Schedule of Benefits

HARVARD PILGRIM CHOICENET℠ BEST BUY TIERED COPAYMENT HMO MASSACHUSETTS

Please Note: This plan includes a tiered provider network called the "ChoiceNet" Network. In this plan, Members pay different levels of Copayments, Coinsurance or Deductibles depending on the tier of the provider delivering a covered service or supply. This plan may make changes to a Provider's benefit tier annually on January 1. Please consult the HPHC ChoiceNet Provider Directory or visit the provider search tool at **www.harvardpilgrim.org** to determine the tier of Providers in the ChoiceNet Network.

This Schedule of Benefits summarizes your Benefits under Harvard Pilgrim ChoiceNet℠ Best Buy Tiered Copayment 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.

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 PCP is not needed. Your emergency room Member Cost Sharing, including your Deductible if applicable, is listed in the tables below.

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**.

MEMBER COST SHARING

Members are required to share the cost of the Covered Benefits provided under the Plan. This section describes the payments for which you are responsible, called Member Cost Sharing. The tables, set forth below, show the specific Member Cost Sharing amounts for the different services covered by the Plan.

TIERED PROVIDERS

Most hospitals and physicians covered by the Plan are placed into one of three benefit levels or "tiers" based on national measures of cost efficiency and relative quality. Member Cost Sharing for these providers depends upon the tier in which a provider is placed. Tier 1 is the lowest cost tier. Tier 2 is the medium cost tier. Tier 3 is the highest cost tier. Please see your Benefit Handbook for more information on how hospitals and physicians are tiered under the Plan. Only acute care hospitals, Primary Care Physicians (PCPs) and medical specialists are assigned to one of three tiers. All other covered providers are assigned to Tier 1.

You can lower your out-of-pocket cost by selecting the physicians and hospitals in the lower cost tiers. The tables set forth below list the Member Cost Sharing for each type of tiered service. The

Plan's Provider Directory lists all Plan Providers and their tier. You can access the Provider Directory at **www.harvardpilgrim.org**. You may also obtain a paper copy of the directory, free of charge, by calling Harvard Pilgrim'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 or to a Tier 3 Hospital.

DEDUCTIBLES

A Deductible is a specific annual 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. Your Plan's Deductible amounts are listed in the tables below.

The Plan has a maximum Deductible, which is the total amount of Deductible payments you are responsible for in a calendar year. Any Deductible amount you incur for Covered Services in a calendar year will apply toward the maximum Deductible. In addition, any Deductible amount you incur during a calendar year applies towards a Deductible of any tier. However, if your Plan includes outpatient pharmacy coverage, your drug benefit may be subject to a separate Deductible. Payments made toward the prescription drug Deductible are not counted toward the Deductible amounts listed in the tables below. Please refer to your Prescription Drug Brochure for specific information on your prescription drug Deductible, if any.

The Plan also has limits on the Deductible amounts that apply to each tier. If you only use services in Tier 1 during the calendar year, you would only be responsible for the Tier 1 Deductible amount in that calendar year. If you only use services in Tiers 1 and 2 in a calendar year, you would only be responsible for the Tier 2 Deductible amount in that calendar year. As explained above, even if you use Tier 3 services, your total liability for Deductible charges, not including any prescription drug deductible, is limited to the maximum Deductible amount stated in the table below.

The Deductible is applicable to most services covered by the Plan. You can learn about the services that require payment of a Deductible and the amounts from the tables below. Deductible amounts are incurred on the date of service.

Your Plan has both an individual Deductible and a family Deductible. However, the family Deductible only applies if you have Family Coverage. Unless a family Deductible applies, you are responsible for the individual Deductible for Covered Benefits each calendar year. If you have family coverage, the Deductible can be satisfied in one of two ways:

a. If a Member of a covered family meets the 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 are deemed to have met the Deductible for the remainder of the calendar year.

Any Deductible amount incurred for any Covered Service during a calendar year will apply toward the Deductible for that year. For example, a Member incurred a Deductible for care in a Tier 1 hospital in January. The Deductible amount incurred in January will apply toward the Deductible payable under the Plan for any Covered Service received later in the calendar year. This includes care in a Tier 2 or Tier 3 hospital to which a higher Deductible applies. Once the Deductible is met, no further Deductible applies for the remainder of the calendar year. However, coverage by the Plan remains subject to any other Member Cost Sharing that may apply.

DEDUCTIBLE AND OTHER COST SHARING

For certain services, both a Deductible and either a Copayment or Coinsurance may apply. In such cases, you must completely satisfy the Deductible before the Plan pays benefits on services subject to the Deductible. Once you have satisfied the annual Deductible, you are still responsible for any applicable Copayments or Coinsurance.

COINSURANCE

Coinsurance is a percentage of the cost for certain services that is payable by the Member. Please see the table below for the Coinsurance amounts that apply to your Plan.

COPAYMENTS

A Copayment is a fixed dollar amount that is payable by the Member for certain covered services. Please see the table below for the Copayment amounts that apply to your Plan. Your identification card contains the Copayment amounts that apply to the Plan's most frequently used services.

Copayments are due at the time services are rendered or when billed by the provider. Different Copayments apply depending on the type of service, the tier placement of the provider, the specialty of the provider and the location of service.

Your Plan has two types of Copayments that apply to certain office visits with physicians and other health professionals covered by the Plan. A lower Copayment, known as the "Primary Care Copayment," applies to some outpatient services, including certain office visits for primary care, obstetrical care, gynecological care, and mental health care . Some outpatient specialty care requires payment of a higher Copayment, known as the "Specialty and Hospital Based Care Copayment." The Copayments that apply to your Plan are listed in the tables below.

With the exception of certain preventive services, which are never subject to Member Cost Sharing, the following Copayments apply to the outpatient services covered by your Plan:

THE PRIMARY CARE COPAYMENT

The Primary Care Copayment always applies to the following outpatient services:

- Applied behavioral analysis
- Mental health care (including the treatment of substance abuse disorders)
- Pediatric preventive Dental Care
- Routine eye examinations

In addition to the services listed above, the Primary Care Copayment applies to covered outpatient professional services, other than services received at a professional office operated by a hospital, from the following types of providers:

- All Primary Care Providers. The term "Primary Care Provider" (PCP) includes physicians, physician assistants and nurse practitioners in the following specialties: internal medicine, family practice, general practice and pediatrics
- Obstetricians and Gynecologists
- Certified nurse midwives
- Nurse practitioners who bill independently
- Chiropractors

THE SPECIALTY AND HOSPITAL BASED CARE COPAYMENT
The Specialty and Hospital Based Care Copayment applies to the following outpatient professional services:

- Any covered **service** or **provider** that is not listed above under Primary Care Copayment, or
- Any **service** provided in a hospital operated doctor's office, except the specific services under the Primary Care Copayment listed above.

If a provider is categorized at both Copayment levels, the Primary Care Copayment applies. For example, if a provider is both a PCP and a cardiologist, you will be responsible for the Primary Care Copayment.

COVERED BENEFITS

Your Covered Benefits are administered on a calendar year basis.

General Cost Sharing Features:	Tier 1 Member Cost Sharing:	Tier 2 Member Cost Sharing:	Tier 3 Member Cost Sharing:
Coinsurance and Copayments			
	See Covered Benefits below		
Primary Care Copayments			
	Your Plan has a $20 Copayment per visit	Your Plan has a $20 Copayment per visit	Your Plan has a $20 Copayment per visit
Specialty and Hospital Based Care Copayments			
	Your Plan has a $25 Copayment per visit	Your Plan has a $25 Copayment per visit	Your Plan has a $25 Copayment per visit
Deductibles			
– Applies to all services except where specifically noted below. – The Deductible amount in each tier is the maximum you would pay for all services during the calendar year in that tier or a lower tier.	None	None	None
Maximum Deductible			
	None		
Out-of-Pocket Maximum			
Includes all Member Cost Sharing except Member Cost Sharing for prescription drugs, which has a separate Out-of-Pocket Maximum	$1,200 per Member per calendar year $2,400 per family per calendar year		

Benefit	Tier 1 Member Cost Sharing	Tier 2 Member Cost Sharing	Tier 3 Member Cost Sharing
Ambulance Transport			
– Emergency ambulance transport	No charge		
– Non-emergency ambulance transport	No charge		
Autism Spectrum Disorders Treatment			
– Applied behavior analysis	Tier 1 Primary Care Copayment: $20 per visit		
Chemotherapy and Radiation Therapy			
	No charge		
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 **Please Note:** Services must be received within 3 days of injury	Your Member Cost Sharing will depend upon the types of services provided and the tier placement of the provider rendering services, as listed in this Schedule of Benefits. For example, for services provided in a dentist's office, see "Physician and Other Professional Office Visits." For services provided in a hospital emergency room, see "Emergency Room Care."		
– Extraction of teeth impacted in bone	Your Member Cost Sharing will depend upon the types of services provided and the tier placement of the provider rendering services, as listed in this Schedule of Benefits. For example, for services provided in a dentist's office, see "Physician and Other Professional Office Visits."		
– Preventive dental care for children (up to the age of 13) – Limited to 2 preventive dental exams per calendar year, only the following services are included: – Cleaning – Fluoride treatment – Teaching plaque control – X-rays	Tier 1 Primary Care Copayment: $20 per visit		
Dialysis			
– Non–hospital based dialysis services	No charge		
– Hospital based dialysis services	See "Hospital – Inpatient Services." for your Member Cost Sharing.		
– Installation of home equipment is covered up to $300 in a Member's lifetime.	No charge		
Durable Medical Equipment			
– Durable medical equipment	20% Coinsurance		
– Blood glucose monitors, infusion devices and insulin pumps (including supplies)	No charge		
– Oxygen and respiratory equipment	No charge		

Benefit	Tier 1 Member Cost Sharing	Tier 2 Member Cost Sharing	Tier 3 Member Cost Sharing
Early Intervention Services			
	No charge		
	Please Note: The Plan does not cover the Family Participation Fee required by the Massachusetts Department of Public Health.		
Emergency Admission Services			
	$150 Copayment per admission		
Emergency Room Care			
	$100 Copayment per visit This Copayment is waived if admitted to the hospital directly from the emergency room.		
Hearing Aids (for Members up to the age of 22)			
– Limited to $2,000 per hearing aid every 36 months, for each hearing impaired ear	No charge		
Home Health Care			
	Your Member Cost Sharing will depend upon the types of services provided and the tier placement of the provider rendering services, as listed in this Schedule of Benefits. For example, for services provided by a physician, see "Physician and Other Professional Office Visits." For inpatient hospital care, see "Hospital – Inpatient Services."		
Hospice – Outpatient Services			
	Your Member Cost Sharing will depend upon the types of services provided and the tier placement of the provider rendering services, as listed in this Schedule of Benefits. For example, for services provided by a physician, see "Physician and Other Professional Office Visits." For inpatient hospital care, see "Hospital – Inpatient Services."		
Hospital – Inpatient Services			
– Acute hospital care	$150 Copayment per admission	$150 Copayment per admission	$450 Copayment per admission
– Inpatient maternity care	$150 Copayment per admission	$150 Copayment per admission	$450 Copayment per admission
– Inpatient routine nursery care, including prophylactic medication to prevent gonorrhea	No charge		
– Inpatient rehabilitation – limited to 100 days per calendar year	$150 Copayment per admission		
– Skilled nursing facility – limited to 100 days per calendar year	$150 Copayment per admission		

Benefit	Tier 1 Member Cost Sharing	Tier 2 Member Cost Sharing	Tier 3 Member Cost Sharing
Hypodermic Syringes and Needles			
	Subject to the applicable pharmacy Member Cost Sharing in your Outpatient Prescription Drug Schedule of Benefits and 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. All Copayments are based on a 30 day supply. 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**.		
Infertility Services and Treatments (see the Benefit Handbook for details)			
	Your Member Cost Sharing will depend upon the types of services provided and the tier placement of the provider rendering services, as listed in this Schedule of Benefits. For example, for services provided by a physician, see "Physician and Other Professional Office Visits."		
Laboratory and Radiology Services			
– Non–hospital based laboratory and x-rays	No charge		
– Physician and hospital based laboratory and x-rays	No charge	No charge	No charge
Non–hospital based advanced radiology – CT scans – PET scans – MRI – MRA – Nuclear medicine services	$100 Copayment per procedure		
Physician and hospital based advanced radiology – CT scans – PET scans – MRI – MRA – Nuclear medicine services	$100 Copayment per procedure	$100 Copayment per procedure	$100 Copayment per procedure
Please Note: No Member Cost Sharing applies to certain preventive care services. For a list of covered preventive services, please see the Preventive Services notice at: **www.harvardpilgrim.org**.			
Low Protein Foods			
– Limited to $5,000 per calendar year	No charge		
Maternity Care - Outpatient			
– Routine outpatient prenatal and postpartum care	No charge		

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Benefit	Tier 1 Member Cost Sharing	Tier 2 Member Cost Sharing	Tier 3 Member Cost Sharing
Maternity Care - Outpatient (Continued)			
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 Office Visits" for your applicable Member Cost Sharing. Please see your Benefit Handbook for more information on maternity care.			
Medical Formulas			
	No charge		
Mental Health Care (Including the Treatment of Substance Abuse Disorders)			
– Inpatient mental health care services	$150 Copayment per admission		
Intermediate Mental Health Care Services – Acute residential treatment (including detoxification), crisis stabilization and in-home family stabilization – Intensive outpatient programs, partial hospitalization and day treatment programs	No charge		
– Outpatient mental health care services	**Group therapy –** $10 Copayment per visit **Individual therapy –** Tier 1 Primary Care Copayment: $20 per visit		
– Detoxification	Tier 1 Primary Care Copayment: $20 per visit		
– Medication management	Tier 1 Primary Care Copayment: $20 per visit		
Psychological testing and neuropsychological assessment – Performed by a licensed mental health professional	No charge		
– Performed by a neurologist or other medical specialist.	See the benefit for "Treatments and Procedures" under "Physicians and other Professional Office Visits."		
Ostomy Supplies			
	20% Coinsurance		
Physician and Other Professional Office Visits **(This includes all covered Plan Providers unless otherwise listed in this Schedule of Benefits.)**			
– Routine examinations for preventive care, including immunizations	No charge		
– Consultations, evaluations, sickness and injury care	Primary Care Copayment: $20 per visit Specialty and Hospital Based Care Copayment: $25 per visit	Primary Care Copayment: $20 per visit Specialty and Hospital Based Care Copayment: $25 per visit	Primary Care Copayment: $20 per visit Specialty and Hospital Based Care Copayment: $25 per visit

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Benefit	Tier 1 Member Cost Sharing	Tier 2 Member Cost Sharing	Tier 3 Member Cost Sharing
Physician and Other Professional Office Visits (This includes all covered Plan Providers unless otherwise listed in this Schedule of Benefits.) (Continued)			
Treatments and Procedures, including but not limited to: – Administration of injections – Allergy treatments – Casting, suturing and the application of dressings – Genetic counseling – Neurological testing – Non-routine foot care – Office surgical procedure – Pregnancy testing	No charge	No charge	No charge
– Administration of allergy injections	No charge	No charge	No charge
Preventive Services and Tests			
– Preventive care services, including all FDA approved contraceptive devices. Under the federal health care reform law, many preventive services and tests are covered with no Member Cost Sharing. For a list of covered preventive services, please see the Preventive Services notice on our website at: **www.harvardpilgrim.org**. You may also get a copy of the Preventive Services notice by calling the Member Services Department at **1–888–333–4742**.	No charge		
Under federal law the list of preventive services and tests 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 women, 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 U.S. Department of Health and Human Services at: **https://www.healthcare.gov/what-are-my-preventive-care-benefits/#part=1**. 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**.			
Additional Preventive Services and Tests – Fetal ultrasound – Hepatitis C testing – Lead level testing – Prostate-specific antigen (PSA) screening – Routine hemoglobin tests	No charge		

Benefit	Tier 1 Member Cost Sharing	Tier 2 Member Cost Sharing	Tier 3 Member Cost Sharing
Prosthetic Devices			
	20% Coinsurance		
Rehabilitation Therapy - Outpatient			
– Cardiac rehabilitation	No charge	No charge	No charge
– Pulmonary rehabilitation therapy	Tier 1 Primary Care Copayment: $20 per visit		
– Speech-language and hearing services	Tier 1 Primary Care Copayment: $20 per visit		
– Occupational therapy – limited to 90 consecutive days – Physical therapy – limited to 90 consecutive days **Please Note:** Outpatient physical and occupational therapy is covered to the extent Medically Necessary for: (1) children under the age of three and (2) the treatment of Autism Spectrum Disorders.	Tier 1 Primary Care Copayment: $20 per visit		
Scopic Procedures - Outpatient Diagnostic and Therapeutic			
– Colonoscopy, endoscopy and sigmoidoscopy	Your Member Cost Sharing will depend upon where the service is provided and the tier placement of the provider rendering services, as listed in this Schedule of Benefits. For example, for a service provided in an outpatient surgical center, see "Surgery – Outpatient." For services provided in a physician's office, see "Physician and Other Professional Office Visits." For inpatient hospital care, see "Hospital – Inpatient Services."		
Please Note: No Member Cost Sharing applies to certain preventive care services. For a list of covered preventive services, please see the Preventive Services notice at: **www.harvardpilgrim.org**.			
Spinal Manipulative Therapy (including care by a chiropractor)			
	Tier 1 Primary Care Copayment: $20 per visit		
Surgery – Outpatient			
	$150 Copayment per visit	$150 Copayment per visit	$150 Copayment per visit
Vision Services			
– Routine eye examinations – limited to 1 exam per calendar year	Tier 1 Primary Care Copayment: $20 per visit	Tier 1 Primary Care Copayment: $20 per visit	Tier 1 Primary Care Copayment: $20 per visit
– Vision hardware for special conditions (see the Benefit Handbook for details)	No charge		

Benefit	Tier 1 Member Cost Sharing	Tier 2 Member Cost Sharing	Tier 3 Member Cost Sharing
Voluntary Sterilization			
	Your Member Cost Sharing will depend upon where the service is provided and the tier placement of the provider rendering services, as listed in this Schedule of Benefits. For example, for a service provided in an outpatient surgical center, see "Surgery– Outpatient." For services provided in a physician's office, see "Physician and Other Professional Office Visits." For inpatient hospital care, see "Hospital – Inpatient Services		
Please Note: No Member Cost Sharing applies to certain preventive care services. For a list of covered preventive services, please see the Preventive Services notice at: **www.harvardpilgrim.org.**			
Wigs and Scalp Hair Prostheses as required by law			
– Limited to $350 per calendar year (see the Benefit Handbook for details)	20% Coinsurance		

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MASSACHUSETTS HMO
General List of Exclusions

The following list identifies services that are generally excluded from Harvard Pilgrim HMO Plans. Additional services may be excluded related to access or product design. For a complete list of exclusions please refer to the specific plan's Benefit Handbook.

Exclusion	Description
Alternative Treatments	
	1. Acupuncture care, except when specifically listed as a Covered Benefit. 2. Acupuncture services that are outside the scope of standard acupuncture care. 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 (therapeutic outdoor 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. 7. Myotherapy.
Dental Services	
	1. Dental Care, except the specific dental services listed as Covered Benefits in this Benefit Handbook, your Schedule of Benefits, and any associated riders. 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 and any associated riders). 4. Pediatric dental care, except when specifically listed as a Covered Benefit (please see your Schedule of Benefits and any associated riders).
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. 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.

Exclusion	Description
Foot Care	
	1. Foot orthotics, except for the treatment of severe diabetic foot disease or when specifically listed as a Covered Benefit. . 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.
Maternity Services	
	1. Planned home births. 2. Services for a newborn who has not been enrolled as a Member, other than nursery charges for routine services provided to a healthy newborn.
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 substance abuse 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. 8. 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. Spinal manipulative therapy (including care by a chiropractor), except when specifically listed as a Covered Benefit. 3. Commercial diet plans, weight loss programs and any services in connection with such plans or programs, except as provided in the Benefit Handbook under Wellness Benefits. 4. If a service is listed as requiring that it be provided at a Center of Excellence, no In-Network coverage will be provided if that service is received from a Provider that has not been designated as a Center of Excellence. 5. 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). 6. Physical examinations and testing for insurance, licensing or employment. 7. Services for Members who are donors for non-members, except as described under Human Organ Transplant Services. 8. Testing for central auditory processing. 9. Group diabetes training, educational programs or camps.

Exclusion	Description
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. 3. Charges for missed appointments. 4. Concierge service fees. (See the Plan's *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 drugs, if infertility services are not a Covered Benefit. 4. Infertility drugs that must be purchased at an outpatient pharmacy, unless your Plan includes outpatient pharmacy coverage. 5. Infertility treatment for Members who are not medically infertile. 6. Infertility treatment and birth control drugs, implants and devices, except when specifically listed as a Covered Benefit. 7. Reversal of voluntary sterilization (including any services for infertility related to voluntary sterilization or its reversal). 8. Sperm collection, freezing and storage except as described in the Plan's *Benefit Handbook.* 9. Sperm identification when not Medically Necessary (e.g., gender identification). 10. The following fees: wait list fees, non-medical costs, shipping and handling charges etc. 11. Voluntary sterilization, including tubal ligation and vasectomy, except when specifically listed as a Covered Benefit. 12. Voluntary termination of pregnancy, unless the life of the mother is in danger or unless it is specifically listed as a Covered Benefit.
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.

Exclusion	Description
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. 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 the Plan's Benefit Handbook. 2. Hearing aids for self-insured groups, except when specifically listed as a Covered Benefit. 3. Hearing aid batteries, and any device used by individuals with hearing impairment to communicate over the telephone or internet, such as TTY or TDD. 4. Refractive eye surgery, including, but not limited to, lasik surgery, orthokeratology and lens implantation for the correction of myopia, hyperopia and astigmatism. 5. Routine eye examinations, except when specifically listed as a Covered Benefit.
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 and hypodermic syringes and needles, as required by Massachusetts law, 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 Plan's Benefit Handbook, Schedule of Benefits or Prescription Drug Brochure (if applicable). 9. Services that are not Medically Necessary. 10. Taxes or governmental assessments on services or supplies.

Exclusion	Description
All Other Exclusions (Continued)	
	11. Transportation other than by ambulance. 12. 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.