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Schedule of Benefits

Harvard Pilgrim Health Care of New England, Inc.

BEST BUY HMO – LP
NEW HAMPSHIRE

Coverage under this Plan is under the jurisdiction of the New Hampshire Insurance Commissioner.

IMPORTANT INFORMATION: This policy reflects the known requirements for compliance under The Affordable Care Act as passed on March 23, 2010. As additional guidance is forthcoming from the U.S. Department of Health and Human Services, and the New Hampshire Insurance Department, those changes will be incorporated into your health insurance policy.

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

In a Medical Emergency you should go to the nearest emergency facility or call 911 or other local emergency number. A Referral from your 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** or by calling **1-888-888-4742 ext. 38723**.

Select LP Providers

HPHC-NE has designated certain facilities as Select LP Providers. These providers were chosen based on their cost efficiency and render the same quality of service at a lower cost than other Plan Providers in the network. When you receive certain services from a Select LP Provider, your Member out-of-pocket costs will be less than if you received the same service from providers that are not Select LP Providers. The tables set forth below identify the outpatient services which may be obtained from Select LP providers and list the Member Cost Sharing for those services when provided by a Select LP Provider or other Plan Provider.

The Plan's Provider Directory lists all Plan Providers including those providers that are Select LP Providers. 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 the Member Services Department at **1-888-333-4742**.

HPHC-NE establishes its list of Select LP Providers in January of each year. HPHC-NE will not remove providers from its Select LP Provider List during January through the following December of each year. HPHC-NE may also add Select LP Providers to its list any time during the year.

Copayment Levels

There are two types of office visit Copayments that apply to your Plan: a lower Copayment, known as "Level 1" and a higher Copayment known as "Level 2."

Level 1 applies to covered outpatient professional services from the following types of providers: all Primary Care Providers (PCPs); obstetricians and gynecologists; Licensed Mental Health Professionals; certified midwives; and nurse practitioners.

Level 2 applies to most outpatient specialty care.

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

Your Plan may have other Copayment amounts. Please see the benefit table below for specific Copayment requirements.

Covered Benefits

Your Covered Benefits are administered on a Calendar Year basis. 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 physician'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 "Surgery – Outpatient."

General Cost Sharing Features:	Member Cost Sharing:
Coinsurance and Copayments	
	See the benefits table below
Deductible	
	$3,000 per Member per Calendar Year $9,000 per family per Calendar Year
Deductible Rollover	
None	
Durable Medical Equipment and Prosthetic Devices Deductible	
	$100 per Member per Calendar Year
Out-of-Pocket Maximum	
Includes all Member Cost Sharing	$6,500 per Member per Calendar Year $13,000 per family per Calendar Year

Benefit	Member Cost Sharing
Acupuncture Treatment for Injury or Illness	
– Limited to 20 visits per Calendar Year	Level 1: $25 Copayment per visit
Ambulance Transport	
Emergency ambulance transport	Deductible, then no charge
Non-emergency ambulance transport	Deductible, then no charge
Autism Spectrum Disorders Treatment	
Applied behavior analysis	Level 1: $25 Copayment per visit
Chemotherapy and Radiation Therapy	
Chemotherapy	Deductible, then no charge

Benefit	Member Cost Sharing
Chemotherapy and Radiation Therapy (Continued)	
Radiation therapy	Deductible, then no charge
Chiropractic Care	
– Limited to 12 visits per Calendar Year	Level 1: $25 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.	
Extraction of teeth impacted in bone (performed in a physician's office)	Not covered
Preventive dental care for children	Not covered
Outpatient surgery expenses for dental care	Your Member Cost Sharing will depend upon the types of services provided, as listed in this Schedule of Benefits. For example, for services provided by a physician, see "Physician and Other Professional Office Visits." For day surgery, see "Surgery – Outpatient."
Dialysis	
	Deductible, then no charge
Durable Medical Equipment	
Durable medical equipment	Durable Medical Equipment and Prosthetic Devices Deductible, then 20% Coinsurance
Blood glucose monitors, infusion devices and insulin pumps (including supplies)	No charge
Oxygen and respiratory equipment	No charge
Early Intervention	
– Limited to $3,200 per Member per Calendar Year, up to $9,600 per lifetime	Level 1: $25 Copayment per visit
Emergency Room Care	
– Medical Emergency services	Deductible, then $250 Copayment per visit This Copayment is waived if admitted to the hospital directly from the emergency room.
– Services that do not meet the definition of Medical Emergency	Deductible, then 50% Coinsurance
Hearing Aids	
– Limited to $1,500 per hearing aid every 60 months, for each hearing impaired ear	20% Coinsurance
Home Health Care	
	Deductible, then no charge
If services include the administration of drugs, please see the benefit for "Medical Drugs" for Member Cost Sharing details.	
Hospice - Outpatient	
	Deductible, then no charge
Hospital – Inpatient Services	
Acute hospital care	Deductible, then no charge

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Benefit	Member Cost Sharing
Hospital – Inpatient Services (Continued)	
Inpatient maternity care	Deductible, then no charge
Inpatient routine nursery care	No charge
Inpatient rehabilitation – limited to 100 days per Calendar Year Day limits combined with skilled nursing facility care	Deductible, then no charge
Skilled nursing facility – limited to 100 days per Calendar Year Day limits combined with inpatient rehabilitation care	Deductible, then no charge
Infertility Services and Treatments	
Diagnostic services for infertility including: consultation, evaluation and laboratory tests	Your Member Cost Sharing will depend upon the types of services provided, as listed in this Schedule of Benefits. For example, for services provided by a physician, see "Physician and Other Professional Office Visits.
Infertility treatment (see the Benefit Handbook for details)	Not covered
Laboratory, Radiology and Other Diagnostic Services	
Laboratory	**Select LP Providers** No charge **Other Plan Providers** 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 – in an acute hospital or hospital affiliated facility	Deductible, then $350 Copayment per visit
– in an physician's office or non-hospital affiliated facility	$250 Copayment per visit
Other diagnostic tests	Deductible, then no charge
Low Protein Foods	
– Limited to $1,800 per Member per Calendar Year	20% Coinsurance
Maternity Care – Outpatient	
Routine outpatient prenatal and postpartum care	No charge
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, Member Cost Sharing for services provided by a specialist is listed under "Physician and Other Professional Office Visits" and Member Cost Sharing for an ultrasound billed as a specialized or non-routine service is listed under "Laboratory and Radiology Services."	
Medical Drugs (drugs that cannot be self-administered)	
Medical drugs received in a physician's office or other outpatient facility	Deductible, then no charge
Medical drugs received in the home	Deductible, then no charge

Benefit	Member Cost Sharing
Medical Drugs (drugs that cannot be self-administered) (Continued)	
Some Medical Drugs may be supplied by a specialty pharmacy. When Medical Drugs are supplied by a specialty pharmacy, the Member Cost Sharing listed above will apply.	
Medical Formulas	
	20% Coinsurance
Mental Health and Substance Use Disorder Treatment	
Inpatient services	Deductible, then no charge
Partial hospitalization services	Deductible, then no charge
Outpatient group therapy	$10 Copayment per visit
Outpatient treatment including individual therapy, detoxification, and medication management	Level 1: $25 Copayment per visit
Outpatient methadone maintenance	No charge
Outpatient psychological testing	Level 1: $25 Copayment per visit
eVisits	No charge
Observation Services	
	Deductible, then no charge
Ostomy Supplies	
	Durable Medical Equipment and Prosthetic Devices Deductible, then 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
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 the Preventive Services Notice on our website at **www.harvardpilgrim.org**. 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	Level 1: $25 Copayment per visit Level 2: $50 Copayment per visit
Additional Member Cost Sharing may apply. Please refer to the specific benefit in this Schedule of Benefits. For example, if you need sutures, please refer to office based treatments and procedures below. If you need an x-ray or have blood drawn, please refer to "Laboratory, Radiology and Other Diagnostic Services."	
Office based treatment and procedures including but not limited to: casting, suturing and the application of dressings, non-routine foot care, and surgical procedures	Deductible, then no charge
Administration of allergy injections	$25 Copayment per visit
eVisits	No charge

Benefit	Member Cost Sharing
Preventive Services and Tests	
	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, 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**. Harvard Pilgrim will add or delete services from this benefit for preventive services and tests in accordance with Federal guidance.	
Prosthetic Devices	
	Durable Medical Equipment and Prosthetic Devices Deductible, then 20% Coinsurance
Rehabilitation and Habilitation Services – Outpatient	
Cardiac rehabilitation Pulmonary rehabilitation therapy	Level 2: $50 Copayment per visit
Occupational, physical and speech therapy – limited to 60 visits combined per Calendar Year	Level 2: $50 Copayment per visit
Please Note: Outpatient physical, occupational and speech therapies are covered without limits to the extent Medically Necessary for children under the age of three.	
Scopic Procedures - Outpatient Diagnostic and Therapeutic	
Colonoscopy, endoscopy and sigmoidoscopy	**Select LP Providers** $125 Copayment per visit **Other Plan Providers** Deductible, then $250 Copayment per visit
Surgery – Outpatient	
	Select LP Providers $125 Copayment per visit **Other Plan Providers** Deductible, then $250 Copayment per visit
Telemedicine – Outpatient	
	Your Member Cost Sharing will depend upon the types of services provided, as listed in this Schedule of Benefits. For example, for services provided by a physician, see "Physician and Other Professional Office Visits."
For inpatient hospital care, see "Hospital – Inpatient Services" for cost sharing details.	
Urgent Care Services	
Convenience care clinic	Level 1: $25 Copayment per visit
Urgent care center	$50 Copayment per visit
Hospital urgent care center	Deductible, then $125 Copayment per visit
Additional Member Cost Sharing may apply. Please refer to the specific benefit in this Schedule of Benefit. For example, if you have an x-ray or have blood drawn, please refer to "Laboratory and Radiology Services."	
Vision Services	
Routine eye examinations – limited to 1 exam per Calendar Year	Level 1: $25 Copayment per visit
Vision hardware for special conditions	Deductible, then no charge

Benefit	Member Cost Sharing
Voluntary Sterilization – in a Physician's Office	
	Deductible, then no charge
Voluntary Termination of Pregnancy	
	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 "Office based treatments and procedures." For inpatient hospital care, see "Hospital – Inpatient Services."
Wigs and Scalp Hair Prostheses as required by law	
See the Benefit Handbook for details	Durable Medical Equipment and Prosthetic Devices Deductible, then 20% Coinsurance

Language Assistance Services

Español (Spanish) ATENCIÓN: Si usted habla español, servicios de asistencia lingüística, de forma gratuita, están a su disposición. Llame al 1-888-333-4742 (TTY: 711).

Português (Portuguese) ATENÇÃO: Se você fala português, encontram-se disponíveis serviços linguísticos gratuitos. Ligue para 1-888-333-4742 (TTY: 711).

Kreyòl Ayisyen (French Creole) ATANSYON: Si nou palé Kreyòl Ayisyen, gen asistans pou sèvis ki disponib nan lang nou pou gratis. Rele 1-888-333-4742 (TTY: 711).

繁體中文 (Traditional Chinese) 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-888-333-4742（TTY：711）。

Tiếng Việt (Vietnamese) CHÚ Ý: Nếu quí vị nói Tiếng Việt, dịch vụ thông dịch của chúng tôi sẵn sàng phục vụ quí vị miễn phí. Gọi số 1-888-333-4742 (TTY: 711).

Русский (Russian) ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-888-333-4742 (телетайп: 711).

العربية (Arabic)
إنتباه: إذا أنت تتكلم اللغة **العربية**، خدمات المساعدة اللغوية متوفرة لك مجانا. **إتصل على 1 888-333-4742**
(TTY: 711)

ខ្មែរ (Cambodian) [ប្រសូជូនដំណឹង៖ បើអ្នកនិយាយភាសាខ្មែរ, សេវាកម្មបកប្រែ ជូនលោកអ្នកដោយឥតគិតថ្លៃ។ ចូរ ទូរស័ព្ទ 1-888-333-4742 (TTY: 711)។

Français (French) ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-888-333-4742 (ATS: 711).

Italiano (Italian) ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-888-333-4742 (TTY: 711).

한국어 (Korean) '알림': 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-888-333-4742 (TTY: 711) 번으로 전화해 주십시오.

ελληνικά (Greek) ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, υπάρχουν στη διάθεσή σας δωρεάν υπηρεσίες γλωσσικής υποστήριξης. Καλέστε 1-888-333-4742 (TTY: 711).

Polski (Polish) UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-888-333-4742 (TTY: 711).

हिंदी (Hindi) ध्यान दीजिए: अगर आप हिंदी बोलते हैं तो आपके लिये भाषाकी सहायता मुफ्त में उपलब्ध है. जानकारी के लिये फोन करे. 1-888-333-4742 (TTY: 711)

ગુજરાતી (Gujarati) ધ્યાન આપો : જો તમે ગુજરાતી બોલતા હો તો આપને માટે ભાષાકીય સહાય તદ્દન મફત ઉપલબ્ધ છે. વિશેષ માહિતી માટે ફોન કરો. 1-888-333-4742 (TTY: 711)

ພາສາລາວ (Lao) ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-888-333-4742 (TTY: 711).

ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call 1-888-333-4742 (TTY: 711).

Harvard Pilgrim Health Care includes Harvard Pilgrim Health Care, Harvard Pilgrim Health Care of Connecticut, Harvard Pilgrim Health Care of New England and HPHC Insurance Company.

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General Notice About Nondiscrimination and Accessibility Requirements

Harvard Pilgrim Health Care and its affiliates as noted below ("HPHC") comply with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. HPHC does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

HPHC:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, audio, other formats)
- Provides free language services to people whose primary language is not English, such as qualified interpreters.

If you need these services, contact our Civil Rights Compliance Officer.

If you believe that HPHC has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with: Civil Rights Compliance Officer, 93 Worcester St, Wellesley, MA 02481, (866) 750-2074, TTY service: 711, Fax: (617) 509-3085, Email: civil_rights@harvardpilgrim.org. You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, the Civil Rights Compliance Officer is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
(800) 368-1019, (800) 537-7697 (TTY)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Harvard Pilgrim Health Care includes Harvard Pilgrim Health Care, Harvard Pilgrim Health Care of Connecticut, Harvard Pilgrim Health Care of New England and HPHC Insurance Company.

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Harvard Pilgrim Health Care of New England, Inc.
NEW HAMPSHIRE 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 or holistic 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 and wellness clinics. 6. Massage therapy when performed by anyone other than a licensed physical therapist, physical therapy assistant, occupational therapist, or certified occupational therapy assistant. 7. Myotherapy. 8. Services by a Naturopath that are not covered by other Providers under the Plan.
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. Non-durable medical equipment, unless used as part of the treatment at a medical facility or as part of approved home health care services. 4. 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.
Gender Reassignment Surgery	
	1. Face-lifting. 2. Lip reduction/enhancement. 3. Blepharoplasty. 4. Laryngoplasty, or other voice modification surgery. 5. Facial implants or injections. 6. Silicone injections of the breast. 7. Liposuction. 8. Electrolysis, hair removal, or hair transplantation. 9. Collagen injections. 10. Removal of redundant skin. 11. Reversal of gender reassignment surgery and all related drugs and procedures. 12. Gender reassignment surgery and all related drugs and procedures for self-insured groups, unless covered under a separate rider.
Maternity Services	
	1. Delivery outside the Service Area after the 37th week of pregnancy, or after you have been told that you are at risk for early delivery. 2. Routine pre-natal and post-partum care when you are traveling outside the Service Area.
Mental Health Care	
	1. Biofeedback. 2. Educational services or testing. No benefits are provided: (1) for educational services intended to enhance educational achievement; (2) to resolve problems of school performance; or (3) to treat learning disabilities. 3. Methadone maintenance, except when specifically listed as a Covered Benefit. 4. Sensory integrative praxis tests. 5. Mental health care that is (1) provided to Members who are confined or committed to a jail, house of correction, or prison, or (2) provided by the Department of Youth Services or the Department of Mental Health. 6. Services or supplies for the diagnosis or treatment of mental health and drug and alcohol rehabilitation services that, in the reasonable judgment of the Behavioral Health Access Center, are any of the following: • Not consistent with prevailing national standards of clinical practice for the treatment of such conditions.

Exclusion	Description
Mental Health Care (Continued)	
	• 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.
Physical Appearance	
	1. Cosmetic Services, including drugs, devices, treatments and procedures, except for (1) Cosmetic Services that are incidental to the correction of Physical Functional Impairment, (2) restorative surgery to repair or restore appearance damaged by an accidental injury, and (3) post-mastectomy care. 2. Hair removal or restoration, including, but not limited to, electrolysis, laser treatment, transplantation or drug therapy. 3. Liposuction or removal of fat deposits considered undesirable. 4. Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures). 5. Skin abrasion procedures performed as a treatment for acne. 6. Treatment for skin wrinkles or any treatment to improve the appearance of the skin. 7. Treatment for spider veins. 8. Wigs, except as required by law or when specifically listed as a Covered Benefit.
Procedures and Treatments	
	1. Chiropractic care, except when specifically listed as a Covered Benefit. 2. Care by a chiropractor outside the scope of standard chiropractic practice, including but not limited to, surgery, prescription or dispensing of drugs or medications, internal examinations, obstetrical practice, or treatment of infections and diagnostic testing for chiropractic care. 3. Commercial diet plans, weight loss programs and any services in connection with such plans or programs. 4. 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. 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. 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, 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 when infertility treatment is listed as a Covered Benefit. 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 either: 1) the life of the mother is in danger, or 2) voluntary termination of pregnancy 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
Telemedicine	
	1. Telemedicine services involving fax, texting, or audio-only telephone. 2. Provider fees for technical costs for the provision of telemedicine services.
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 when specifically listed as a Covered Benefit. 2. Hearing aid batteries, cords, and individual or group auditory training devices and any instrument or device used by a public utility in providing telephone or other communication services. 3. Refractive eye surgery, including, but not limited to, lasik surgery, orthokeratology and lens implantation for the correction of naturally occurring myopia, hyperopia and astigmatism. 4. 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, 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. Medical services that are provided to Members who are confined or committed to jail, house of correction, or prison, or (2) provided by the Department of Youth Services. 7. Services for non-Members. 8. Services for which no charge would be made in the absence of insurance. 9. Services for which no coverage is provided in the Plan's Benefit Handbook, Schedule of Benefits or Prescription Drug Brochure (if applicable).

Exclusion	Description
All Other Exclusions (Continued)	
	10. Services that are not Medically Necessary. 11. Services your PCP or a Plan Provider has not provided, arranged or approved except as described in the Plan's Benefit Handbook. 12. Taxes or governmental assessments on services or supplies. 13. Transportation other than by ambulance. 14. 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.