Schedule of Benefits

Harvard Pilgrim Health Care of New England, Inc.

THE ELEVATEHEALTH℠ HMO
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 summarizes your Benefits under The ElevateHealth℠ HMO (the Plan) and states the Member Cost Sharing amounts that you must pay for Covered Benefits. However, it is only a summary of your benefits. Please see your Benefit Handbook and Prescription Drug Brochure (if you have the Plan's outpatient pharmacy coverage) for detailed information on benefits covered by the Plan and the terms and conditions of coverage.

Services are covered when Medically Necessary. Subject to the exceptions listed in the section of the Benefit Handbook titled, "How The Plan Works" all services must be (1) provided or arranged by your Primary Care Provider (PCP) and (2) provided by a Plan Provider. These requirements do not apply to care needed in a Medical Emergency.

In a Medical Emergency you should go to the nearest emergency facility or call 911 or other local emergency access number. A Referral from your PCP is not needed. Your emergency room Member Cost Sharing, including your Deductible if applicable, is listed in the tables below.

We use clinical review criteria to evaluate whether certain services or procedures are Medically Necessary for a Member's care. Members or their practitioners may obtain a copy of our clinical review criteria applicable to a service or procedure for which coverage is requested. Clinical review criteria may be obtained by calling **1-888-888-4742 ext. 38723**.

Deductible

A Deductible is a specific 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. Not all services under this Plan are subject to the Deductible. Your Deductible amounts are listed below.

Your Plan may have both an individual Deductible and a family Deductible. Unless a family Deductible applies, you are responsible for the individual Deductible for covered services each Plan Year. If you are a Member with a family Deductible, your Deductible can be satisfied in one of two ways:

a. If a Member of a covered family meets an individual Deductible, then services for that Member that are subject to that Deductible are covered by the Plan for the remainder of the Plan Year.

b. If any number of Members in a covered family collectively meet the family Deductible, then all Members of the covered family receive coverage for services subject to that Deductible for the remainder of the Plan Year.

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

Copayment

A Copayment is a fixed dollar amount that you must pay for certain Covered Benefits. Copayments are due at the time of service or when billed by the Provider.

Your Plan has two levels of Copayments that apply to most outpatient services you receive while a Member of the Plan. These are known as Copayment Level 1 and Copayment Level 2. Copayment Level 1 is lower than the Copayment Level 2.

You may have additional Copayments that apply to other services covered under the Plan. Your specific Copayment amounts are listed in the table below.

COPAYMENT LEVEL 1

Copayment Level 1 applies to covered outpatient professional services from the following types of Plan Providers:

- Primary care providers (PCP)
- Obstetricians and gynecologists
- Nurse practitioners who bill independently
- Services provided by certified midwives
- Chiropractors

In addition to the providers listed above, Copayment Level 1 also applies to the following outpatient services:

- Acupuncture services
- Applied behavior analysis
- Early intervention services
- Mental health and drug and alcohol rehabilitation services
- Routine eye examinations

COPAYMENT LEVEL 2

Copayment Level 2 applies to covered outpatient services not specifically listed above as requiring payment of a Level 1 Copayment. For example, specialty care requires payment of the Level 2 Copayment. Copayment Level 2 is higher than Copayment Level 1.

If a Provider is both a Copayment Level 1 Provider and a Copayment Level 2 Provider, the Copayment Level 1 applies. For example, if a Provider is both a PCP and a Cardiologist, you will be responsible for the Level 1 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:
Tiered Copayments	
	Copayment Level 1: Your Plan has a $25 Copayment per visit **Copayment Level 2:** Your Plan has a $50 Copayment per visit
Coinsurance and Other Copayments	
	See Covered Benefits below
Deductible	
	$4,000 per Member per Plan Year $12,000 per family per Plan Year
Durable Medical Equipment and Prosthetic Devices Deductible	
	$100 per Member per Plan Year
Deductible Rollover	
– None	
Out-of-Pocket Maximum	
Includes all Member Cost Sharing	$6,500 per Member per Plan Year $13,000 per family per Plan Year
Prior Carrier Credit	
– Your Plan has a Prior Carrier Credit for the first Plan Year of coverage toward the Deductible and Coinsurance that applies to your Out-of-Pocket Maximum. See Prior Carrier Credit in your Benefit Handbook for details.	

Benefit	Member Cost Sharing
Acupuncture Treatment for Injury or Illness	
– Limited to 20 visits per Plan Year	Copayment 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 – limited to $36,000 per Plan Year for Members through the age of 12 and $27,000 per Plan Year for Members age 13 to 21	Copayment Level 1: $25 Copayment per visit

Benefit	Member Cost Sharing
Bariatric Surgery	
	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."
Chemotherapy and Radiation Therapy	
– Chemotherapy	No charge
– Radiation therapy	No charge
Chiropractic Care	
– Limited to 12 visits per Plan Year	Copayment 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.	
– Accidental injury 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 in a dentist's office, see "Physician and Other Professional Office Visits." For services provided in a hospital emergency room, see "Emergency Room Care."
Please note: No Member Cost Sharing applies to certain preventive care services. For a list of covered preventive services, please see the Preventive Services notice on our website at: **www.harvardpilgrim.org**.	
– 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	
– Dialysis services	Deductible, then no charge
– Installation of home equipment	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 Plan Year, up to $9,600 per lifetime	Copayment Level 1: $25 Copayment per visit
Emergency Room Care	
	Deductible, then $250 Copayment per visit This Copayment is waived if admitted to the hospital directly from the emergency room.

Benefit	Member Cost Sharing
Gender Reassignment Surgery	
	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."
Hearing Aids	
– Limited to $1,500 per hearing aid every 60 months, for each hearing impaired ear	No charge
Home Health Care	
	No charge
Hospice – Outpatient Services	
	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."
Hospital – Inpatient Services	
– Acute hospital care	Deductible, then no charge
– Inpatient maternity care	Deductible, then no charge
– Inpatient routine nursery care, including prophylactic medication to prevent gonorrhea	No charge
– Inpatient rehabilitation – limited to 100 days per Plan Year Day limits combined with skilled nursing facility care	Deductible, then no charge
– Skilled nursing facility – limited to 100 days per Plan Year Day limits combined with inpatient rehabilitation care	Deductible, then no charge
Infertility Services and Treatments (see the Benefit Handbook for details)	
The Plan covers the following diagnostic services for infertility: – Consultation – Evaluation – Laboratory tests **Please Note:** The Plan does not cover infertility treatment.	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."
Laboratory and Radiology Services	
– Laboratory	Deductible, then no charge

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Benefit	Member Cost Sharing
Laboratory and Radiology Services (Continued)	
– X-rays	Deductible, then no charge
Advanced radiology – CT scans – PET scans – MRI – MRA – Nuclear medicine services	Deductible, then no charge
Please Note: No Member Cost Sharing applies to certain preventive care services. For a list of covered preventive services, please see the Preventive Services notice on our website at: **www.harvardpilgrim.org**.	
Low Protein Foods	
– Limited to $1,800 per Member per Plan Year	No charge
Maternity Care – Outpatient	
– Routine outpatient prenatal and postpartum care	No charge
Please Note: Routine prenatal and postpartum care is usually received and billed from the same Provider as a single or bundled service. Different Member Cost Sharing may apply to any specialized or non-routine service that is billed separately from your routine outpatient prenatal and postpartum care. For example, for services provided by another physician or specialist, see "Physician and Other Professional Office Visits" for your applicable Member Cost Sharing. Please see your Benefit Handbook for more information on maternity care.	
Medical Formulas	
	No charge
Mental Health and Drug and Alcohol Rehabilitation Services	
Inpatient Mental Health Care Services	No charge
– Partial hospitalization	No charge
Outpatient Mental Health Services	Group therapy – $10 Copayment per visit Individual therapy – Copayment Level 1: $25 Copayment per visit
– Medication management	Copayment Level 1: $25 Copayment per visit
– Psychological testing	Copayment Level 1: $25 Copayment per visit
Inpatient Drug and Alcohol Rehabilitation Services	No charge
– Inpatient detoxification	No charge
– Partial hospitalization	No charge
Outpatient Drug and Alcohol Rehabilitation Services	Group therapy – $10 Copayment per visit Individual therapy – Copayment Level 1: $25 Copayment per visit
– Outpatient detoxification	Copayment Level 1: $25 Copayment per visit
Ostomy Supplies	
	Durable Medical Equipment and Prosthetic Devices Deductible, then 20% Coinsurance

Benefit	Member Cost Sharing
Physician and Other Professional Office Visits (This includes all covered Plan Providers unless otherwise listed in this Schedule of Benefits)	
– Routine examinations for preventive care, including immunizations	No charge
– Consultations, evaluations, sickness and injury care	Copayment Level 1: $25 Copayment per visit Copayment Level 2: $50 Copayment per visit
– Treatment and procedures including but not limited to: – Casting, suturing and the application of dressings – Non-routine foot care – Surgical procedures	Deductible, then no charge
– Administration of allergy injections	$5 Copayment per visit
Preventive Services and Tests	
– Preventive care services, including all FDA approved contraceptive devices. Under the federal health care reform law, many preventive services and tests are covered with no Member Cost Sharing. For a complete list of covered preventive services, go to **www.harvardpilgrim.org.** You may also get a copy of the Preventive Services Notice by calling the Member Services Department at **1–888–333–4742**.	No charge
Under federal law the list of preventive services and tests covered above may change periodically based on the recommendations of the following agencies: a. Grade "A" and "B" recommendations of the United States Preventive Services Task Force; b. With respect to immunizations, the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention; and c. With respect to services for women, infants, children and adolescents, the Health Resources and Services Administration. Information on the recommendations of these agencies may be found on the web site of the U.S. Department of Health and Human Services at: **www.healthcare.gov/what-are-my-preventive-care-benefits/#part=1**. Harvard Pilgrim will add or delete services from this benefit for preventive services and tests in accordance with changes in the recommendations of the agencies listed above. You can find a list of the current recommendations for preventive care on Harvard Pilgrim's web site at **www.harvardpilgrim.org**.	
Prosthetic Devices	
	Durable Medical Equipment and Prosthetic Devices Deductible, then 20% Coinsurance
Rehabilitation Therapy - Outpatient	
– Cardiac rehabilitation – Pulmonary rehabilitation therapy	Copayment Level 1: $25 Copayment per visit Copayment Level 2: $50 Copayment per visit

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Benefit	Member Cost Sharing
Rehabilitation Therapy - Outpatient (Continued)	
– Occupational, physical and speech therapy – limited to 60 visits combined per Plan Year **Please Note:** Outpatient physical, occupational and speech therapies are covered to the extent Medically Necessary for children under the age of three.	Copayment Level 2: $50 Copayment per visit
Scopic Procedures - Outpatient Diagnostic and Therapeutic	
Colonoscopy, endoscopy and sigmoidoscopy	Deductible, then no charge
– In a freestanding ambulatory surgery center	$100 Copayment per visit
Please Note: No Member Cost Sharing applies to certain preventive care services. For a list of covered preventive services, please see the Preventive Services notice on our website at: **www.harvardpilgrim.org**.	
Surgery – Outpatient	
– Outpatient Hospital Facility	Deductible, then no charge
– In a freestanding ambulatory surgery center	$100 Copayment per visit
Telemedicine	
– Outpatient and inpatient telemedicine services	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."
Urgent Care Center Services	
	Deductible, then $75 Copayment per visit
Vision Services	
– Routine eye examinations – limited to 1 exam per Plan Year	Copayment Level 1: $25 Copayment per visit
– Vision hardware for special conditions (see the Benefit Handbook for details)	No charge
Voluntary Sterilization	
	Your Member Cost Sharing will depend upon where the service is provided as listed in this Schedule of Benefits. For example, for a service provided in an outpatient surgical center, see "Surgery– Outpatient." For services provided in a physician's office, see "Physician and Other Professional Office Visits." For inpatient hospital care, see "Hospital – Inpatient Services."
Please Note: No Member Cost Sharing applies to certain preventive care services. For a list of covered preventive services, please see the Preventive Services notice on our website at: **www.harvardpilgrim.org**.	

Benefit	Member Cost Sharing
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 "Physician and Other Professional Office Visits." 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

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 services, except when specifically listed as a Covered Benefit. 2. Acupuncture services that are outside the scope of standard acupuncture treatment, except when specifically listed as a Covered Benefit, including services for preventive, maintenance, or wellness care, thermography, hair analysis, heavy metal screening or mineral studies, massage or soft-tissue techniques, diagnostic services, x-rays or services related to menstrual cramps. 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. 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 the specific dental services listed in this Benefit Handbook, your Schedule of Benefits, and any associated riders. 2. All services of a dentist for Temporomandibular Joint Dysfunction (TMD). 3. Extraction of teeth, except when specifically listed as a Covered Benefit (please see your Schedule of Benefits and any associated riders). 4. Pediatric dental care, except when specifically listed as a Covered Benefit (please see your Schedule of Benefits and any associated riders).

Exclusion	Description
Durable Medical Equipment and Prosthetic Devices	
	1. Any devices or special equipment needed for sports or occupational purposes. 2. Any home adaptations, including, but not limited to home improvements and home adaptation equipment. 3. Myoelectric and bionic arms and legs, except when specifically listed as a Covered Benefit. 4. Non-durable medical equipment, unless used as part of the treatment at a medical facility or as part of approved home health care services. 5. Repair or replacement of durable medical equipment or prosthetic devices as a result of loss, negligence, willful damage, or theft.
Experimental, Unproven or Investigational Services	
	1. Any products or services, including, but not limited to, drugs, devices, treatments, procedures, and diagnostic tests that are Experimental, Unproven, or Investigational.
Foot Care	
	1. Foot orthotics, except for the treatment of severe diabetic foot disease or when specifically listed as a Covered Benefit. 2. Routine foot care. Examples include nail trimming, cutting or debriding and the cutting or removal of corns and calluses. This exclusion does not apply to preventive foot care for Members with diabetes.
Maternity Services	
	1. 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. 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, prison, or custodial facility of the Department of Youth Services; or (2) provided by 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. • Not consistent with prevailing professional research demonstrating that the services or supplies will have a measurable and beneficial health outcome.

Exclusion	Description
Mental Health Care (Continued)	
	• 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. Gender reassignment surgery and all related drugs and procedures. 5. 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. 6. Nutritional or cosmetic therapy using vitamins, minerals or elements, and other nutrition-based therapy. Examples include supplements, electrolytes, and foods of any kind (including high protein foods and low carbohydrate foods). 7. Physical examinations and testing for insurance, licensing or employment. 8. Services for Members who are donors for non-members, except as described under Human Organ Transplant Services. 9. Testing for central auditory processing. 10. Group diabetes training, educational programs or camps.

Exclusion	Description
Providers	
	1. Charges for services which were provided after the date on which your membership ends. 2. Charges for any products or services, including, but not limited to, professional fees, medical equipment, drugs, and hospital or other facility charges, that are related to any care that is not a Covered Benefit. 3. Charges for missed appointments. 4. Concierge service fees. (See the Plan's Benefit Handbook for more information.) 5. Follow-up care after an emergency room visit, unless provided or arranged by your PCP. 6. Inpatient charges after your hospital discharge. 7. Provider's charge to file a claim or to transcribe or copy your medical records. 8. Services or supplies provided by: (1) anyone related to you by blood, marriage or adoption, or (2) anyone who ordinarily lives with you.
Reproduction	
	1. Any form of Surrogacy or services for a gestational carrier. 2. Infertility drugs if a member is not in a Plan authorized cycle of infertility treatment. 3. Infertility drugs, if infertility services are not a Covered Benefit. 4. Infertility drugs that must be purchased at an outpatient pharmacy, unless your Plan includes outpatient pharmacy coverage. 5. Infertility treatment for Members who are not medically infertile. 6. Infertility treatment, except when specifically listed as a Covered Benefit , including, but not limited to, therapeutic donor insemination, including related sperm procurement and banking, donor egg procedures, including related egg and inseminated egg procurement, processing and banking, assisted hatching, gamete intrafallopian transfer (GIFT), intra-cytoplasmic sperm injection (ICSI), intra-uterine insemination (IUI), in-vitro fertilization (IVF), zygote intrafallopian transfer (ZIFT), preimplantation genetic diagnosis (PGD), miscrosurgical epididiymal sperm aspiration (MESA) and testicular sperm extraction (TESE). 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 .

Exclusion	Description
Reproduction (Continued)	
	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.
Telemedicine	
	1. Telemonitoring, telemedicine services involving e-mail, fax, or audio-only telephone, telemedicine services involving stored images forwarded for future consultation, i.e. "store and forward" telecommunication.
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. Home health care services that extend beyond care on a short-term intermittent basis. 5. Pain management programs or clinics. 6. Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, and diversion or general motivation. 7. Private duty nursing. 8. Sports medicine clinics. 9. Vocational rehabilitation, or vocational evaluations on job adaptability, job placement, or therapy to restore function for a specific occupation.
Vision and Hearing	
	1. Eyeglasses, contact lenses and fittings, except as listed in the Plan's Benefit Handbook and any associated riders. 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 myopia, hyperopia and astigmatism. 4. Routine eye examinations, except when specifically listed as a Covered Benefit.

Exclusion	Description
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. 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 your Plan includes outpatient pharmacy coverage). 9. Services that are not Medically Necessary. 10. Services your PCP or a Plan Provider has not provided, arranged or approved except as described in the Plan's Benefit Handbook. 11. Taxes or governmental assessments on services or supplies. 12. Transportation other than by ambulance. 13. The following products and services: • Air conditioners, air purifiers and filters, dehumidifiers and humidifiers. • Car seats. • Chairs, bath chairs, feeding chairs, toddler chairs, chair lifts, recliners. • Electric scooters. • Exercise equipment. • Home modifications including but not limited to elevators, handrails and ramps. • Hot tubs, jacuzzis, saunas or whirlpools. • Mattresses. • Medical alert systems. • Motorized beds. • Pillows. • Power-operated vehicles. • Stair lifts and stair glides. • Strollers. • Safety equipment. • Vehicle modifications including but not limited to van lifts. • Telephone. • Television.