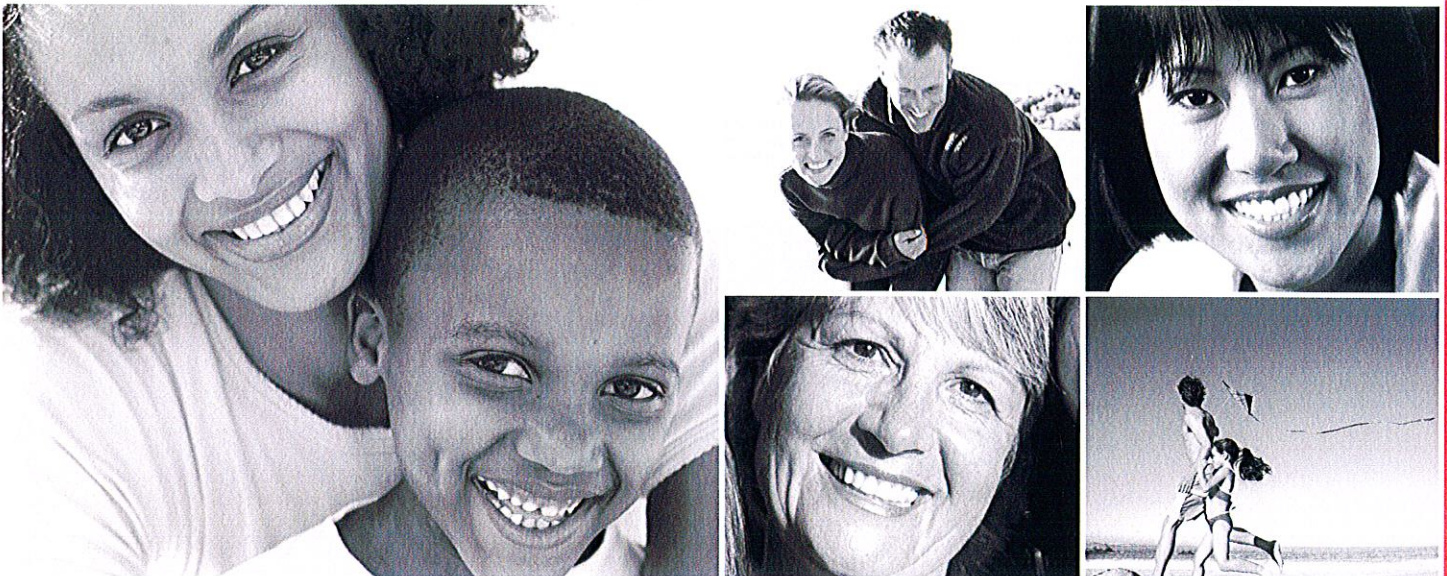


Schedule of Benefits

for the Harvard Pilgrim HMO



Harvard Pilgrim
Health Care

Schedule of Benefits

N-LCF, 11/10
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The Harvard Pilgrim Maine DifferenceSM Deductible Tiered Copayment HMO
Maine

Services listed are covered when Medically Necessary and provided or arranged by Harvard Pilgrim Health Care providers. Please see your Benefit Handbook for details.

Member Cost Sharing Summary

Members are required to share the cost of the benefits provided under the Plan. The following is a summary of the cost sharing amounts under your Plan.

Deductible

Your Plan has a Deductible of \$1,000 per Member or \$2,000 per family per calendar year.

Coinsurance

Your Plan has Coinsurance of 30% of covered charges after the Deductible is met until the Out-of-Pocket Maximum is reached.

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

Your Plan has different Copayments depending on the type of service, the specialty of the provider and the location of service. The Copayments that apply to your Plan are listed below.

Copayment Level 1: Your Plan has a \$25 Copayment per visit.

A lower Copayment, known as "Copayment Level 1," applies to some outpatient services, including most primary care, obstetrical care, gynecological care, mental health care and substance abuse rehabilitation.

Copayment Level 2: Your Plan has a \$35 Copayment per visit.

Most outpatient specialty care requires payment of a higher Copayment, known as "Copayment Level 2."

Emergency Room Copayment: Your Plan has a \$150 Copayment per visit in the emergency room.

Out-of-Pocket Maximum

Your Plan has an Out-of-Pocket Maximum of \$2,500 per Member or \$5,000 per family per calendar year, including Copayments, Deductible and Coinsurance (not including riders providing benefits for prescription drugs and vision hardware).

Please refer to the section titled "Member Cost Sharing" at the end of this document for further information on your Copayments, Deductible, Coinsurance and Out-of-Pocket Maximum.

Copayment Level 1

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

- Mental health services
- Substance abuse services
- Administration of allergy injections
- Physical therapy
- Occupational therapy
- Speech therapy
- Routine eye examinations
- Infertility consultations and evaluations

In addition to the Special Level 1 list, Copayment Level 1 applies to covered physician services, other than services received at a physicians office operated by a hospital, 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
- Chiropractors

Copayment Level 2

Copayment Level 2 applies to the following physician services:

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

Service

Inpatient Acute Hospital Services

- Coronary care
 - Hospital services
 - Intensive care
 - Physicians' and surgeons' services including consultations
 - Semi-private room and board
- 30% Coinsurance per admission
after the Deductible has been met.
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Day Surgery Services

- Hospital services
 - Physicians' and surgeons' services including consultations
- 30% Coinsurance per admission
after the Deductible has been met.
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Skilled Nursing Facility Care and Inpatient Rehabilitation Services

- Covered up to 100 days combined per calendar year
- 30% Coinsurance per admission
after the Deductible has been met.
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Hospital Outpatient Department Services

- Anesthesia services
 - CT Scans and MRI
 - Endoscopic procedures
 - Laboratory tests and x-rays
 - Physicians' and surgeons' services
- 30% Coinsurance after the
Deductible has been met.
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- Chemotherapy
 - Radiation Therapy
- 20% Coinsurance after the
Deductible has been met.
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No cost sharing applies to certain preventive care services and tests. See "Physician Services" for details.

Physician Services

All covered services including the following:

<ul style="list-style-type: none"> ▪ Administration of injections ▪ Allergy tests and treatments ▪ Changes and removals of casts, dressings, or sutures ▪ Chemotherapy ▪ Diabetes self-management, including education and training ▪ Family planning services ▪ Health education, including nutritional counseling ▪ Medical treatment of temporomandibular joint dysfunction (TMD) ▪ Annual eye examinations ▪ Sick visits, including medication management ▪ Vision and hearing screenings 	<p>Copayment Level 1: \$25 per visit Copayment Level 2: \$35 per visit The Deductible does not apply to these services.</p>
<ul style="list-style-type: none"> ▪ Administration of allergy injections 	<p>Copayment Level 1: \$25 per visit The Deductible does not apply to these services.</p>
<ul style="list-style-type: none"> ▪ CT Scans and MRI ▪ Diagnostic screening and tests (except the preventive services listed below) 	<p>30% Coinsurance after the Deductible has been met.</p>
<ul style="list-style-type: none"> ▪ Preventive care, including routine physical, gynecological, well child, school, camp, sports and premarital examinations 	<p>Covered in full. The Deductible does not apply to these services.</p>

Please note that Copayment Level 2 applies to physicians' services rendered in a hospital operated physician's office except, for the Special Level 1 Services listed at the beginning of this document. Please see the Section titled "Member Cost Sharing" at the beginning of this document for detailed information on Copayments and Special Level 1 Services.

Physician Services (Continued)

The following preventive services and tests 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 counseling for genetic susceptibility screening
- Cervical cancer screening, including pap smears
- 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
- HIV screening
- Immunizations, including flu shots (for children and adults as appropriate)
- Iron deficiency prevention (primary care counseling for children age 6 to 12 months only)
- 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)

Covered in full.
The Deductible
does not apply
to these
services.

Physician Services (Continued)

Under federal law the list of preventive care services covered under this benefit 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>

HPHC will add or delete services from this benefit for preventive care services 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 HPHC's web site at www.harvardpilgrim.org.

Coverage is also provided for the following preventive services and tests:

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| <ul style="list-style-type: none">▪ Fetal ultrasound▪ Hepatitis C testing▪ Prostate-specific antigen (PSA) screening▪ Routine hemoglobin tests▪ Routine urinalysis | Covered in full. The Deductible does not apply to these services. |
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Maternity Services

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| <ul style="list-style-type: none">▪ Prenatal and postpartum care, 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. | Covered in full. The Deductible does not apply to these services. |
| <ul style="list-style-type: none">▪ All hospital services for mother | 30% Coinsurance per admission after the Deductible has been met. |
| <ul style="list-style-type: none">▪ Routine nursery charges for newborn, including prophylactic medication to prevent gonorrhea and screenings for the following: hearing loss; congenital hypothyroidism; phenylketonuria (PKU); and sickle cell disease. | Covered in full. The Deductible does not apply to these services. |
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Mental Health and Drug and Alcohol Rehabilitation Services

Inpatient Services

- Mental health services
 - Drug and alcohol rehabilitation services 30% Coinsurance per admission after the Deductible has been met.
 - Detoxification services
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Partial Hospitalization Services

- Partial hospitalization for mental health and drug and alcohol rehabilitation services 30% Coinsurance after the Deductible has been met.
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Outpatient Services

- Mental health services
 - Individual therapy Copayment Level 1: \$25 per visit. The Deductible does not apply to these services.
 - Group therapy \$10 Copayment per visit. The Deductible does not apply to these services.
 - Mental health services in the home Copayment Level 1: \$25 per visit. The Deductible does not apply to these services.
 - Drug and alcohol rehabilitation services
 - Individual therapy Copayment Level 1: \$25 per visit. The Deductible does not apply to these services.
 - Group therapy \$10 Copayment per visit. The Deductible does not apply to these services.
 - Detoxification services Copayment Level 1: \$25 per visit. The Deductible does not apply to these services.
 - Medication management Copayment Level 1: \$25 per visit. The Deductible does not apply to these services.
 - Psychological testing Copayment Level 1: \$25 per visit. The Deductible does not apply to these services.
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Home Health Care Services

The following services are covered on a short-term intermittent basis:

- Skilled nursing care
 - Physical, occupational or speech therapy
 - Durable medical equipment and supplies
 - Medical social services
 - Nutritional counseling
 - Services of a home health aide
- 20% Coinsurance after the Deductible has been met.
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Dental Services

- Extraction of impacted teeth
- 30% Coinsurance after the Deductible has been met.
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- Initial emergency treatment (as described in your Benefit Handbook)
- Copayment Level 2: \$35 per visit. The Deductible does not apply to these services. If inpatient or day surgery services are required, please see "Inpatient Acute Hospital Services" or "Day Surgery Services" for cost sharing.
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Emergency Services

- Members are required to call their Primary Care Physician before using hospital emergency room services except when the Member is in a Medical Emergency or is outside HPHC's Service Area when emergency care is required. The HPHC Service Area is the state in which you live.
- \$150 Copayment per visit in the emergency room. This Copayment is waived if admitted directly to the hospital from the emergency room. The Deductible does not apply to these services. See "Physician's Services" for coverage of emergency services by a physician in any other location.
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Diabetes Equipment and Supplies

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| ▪ Therapeutic molded shoes and inserts, dosage gauges, injectors, lancet devices, voice synthesizers and visual magnifying aids | Subject to the applicable cost sharing, if any, under the durable medical and prosthetic equipment benefit. |
| ▪ Blood glucose monitors, insulin pumps and supplies and infusion devices | Covered in full. The Deductible does not apply to these services. |
| ▪ Insulin, insulin syringes, insulin pens with insulin, lancets, oral agents for controlling blood sugar, blood test strips, and glucose, ketone and urine test strips | Subject to the applicable prescription drug Copayment listed on your ID card, if your Employer Group has selected prescription drug coverage. If prescription drug coverage is not available, then you will pay a \$10 Copayment for Tier 1 items, \$25 Copayment for Tier 2 items and a \$40 Copayment for Tier 3 items. |
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Durable Medical and Prosthetic Equipment

Coverage includes, but is not limited to:

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| ▪ Durable medical equipment
▪ Prosthetic devices
▪ Breast prostheses, including replacements and mastectomy bras
▪ Ostomy supplies
▪ Oxygen and respiratory equipment
▪ Wigs - up to a limit of \$350 per calendar year, when needed as a result of any form of cancer or leukemia, alopecia areata, alopecia totalis or permanent hair loss due to injury | 20% Coinsurance based on the cost of equipment to HPHC, after the Deductible has been met. |
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Prosthetic Arms and Legs

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| ▪ Prosthetic Arms and Legs | 20% Coinsurance based on the cost of the prosthetic to HPHC. |
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Autism Spectrum Disorders Treatment for Members up to the age of 6

<ul style="list-style-type: none">Applied behavioral analysis - limited to \$36,000 per calendar year	Copayment Level 1: \$25 Copayment per visit. The Deductible does not apply to these services.
<ul style="list-style-type: none">All other benefits are covered as stated in this Schedule of BenefitsNo benefit limit applies to physical therapy, occupational therapy or speech therapy 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 Services." For services by a speech therapist, physical therapist and occupational therapist, see "Other Health Services."

Early Intervention Services

<ul style="list-style-type: none">Early intervention services – limited to \$3,200 per Member per calendar year up to a maximum of \$9,600	Your Member cost sharing depends upon the type of service provided, as listed in this Schedule of Benefits. For example: for services by a speech therapist, physical therapist and occupational therapist, see "Other Health Services."
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Other Health Services

<ul style="list-style-type: none">Chiropractic care (as described in your <i>Benefit Handbook</i>)	Copayment Level 1: \$25 per visit. The Deductible does not apply to these services
<ul style="list-style-type: none">Cardiac rehabilitationDialysis	Copayment Level 1: \$25 per visit. Copayment Level 2: \$35 per visit. The Deductible does not apply to these services.
<ul style="list-style-type: none">House calls	Copayment Level 1: \$25 per visit. Copayment Level 2: \$35 per visit. The Deductible does not apply to these services.
<ul style="list-style-type: none">Physical, speech, and occupational therapies – combined up to 40 visits per calendar year	Copayment Level 1: \$25 per visit. The Deductible does not apply to these services
<ul style="list-style-type: none">Hospice services	20% Coinsurance after the Deductible has been met. If inpatient services are required, please see "Inpatient Acute Hospital Services" for cost sharing.

Other Health Services (Continued)

▪ Ambulance services	Covered in full. The Deductible does not apply to these services.
▪ Low protein foods (\$3,000 per calendar year)	Covered in full. The Deductible does not apply to these services.
▪ State mandated formulas	
▪ Infertility consultations and evaluations	Copayment Level 1: \$25 per visit. The Deductible does not apply to these services.
▪ Vision hardware for special conditions (as described in your <i>Benefit Handbook</i>)	30% Coinsurance after the Deductible has been met.
▪ Hearing Aids for Members up to the age of 19 - limited to 1 hearing aid every 36 months, per hearing impaired ear, up to \$1,400	20% Coinsurance based on the cost of equipment to HPHC, after the Deductible has been met.
▪ Telemedicine	Your Member cost sharing will depend upon the types of services provided, as listed in this <i>Schedule of Benefits</i> . For example, for services provided by a physician, see "Physician Services." For inpatient hospital care, see "Inpatient Acute Hospital Services."

Special Enrollment Rights

If an employee declines enrollment for the employee and his or her Dependents (including his or her spouse) because of other health insurance coverage, the employee may be able to enroll himself or herself, along with his or her Dependents in this Plan if the employee or his or her Dependents lose eligibility for that other coverage (or if the employer stops contributing toward the employee's or Dependents' other coverage). However, enrollment must be requested within 30 days after the other coverage ends (or after the employer stops contributing toward the employee's or Dependents' other coverage). In addition, if an employee has a new Dependent as a result of marriage, birth, adoption or placement for adoption, or if a court order is issued changing custody of a child, the employee may be able to enroll along with his or her Dependents. However, enrollment must be requested within 30 days after the marriage, birth, adoption or placement for adoption, or court order changing custody of a child.

Special enrollment rights may also apply to persons who lose coverage under Medicaid or the Children's Health Insurance Program (CHIP) or become eligible for state premium assistance under Medicaid or CHIP. An employee or Dependent who loses coverage under Medicaid or CHIP as a result of the loss of Medicaid or CHIP eligibility may be able to enroll in this Plan, if enrollment is requested within 60 days after Medicaid or CHIP coverage ends. An employee or Dependent who becomes eligible for group health plan premium assistance under Medicaid or CHIP may be able to enroll in this Plan if enrollment is requested within 60 days after the employee or Dependent is determined to be eligible for such premium assistance.

Membership Requirements

There are a few important requirements that you must meet in order to be covered by the Plan.

- Members must live in the HPHC Enrollment Area for at least nine months of the year. An exception is made for full-time student dependents and dependents enrolled under Qualified Medical Support Orders.
- All your medical and health care needs must be provided or arranged by your Primary Care Physician (PCP), except in a Medical Emergency, when you are temporarily outside the HPHC Service Area or when you need one of the special services that do not require a referral. The HPHC Service Area is the state in which you live.

Member Cost Sharing

Deductible

A Deductible is a specific dollar amount that is payable by a Member for covered benefits each calendar year before benefits subject to the Deductible are available under the Plan. Deductible amounts are incurred as of the date of service.

Unless a Family Deductible applies, each Member is responsible for the per Member Deductible for covered services each calendar year. 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 in a calendar year. In such event, the Member Deductible is deemed to be met. Deductible applies in a calendar year. In such event, the Member Deductible is met.

Deductible carryover

Your Plan has a Deductible carryover that allows you to apply any Deductible amount paid for covered services during the last three (3) months of a calendar year toward the Deductible for the next year. In order for a Deductible carryover to apply, the Member (or family) must have had continuous coverage under the Plan through the same Employer Group at the time the charges for the prior year were incurred.

Coinsurance

Coinsurance is the portion of covered charges that are the responsibility of the Member. Coinsurance amounts are in addition to the Deductible and any applicable Copayments.

Copayments

Copayments are a fixed dollar amount you must pay for certain covered benefits. The Copayment is due at the time of service or when billed by the provider. Your Copayment does not apply to your annual Deductible.

Out-of-Pocket Maximum

The maximum Copayments, Deductible and Coinsurance amounts you (or your covered family) will be required to pay for all services per calendar year (not including riders providing benefits for prescription drugs and vision hardware). HPHC will notify you if you have reached the Out-of-Pocket Maximum. If you believe you have reached the Out-of-Pocket Maximum, but have not been notified, please contact HPHC.

Exclusions

- Services not approved, arranged, or provided by your PCP except: (1) in a Medical Emergency; (2) when you are outside of the HPHC Service Area; or (3) when they are one of the special services that do not require a referral listed in your Benefit Handbook
- Cosmetic procedures, except as described in your Benefit Handbook
- Commercial diet plans, or weight loss programs and any services in connection with such plans or programs
- Transsexual surgery and all related drugs or procedures
- Any products or services, including, but not limited, to drugs, devices, treatments, procedures, and diagnostic tests, which are Experimental, Unproven, or Investigational
- Refractive eye surgery, including laser surgery and orthokeratology, for correction of myopia, hyperopia and astigmatism
- Transportation other than by ambulance
- Costs for any services for which you are entitled to treatment at government expense, including military service connected disabilities
- Costs for services covered by third party liability, other insurance coverage, and which are required to be covered by a workers' compensation plan, or an employer under state or federal law, unless a notice of controversy has been filed with the Workers' Compensation Board contesting the work-relatedness of the claimant's condition and no decision has been made by the Board
- Hair removal or restoration, including, but not limited to, electrolysis, laser treatment, transplantation or drug therapy
- Routine foot care, biofeedback, pain management programs, myotherapy, and sports medicine clinics
- Massage therapy when performed by anyone other than a licensed physical therapist, physical therapy assistant, occupational therapist, or certified occupational therapy assistant
- Any treatment with crystals
- 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
- Sensory integrative praxis tests
- Testing of central auditory processing
- Physical examinations for insurance, licensing, or employment purposes
- Vocational rehabilitation, or vocational evaluations on job adaptability, job placement, or therapy to restore function for a specific occupation
- Rest or custodial care
- Personal comfort or convenience items (including telephone and television charges), exercise equipment, and repair or replacement of durable medical equipment or prosthetic devices as a result of loss, negligence, willful damage, or theft
- Non-durable medical equipment, unless used as part of the treatment at a medical facility or as part of approved home health care services
- Reversal of voluntary sterilization (including procedures necessary for conception as a result of voluntary sterilization)
- Any form of surrogacy
- Infertility treatment for Members who are not medically infertile
- Routine maternity (prenatal and postpartum) care when you are traveling outside the HPHC Service Area
- Delivery outside the HPHC Service Area after the 37th week of pregnancy, or after you have been told that you are at risk for early delivery
- Devices or special equipment needed for sports or occupational purposes
- Care 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
- Services for which no charge would be made in the absence of insurance
- 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 service under your Benefit Handbook

- Services for non-Members and services after the date on which your membership is terminated, except as required by Maine law
- Services or supplies given to you by: (1) anyone related to you by blood, marriage, or adoption, or, (2) anyone who ordinarily lives with you
- Charges for missed appointments
- Services that are not Medically Necessary
- Services for which no coverage is provided in your Benefit Handbook, this Schedule of Benefits or the Prescription Drug Brochure (if your Employer Group has selected this coverage)
- Any home adaptations, including, but not limited to home improvements and home adaptation equipment
- All charges over the semi-private room rate, except when a private room is Medically Necessary
- Hospital charges after the date of discharge
- Follow-up care to an emergency room visit unless provided or arranged by your PCP
- Birth control injections, implants and devices, if your Employer Group has not purchased the prescription drug rider
- Acupuncture, aromatherapy and alternative medicine
- Costs of tests or measurements conducted primarily for the purpose of a clinical trial
- Any services or devices reasonably expected to be paid for by the sponsors of an approved clinical trial
- Methadone maintenance
- A provider's charge to file a claim or to transcribe or copy your medical records
- Any service or supply furnished along with a non-covered service
- Taxes or assessments on services or supplies
- Any services excluded in your Benefit Handbook
- Continuous or long-term home health care services
- Private duty nursing
- Dental services (except the specific dental services listed in your Benefit Handbook and this Schedule of Benefits), including: restorative, periodontal, orthodontic, endodontic, and prosthodontic services; dental services for prosthodontic, or periodontal procedures; and dental fillings, crowns, gum care (including gum surgery), braces, root canals, bridges, bonding and dentures.
- Preventive dental care
- Unless otherwise specified in this Benefit Handbook or the Schedule of Benefits (and required by Maine law), the Plan does not cover food or nutritional supplements, including FDA-approved medical foods obtained by prescription.
- Group diabetes training, educational programs, or camps.
- Health resorts, recreational programs, camps, wilderness programs, outdoor skills programs, relaxation or lifestyle programs, including any services provided in conjunction with, or as part of such types of programs
- Eyeglasses, contact lenses and fittings, except as listed in your Benefit Handbook or unless your Employer Group has purchased the VisionCare Rider
- Wigs, except as described in your Benefit Handbook
- Foot orthotics, except for the treatment of severe diabetic foot disease
- Infertility treatment
- Therapeutic donor insemination, including related sperm procurement and banking
- Advanced reproductive technologies, including, but not limited to, in-vitro fertilization, gamete intrafallopian transfer, zygote intrafallopian transfer, intra-cytoplasmic sperm injection and donor egg procedures, including related egg and inseminated egg procurement, processing and banking
- 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
- 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
- Services provided to a Member with autism spectrum disorders under an individualized education plan or an individualized family service plan.

