NPVR00031501

Schedule of Benefits

THE HARVARD PILGRIM CHOICENET℠ BEST BUY HMO
MMHG Benchmark
MASSACHUSETTS

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

This Schedule of Benefits 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 access number. A Referral from your PCP is not needed. Your emergency room Member Cost Sharing is listed in the tables below.

Medical Necessity Guidelines

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 Medical Necessity Guidelines on our website at **www.harvardpilgrim.org** or by calling the Member Services Department at **1-888-333-4742.**

Tiered Providers

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

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

Please Note: When you choose a PCP, it is important to consider the tier of the hospital that your PCP uses. For example, a Tier 1 PCP may admit patients to a Tier 2 or to a Tier 3 Hospital.

Deductibles

A Deductible is a specific annual dollar amount that is payable by the Member for Covered Benefits received each Plan Year before any benefits subject to the Deductible are payable by the Plan. If a family Deductible applies, it is met when any combination of Members in a covered family incur expenses for services to which the Deductible applies. Your Plan's Deductible amounts are listed in the tables below.

The Plan has a maximum Deductible, which is the total amount of Deductible payments you are responsible for in a Plan Year. Any Deductible amount you incur for Covered Plan Year will apply toward the maximum Deductible. In addition, any Deductible amount you incur during a Plan Year applies towards a Deductible of any tier.

The Plan also has limits on the Deductible amounts that apply to each tier. If you only use services in Tier 1 during the Plan Year, you would only be responsible for the Tier 1 Deductible amount in that Plan Year. If you only use services in Tiers 1 and 2 in a Plan Year, you would only be responsible for the Tier 2 Deductible amount in that Plan Year. As explained above, even if you use Tier 3 services, your total liability for Deductible charges is limited to the maximum Deductible amount stated in the table below.

Copayment Levels

There are two types of office visit Copayments that apply to your Plan: a lower Copayment, known as the "Primary Care Copayment," and a higher Copayment, known as the "Specialty and Hospital Based Care Copayment."

The Primary Care Copayment applies to covered outpatient professional services, other than services received at a professional office operated by a hospital, from the following types of providers: all Primary Care Providers (PCPs); obstetricians and gynecologists; Licensed Mental Health Professionals; certified nurse midwives; and nurse practitioners who bill independently.

The Specialty and Hospital Based Care Copayment applies to most outpatient specialty care.

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

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 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**. 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:	Tier 1 Member Cost Sharing:	Tier 2 Member Cost Sharing:	Tier 3 Member Cost Sharing:
Coinsurance and Copayments			
	See the benefits table below		

General Cost Sharing Features:	Tier 1 Member Cost Sharing:	Tier 2 Member Cost Sharing:	Tier 3 Member Cost Sharing:
Deductibles			
The following Deductibles apply to all services except where specifically noted below. The Deductible amount listed in each tier is the maximum you would pay for all services during the Plan Year in that tier or a lower tier.	$300 per Member per Plan Year $900 per family per Plan Year	$300 per Member per Plan Year $900 per family per Plan Year	$300 per Member per Plan Year $900 per family per Plan Year
Maximum Deductible			
	$300 per Member per Plan Year $900 per family per Plan Year		
Deductible Rollover			
	None		
Out-of-Pocket Maximum			
Includes all Member Cost Sharing except Member Cost Sharing for prescription drugs, which has a separate Out-of-Pocket Maximum	$2,000 per Member per Plan Year $4,000 per family per Plan Year		

Benefit	Tier 1 Member Cost Sharing	Tier 2 Member Cost Sharing	Tier 3 Member Cost Sharing
Acupuncture Treatment for Injury or Illness			
– Limited to 12 visits per Plan Year	Copayment: $20 per visit		
Ambulance Transport			
Emergency ambulance transport	Tier 1 Deductible, then no charge		
Non-emergency ambulance transport	Tier 1 Deductible, then no charge		
Autism Spectrum Disorders Treatment			
Applied behavior analysis	Tier 1 Primary Care Copayment: $20 per visit		
Chemotherapy and Radiation Therapy			
	Tier 1 Deductible, then no charge		
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)	Deductible, then no charge	Deductible, then no charge	Deductible, then no charge
Preventive dental care for children (up to the age of 13) – limited to 2 preventive dental exams per Plan Year, only the following services are included: cleaning, fluoride treatment, teaching plaque control and x-rays.	Tier 1 Primary Care Copayment: $20 per visit		

Benefit	Tier 1 Member Cost Sharing	Tier 2 Member Cost Sharing	Tier 3 Member Cost Sharing
Dialysis			
	Tier 1 Deductible, then no charge		
Installation of home equipment is covered up to $300 in a Member's lifetime	Tier 1 Deductible, then no charge		
Durable Medical Equipment			
Durable medical equipment	Tier 1 Deductible, then no charge		
Blood glucose monitors, infusion devices and insulin pumps (including supplies)	No charge		
Oxygen and respiratory equipment	No charge		
Early Intervention Services			
	No charge		
The Plan does not cover the family participation fee required by the Massachusetts Department of Public Health			
Emergency Admission Services			
	Tier 1 Deductible, then $500 Copayment per admission		
Emergency Room Care			
	Tier 1 Deductible, then $100 Copayment per visit		
This Copayment is waived if admitted to the hospital directly from the emergency room.			
Hearing Aids			
– Limited to $1,500 per hearing impaired ear every 2 Plan Years	No charge		
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 $500 Copayment per admission	Deductible, then $500 Copayment per admission	Deductible, then $1,500 Copayment per admission
Inpatient maternity care	Deductible, then $500 Copayment per admission	Deductible, then $500 Copayment per admission	Deductible, then $1,500 Copayment per admission
Inpatient routine nursery care	No charge		
Inpatient rehabilitation	Tier 1 Deductible, then no charge		
Skilled nursing facility – limited to 100 days per Plan Year	Tier 1 Deductible, then 20% Coinsurance		
Infertility Services and Treatments (see the Benefit Handbook for details)			
	Your Member Cost Sharing will depend upon where the service is provided and the tier placement of the provider rendering services, as listed in this Schedule of Benefits. For example, for services provided by a physician, see "Physician and Other Professional Office Visits."		

Benefit	Tier 1 Member Cost Sharing	Tier 2 Member Cost Sharing	Tier 3 Member Cost Sharing
Laboratory, Radiology and Other Diagnostic Services			
Non–hospital based laboratory	Tier 1 Deductible, then no charge		
Physician and hospital based laboratory	Deductible, then no charge	Deductible, then no charge	Deductible, then no charge
Non–hospital based radiology	Tier 1 Deductible, then no charge		
Physician and hospital based radiology	Deductible, then no charge	Deductible, then no charge	Deductible, then no charge
Non–hospital based genetic testing	Tier 1 Deductible, then no charge		
Physician and hospital based genetic testing	Deductible, then no charge	Deductible, then no charge	Deductible, then no charge
Non–hospital based advanced radiology, including CT scans, PET scans, MRI, MRA and nuclear medicine services	Tier 1 Deductible, then no charge		
Hospital based advanced radiology, including CT scans, PET scans, MRI, MRA and nuclear medicine services	Deductible, then $100 Copayment per procedure	Deductible, then $100 Copayment per procedure	Deductible, then $100 Copayment per procedure
Non–hospital based diagnostic services	Tier 1 Deductible, then no charge		
Physician and hospital based diagnostic services	Deductible, then no charge	Deductible, then no charge	Deductible, then no charge
Low Protein Foods			
– Limited to $5,000 per Plan Year	Tier 1 Deductible, then no charge		
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, Radiology and Other Diagnostic 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	Deductible, then no charge	Deductible, then no charge
Medical drugs received in the home	Deductible, then no charge	Deductible, then no charge	Deductible, then no charge
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			
	Tier 1 Deductible, then no charge		
Mental Health and Substance Use Disorder Treatment			
Inpatient Services	Tier 1 Deductible, then $200 Copayment per admission		

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Benefit	Tier 1 Member Cost Sharing	Tier 2 Member Cost Sharing	Tier 3 Member Cost Sharing
Mental Health and Substance Use Disorder Treatment (Continued)			
Intermediate care services – Acute residential treatment (including detoxification), crisis stabilization and in-home family stabilization – Intensive outpatient programs, partial hospitalization and day treatment programs	Tier 1 Deductible, then no charge		
Outpatient group therapy	Copayment: $10 per visit		
Outpatient treatment, including individual therapy, outpatient detoxification and medication management	Tier 1 Primary Care Copayment: $20 per visit		
Outpatient methadone maintenance	No charge		
Outpatient psychological testing and neuropsychological assessment – Performed by a licensed mental health professional	Tier 1 Deductible, then no charge		
– Performed by a neurologist or other medical specialist	See the benefit for "Treatments and Procedures" under "Physicians and other Professional Office Visits."		
Observation Services			
	Tier 1 Deductible, then no charge		
Ostomy Supplies			
	Tier 1 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		
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, Radiology and Other Diagnostic Services" for the Member Cost Sharing that applies to diagnostic services not included on this list.			
Consultations, evaluations, sickness and injury care	Primary Care Copayment: $20 per visit Specialty and Hospital Based Care Copayment: $60 per visit	Primary Care Copayment: $20 per visit Specialty and Hospital Based Care Copayment: $60 per visit	Primary Care Copayment: $20 per visit Specialty and Hospital Based Care Copayment: $60 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."			

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Benefit	Tier 1 Member Cost Sharing	Tier 2 Member Cost Sharing	Tier 3 Member Cost Sharing
Physician and Other Professional Office Visits (This includes all covered Plan Providers unless otherwise listed in this Schedule of Benefits) (Continued)			
Office based 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, and surgical procedures	Deductible, then no charge	Deductible, then no charge	Deductible, then no charge
Administration of allergy injections	No charge	No charge	No charge
Preventive Services and Tests			
	No charge		
Under federal and state 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 and state guidance.			
The following additional preventive services, tests and devices: alpha-fetoprotein (AFP), fetal ultrasound, hepatitis C testing, lead level testing, prostate-specific antigen (PSA) screening, routine hemoglobin tests, group B streptococcus (GBS), routine urinalysis, blood pressure monitor, retinopathy screening, and international normalized ratio (INR) testing.	No charge		
Prosthetic Devices			
	Tier 1 Deductible, then no charge		
Rehabilitation and Habilitation Services - Outpatient			
Cardiac rehabilitation	Deductible, then no charge	Deductible, then no charge	Deductible, then no charge
Pulmonary rehabilitation therapy	Tier 1 Primary Care Copayment: $20 per visit		
Speech-language and hearing services	Tier 1 Primary Care Copayment: $20 per visit		
Physical and occupational therapies – combined up to 60 visits per Plan Year	Tier 1 Primary Care Copayment: $20 per visit		
Scopic Procedures - Outpatient Diagnostic and Therapeutic			
Colonoscopy, endoscopy and sigmoidoscopy	Your Member Cost Sharing will depend upon where the service is provided and the tier placement of the provider rendering services, as listed in this Schedule of Benefits. For example, for a service provided in an outpatient surgical center, see "Surgery – Outpatient." For services provided in a physician's office, see "Physician and Other Professional Office Visits." For inpatient hospital care, see "Hospital – Inpatient Services."		

Benefit	Tier 1 Member Cost Sharing	Tier 2 Member Cost Sharing	Tier 3 Member Cost Sharing
Spinal Manipulative Therapy (including care by a chiropractor)			
– Limited to 20 visits per Plan Year	Tier 1 Primary Care Copayment: $20 per visit		
Surgery – Outpatient			
	Deductible, then $250 Copayment per visit	Deductible, then $250 Copayment per visit	Deductible, then $250 Copayment per visit
Telemedicine Virtual Visit Services- Outpatient			
	Primary Care Copayment: $20 per visit Specialty and Hospital Based Care Copayment: $60 per visit	Primary Care Copayment: $20 per visit Specialty and Hospital Based Care Copayment: $60 per visit	Primary Care Copayment: $20 per visit Specialty and Hospital Based Care Copayment: $60 per visit
For inpatient hospital care, see "Hospital – Inpatient Services" for cost sharing details.			
Urgent Care Services			
Convenience care clinic	$20 Copayment per visit	$20 Copayment per visit	$20 Copayment per visit
Urgent care center	$20 Copayment per visit	$20 Copayment per visit	$20 Copayment per visit
Hospital urgent care center	$20 Copayment per visit	$20 Copayment per visit	$20 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, Radiology and Other Diagnostic Services."			
Vision Services			
Routine eye examinations – limited to 1 exam every 2 Plan Years	No charge	No charge	No charge
Vision hardware for special conditions	Tier 1 Deductible, then no charge		
Voluntary Sterilization in a Physician's Office			
	Deductible, then no charge	Deductible, then no charge	Deductible, then no charge
Voluntary Termination of Pregnancy			
	No charge		
Wigs and Scalp Hair Prostheses as required by law			
	No charge		

General List of Exclusions
MASSACHUSETTS

The following list identifies services that are generally excluded from Harvard Pilgrim 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
Alternative Treatments
• Acupuncture care, except when specifically listed as a Covered Benefit. • Acupuncture services that are outside the scope of standard acupuncture care. • Alternative, holistic or naturopathic services and all procedures, laboratories and nutritional supplements associated with such treatments, except when specifically listed as a Covered Benefit. • Aromatherapy, treatment with crystals and alternative medicine. • Any of the following types of programs: Health resorts, spas, recreational programs, camps, outdoor skills programs, therapeutic or educational boarding schools, educational programs for children in residential care, self-help programs, life skills programs, relaxation or lifestyle programs, and wilderness programs (therapeutic outdoor programs). • Massage therapy. • Myotherapy.
Dental Services
• Dental Care, except when specifically listed as a Covered Benefit. • All services of a dentist for Temporomandibular Joint Dysfunction (TMD). • Extraction of teeth, except when specifically listed as a Covered Benefit. • Pediatric dental care, except when specifically listed as a Covered Benefit.
Durable Medical Equipment and Prosthetic Devices
• Any devices or special equipment needed for sports or occupational purposes. • Any home adaptations, including, but not limited to home improvements and home adaptation equipment. • Non-durable medical equipment, unless used as part of the treatment at a medical facility or as part of approved home health care services. • 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
• Any products or services, including, but not limited to, drugs, devices, treatments, procedures, and diagnostic tests that are Experimental, Unproven, or Investigational.
Foot Care
• Foot orthotics, except for the treatment of severe diabetic foot disease. • 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
• 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. • Planned home births. • Routine pre-natal and post-partum care when you are traveling outside the Service Area.

Exclusion
Mental Health and Substance Use Disorder Treatment
• Biofeedback. • 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 or developmental functioning, (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. • Any of the following types of programs: programs in which the patient has a pre-defined duration of care without the Plan's ability to conduct concurrent determinations of continued medical necessity, programs that only provide meetings or activities not based on individualized treatment plans, programs that focus solely on interpersonal or other skills rather than directed toward symptom reduction and functional recovery related to specific mental health disorders, and tuition based programs that offer educational, vocational, recreational, or personal developmental activities. • Methadone maintenance, except when specifically listed as a Covered Benefit. • Sensory integrative praxis tests. • Services for any condition with only a "Z Code" designation in the Diagnostic and Statistical Manual of Mental Disorders, which means that the condition is not attributable to a mental disorder. • Mental health and substance use disorder treatment 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. • Services or supplies for the diagnosis or treatment of mental health and substance use disorders that, in the reasonable judgment of the Behavioral Health Access Center, are any of the following: not consistent with prevailing national standards of clinical practice for the treatment of such conditions; not consistent with prevailing professional research demonstrating that the services or supplies will have a measurable and beneficial health outcome; typically do not result in outcomes demonstrably better than other available treatment alternatives that are less intensive or more cost effective.. • 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.
Physical Appearance
• 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. • Hair removal or restoration, including, but not limited to, electrolysis, laser treatment, transplantation or drug therapy. • Liposuction or removal of fat deposits considered undesirable. • Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures). • Skin abrasion procedures performed as a treatment for acne. • Treatment for skin wrinkles and skin tags or any treatment to improve the appearance of the skin. • Treatment for spider veins.
Procedures and Treatments
• 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. • Spinal manipulative therapy (including care by a chiropractor), except when specifically listed as a Covered Benefit. • Commercial diet plans, weight loss programs and any services in connection with such plans or programs, except when specifically listed as a Covered Benefit. **Please note**: If you have coverage through an employer group plan, your employer may participate in other wellness and health improvement incentive programs offered by Harvard Pilgrim. Please review all your Plan documents for the amount of incentives, if any, available under your Plan. • Gender reassignment surgery and all related drugs and procedures for self-insured groups, unless covered under a separate rider. • 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. • 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). • Physical examinations and testing for insurance, licensing or employment. • Services for Members who are donors for non-members, except as described under Human Organ Transplant Services. • Testing for central auditory processing. • Group diabetes training, educational programs or camps.

This exclusion list is not binding and is provided exclusively for information purposes. Please see your Benefit Handbook and Schedule of Benefits.

Exclusion
Providers
• Charges for services which were provided after the date on which your membership ends. • 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. • Charges for missed appointments. • Concierge service fees. (See the Plan's *Benefit Handbook* for more information.) • Follow-up care after an emergency room visit, unless provided or arranged by your PCP. • Inpatient charges after your hospital discharge. • Provider's charge to file a claim or to transcribe or copy your medical records. • Services or supplies provided by: (1) anyone related to you by blood, marriage or adoption, or (2) anyone who ordinarily lives with you.
Reproduction
• Any form of Surrogacy or services for a gestational carrier. • Infertility drugs if a Member is not in a Plan authorized cycle of infertility treatment. • Infertility drugs, if infertility services are not a Covered Benefit. • Infertility drugs that must be purchased at an outpatient pharmacy, unless your Plan includes outpatient pharmacy coverage. • Infertility treatment for Members who are not medically infertile. • Infertility treatment and birth control drugs, implants and devices, except when specifically listed as a Covered Benefit. • Reversal of voluntary sterilization (including any services for infertility related to voluntary sterilization or its reversal). • Sperm collection, freezing and storage except as described in the Plan's *Benefit Handbook.* • Sperm identification when not Medically Necessary (e.g., gender identification). • The following fees: wait list fees, non-medical costs, shipping and handling charges etc. • Voluntary sterilization, including tubal ligation and vasectomy, except when specifically listed as a Covered Benefit. • 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
• Costs for any services for which you are entitled to treatment at government expense, including military service connected disabilities. • Costs for services for which payment is required to be made by a Workers' Compensation plan or an Employer under state or federal law.
Telemedicine Services
• Telemedicine services involving e-mail, fax, texting, or audio-only telephone. • Provider fees for technical costs for the provision of telemedicine services.
Types of Care
• Custodial Care. • Recovery programs including rest or domiciliary care, sober houses, transitional support services, and therapeutic communities. • All institutional charges over the semi-private room rate, except when a private room is Medically Necessary. • Pain management programs or clinics. • 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. • Private duty nursing. • Sports medicine clinics. • Vocational rehabilitation, or vocational evaluations on job adaptability, job placement, or therapy to restore function for a specific occupation.
Vision and Hearing
• Eyeglasses, contact lenses and fittings, except when specifically listed as a Covered Benefit. • Hearing aids, except when specifically listed as a Covered Benefit. • Hearing aid batteries, and any device used by individuals with hearing impairment to communicate over the telephone or internet, such as TTY or TDD. • Refractive eye surgery, including, but not limited to, lasik surgery, orthokeratology and lens implantation for the correction of naturally occurring myopia, hyperopia and astigmatism. • Routine eye examinations, except when specifically listed as a Covered Benefit.

This exclusion list is not binding and is provided exclusively for information purposes. Please see your Benefit Handbook and Schedule of Benefits.

Exclusion
All Other Exclusions
• 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. • Any service or supply furnished in connection with a non-Covered Benefit. • Any service or supply (with the exception of contact lenses) purchased from the internet. • Beauty or barber service. • Diabetes equipment replacements when solely due to manufacturer warranty expiration. • Donated or banked breast milk. • Food or nutritional supplements, including, but not limited to, FDA-approved medical foods obtained by prescription, except as required by law and prescribed for Members who meet HPHC policies for enteral tube feedings. • Guest services. • Medical services that are provided to Members who are confined or committed to jail, house of correction, prison, or custodial facility of the Department of Youth Services. • Services for non-Members. • Services for which no charge would be made in the absence of insurance. • Services for which no coverage is provided in the Plan's Benefit Handbook, this Schedule of Benefits, or Prescription Drug Brochure (if applicable). • Services that are not Medically Necessary. • 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"*. • Taxes or governmental assessments on services or supplies. • Transportation other than by ambulance. • 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.

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