Schedule of Benefits

THE HARVARD PILGRIM TIERED COPAYMENT HMO
MASSACHUSETTS

This Schedule of Benefits summarizes your Benefits under The Harvard Pilgrim 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**.

Your Covered Benefits are administered on a Calendar Year basis.

DEDUCTIBLE

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.

Not all services under this Plan are subject to the Deductible. Deductible amounts are incurred on the date of service. Your Plan Deductible amounts are listed below.

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

a. If a Member of a covered family meets 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 receive coverage for services subject to that Deductible for the remainder of the Calendar Year.

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

PRESCRIPTION DRUG DEDUCTIBLE

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 amount(s) listed below. Please refer to your Prescription Drug Brochure for specific information on your prescription drug Deductible, if any.

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 covered services that is payable by the Member. Please see the tables below for the Coinsurance amounts that apply to your Plan.

COPAYMENTS

A Copayment is a dollar amount that is payable by the Member for certain covered services. The Copayment is due at the time services are rendered or when billed by the provider. Different Copayments apply depending on the type of service, the specialty of the provider and the location of service.

There are two types of outpatient Copayments that apply to your Plan. A lower Copayment, known as "Copayment Level 1," applies to some outpatient services, including most primary care, obstetrical care, gynecological care, and mental health care (including the treatment of substance abuse disorders). Most outpatient specialty care requires payment of a higher Copayment, known as "Copayment Level 2." The Level 1 and Level 2 Copayments that apply to your Plan are listed 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:

COPAYMENT LEVEL 1

Copayment Level 1 always applies to the following outpatient services regardless of the provider or location of service:

- Infertility services and treatments
- Physical and Occupational Therapy
- Pulmonary Rehabilitation Therapy
- Routine eye examinations
- Speech-language and hearing services
- Voluntary sterilization
- Voluntary termination of pregnancy

In addition to the Level 1 Services listed above, Copayment Level 1 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

COPAYMENT LEVEL 2

Copayment Level 2 applies to the following outpatient professional services:

- Any covered **service** or **provider** that is not listed under Copayment Level 1 or
- Any **service** provided in a hospital operated doctor's office, except the specific services listed under Copayment Level 1 above.

If a provider is categorized as both a Copayment Level 1 provider and a Copayment Level 2 provider, Copayment Level 1 applies. For example, if a provider is both a PCP and a cardiologist, you will be responsible for Copayment Level 1.

A Copayment applies to all services except where specifically stated in the tables below.

Please Note: Occasionally the Copayment may exceed the contract rate payable by the Plan for a service. If the Copayment is greater than the contract rate, you are responsible for the full Copayment, and the provider keeps the entire Copayment.

General Cost Sharing Features:	Member Cost Sharing:
Tiered Copayments	
	Copayment Level 1: Your Plan has a $20 Copayment per visit **Copayment Level 2:** Your Plan has a $40 Copayment per visit
Please see the "Copayments" section for an explanation of your Level 1 and your Level 2 Copayments.	
Coinsurance and Copayments	
	See Covered Benefits below
Deductible	
– The Deductible applies to all services except where specifically noted below.	$150 per Member per calendar year $300 per family per calendar year

General Cost Sharing Features:	Member Cost Sharing:
Out-of-Pocket Maximum	
Includes all Member Cost Sharing. **Please note:** The Out-of-Pocket Maximum includes mental health care (including the treatment of substance abuse disorders) cost sharing administered by United Behavioral Health.	$3,500 per Member per Calendar Year $8,750 per family per Calendar Year

Benefit	Member Cost Sharing:
Acupuncture Treatment for Injury or Illness	
For the acupuncture provider directory, go to **http://hphcacu.wholehealthmd.com**	
– Limited to 20 visits per Calendar Year	Copayment Level 1: $20 Copayment per visit
Ambulance Transport	
– Emergency ambulance transport	No charge
– Non-emergency ambulance transport	No charge
Chemotherapy and Radiation Therapy – Other than Inpatient	
– Outpatient hospital or other facility	Deductible, then no charge
– Physician office visit	Copayment Level 1: $20 Copayment per visit Copayment Level 2: $40 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 **Please Note:** Services must be received within 3 days of injury	Your Member Cost Sharing will depend upon the types of services provided, as listed in this Schedule of Benefits. For example, for services provided in a dentist's office, see "Physician and Other Professional Office Visits." 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, 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 14) – limited to 2 preventive dental exams per Calendar Year, only the following services are included: – cleaning – fluoride treatment – teaching plaque control – x-rays	No charge

Benefit	Member Cost Sharing:
Dialysis	
– Dialysis services	Deductible, then no charge
– Installation of home equipment is covered up to $300 in a Member's lifetime.	Deductible, then no charge
Durable Medical Equipment	
– Durable Medical Equipment	Deductible, then no charge
– Blood Glucose Monitors, Infusion Devices and Insulin Pumps (including supplies)	Deductible, then no charge
– Pharmacy supplies	Prescription drug coverage is available from CVS/Caremark. For more information, please call **1-855-248-3445**.
– Oxygen and Respiratory Equipment	Deductible, then no charge
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 Room Care	
	Deductible, then $150 Copayment per visit This Copayment is waived if admitted to the hospital directly from the emergency room.
Hearing Aids	
– Limited to $2,500 per calendar year	Deductible, then no charge
Home Health Care	
	Deductible, then no charge
Hospice – Outpatient Services	
	Deductible, then no charge
Hospital – Inpatient Services	
– Acute Hospital Care	Deductible, then $350 Copayment per admission
– Inpatient Maternity Care	Deductible, then $350 Copayment per admission
– Inpatient Routine Nursery Care, including prophylactic medication to prevent gonorrhea	No charge
– Inpatient Rehabilitation – Limited to 100 days per Calendar Year	Deductible, then $350 Copayment per admission
– Skilled Nursing Facility – Limited to 100 days per Calendar Year	Deductible, then no charge

Benefit	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)	
– Member's must be enrolled in **EMC's Reproductive Resource Services (RRS) Program** in order to be eligible for infertility services. Please call **1-866-774-4626** from more information on the program. – Certain infertility services, including Assisted Reproductive Technologies (ART) are subject to Harvard Pilgrim Health Care Prior Approval based on relevant clinical criteria. ART services are limited to a maximum of (6) cycles per lifetime to be evaluated and authorized based on relevant clinical criteria at that point in time. Clinical criteria are available from Harvard Pilgrim upon request.	Copayment Level 1: $20 Copayment per visit for outpatient services If inpatient services are required please see "Hospital - Inpatient Services" for Member Cost Sharing details.
Laboratory and Radiology Services	
– Laboratory services at a physician's office or non-hospital affiliated facility	No charge
– Laboratory services at an Acute Hospital or hospital affiliated facility	Deductible, then 10% Coinsurance
– x-rays at a physician's office, non-hospital affiliated facility	No charge
– x-rays at an Acute Hospital, and hospital affiliated facility	Deductible, then no charge
– High end radiology (CT scans, PET scans, MRI and MRA, and nuclear medicine services) at a physician's office or non-hospital affiliated facility	Deductible, then no charge

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Benefit	Member Cost Sharing:
Laboratory and Radiology Services (Continued)	
– High end radiology (CT scans, PET scans, MRI and MRA, and nuclear medicine services) at an Acute hospital or hospital affiliated facility	Deductible, then 10% Coinsurance
No Member Cost Sharing applies to certain preventive care services. See "Preventive Services and Tests," below.	
Low Protein Foods	
– Limited to $5,000 per Calendar Year	Deductible, then no charge
Maternity Care - Outpatient	
EMC's Maternity Support Program - The program assists parents-to-be through the whole maternity experience including integration with other Maternity Management and wellness programs. Please call **1-877-201-5328** for more information on the program.	
Routine outpatient prenatal and postpartum care	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, 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	
	Deductible, then no charge
Mental Health Care (Including the Treatment of Substance Abuse Disorders)	
Benefits for mental health and drug and alcohol rehabilitation services are covered under your Behavioral Health Benefits administered by United Behavioral Health. To avail yourself of these services, please call **1-866-808-5062.**	
Ostomy Supplies	
	Deductible, then no charge
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	Copayment Level 1: $20 Copayment per visit Copayment Level 2: $40 Copayment per visit
– Administration of allergy injections	$5 Copayment per visit
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

Benefit	Member Cost Sharing:
Preventive Services and Tests (Continued)	
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 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**.	
Prosthetic Devices	
	Deductible, then no charge
Rehabilitation Therapy - Outpatient	
– Cardiac Rehabilitation	Copayment Level 1: $20 Copayment per visit Copayment Level 2: $40 Copayment per visit
– Pulmonary rehabilitation therapy	Copayment Level 1: $20 Copayment per visit
– Speech-Language and Hearing Services	Copayment Level 1: $20 Copayment per visit
– Occupational therapy – limited to 100 visits per Calendar Year – Physical therapy – limited to 100 visits per Calendar Year	Copayment Level 1: $20 Copayment per visit
Scopic Procedures - Outpatient Diagnostic and Therapeutic	
– Colonoscopy, endoscopy and sigmoidoscopy	Your Member Cost Sharing will depend upon where the service is provided 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)	
– Limited to 20 visits per Calendar Year	Copayment Level 1: $20 Copayment per visit
Surgery – Outpatient	
	Deductible, then $200 Copayment per visit
Telehealth	
Non-urgent/non-emergent medical consultations by phone or video are available to EMC members by calling Teladoc at 1-800-TELADOC.	No charge

THE HARVARD PILGRIM TIERED COPAYMENT HMO - *MASSACHUSETTS*

Benefit	Member Cost Sharing:
Urgent Care Center Services	
– Convenience care clinic	$20 Copayment per visit
– Urgent care clinic (including hospital urgent care clinic)	$40 Copayment per visit
Vision Services	
– Routine eye examinations – limited to 1 exam per Calendar Year	Copayment Level 1: $20 Copayment per visit
– Vision hardware for special conditions (see the Benefit Handbook for details)	No charge
Voluntary Sterilization	
	Copayment Level 1: $20 Copayment per visit **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**.
Voluntary Termination of Pregnancy	
	Copayment Level 1: $20 Copayment per visit
Wigs and Scalp Hair Prostheses as required by law	
	Deductible, then no charge

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. 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. 6. Massage therapy. 7. Myotherapy.
Dental Services	
	1. Dental Care, except when specifically listed as a Covered Benefit. 2. All services of a dentist for Temporomandibular Joint Dysfunction (TMD). 3. Extraction of teeth, except when specifically listed as a Covered Benefit. 4. Pediatric dental care, except when specifically listed as a Covered Benefit.
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. 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. 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. 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. Planned home births. 3. 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. Methadone maintenance, except when specifically listed as a Covered Benefit. 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 when specifically listed as a Covered Benefit. 4. Gender reassignment surgery and all related drugs and procedures for self-insured groups, unless covered under a separate rider. 5. 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. 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.

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. 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.
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. 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, except when specifically listed as a Covered Benefit. 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 when specifically listed as a Covered Benefit. 2. Hearing aids, 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 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.

Exclusion	Description
All Other Exclusions (Continued)	
	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.