Schedule of Benefits

Harvard Pilgrim Health Care, Inc.

THE HARVARD PILGRIM BEST BUY COPAYMENT HMO 1500
MASSACHUSETTS

This Schedule of Benefits summarizes your Benefits under The Harvard Pilgrim Best Buy Copayment HMO 1500 (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 for detailed information on benefits covered by the Plan and the terms and conditions of coverage.

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

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

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

Your Covered Benefits are administered on a Plan Year basis.

DEDUCTIBLE

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.

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

Your Plan has both an individual Deductible and a family Deductible. However, please note that a Family Deductible only applies if you have Family coverage. Unless a family Deductible applies, you are responsible for the individual Deductible for Covered Benefits each 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 the 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.

Your Deductible applies to all services covered under the Plan except the following:

- Applied Behavior Analysis

- Blood glucose monitors, insulin pumps and infusion devices
- Early intervention services
- Examinations and consultations performed by physicians and podiatrists, including periodic routine exams for preventive care
- Family planning consultations and consultations concerning contraception
- Outpatient mental health care services (including the treatment of substance abuse disorders)
- Preventive Care and Preventive Services and Tests, including FDA approved contraceptive devices
- Routine prenatal and postpartum care in a physician's office
- Routine nursery charges for newborn care
- Spinal Manipulative Therapy (including care by a chiropractor)
- Well child care, including vision and auditory screenings

Please note: treatments and procedures by physicians and podiatrists **are** subject to the Deductible.

PRESCRIPTION DRUG DEDUCTIBLE

If your Plan includes outpatient pharmacy coverage, your drug benefit may be subject to a separate Deductible. Payments made toward the prescription drug Deductible are not counted toward the Deductible amount(s) listed below. Please refer to your Prescription Drug Brochure for specific information on your prescription drug Deductible, if any.

DEDUCTIBLE AND OTHER COST SHARING

For certain services, both a Deductible and either a Copayment or Coinsurance may apply. In such cases, you must completely satisfy the Deductible before the Plan pays benefits on services subject to the Deductible. Once you have satisfied the annual Deductible, you are still responsible for any applicable Copayments or Coinsurance.

COINSURANCE

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

COPAYMENTS

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

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

With the exception of preventive services, which are never subject to Member Cost Sharing, the following Copayments apply to the outpatient services covered by your Plan:

Copayment Level 1

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

- Applied Behavior Analysis
- Mental health care (including the treatment of substance abuse disorders)
- Routine eye examinations

In addition to the Level 1 Services listed above, Copayment Level 1 applies to covered outpatient professional services, other than services received at a professional office operated by a hospital, from the following types of providers:

- All Primary Care Providers. The term "Primary Care Provider" (PCP) includes physicians, physician assistants and nurse practitioners in the following specialties: Internal Medicine, Family Practice, General Practice and Pediatrics
- Obstetricians and Gynecologists
- Certified Nurse Midwives
- Nurse Practitioners who bill independently
- Chiropractors

Copayment Level 2

Copayment Level 2 applies to the following outpatient professional services:

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

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

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

General Cost Sharing Features:	Member Cost Sharing:
Deductible	
– The Deductible applies to all services except where specifically noted below.	$1,500 per Member per Plan Year $3,000 per family per Plan Year
Tiered Copayments	
	Copayment Level 1: Your Plan has a $25 Copayment per visit **Copayment Level 2**: Your Plan has a$40 Copayment per visit
Please see the section titled "Copayments" above for an explanation of your Level 1 and your Level 2 Copayments.	
Out-of-Pocket Maximum	
– Includes all Member Cost Sharing	$5,000 per Member per Plan Year $10,000 per family per Plan Year

Benefit	Member Cost Sharing:
Ambulance Transport	
– Emergency ambulance transport	Deductible, then no charge
– Non-emergency ambulance transport	Deductible, then no charge
Autism Spectrum Disorders Treatment	
Applied Behavior Analysis – No benefit limit applies to this service.	Copayment Level 1: $25 Copayment per visit
Chemotherapy and Radiation Therapy - Other than Inpatient	
– Outpatient Hospital or Other Facility	Deductible, then no charge
– Physician Office Visit	Copayment Level 1: $25 Copayment per visit Copayment Level 2: $40 Copayment per visit
Dental Services	
– Emergency Dental Care **Please note:** services must be received within 3 days of injury	Your Member Cost Sharing will depend upon the types of services provided, as listed in this Schedule of Benefits. For example, for services provided in a dentist's office, see "Physician and Other Professional Office Visits." For services provided in a hospital emergency room, see "Emergency Room Care."
– Extraction of teeth impacted in bone	Your Member Cost Sharing will depend upon the types of services provided, as listed in this Schedule of Benefits." For example, for services provided in a dentist's office, see "Physician and Other Professional Office Visits."
Important Notice: Coverage of Dental Care is very limited. Please see your Benefit Handbook for the details of your coverage.	
Dialysis	
– Dialysis services	Deductible, then no charge
– Installation of home equipment	Deductible, then no charge
Durable Medical Equipment	
	Deductible, then 20% Coinsurance Member Cost Sharing does not apply to the following: – Blood glucose monitors – Infusion devices – Insulin pumps (including supplies) – Respiratory equipment – Oxygen and oxygen equipment
Early Intervention Services	
	No charge
Emergency Room Care	
	Deductible, then $150 Copayment per visit This Copayment is waived if admitted to the hospital directly from the emergency room.
Hearing Aids (for Members up to the age of 22)	
– Limited to $2,000 per hearing aid every 36 months, for each hearing impaired ear	No charge
Home Health Care	
	Deductible, then no charge
Hospice - Outpatient Services	
	Deductible, then no charge

Benefit	Member Cost Sharing:
Hospital – Inpatient Services	
– Acute Hospital Care	Deductible, then $250 Copayment per admission
– Inpatient Maternity Care	Deductible, then $250 Copayment per admission
– Inpatient Routine Nursery Care (as described in your Benefit Handbook)	No charge
– Inpatient Rehabilitation – Limited to 60 days per Plan Year	Deductible, then $250 Copayment per admission
– Skilled Nursing Facility – Limited to 100 days per Plan Year	Deductible, then $250 Copayment per admission
Infertility Services and Treatments (see the Benefit Handbook for details)	
	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 and x-rays	Deductible, then no charge
Advanced radiology – CT scans – PET scans – MRI – MRA – Nuclear medicine services	Deductible, then $150 Copayment per procedure
Low Protein Foods	
	Deductible, then 20% Coinsurance
Maternity Care - Outpatient	
Childbirth classes – Coverage for 1 initial childbirth course or 1 refresher course per pregnancy (see the Benefit Handbook for details)	No charge
Routine outpatient prenatal and postpartum care	No charge
Please Note: Routine prenatal and postpartum care is usually received and billed from the same Provider as a single or bundled service. Different Member Cost Sharing may apply to any specialized or non-routine service that is billed separately from your routine outpatient prenatal and postpartum care. For example, for services provided by another physician or specialist, see "Physician and Other Professional Office Visits" for your applicable Member Cost Sharing. Please see your Benefit Handbook for more information on maternity care.	
Medical Formulas	
	Deductible, then 20% Coinsurance

Benefit	Member Cost Sharing:
Mental Health Care (Including the Treatment of Substance Abuse Disorders)	
Inpatient Mental Health Care Services	Deductible, then $250 Copayment per admission
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	Deductible, then no charge
Outpatient Mental Health Care Services	Group therapy – $10 Copayment per visit Individual therapy – Copayment Level 1: $25 Copayment per visit
– Detoxification	Copayment Level 1: $25 Copayment per visit
– Medication management	Copayment Level 1: $25 Copayment per visit
– Psychological testing and neuropsychological assessment	Deductible, then no charge
Ostomy Supplies	
	Deductible, then 20% Coinsurance
Physician and Other Professional Office Visits (This includes all covered Plan Providers unless otherwise listed in this Schedule of Benefits.)	
– Routine examinations for preventive care, including immunizations	No charge
– Consultations, evaluations and sickness and injury care	Copayment Level 1: $25 Copayment per visit Copayment Level 2: $40 Copayment per visit
– Administration of allergy injections	Deductible, then no charge
Preventive Services and Tests	
– Preventive care services, including 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 **https://www.harvardpilgrim.org/pls/portal/docs/page/members/for_members/preventive_care_CC4297.pdf**	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 US Department of Health and Human Services at: **http://www.healthcare.gov/center/regulations/prevention/recommendations.html**.	
Prosthetic Devices	
	Deductible, then 20% Coinsurance

Benefit	Member Cost Sharing:
Rehabilitation Therapy - Outpatient	
– Cardiac Rehabilitation	Deductible, then no charge
– Pulmonary rehabilitation therapy	Deductible, then no charge
– Speech-Language and Hearing Services	Deductible, then no charge
– Physical and occupational therapies combined up to 60 visits per Plan Year **Please note:** Outpatient physical and occupational therapy 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
Scopic Procedures - Outpatient Diagnostic and Therapeutic	
– Colonoscopy, endoscopy and sigmoidoscopy	Your Member Cost Sharing will depend upon where the service is provided as listed in this Schedule of Benefits. For example, for a service provided in an outpatient surgical center, see "Surgery– Outpatient." For services provided in a physician's office, see "Physician and Other Professional Office Visits." For inpatient hospital care, see "Hospital – Inpatient Services."
Spinal Manipulative Therapy (including care by a chiropractor)	
– Limited to 12 visits per Plan Year	Copayment Level 1: $25 Copayment per visit
Surgery - Outpatient	
	Deductible, then $250 Copayment per visit
Vision Services	
– Routine eye examinations limited to (1 per Plan Year)	Copayment Level 1: $25 Copayment per visit
– Vision hardware for special conditions (see the Benefit Handbook for details)	Deductible, then 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."
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."
Wellness Benefits	
Fitness club reimbursement – Coverage provided for the greater of 1 month of membership or $150 per Plan Year (see the Benefit Handbook for details)	No charge

Benefit	Member Cost Sharing:
Wellness Benefits (Continued)	
Weight loss programs – Coverage provided for 3 months of membership at Weight Watchers per Plan Year (see the Benefit Handbook for details)	No charge
Wigs and Scalp Hair Prostheses	
– Limited to 1 synthetic monofilament wig per Plan Year (see the Benefit Handbook for details)	Deductible, then 20% Coinsurance

Outpatient Prescription Drug Coverage

Benefit:	Member Cost Sharing:
Your pharmacy Copayments for up to a 30-day supply are:	
Tier 1:	$15
Tier 2:	$25
Tier 3:	$50
Harvard Pilgrim's mail service prescription drug program.	
You may purchase a 90-day supply of maintenance medications through the Plan's Mail Service Prescription Drug Program. Your mail service Copayments for a 90-day supply are:	
Tier 1:	$30
Tier 2:	$50
Tier 3:	$150
A summary of your cost sharing amounts for your prescription drug coverage is also shown on your Plan identification (ID) card. To obtain coverage for your prescription drugs bring your prescription or refill to a participating pharmacy, along with your ID card, and pay the appropriate amount. Please refer to your Prescription Drug Brochure for detailed information about your coverage.	

Harvard Pilgrim Health Care, Inc.
MASSACHUSETTS 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, holistic or naturopathic 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. 7. Myotherapy.
Dental Services	
	1. Dental Care, except the specific dental services listed as Covered Benefits in the Plan's Benefit Handbook and Schedule of Benefits. 2. All services of a dentist for Temporomandibular Joint Dysfunction (TMD). 3. Extraction of teeth, except when specifically listed as a Covered Benefit. 4. Preventive dental care for children, except when specifically listed as a Covered Benefit. 5. Dentures.
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 leg, 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.

Exclusion	Description
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. Planned home births. 3. Routine pre-natal and post-partum care when you are traveling outside the Service Area.
Mental Health Care	
	1. Biofeedback. 2. Educational services or testing, except services covered under the benefit for Early Intervention Services. No benefits are provided: (1) for educational services intended to enhance educational achievement; (2) to resolve problems of school performance; or (3) to treat learning disabilities. 3. Methadone maintenance. 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. 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 and birth control drugs, implants and devices. 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 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. 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. 2. Hearing aids for self-insured groups, except when specifically listed as a Covered Benefit. 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.
All Other Exclusions	
	1. Any service or supply furnished in connection with a non-Covered Benefit. 2. Beauty or barber service. 3. Any drug or other product obtained at an outpatient pharmacy, except for pharmacy supplies covered under the benefit for diabetes services and hypodermic syringes and needles, as required by law, unless your Plan includes outpatient pharmacy coverage. 4. Food or nutritional supplements, including, but not limited to, FDA-approved medical foods obtained by prescription, except as required by law. 5. Guest services. 6. Services for non-Members. 7. Services for which no charge would be made in the absence of insurance. 8. Services for which no coverage is provided in the Plan's Benefit Handbook, Schedule of Benefits or Prescription Drug Brochure. 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.*

Exclusion	Description
All Other Exclusions (Continued)	
	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.