover the family participation fee required by the Massachusetts Department of Public Health.	
Emergency Admission	
	Hospital Tier 1: $275 Copayment per admission, then Deductible Hospital Tier 2: $500 Copayment per admission, then Deductible **Please Note:** Emergency admission to a mental health facility is subject to a $275 Copayment per admission
Emergency Room Care	
	$100 Copayment per visit, then the Deductible
This $100 Copayment is waived if the patient is admitted directly to the hospital from the emergency room.	

Benefit	Member Cost Sharing
Hearing Aids	
Hearing Aids (for Members up to the age of 22) – $2,000 per hearing aid every 24 months, for each hearing impaired ear	No charge
Hearing aids – (for Members ages 22 and older) – $2,000 every 2 Plan Years	No charge for the first $500 20% Coinsurance on the remaining $1,500 (which equals $300). **Note:** The $2,000 benefit includes the $1,700 maximum paid by the Plan and the $300 Member Cost Sharing.
Home Health Care Services	
	Deductible, then no charge No cost sharing or benefit limit applies to durable medical equipment, physical therapy or occupational therapy received as part of authorized home health care.
Hospice – Outpatient	
	Deductible, then no charge
Hospital – Inpatient Services	
Acute hospital care	Hospital Tier 1: $275 Copayment per admission, then Deductible Hospital Tier 2: $500 Copayment per admission, then Deductible
Inpatient maternity care Non-routine inpatient services for the newborn	Hospital Tier 1: $275 Copayment per admission, then Deductible Hospital Tier 2: $500 Copayment per admission, then Deductible
Inpatient routine nursery care	No charge
Inpatient rehabilitation	Deductible, then no charge
Skilled Nursing Facility limited to 45 days per Plan Year	Deductible, then 20% Coinsurance
Infertility Services and Treatments (see the Benefit Handbook for details)	
– Advanced reproductive technologies are limited to 5 cycles per lifetime	Tier 1 PCP Copayment: $20 per visit Tier 2 PCP Copayment: $20 per visit. Tier 1 Specialist Copayment: $30 per visit Tier 2 Specialist Copayment: $60 per visit
Laboratory, Radiology and Other Diagnostic Services	
Laboratory	Deductible, then no charge
Genetic testing	Deductible, then no charge
Radiology	Deductible, then no charge
Advanced radiology, including CT scans, PET scans, MRI, MRA and nuclear medicine services	$100 Copayment per scan , then Deductible There is a maximum of one Copayment per Member per day.
Other diagnostic services	Deductible, then no charge

Benefit	Member Cost Sharing
Low Protein Foods	
	Deductible, then no charge
Maternity Care - Outpatient	
Routine outpatient prenatal and postpartum care	No charge
Non-routine outpatient prenatal and postpartum car	Deductible, then no charge
Medical Drugs (drugs that cannot be self-administered)	
Medical drugs received in a doctor's office or other outpatient facility	Deductible, then no charge
Medical drugs received in the home	Deductible, then no charge
Some medical drugs received in a physician's office or outpatient facility may be provided by the Specialty Pharmacy Program under your outpatient prescription drug benefit. Your outpatient prescription drug coverage is not administered by HPHC. Please see your **Express Scripts Prescription Drug Plan brochure** or call **Express Scripts** at **855–283–7679** for information on coverage of outpatient prescription drugs.	
Medical Formulas	
	Deductible, then no charge
Mental Health and Substance Use Disorder Treatment	
Inpatient services – Mental health services – Drug and Alcohol Rehabilitation Services – Detoxification	$275 Copayment per admission
Intermediate services – Acute residential treatment, including detoxification (long-term residential treatment is not covered), crisis stabilization, and in home family stabilization – Intensive outpatient programs, partial hospitalization and day treatment programs, 24-hour intermediate care facilities, and therapeutic foster care	No charge
Outpatient therapy services – Mental health services – Drug and alcohol rehabilitation services	Group therapy – $15 Copayment per visit Individual therapy – $20 Copayment per visit Telemedicine – $15 Copayment per visit
Outpatient detoxification	No charge
Outpatient medication management	$15 Copayment per visit
Outpatient methadone maintenance	No charge
Outpatient psychological testing and neuropsychological assessment	No charge

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Benefit	Member Cost Sharing
Mental Health and Substance Use Disorder Treatment (Continued)	
Prior Approval is not required to obtain substance use disorders treatment from a Primary Choice Provider. In addition, when services are obtained from a Primary Choice Provider, the Plan will not deny coverage for the first 14 days of (1) Acute Treatment Services or (2) Clinical Stabilization Services for the treatment of substance use disorders so long as the Plan receives notice from the Primary Choice Provider within 48 hours of admission. The terms "Acute Treatment Services" and "Clinical Stabilization Services" are defined in the Glossary of your Benefit Handbook. Services beyond the 14 day period may be subject to concurrent review as described in section J. Utilization Review Procedures of your Handbook.	
Ostomy Supplies	
	Deductible, then no charge
Outpatient Prescription Drug Coverage	
Your outpatient prescription drug coverage is not administered by HPHC. Please see your **Express Scripts Prescription Drug Plan brochure** or call **Express Scripts** at **855–283–7679** for information on coverage of outpatient prescription drugs. Regardless of whether the Express Scripts brochure is specifically noted in a handbook section, any reference to outpatient drugs found within this handbook is governed by the Express Scripts Prescription Drug Plan brochure.	
Physician and Other Professional Office Visits (This includes all covered Primary Choice Providers unless otherwise listed in this Schedule of Benefits.)	
Routine examinations for preventive care, including immunizations	No charge
Not all 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 our website at **www.harvardpilgrim.org/GIC**. Please see "Laboratory and Radiology Services" for the Member Cost Sharing that applies to diagnostic services not included on this list.	
Consultations, evaluations, sickness and injury care Nutritional counseling (limited to 3 visits for non-diabetes and non-eating disorder related conditions per Plan Year)	Tier 1 PCP Copayment: $20 per visit Tier 2 PCP Copayment: $20 per visit. Tier 1 Specialist Copayment: $30 per visit Tier 2 Specialist Copayment: $60 per visit
Administration of allergy injections Allergy tests and treatments Diagnostic screening and tests (including EKGs)	Deductible, then no charge

Benefit	Member Cost Sharing
Preventive Services and Tests	
Preventive care services, including all FDA approved generic contraceptive devices. Under the federal health care reform law, many preventive services and tests are covered with no member cost sharing. For a complete list of covered preventive services, please see the Preventive Services notice on our website at **www.harvardpilgrim.org/GIC**. You may also get a copy of the Preventive Services notice by calling the Member Services Department at **1–888–333–4742**	No charge
Under federal law, many preventive services and tests are covered with no Member Cost Sharing, including preventive colonoscopies, certain labs and x-rays, voluntary sterilization for women, and all FDA approved contraceptive devices. For a complete list of covered preventive services and tests go to HPHC's web site at **www.harvardpilgrim.org/GIC**. You may also get a copy by calling the Member Services department at **1–888–333–4742**. HPHC will add or delete services from this benefit for preventive services and tests in accordance with Federal guidance.	
Prosthetics	
	Deductible, then no charge
Reconstructive Surgery	
	Hospital Tier 1: $275 Copayment per admission, then Deductible Hospital Tier 2: $500 Copayment per admission, then Deductible
Rehabilitation and Habilitation Services - Outpatient	
Cardiac rehabilitation	Tier 1 PCP Copayment: $20 per visit Tier 2 PCP Copayment: $20 per visit. Tier 1 Specialist Copayment: $30 per visit Tier 2 Specialist Copayment: $60 per visit
Pulmonary rehabilitation therapy	$20 Copayment per visit
Speech-language and hearing services	No charge
Occupational therapy limited to 90 consecutive days per illness or injury Physical therapy limited to 90 consecutive days per illness or injury	$20 Copayment per visit
Outpatient physical and occupational therapy is not subject to the limit listed above and is covered to the extent Medically Necessary for: (1) children under the age of three and (2) the treatment of Autism Spectrum Disorders.	

Benefit	Member Cost Sharing
Scopic Procedures - Outpatient Diagnostic and Therapeutic	
Colonoscopy, endoscopy and sigmoidoscopy	Surgical Day Care: $250 Copayment per visit, then Deductible There is a maximum of four Surgical Day Care Copayments per Member per Plan Year.
Smoking Cessation	
Smoking Cessation (please see your Benefit Handbook for details on your coverage)	No charge
Surgical Day Care	
	$250 Copayment per visit, then Deductible There is a maximum of four Surgical Day Care Copayments per Member per Plan Year.
Telemedicine	
Outpatient telemedicine services: - Medical services	$15 Copayment per visit
- Mental health and substance use disorder services	$15 Copayment per visit
For inpatient hospital care, see "Hospital - Inpatient Services."	
Temporomandibular Joint Dysfunction Services	
	Tier 1 PCP Copayment: $20 per visit Tier 2 PCP Copayment: $20 per visit. Tier 1 Specialist Copayment: $30 per visit Tier 2 Specialist Copayment: $60 per visit
No Dental Care is covered for the treatment of Temporomandibular Joint Dysfunction (TMD).	
Transgender Health Services	
	Hospital Inpatient Services: Hospital Tier 1: $275 Copayment per admission, then Deductible Hospital Tier 2: $500 Copayment per admission, then Deductible Surgical Day Care: $250 Copayment per visit, then Deductible
Urgent Care Services	
Convenience care clinic	$20 Copayment per visit
Urgent care clinic (including hospital urgent care clinic)	$20 Copayment per visit
Additional Member Cost Sharing may apply. Please refer to the specific benefit in this Schedule of Benefits. For example, if you have an x-ray or have blood drawn, please refer to "Laboratory and Radiology Services."	

Benefit	Member Cost Sharing
Vision Services	
Routine eye examinations – limited to 1 exam every 24 months	Optometrist Copayment: $20 per visit Ophthalmologist Copayment: – Tier 1 Specialist Copayment: $30 per visit. – Tier 2 Specialist Copayment: $60 per visit.
Vision hardware (such as eyeglasses or contact lenses) only for limited conditions (please see your Benefit Handbook for details and limits on your coverage)	Deductible, then no charge
Voluntary Sterilization	
	Office visits: Tier 1 Specialist Copayment: $30 per visit Tier 2 Specialist Copayment: $60 per visit Surgical Day Care: $250 Copayment per visit, then Deductible
Voluntary Termination of Pregnancy	
	Office visits: Tier 1 Specialist Copayment: $30 per visit Tier 2 Specialist Copayment: $60 per visit Surgical Day Care: $250 Copayment per visit, then Deductible
Wigs and Scalp Hair Prostheses	
When needed as a result of any form of cancer or leukemia, alopecia areata, alopecia totalis or permanent hair loss due to injury	No charge

General List of Exclusions

Exclusion	Description
Alternative Treatments	
	1. Acupuncture services. 2. Alternative, holistic or naturopathic services and all procedures, laboratories and nutritional supplements associated with such treatments. 3. Aromatherapy, treatment with crystals and alternative medicine. 4. Any of the following types of programs: Health resorts, spas, recreational programs, camps, wilderness programs (therapeutic outdoor programs), outdoor skills programs, educational programs for children in residential care, self-help programs, life skills programs, relaxation or lifestyle programs, including any services provided in conjunction with, or as part of such types of programs and wellness clinics 5. Massage therapy. 6. Myotherapy
Dental Services	
	1. Dental services, except the specific dental services listed as Covered Benefits in your Benefit Handbook and your Schedule of Benefits. 2. All services of a dentist for Temporomandibular Joint Dysfunction (TMD). 3. Preventive Dental Care.
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. Devices and procedures intended to reduce snoring including, but not limited to, laser-assisted uvulopalatoplasty, somnoplasty, and snore guards 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.
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.
Foot Care	
	1. Foot orthotics, except for the treatment of severe diabetic foot disease 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.

Exclusion	Description
Maternity Services	
	1. Childbirth classes. 2. 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. 3. Planned home births. 4. Routine pre-natal and post-partum care when you are traveling outside the Service Area.
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; (3) to treat learning disabilities; (4) for driver alcohol education; or (5) for community reinforcement approach and assertive continuing care. 3. Sensory integrative praxis tests. 4. Services for any condition with only a "Z Code" designation in the Diagnostic and Statistical Manual of Mental Disorders, which means that the condition is not attributable to a mental disorder. 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 substance use disorders that, in the reasonable judgment of the Behavioral Health Access Center, are any of the following: • Not consistent with prevailing national standards of clinical practice for the treatment of such conditions. • Not consistent with prevailing professional research demonstrating that the services or supplies will have a measurable and beneficial health outcome. • Typically do not result in outcomes demonstrably better than other available treatment alternatives that are less intensive or more cost effective. 7. 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.

Exclusion	Description
Physical Appearance	
	1. Cosmetic Services, including drugs, devices, treatments and procedures, except for (1) Cosmetic Services that are incidental to the correction of a 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.
Procedures and Treatments	
	1. 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. 2. Commercial diet plans, weight loss programs and any services in connection with such plans or programs. 3. If a service is listed as requiring that it be provided at a Center of Excellence, no coverage will be provided if that service is received from a Provider that has not been designated as a Center of Excellence. Please see your Benefit Handbook for more information. 4. 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). 5. Physical examinations and testing for insurance, licensing or employment. 6. Services for Members who are donors for non-members, except as described under Human Organ Transplant Services. 7. Testing for central auditory processing. 8. Group diabetes training, educational programs or camps.

Exclusion	Description
Providers	
	1. Charges for services 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 your Handbook. 3. Charges for missed appointments. 4. Concierge service fees. Please see your Benefit Handbook 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.
Reproduction	
	1. Any form of Surrogacy or services for a gestational carrier. 2. Infertility drugs if a Member is not in a Plan authorized cycle of infertility treatment. 3. Infertility treatment for Members who are not medically infertile. 4. Reversal of voluntary sterilization (including any services for infertility related to voluntary sterilization or its reversal). 5. Sperm collection, freezing and storage except as described in your Benefit Handbook. 6. Sperm identification when not Medically Necessary (e.g., gender identification). 7. The following fees: wait list fees, non-medical costs, shipping and handling charges etc.
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.
Telemedicine Services	
	1. Telemedicine services involving e-mail, fax, texting, or audio-only telephone. 2. Provider fees for technical costs for the provision of telemedicine services.

Exclusion	Description
Transgender Health Services	
	1. Abdominoplasty. 2. Chemical peels. 3. Collagen injections. 4. Dermabrasion 5. Electrolysis or laser hair removal (for all indications, except when required pre-operatively for genital surgery). 6. Gender reassignment reversal surgery and all related drugs and procedures. 7. Hair transplantation 8. Implantations (e.g. calf, pectoral, gluteal) 9. Liposuction. 10. Lip reduction/enhancement. 11. Panniculectomy 12. Removal of redundant skin. 13. Silicone injections (e.g. for breast enlargement). 14. Voice modification therapy/surgery 15. Reimbursement for travel expenses
Types of Care	
	1. Custodial Care. 2. Recovery programs including rest or domiciliary care, sober houses, transitional support services, and therapeutic communities. 3. All institutional charges over the semi-private room rate, except when a private room is Medically Necessary. 4. Pain management programs or clinics. 5. Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, and diversion or general motivation. 6. Private duty nursing. 7. Sports medicine clinics. 8. Vocational rehabilitation, or vocational evaluations on job adaptability, job placement, or therapy to restore function for a specific occupation.
Vision and Hearing	
	1. Eyeglasses, contact lenses and fittings, except as listed in your Benefit Handbook. 2. Hearing aid batteries, and any device used by individuals with hearing impairment to communicate over the telephone or internet, such as TTY or TDD. 3. Refractive eye surgery, including but not limited to, lasik surgery, orthokeratology and lens implantation for the correction of naturally occurring myopia, hyperopia and astigmatism

Exclusion	Description
All Other Exclusions	
	1. All food or nutritional supplements except those covered under the benefits for (1) low protein foods and (2) medical formulas. 2. Any drug or other product obtained at an outpatient pharmacy, except when specifically listed as a Covered Benefit under this Benefit Handbook and your Schedule of Benefits. Please see your Benefit Handbook for information on coverage of diabetes equipment and supplies. 3. Any service or supply furnished in connection with a non-Covered Benefit. 4. Beauty or barber service. 5. Diabetes equipment replacements when solely due to manufacturer warranty expiration. 6. Guest services. 7. Medical services that are provided to Members who are confined or commited to jail, house of correction, prison, or custodial facility of the Department of Youth Services. 8. Services for non-Members. 9. Services for which no charge would be made in the absence of insurance. 10. Services for which no coverage is provided by the Plan. 11. Services that are not Medically Necessary. 12. Services your PCP or Primary Choice Provider has not provided, arranged or approved except as described in your Benefit Handbook. 13. Taxes or governmental assessments on services or supplies. 14. Transportation other than by ambulance. 15. 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.