**Schedule of Benefits**

The Harvard Pilgrim 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.*

<table>
<thead>
<tr>
<th>Service</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Inpatient Acute Hospital Services (including Day Surgery)</strong></td>
<td></td>
</tr>
<tr>
<td>• Coronary care</td>
<td>Subject to the Hospital Inpatient Coinsurance 1</td>
</tr>
<tr>
<td>• Hospital services</td>
<td></td>
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<tr>
<td>• Intensive care</td>
<td></td>
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<tr>
<td>• Semi-private room and board</td>
<td></td>
</tr>
<tr>
<td>• Physicians’ and surgeons’ services including consultations</td>
<td>Covered in full.</td>
</tr>
<tr>
<td><strong>Skilled Nursing Facility Care Services</strong></td>
<td></td>
</tr>
<tr>
<td>• Covered up to 100 days per calendar year</td>
<td>Subject to the Hospital Inpatient Coinsurance 1</td>
</tr>
<tr>
<td><strong>Inpatient Rehabilitation Services</strong></td>
<td></td>
</tr>
<tr>
<td>• Covered up to 100 days per calendar year</td>
<td>Subject to the Hospital Inpatient Coinsurance 1</td>
</tr>
</tbody>
</table>

1 Your Plan has a Hospital Inpatient Coinsurance (including Day Surgery) of 20% per admission.
### 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. See "Physician's Services" for coverage of emergency services by a physician in any other location.

### Hospital Outpatient Department Services
- Anesthesia services
- Chemotherapy
- Endoscopic procedures
- Laboratory tests and x-rays
- Physicians' and surgeons' services
- Radiation therapy
No cost sharing applies to certain preventive care services and tests. See “Physician Services” for details.

Covered in full.

### Physician Services
- Administration of injections
- Allergy tests and treatments
- Changes and removals of casts, dressings, or sutures
- Chemotherapy
- Diabetes self-management, including education and training
- Diagnostic screening and tests, including blood tests and screenings mandated by state law
- 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
- Administration of allergy injections $25 Copayment per visit. (Please note: diagnostic tests, x-rays, and immunizations will be covered in full if billed without an office visit and no other services are provided.)
- Preventive care, including routine physical, gynecological, well child, school, camp, sports and premarital examinations $5 Copayment per visit. Covered in full.
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)
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.

Maternity Services

- 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.

- All hospital services for mother Subject to the Hospital Inpatient Coinsurance 1

- 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.

- Inpatient and outpatient physician services Covered in full.

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**Mental Health and Drug and Alcohol Rehabilitation Services**

Please note that no day or visit limits apply to mental health treatment for the biologically based mental illnesses described in your Benefit Handbook. The applicable cost sharing amounts for the treatment of biologically based mental illnesses will not exceed the cost sharing amounts for the treatment of physical conditions.

**Inpatient Services**

- Mental health services in a licensed general hospital - unlimited days
- Mental health services in a psychiatric hospital - up to 31 days per calendar year
- Drug and alcohol rehabilitation services
- Detoxification services

| Subject to the Hospital Inpatient Coinsurance ¹ |

**Partial Hospitalization Services**

- Partial hospitalization for mental health services - up to 62 days per calendar year. Please note: Each partial hospitalization day counts as one-half of an inpatient day and is deducted from the limit available for inpatient services.
- Partial hospitalization for drug and alcohol rehabilitation services – unlimited

| Covered in full. |

**Outpatient Services**

- Mental health services - Covered up to 40 visits per calendar year
  - Individual therapy
  - $25 Copayment per visit.
  - Group therapy
  - $10 Copayment per visit.
- Mental health services in the home - home visits count toward the visit limit for outpatient mental health services
- Drug and alcohol rehabilitation services
  - Individual therapy
  - $25 Copayment per visit.
  - Group therapy
  - $10 Copayment per visit.
- Detoxification services
  - $25 Copayment per visit.
- Medication management
  - $25 Copayment per visit.
- Psychological testing
  - $25 Copayment per visit.

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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

Covered in full.

### Dental Services

- Extraction of impacted teeth
- Initial emergency treatment (as described in your Benefit Handbook)

$25 Copayment per visit. If inpatient services are required, please see "Inpatient Acute Hospital Services" for cost sharing.

### Diabetes Equipment and Supplies

- 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.

- 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 $5 Copayment for Tier 1 items, $10 Copayment for Tier 2 items and a $25 Copayment for Tier 3 items.
## Durable Medical and Prosthetic Equipment

Coverage includes, but is not limited to:
- Durable medical equipment
- Prosthetic devices
- Breast prostheses, including replacements and mastectomy bras
- Ostomy supplies
- Oxygen and respiratory equipment (No cost sharing, if any, applies)
- 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, not to exceed a Member's total expense of $500 per calendar year. |

## Prosthetic Arms and Legs

- Prosthetic arms and legs

| 20% Coinsurance based on the cost of the prosthetic to HPHC, not to exceed a Member's total expense of $1,000 per calendar year. |

## Autism Spectrum Disorders Treatment for Members up to the age of 6

- Applied behavioral analysis - limited to $36,000 per calendar year

| $25 Copayment per visit. |

- All other benefits are covered as stated in this Schedule of Benefits
- No 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

- 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.” |
### Other Health Services

- Cardiac rehabilitation
- Chiropractic care (as described in your Benefit Handbook)
- Dialysis
- Physical, speech, and occupational therapies combined - 40 visits per calendar year
- Second opinion
- House calls

<table>
<thead>
<tr>
<th>Service</th>
<th>Description</th>
</tr>
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<tbody>
<tr>
<td>$25 Copayment per visit.</td>
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<tr>
<td>Hospice services</td>
<td>Covered in full. If inpatient services are required, please see &quot;Inpatient Acute Hospital Services&quot; for cost sharing.</td>
</tr>
<tr>
<td>Ambulance services</td>
<td>Covered in full.</td>
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<tr>
<td>Low protein foods ($3,000 per calendar year)</td>
<td></td>
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<tr>
<td>State mandated formulas</td>
<td></td>
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<tr>
<td>Infertility services (limited to consultation and evaluation)</td>
<td>$25 Copayment per visit.</td>
</tr>
<tr>
<td>Vision hardware for special conditions (as described in your Benefit Handbook)</td>
<td>Covered in full.</td>
</tr>
<tr>
<td>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</td>
<td>20% Coinsurance based on the cost of equipment to HPHC.</td>
</tr>
<tr>
<td>Telemedicine</td>
<td>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 Services” For inpatient hospital care, see “Inpatient Acute Hospital Services”.</td>
</tr>
</tbody>
</table>
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.

Out-of-Pocket Maximums

Your Plan has an Out-of-Pocket Maximum of $2,000 per Member and $4,000 per covered family per calendar year. This is the total amount in Copayments and Coinsurance you (or your covered family) are required to pay each calendar year for services covered by the Plan, excluding prescription drugs and infertility treatment. HPHC will notify when you have reached your Out-of-Pocket Maximum. If you believe you have reached the Out-of-Pocket Maximum but have not been notified, please contact HPHC.

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 which do not require a referral. The HPHC Service Area is the state in which you live.
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
Exclusions

- 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 temporomandibular joint dysfunction (TMD); removal of impacted teeth to prepare for or support orthodontic, 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, intracytoplasmic 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.