ID: MD0000002834
CODE: CA-SSF

Schedule of Benefits

THE HPHC INSURANCE COMPANY TIERED COPAY PPO PLAN MASSACHUSETTS

This Schedule of Benefits summarizes your benefits under The HPHC Insurance Company Tiered Copay PPO Plan (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.

There are two levels of coverage - In-Network and Out-of-Network

In-Network coverage applies when you use a Plan Provider for Covered Benefits. When using Plan Providers, coverage is based on the contracted rate between HPHC and the Provider.

Out-of-Network coverage applies when you use a Non-Plan Provider for Covered Benefits. When using Non-Plan Providers, the Plan pays only a percentage of the cost of the care you receive up to the Usual, Customary and Reasonable Charges for the service. In most cases, this will be higher than the HPHC contracted rate. If a Non-Plan Provider charges any amount in excess of the Usual, Customary and Reasonable Charge, you are responsible for the excess amount. Please refer to section I.E.6. Member Cost Sharing in your Benefit Handbook for additional information about Out-of-Network Charges in excess of the Usual, Customary and Reasonable Charge.

You always have coverage for care in a Medical Emergency. In a Medical Emergency, you should go to the nearest emergency facility or call 911 or other local emergency number. Your emergency room Member Cost Sharing is listed below under the heading "Emergency Room Care."

Member Responsibility for Notification and Prior Approval

Members must contact HPHC for coverage of a number of services. These are listed below.

Mental Health Care (Including the Treatment of Substance Abuse Disorders). Prior Approval must be obtained before receiving certain mental health services from Non-Plan Providers. This requirement also applies to treatment of substance abuse disorders. Please refer to our internet site, **www.harvardpilgrim.org**, or contact the Member Services Department at **1-888-333-4742** for a list of services. To obtain Prior Approval for mental health or substance abuse services, please call the Behavioral Health Access Center at **1-888-777-4742**.

Medical Services. Members are required to notify HPHC before the start of any planned inpatient admission to a Non-Plan Medical Facility. Members are also required to obtain Prior Approval from HPHC for certain services. Before you receive services from a Non-Plan Provider, please refer to our Internet site, **www.harvardpilgrim.org**, or contact the Member Services Department at **1-888-333-4742** for a list of Out-of-Network services that require Prior Approval. If you do not provide Notification or obtain Prior Approval when required, you will be responsible for paying the Penalty amount stated in this Schedule of Benefits in addition to any applicable Member Cost Sharing. No coverage will be provided if HPHC determines that the service is not Medically Necessary, and you will be responsible for the entire cost of the service.

Emergency Care. You do not need to contact HPHC before receiving care in a Medical Emergency. In the event of an emergency hospital admission to a Non-Plan Provider, you must

EFFECTIVE DATE: 6/1/2012

notify HPHC within 48 hours of the admission, unless notification is not possible because of your condition. If notice is given to HPHC by an attending emergency physician, no further notification is required. However, if notification is not received when the Member's condition permits it, the Member is responsible for the Penalty amount stated in this Schedule of Benefits. Please call **1-800-708-4414** to notify us of an emergency admission to a Non-Plan facility.

Clinical Review Criteria

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

Preventive Services — In-Network

No Member Cost Sharing applies to certain preventive services received from Plan Providers. These services are summarized below and further described later in this Schedule of Benefits:

- Annual preventive gynecological examinations
- Immunizations
- Specified preventive services and tests
- Routine prenatal and routine postpartum care
- Routine well physical examinations (including well child care, vision and auditory screening for children, nutrition counseling and health education)

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. Your identification card contains the Copayment amounts that apply to the Plan’s most frequently used services.

There are two types of Copayments that apply to In-Network outpatient services received from physicians and other health professionals covered by 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 the preventive services listed above, 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
- Infertility services and treatments
- Mental health care (including the treatment of substance abuse disorders)

- Rehabilitation therapy — outpatient
- Speech — language and hearing services
- Voluntary termination of pregnancy
- Voluntary sterilization

In addition to the Level 1 Services, Copayment Level 1 applies to covered outpatient professional services, other than services provided in a hospital operated doctor's office, from the following types of providers:

- All Primary Care Physicians. The term "Primary Care Physician" (PCP) includes the following specialties: Internal Medicine, Family Practitioner, General Practitioner and Pediatrician
- Obstetricians and Gynecologists
- Certified Nurse Midwives
- Nurse Practitioners who bill independently

Copayment Level 2

Level 2 Services — Copayment Level 2 applies to the following outpatient professional services:

- Any covered services or provider not listed under Copayment Level 1
- Any service provided in a hospital operated doctor's office, except the Level 1 Services listed 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 noted below.

Please Note: Occasionally the Copayment may exceed the contract rate payable by the Plan for a service. If the Copayment is greater than the contract rate, you are responsible for the full Copayment, and the provider keeps the entire Copayment.

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.

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 a**1-888-333-4742**.

General Cost Sharing Features:	Member Cost Sharing:
Copayments	
	Copayment Level 1: Your Plan has a $20 Copayment per visit **Copayment Level 2**: Your Plan has a $35 Copayment per visit
Please see the section titled "Copayments" above for an explanation of your Level 1 and your Level 2 Copayments.	
Coinsurance	
	See Covered Benefits below

General Cost Sharing Features:	Member Cost Sharing:
In-Network Deductible	
	$250 per Member per Plan Year $750 per family per Plan Year
Out-of-Network Deductible	
	$400 per Member per Plan Year $800 per family per Plan Year
In-Network Out-of-Pocket Maximum	
- Includes all Member Cost Sharing except charges for prescription drugs.	$2,000 per Member per Plan Year $4,000 per family per Plan Year
Out-of-Network Out-of-Pocket Maximum	
Includes all Member Cost Sharing except charges for vision hardware for special conditions, and outpatient prescription drugs. Any charges above the Usual, Customary and Reasonable Charges and any penalty for failure to receive Prior Approval when using Non-Plan Providers do not apply to the Out-of-Pocket Maximum.	$3,000 per Member per Plan Year
Out-of-Network Penalty Payment	
- does not count toward the Deductible or Out-of-Pocket Maximum.	$500

Benefit	In-Network Plan Providers Member Cost Sharing	Out-of-Network Non-Plan Providers Member Cost Sharing
Ambulance Transport		
– Emergency ambulance transport	No charge	Same as In-Network
– Non-emergency ambulance transport	No charge	Deductible, then 20% Coinsurance
Autism Spectrum Disorders Treatment		
Professional Services – Coverage for the treatment of Autism Spectrum Disorders is provided for all of the services otherwise covered under your Plan. However, no benefit limit applies to services for the treatment of Autism Spectrum Disorders.	Your Member cost sharing depends upon the type of service provided, as listed in this Schedule of Benefits. For example: For services provided by a physician see “Physician and Other Professional Office Visits.” For services by a Licensed Mental Health Professional see “Mental Health Care (Including the Treatment of Substance Abuse Disorders).” For services by a physical therapist and occupational therapist, see “Rehabilitation Therapy - Outpatient.”	Your Member cost sharing depends upon the type of service provided, as listed in this Schedule of Benefits. For example: For services provided by a physician see “Physician and Other Professional Office Visits.” For services by a Licensed Mental Health Professional see “Mental Health Care (Including the Treatment of Substance Abuse Disorders).” For services by a physical therapist and occupational therapist, see “Rehabilitation Therapy - Outpatient.”

Benefit	In-Network Plan Providers Member Cost Sharing	Out-of-Network Non-Plan Providers Member Cost Sharing
Autism Spectrum Disorders Treatment (Continued)		
Applied Behavior Analysis – no benefit limit applies to this service.	Copayment Level 1: $20 Copayment per visit.	Deductible, then 20% Coinsurance
Cardiac Rehabilitation		
	Deductible, then no charge	Deductible, then 20% Coinsurance
Chemotherapy and Radiation Therapy — Outpatient		
– Chemotherapy – Radiation therapy	No charge	Deductible, then 20% Coinsurance
Clinical Trials for the Treatment of Cancer		
	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."	
Dental Services		
– Emergency 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."	
– 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."	
– Preventive dental care for children (up to the age of 13)	No charge	Deductible, then 20% Coinsurance
Important Notice: Coverage of Dental Care is very limited. Please see your Benefit Handbook for the details of your coverage.		
Diabetes Services and Supplies		
– Self management and training/diabetic eye examinations/foot care	Copayment Level 1: $20 Copayment per visit. Copayment Level 2: $35 Copayment per visit.	Deductible, then 20% Coinsurance
– Diabetes equipment	Deductible, then no charge In-Network Member Cost Sharing does not apply to blood glucose monitors or insulin pumps (including supplies) and infusion devices]	Deductible, then 20% Coinsurance
– Pharmacy supplies	Subject to the applicable pharmacy Member Cost Sharing listed on your ID Card.	Subject to the applicable pharmacy Member Cost Sharing listed on your ID Card.

Benefit	In-Network Plan Providers Member Cost Sharing	Out-of-Network Non-Plan Providers Member Cost Sharing
Diabetes Services and Supplies (Continued)		
	If your Plan does not include coverage for outpatient prescription drugs, then coverage is subject to the lower of the pharmacy's retail price or a Copayment of $5 for Tier 1 drugs or supplies, $10 for Tier 2 drugs or supplies, and $25 for Tier 3 drugs or supplies. All Copayments are based on a 30 day supply.	If your Plan does not include coverage for outpatient prescription drugs, then coverage is subject to the lower of the pharmacy's retail price or a Copayment of $5 for Tier 1 drugs or supplies, $10 for Tier 2 drugs or supplies, and $25 for Tier 3 drugs or supplies. All Copayments are based on a 30 day supply.
For information on the different drug tiers, please visit our website at **www.harvardpilgrim.org/members** and select "**pharmacy/drug tier look up**" or contact the Member Services Department at the telephone number listed on your ID card		
Dialysis		
– Dialysis services	Deductible, then no charge	Deductible, then 20% Coinsurance
– Installation of home equipment is covered up to $300 in a Member's lifetime.	No charge	Deductible, then 20% Coinsurance
Durable Medical Equipment and Prosthetic Devices		
	Deductible, then no charge In-Network Member Cost Sharing does not apply to the following: – Respiratory equipment (including oxygen) – Oxygen and oxygen equipment	Deductible, then 20% Coinsurance
Early Intervention Services		
	No charge	No charge
Emergency Admission Services		
	Deductible, then $500 Copayment per admission	Same as In-Network
Emergency Room Care		
	Deductible, then $100 Copayment per visit This Copayment is waived if admitted to the hospital directly from the emergency room.	Same as In-Network
Family Planning Services		
	Copayment Level 1: $20 Copayment per visit. Copayment Level 2: $35 Copayment per visit.	Deductible, then 20% Coinsurance

Benefit	**In-Network Plan Providers Member Cost Sharing**	**Out-of-Network Non-Plan Providers Member Cost Sharing**
Home Health Care		
	Deductible, then no charge	Deductible, then 20% Coinsurance
Hospice Services		
	Deductible, then no charge If inpatient services are required please see "Hospital - Inpatient Services" or "Skilled Nursing Facility Care" for Member Cost Sharing details.	Deductible, then 20% Coinsurance If inpatient services are required please see "Hospital - Inpatient Services" or "Skilled Nursing Facility Care" for Member Cost Sharing details.
Hospital – Inpatient Services		
	Deductible, then $500 Copayment per admission	$500 Copayment per admission, then Deductible and 20% Coinsurance
House Calls		
	Copayment Level 1: $20 Copayment per visit. Copayment Level 2: $ 35 Copayment per visit.	Deductible, then 20% Coinsurance
Human Organ Transplant 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."	
Hypodermic Syringes and Needles		
	Subject to the applicable pharmacy Member Cost Sharing listed on your ID Card. If your Plan does not include coverage for outpatient prescription drugs, then coverage is subject to the lower of the pharmacy's retail price or a Copayment of $5 for Tier 1 drugs or supplies, $10 for Tier 2 drugs or supplies, and $25 for Tier 3 drugs or supplies. All Copayments are based on a 30 day supply.	Subject to the applicable pharmacy Member Cost Sharing listed on your ID Card. If your Plan does not include coverage for outpatient prescription drugs, then coverage is subject to the lower of the pharmacy's retail price or a Copayment of $5 for Tier 1 drugs or supplies, $10 for Tier 2 drugs or supplies, and $25 for Tier 3 drugs or supplies. All Copayments are based on a 30 day supply.
	For information on the different drug tiers, please visit our website at **www.harvardpilgrim.org/members** and select "**pharmacy/drug tier look up**" or contact our Member Services Department at **1-888-333-4742**.	

Benefit	In-Network Plan Providers Member Cost Sharing	Out-of-Network Non-Plan Providers Member Cost Sharing
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." For inpatient hospital care, see "Hospital – Inpatient Services."	
Laboratory and Radiology Services		
– Laboratory and x-rays	Deductible, then No charge	Deductible, then 20% Coinsurance
– High end radiology (CT scans, PET scans, MRI and MRA, and nuclear medicine services) No Member Cost Sharing applies to certain preventive care services. See "Preventive Services and Tests," below.	Deductible, then $100 Copayment per procedure	Deductible, then 20% Coinsurance
Low Protein Foods		
Limited to – $5,000 per Plan Year	Deductible, then no charge	Deductible, then 20% Coinsurance
Maternity Care		
– Routine outpatient prenatal and postpartum care	No charge	Deductible, then 20% Coinsurance
– Preventive services and screenings including: counseling about alcohol and tobacco use, services to promote breastfeeding, routine urinalysis and screenings for the following: asymptomatic bacteriuria; hepatitis B infection; HIV and screenings for STDs (chlamydia, gonorrhea and syphilis); iron deficiency anemia; and Rh (D) incompatibility.	No charge	Deductible, then 20% Coinsurance
Please see "Preventive Services and Tests," below, for additional services and tests covered with no Member Cost Sharing.		
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.		
– Routine nursery care for the newborn, including prophylactic medication to prevent gonorrhea and screenings for the following: hearing loss; congenital hypothyroidism; phenylketonuria (PKU); and sickle cell disease.	No charge.	Deductible, then 20% Coinsurance
– Hospital inpatient services	Deductible, then $500 Copayment per admission	$500 Copayment per admission, then Deductible and 20% Coinsurance

Benefit	In-Network Plan Providers Member Cost Sharing	Out-of-Network Non-Plan Providers Member Cost Sharing
Medical Formulas		
– state mandated formulas	Deductible, then no charge	Deductible, then 20% Coinsurance
Mental Health Care (Including the Treatment of Substance Abuse Disorders)		
Please note: This Plan is subject to Federal Mental Health Parity law.		
Inpatient Mental Health Care Services		
	Deductible, then $500 Copayment per admission	$500 Copayment per admission, then Deductible and 20% Coinsurance
Intermediate Mental Health Care Services		
– Acute residential treatment (including detoxification), crisis stabilization and in-home family stabilization – Intensive outpatient programs, partial hospitalization and day treatment programs	Deductible, then no charge	Deductible, then 20% Coinsurance
Outpatient Mental Health Care Services		
– Group therapy	$10 Copayment per visit	Deductible, then 20% Coinsurance
– Individual therapy	$20 Copayment per visit	Deductible, then 20% Coinsurance
– Detoxification	$20 Copayment per visit	Deductible, then 20% Coinsurance
– Medication management	$20 Copayment per visit	Deductible, then 20% Coinsurance
– Psychological testing and neuropsychological assessment	Deductible, then no charge	Deductible, then 20% Coinsurance
Ostomy Supplies		
	Deductible, then no charge	Deductible, then 20% Coinsurance
Physician and Other Professional Office Visits (This includes all covered Providers unless otherwise listed in this Schedule of Benefits.)		
– Routine examinations for preventive care, including immunizations	No charge	Deductible, then 20% Coinsurance
No Member Cost Sharing applies to certain preventive care services. See "Preventive Services and Tests," below.		
– Consultations, evaluations and sickness and injury care	Copayment Level 1: $20 Copayment per visit. Copayment Level 1 applies to all primary care, obstetrical care and gynecological care services. Copayment Level 2: $35 Copayment per visit.	Deductible, then 20% Coinsurance

Benefit	In-Network Plan Providers Member Cost Sharing	Out-of-Network Non-Plan Providers Member Cost Sharing
Physician and Other Professional Office Visits (This includes all covered Providers unless otherwise listed in this Schedule of Benefits.) (Continued)		
	Copayment Level 2 applies to all care provided by a specialist. Please note that Copayment Level 2 applies to physicians' services rendered in a hospital operated physician's office, except for the Level 1 Services listed at the beginning of this document. Please see the Section titled "Copayments" at the beginning of this document for detailed information, including Level 1 Services.	
– Administration of allergy injections	No charge	Deductible, then 20% Coinsurance
Preventive Services and Tests		
- limited to the following select preventive laboratory and pathology tests and screenings as defined by federal law: – Abdominal aortic aneurysm screening (for males 65-75 one time only, if ever smoked) – Alcohol misuse screening and counseling (primary care visits only) – Aspirin for the prevention of heart disease (primary care counseling only) – Autism screening (for children at 18 and 24 months of age – primary care visits only) – Behavioral assessments (developmental surveillance, for children of all ages – primary care visits only) – Blood pressure screening – Breast cancer chemoprevention counseling (only for women at high risk for Breast Cancer and low risk for adverse effects of chemoprevention) – Breast cancer screening, including mammograms and genetic susceptibility screening – Cervical cancer screening, including pap smears	No charge	Deductible, then 20% Coinsurance

Benefit	In-Network Plan Providers Member Cost Sharing	Out-of-Network Non-Plan Providers Member Cost Sharing
Preventive Services and Tests (Continued) – Cholesterol screening (for adults only) – Colorectal cancer screening, including colonoscopy, sigmoidoscopy and fecal occult blood test – Dental caries prevention - oral fluoride (for children to age 5 only) Note: Coverage for fluoride is only provided if your Plan includes outpatient pharmacy coverage. – Depression screening (primary care visits only) – Diabetes screenings – Diet counseling – Dyslipidemia screening (for children at high risk for higher lipid levels) – Folic acid supplements (women planning or capable of pregnancy only) Note: coverage for folic acid is only provided if your Plan includes outpatient pharmacy coverage. – Hemoglobin A1c – Hepatitis B testing – HIVscreening – Immunizations , including flu shots (for children and adults as appropriate) – Iron deficiency prevention (primary care counseling for children age 6 to 12 months only) Note: Coverage for iron is only provided if your Plan includes outpatient pharmacy coverage. – Lead screening (for children at risk) – Microalbuminuria test – Obesity screening – Osteoporosis screening (to begin at age 60 for women at increased risk) – Ovarian cancer susceptibility screening – Sexually transmitted diseases (STDs) – screenings and counseling – Tobacco use counseling (primary care visits only) – Total cholesterol tests – Tuberculosis skin testing – Vision screening (children to age 5 only)		

Benefit	In-Network Plan Providers Member Cost Sharing	Out-of-Network Non-Plan Providers Member Cost Sharing
Preventive Services and Tests (Continued)		
Please see the Maternity Care benefit for additional services and tests covered with no Member Cost Sharing.		
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 woman, 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**. 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**.		
Reconstructive 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."	
Rehabilitation Hospital Care		
- limited to – 60 days per Plan Year	Deductible, then $500 Copayment per admission	$500 Copayment per admission, then Deductible and 20% Coinsurance
Rehabilitation Therapy - Outpatient		
Occupational therapy - limited to – 30 visits per Plan Year Physical therapy - limited to – 30 visits per Plan Year Pulmonary rehabilitation therapy **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.	Copayment Level 1: $20 Copayment per visit.	Deductible, then 20% Coinsurance
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."	

Benefit	In-Network Plan Providers Member Cost Sharing	Out-of-Network Non-Plan Providers Member Cost Sharing
Skilled Nursing Facility Care		
Limited to – 100 days per Plan Year	Deductible, then $500 Copayment per admission	$500 Copayment per admission, then Deductible and 20% Coinsurance
Speech-Language and Hearing Services		
	Copayment Level 1: $20 Copayment per visit.	Deductible, then 20% Coinsurance
Surgery – Outpatient		
	Deductible, then $150 Copayment per visit	$150 Copayment per visit, then Deductible and 20% Coinsurance
Temporomandibular Joint Dysfunction Services (medical treatment only)		
	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 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."	
Vision Services		
– Routine eye examinations - limited to (1 per Plan Year)	No charge	Deductible, then 20% Coinsurance
– Vision hardware for special conditions (see the Benefit Handbook for details)	Deductible, then no charge	Deductible, then 20% Coinsurance
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."	
Wigs and Scalp Hair Prostheses		
When needed as a result of any form of cancer or leukemia, alopecia areata, alopecia totalis or permanent hair loss due to injury	No charge	Deductible, then 20% Coinsurance

Exclusions

The exclusions headings in this section are intended to group together services, treatments, items, or supplies that fall into a similar category. Actual exclusions appear underneath the headings. A heading does not create, define, modify, limit or expand an exclusion.

The services listed in the table below are not covered by the Plan:

Exclusion	Description
Alternative Treatments	
	a. Acupuncture services, except when specifically listed as a Covered Benefit (please see your Schedule of Benefits). b. Acupuncture services that are outside the scope of standard acupuncture treatment, except when specifically listed as a Covered Benefit (please see your Schedule of Benefits), 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. c. Alternative, holistic or naturopathic services and all procedures, laboratories and nutritional supplements associated with such treatments. d. Aromatherapy, treatment with crystals and alternative medicine. e. 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. f. Massage therapy. g. Myotherapy.
Dental Services	
	a. Dental Care, except the specific dental services listed as Covered Benefits in this Benefit Handbook and your Schedule of Benefits. b. All services of a dentist for Temporomandibular Joint Dysfunction (TMD). c. Extraction of teeth, except when specifically listed as a Covered Benefit (please see your Schedule of Benefits). d. Preventive dental care for children, except when specifically listed as a Covered Benefit (please see your Schedule of Benefits). e. Dentures.
Durable Medical Equipment and Prosthetic Devices	
	a. Any devices or special equipment needed for sports or occupational purposes. b. Any home adaptations, including, but not limited to home improvements and home adaptation equipment. c. Myoelectric and bionic arms and legs, except when specifically listed as a Covered Benefit. (Please see your Schedule of Benefits). d. Non-durable medical equipment, unless used as part of the treatment at a medical facility or as part of approved home health care services. e. 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	
	a. Any products or services, including, but not limited to, drugs, devices, treatments, procedures, and diagnostic tests that are Experimental, Unproven, or Investigational.
Foot Care	
	a. Foot orthotics, except for the treatment of severe diabetic foot disease or when specifically listed as a Covered Benefit. (Please see your Schedule of Benefits). b. 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	
	a. Planned home births.
Mental Health Care	
	a. Biofeedback. b. 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. c. Methadone maintenance. d. Sensory integrative praxis tests. e. 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. f. 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. g. 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. h. 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	
	a. 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. b. Hair removal or restoration, including, but not limited to, electrolysis, laser treatment, transplantation or drug therapy. c. Liposuction or removal of fat deposits considered undesirable. d. Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures). e. Skin abrasion procedures performed as a treatment for acne. f. Treatment for skin wrinkles or any treatment to improve the appearance of the skin. g. Treatment for spider veins.
Procedures and Treatments	
	a. 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. b. Spinal manipulative therapy (including care by a chiropractor), except when specifically listed as a Covered Benefit (please see your Schedule of Benefits). c. Commercial diet plans, weight loss programs and any services in connection with such plans or programs. d. Gender reassignment surgery and all related drugs and procedures. e. If a service is listed as requiring that it be provided at a Center of Excellence, no In-Network coverage will be provided under this Handbook if that service is received from a Provider that has not been designated as a Center of Excellence. Please see *Handbook* section *"Centers of Excellence"* for more information. f. 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). g. Physical examinations and testing for insurance, licensing or employment. h. Services for Members who are donors for non-members, except as described under Human Organ Transplant Services. i. Testing for central auditory processing. j. Group diabetes training, educational programs or camps.

Exclusion	Description
Providers	
	a. Charges for services which were provided after the date on which your membership ends. b. 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 under this Handbook. c. Charges for missed appointments. d. Concierge service fees. (See *Handbook* section *"Provider Fees For Special Services"* for more information.) e. Inpatient charges after your hospital discharge. f. Provider's charge to file a claim or to transcribe or copy your medical records. g. Services or supplies provided by: (1) anyone related to you by blood, marriage or adoption, or (2) anyone who ordinarily lives with you.
Reproduction	
	a. Any form of Surrogacy or services for a gestational carrier. b. Birth control drugs, implants and devices that must be purchased at an outpatient pharmacy, unless your Plan includes outpatient pharmacy coverage. c. Infertility drugs if a member is not in a Plan authorized cycle of infertility treatment. d. Infertility drugs, if infertility services are not a Covered Benefit. e. Infertility drugs that must be purchased at an outpatient pharmacy, unless your Plan includes outpatient pharmacy coverage. f. Infertility treatment for Members who are not medically infertile. g. Infertility treatment and birth control drugs, implants and devices. h. Reversal of voluntary sterilization (including any services for infertility related to voluntary sterilization or its reversal). i. Sperm collection, freezing and storage except as described in the *Benefit Handbook* section *"Covered Benefits"*, *Infertility Services and Treatment*. j. Sperm identification when not Medically Necessary (e.g., gender identification). k. The following fees; wait list fees, non-medical costs, shipping and handling charges etc. l. Voluntary sterilization, including tubal ligation and vasectomy, except when specifically listed as a Covered Benefit (please see your Schedule of Benefits). m. Voluntary termination of pregnancy, except when specifically listed as a Covered Benefit (please see your Schedule of Benefits). n. Voluntary termination of pregnancy, unless the life of the mother is in danger.

Exclusion	Description
Services Provided Under Another Plan	
	a. Costs for any services for which you are entitled to treatment at government expense, including military service connected disabilities. b. Costs for services for which payment is required to be made by a Workers' Compensation plan or an Employer under state or federal law.
Types of Care	
	a. Custodial Care. b. Rest or domiciliary care. c. All institutional charges over the semi-private room rate, except when a private room is Medically Necessary. d. Home health care services that extend beyond care on a short-term intermittent basis. e. Pain management programs or clinics. f. Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, and diversion or general motivation. g. Private duty nursing. h. Sports medicine clinics. i. Vocational rehabilitation, or vocational evaluations on job adaptability, job placement, or therapy to restore function for a specific occupation.
Vision and Hearing	
	a. Eyeglasses, contact lenses and fittings, except as listed in this Benefit Handbook. b. Hearing aids, except when specifically listed as a Covered Benefit (please see your Schedule of Benefits). c. Refractive eye surgery, including, but not limited to, lasik surgery, orthokeratology and lens implantation for the correction of myopia, hyperopia and astigmatism. d. Routine eye examinations, except when specifically listed as a Covered Benefit (please see your Schedule of Benefits).
All Other Exclusions	
	a. Any service or supply furnished in connection with a non-Covered Benefit. b. Beauty or barber service. c. 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. d. Food or nutritional supplements, including, but not limited to, FDA-approved medical foods obtained by prescription, except as required by law. e. Guest services. f. Services for non-Members. g. Services for which no charge would be made in the absence of insurance.

Exclusion	Description
All Other Exclusions (Continued)	
	h. Services for which no coverage is provided in this Benefit Handbook, Schedule of Benefits or Prescription Drug Brochure. i. Services that are not Medically Necessary. j. Taxes or governmental assessments on services or supplies. k. Transportation other than by ambulance. l. 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.