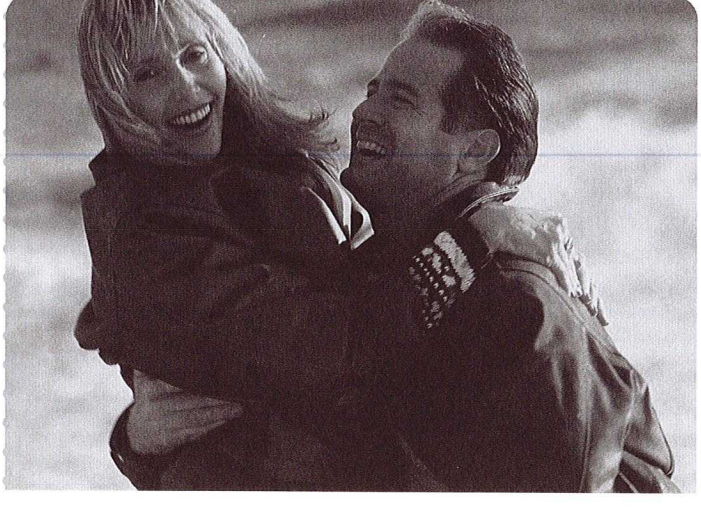
The HPHC Insurance Company Best Buy HSA PPO

Schedule of Benefits



schedule of benefits

HPHC Insurance Company

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Emergency Care. You do not need to contact HPHC before receiving care in a Medical Emergency. In the event of an emergency hospital admission to a Non-Plan Provider, you must notify HPHC within 48 hours of the admission, unless notification is not possible because of your condition. If notice is given to HPHC by an attending emergency physician, no further notification is required. However, if notification is not received when the Member's condition permits it, the Member is responsible for the Penalty amount stated in this Schedule of Benefits. Please call **1-800-708-4414** to notify us of an emergency admission to a Non-Plan facility.

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 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**.

COPAYMENTS

A Copayment is a dollar amount that is payable by the Member for certain Covered Benefits. 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.

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.

COVERED BENEFITS

Your Covered Benefits are administered on a Plan Year basis. Your Plan Year begins on your Employer's Anniversary Date. Please see your Benefit Handbook for more details. If you do not know your Employer's Anniversary Date, please contact your Employer's benefits office or call the Member Services Department at **1-888-333-4742**.

General Cost Sharing Features:	Member Cost Sharing:
Coinsurance and other Copayments	
	See Covered Benefits below
Out-of-Network Coinsurance and Copayments	
	See Covered Benefits below
In-Network Deductible	
	$2,000 for Individual Coverage per Plan Year $4,000 for Family Coverage per Plan Year
Out-of-Network Deductible	
	$4,000 for Individual Coverage per Plan Year $7,000 for Family Coverage per Plan Year
Important Notice: If you have Family Coverage, the Deductible may be met by any combination of covered family Members. The individual Deductible does not apply. No Member in the family is eligible for benefits subject to the Deductible until the Family Coverage Deductible is met.	

General Cost Sharing Features:	Member Cost Sharing:
In-Network Out-of-Pocket Maximum	
Includes all In-Network Member Cost Sharing	$8,000 for Family Coverage per Plan Year – with a $4,000 embedded individual Out-of-Pocket Maximum per Plan Year
Out-of-Network Out-of-Pocket Maximum	
Includes all Out-of-Network Member Cost Sharing except: – Any charges above the Allowed Amount and any penalty for failure to receive Prior Approval when using Non-Plan Providers	$14,000 for Family Coverage per Plan Year – with a $8,000 embedded individual Out-of-Pocket Maximum per Plan Year
Important Notice: If you are a Member with Family Coverage, the Out-of-Pocket Maximum can be satisfied in one of two ways: a. If a Member of a covered family meets an individual embedded Out-of-Pocket Maximum, then that Member has no additional Member Cost Sharing for the remainder of the Plan Year. b. If any number of Members in a covered family collectively meet the family Out-of-Pocket Maximum, then all Members of the covered family have no additional Member Cost Sharing for the remainder of the Plan Year. No one family member may contribute more that the individual embedded Out-of-Pocket Maximum amount to the family Out-of-Pocket Maximum.	
Out-of-Network Penalty Payment	
– Does not count toward the Deductible or Out-of-Pocket Maximum	$500
Deductible Rollover	
– None	

Benefit	In-Network Plan Providers Member Cost Sharing	Out-of-Network Non-Plan Providers Member Cost Sharing
Acupuncture Treatment for Injury or Illness		
– Limited to 20 visits per Plan Year	Deductible, then no charge	Deductible, then 20% Coinsurance
Ambulance Transport		
– Emergency ambulance transport	Deductible, then no charge	Same as In-Network
– Non-emergency ambulance transport	Deductible, then no charge	Deductible, then 20% Coinsurance
Autism Spectrum Disorders Treatment		
– Applied behavior analysis	Deductible, then no charge	Deductible, then 20% Coinsurance
Chemotherapy and Radiation Therapy		
	Deductible, then no charge	Deductible, then 20% Coinsurance

Benefit	In-Network Plan Providers Member Cost Sharing	Out-of-Network Non-Plan Providers Member Cost Sharing
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	Deductible, then no charge	Deductible, then 20% Coinsurance
– Extraction of teeth impacted in bone	Deductible, then no charge	Deductible, then 20% Coinsurance
– Pediatric Dental Care for children (up to the age of 13) – Cleaning – Fluoride treatment – Teaching plaque control – X-rays	$20 Copayment per visit	20% Coinsurance
Dialysis		
– Dialysis services	Deductible, then no charge	Deductible, then 20% Coinsurance
– Installation of home equipment is covered up to $300 in a Member's lifetime.	Deductible, then no charge	Deductible, then 20% Coinsurance
Durable Medical Equipment		
– Durable medical equipment	Deductible, then no charge	Deductible, then 20% Coinsurance
– Blood glucose monitors, infusion devices and insulin pumps (including supplies)	Deductible, then no charge	Same as In-Network
– Oxygen and respiratory equipment	Deductible, then no charge	Deductible, then 20% Coinsurance
Early Intervention Services		
	Deductible, then no charge **Please Note:** The Plan does not cover the family participation fee required by the Massachusetts Department of Public Health	Deductible, then 20% Coinsurance **Please Note:** The Plan does not cover the family participation fee required by the Massachusetts Department of Public Health
Emergency Admission		
	Deductible, then no charge	Same as In-Network
Emergency Room Care		
	Deductible, then no charge	Same as In-Network
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	Deductible, then no charge	Deductible, then 20% Coinsurance

Benefit	In-Network Plan Providers Member Cost Sharing	Out-of-Network Non-Plan Providers Member Cost Sharing
Home Health Care		
	Deductible, then no charge	Deductible, then 20% Coinsurance
Please Note: If your Home Health Care services include the administration of drugs, please see the benefit for "Medical Drugs" for Member Cost Sharing details.		
Hospice - Outpatient		
	Deductible, then no charge	Deductible, then 20% Coinsurance
Hospital – Inpatient Services		
– Acute hospital care	Deductible, then no charge	Deductible, then 20% Coinsurance
– Inpatient maternity care	Deductible, then no charge	Deductible, then 20% Coinsurance
– Inpatient routine nursery care, including prophylactic medication to prevent gonorrhea	No charge	20% Coinsurance
– Home care for mother and newborn following delivery	No charge	20% Coinsurance
– Inpatient rehabilitation – limited to 60 days per Plan Year	Deductible, then no charge	Deductible, then 20% Coinsurance
– Skilled nursing facility – limited to 100 days per Plan Year	Deductible, then no charge	Deductible, then 20% Coinsurance
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 different drug tiers, please visit our website at **www.harvardpilgrim.org/members** and select **"pharmacy/drug tier look up"** or contact our Member Services Department at **1-888-333-4742**.	
Infertility Services and Treatments (see the Benefit Handbook for details)		
	Deductible, then no charge	Deductible, then 20% Coinsurance
Laboratory and Radiology Services		
– Laboratory and x-rays	Deductible, then no charge	Deductible, then 20% Coinsurance

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Benefit	In-Network Plan Providers Member Cost Sharing	Out-of-Network Non-Plan Providers Member Cost Sharing
Laboratory and Radiology Services (Continued)		
Advanced radiology – CT scans – PET scans – MRI – MRA – Nuclear medicine services	Deductible, then no charge	Deductible, then 20% Coinsurance
Please Note: No In-Network 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 Plan Year	Deductible, then no charge	Deductible, then 20% Coinsurance
Maternity Care - Outpatient		
– Routine outpatient prenatal and postpartum care **Note:** Member cost sharing **may** apply to prenatal ultrasounds when billed as a specialized or non-routine service. See "Laboratory and Radiology Services" for your applicable Member Cost Sharing.	No charge The Deductible does not apply to prenatal and postpartum care provided in a physician's office. All other care is covered as stated in this Schedule of Benefits.	20% Coinsurance
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 Drugs (drugs that cannot be self-administered)		
– Medical drugs received in a doctor's office or other outpatient facility	Deductible, then no charge Coverage may also be provided under the Specialty Pharmacy Program. Please see your Prescription Drug Brochure for details.	Deductible, then 20% Coinsurance
– Medical drugs received in the home	Deductible, then no charge Coverage may also be provided under the Specialty Pharmacy Program. Please see your Prescription Drug Brochure for details.	Deductible, then 20% Coinsurance
Please Note: You may also have the Plan's outpatient prescription drug coverage. That benefit provides coverage for most prescription drugs purchased at an outpatient pharmacy. Some medical drugs received in a physician's office or outpatient facility may be provided by the Specialty Pharmacy Program under your outpatient prescription drug benefit. If you have outpatient prescription drug coverage, your Member Cost Sharing will be listed on your ID Card. Please see the Prescription Drug Brochure for a detailed explanation of your benefits.		
Medical Formulas		
	Deductible, then no charge	Deductible, then 20% Coinsurance

Benefit	In-Network Plan Providers Member Cost Sharing	Out-of-Network Non-Plan Providers Member Cost Sharing
Mental Health Care (Including the Treatment of Substance Abuse Disorders)		
Inpatient services – Mental health services – Drug and Alcohol Rehabilitation Services – Detoxification	Deductible, then no charge	Deductible, then 20% Coinsurance
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 for mental health and drug and alcohol rehabilitation services	Deductible, then no charge	Deductible, then 20% Coinsurance
Outpatient services – Mental health services – Drug and alcohol rehabilitation services	**Group therapy** – Deductible, then no charge **Individual therapy** – Deductible, then no charge	**Group therapy** – Deductible, then 20% Coinsurance **Individual therapy** – Deductible, then 20% Coinsurance
– Detoxification	Deductible, then no charge	Deductible, then 20% Coinsurance
– Medication management	Deductible, then no charge	Deductible, then 20% Coinsurance
– Methadone maintenance	Deductible, then no charge	Deductible, then 20% Coinsurance
– Psychological testing and neuropsychological assessment	Deductible, then no charge	Deductible, then 20% Coinsurance
Ostomy Supplies		
	Deductible, then no charge	Deductible, then 20% Coinsurance
Physician and Other Professional Office Visits (This includes all covered Providers unless otherwise listed in this Schedule of Benefits)		
– Consultations, evaluations, sickness, and injury care	Deductible, then no charge	Deductible, then 20% Coinsurance

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Benefit	In-Network Plan Providers Member Cost Sharing	Out-of-Network Non-Plan Providers Member Cost Sharing
Physician and Other Professional Office Visits (This includes all covered 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 – Non-routine foot care – Pregnancy testing – Surgical procedures	Deductible, then no charge	Deductible, then 20% Coinsurance
– Administration of allergy injections	Deductible, then no charge	Deductible, then 20% Coinsurance
Preventive Care Services – the In-Network Deductible and Out-of-Network Deductible do not apply to the preventive services listed below		
– Routine examinations for preventive care, including immunizations	No charge	20% Coinsurance
Preventive Services and Tests – the In-Network Deductible and Out-of-Network Deductible do not apply to the preventive services and tests listed below		
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	20% Coinsurance

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Benefit	In-Network Plan Providers Member Cost Sharing	Out-of-Network Non-Plan Providers Member Cost Sharing
Preventive Services and Tests – the In-Network Deductible and Out-of-Network Deductible do not apply to the preventive services and tests listed below (Continued)		
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 – Routine urinalysis	No charge	20% Coinsurance
Prosthetic Devices		
	Deductible, then no charge	Deductible, then 20% Coinsurance
Rehabilitation and Habilitation Services - Outpatient		
– Cardiac rehabilitation	Deductible, then no charge	Deductible, then 20% Coinsurance
– Pulmonary rehabilitation therapy	Deductible, then no charge	Deductible, then 20% Coinsurance
– Speech-language and hearing services	Deductible, then no charge	Deductible, then 20% Coinsurance
– Occupational therapy – limited to 60 visits per Plan Year – Physical therapy – limited to 60 visits per Plan Year **Please Note:** Outpatient physical and occupational therapy is not subject to the limit listed above and is covered to the extent Medically Necessary for: (1) children under the age of three and (2) the treatment of Autism Spectrum Disorders.	Deductible, then no charge	Deductible, then 20% Coinsurance

Benefit	In-Network Plan Providers Member Cost Sharing	Out-of-Network Non-Plan Providers Member Cost Sharing
Scopic Procedures - Outpatient Diagnostic and Therapeutic		
– Colonoscopy, endoscopy and sigmoidoscopy	Deductible, then no charge	Deductible, then 20% Coinsurance
Please Note: No In-Network Member Cost Sharing applies to certain preventive care services, including screening colonoscopies. 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 Plan Year	Deductible, then no charge	Deductible, then 20% Coinsurance
Surgery – Outpatient		
	Deductible, then no charge	Deductible, then 20% Coinsurance
Urgent Care Services		
– Convenience care clinic	Deductible, then no charge	Deductible, then 20% Coinsurance
– Urgent care clinic (including hospital urgent care clinic)	Deductible, then no charge	Deductible, then 20% Coinsurance
Please Note: 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 Plan Year	$20 Copayment per visit	20% Coinsurance
– Vision hardware for special conditions	Deductible, then no charge	Deductible, then 20% Coinsurance
Voluntary Sterilization		
	Deductible, then no charge	Deductible, then 20% Coinsurance
Please Note: No In-Network 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		
	Deductible, then no charge	Deductible, then 20% Coinsurance
Wigs and Scalp Hair Prostheses as required by law		
– Limited to $350 per Plan Year (see the Benefit Handbook for details)	Deductible, then no charge	Deductible, then 20% Coinsurance

HPHC Insurance Company, Inc.

General List of Exclusions

The following list identifies services that are generally excluded from Harvard Pilgrim PPO and Access America 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. Planned home births.
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. 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. 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 , 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 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.