Schedule of Benefits
The Harvard Pilgrim HMO
Maine Standard A

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

## Service

### Inpatient Acute Hospital Services

- Coronary care
- Hospital services
- Intensive care
- Rehabilitation services
- Semi-private room and board

<table>
<thead>
<tr>
<th>Service</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>$250 Copayment per day up to a maximum of $1,250 per calendar year.</td>
<td>Unlimited days per calendar year.</td>
</tr>
</tbody>
</table>

- Physicians' and surgeons' services including consultations

<table>
<thead>
<tr>
<th>Service</th>
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<tbody>
<tr>
<td>Covered in full.</td>
<td></td>
</tr>
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</table>

### Hospital Outpatient Department Services

- Anesthesia services
- Chemotherapy
- Endoscopic procedures
- Laboratory tests and x-rays
- Physicians' and surgeons' services
- Radiation therapy

<table>
<thead>
<tr>
<th>Service</th>
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<td>Covered in full.</td>
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### Skilled Nursing Facility Care Services

- Covered up to 100 days per calendar year

<table>
<thead>
<tr>
<th>Service</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>$25 Copayment per day.</td>
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</tbody>
</table>
### Maternity Services

- **Prenatal and postpartum care** (see routine physical exam schedule), 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.**

- **Inpatient maternity care for mother** **$250 Copayment per day up to a maximum of $1,250 per calendar year.**

- **Routine nursery care 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 physicians’ and surgeons’ services including consultations** **Covered in full.**

### Physician Services

- **Preventive care** including routine physical examinations, immunizations, school, sports and camp examinations **Covered in full up to the benefit limit described under routine physical exam schedule.**

- **Administration of injections**

- **Allergy tests, administration and treatments**

- **Changes and removals of casts, dressings, or sutures**

- **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**

- **Sick and diagnostic office visits, including medication management**

- **Routine eye exams** **$10 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.)**

- **Chemotherapy** **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:

- Grade “A” and “B” recommendations of the United States Preventive Services Task Force;
- With respect to immunizations, the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention; and
- 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.

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

$10 Copayment per visit (limited to one Copayment per day) up to a maximum of 100 visits per calendar year.

Dental Services

- Extraction of impacted or unerupted teeth
- Treatment for accidental injury (as described in your Benefit Handbook)

$10 Copayment per visit. If inpatient services are required, please see "Inpatient Acute Hospital Services" for cost sharing.

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.
- In a hospital emergency room or physician's office

$50 Copayment per visit in the emergency room or $10 Copayment per visit in a physician's office or hospital outpatient department. The Copayment is waived if admitted directly to the hospital from the emergency room.
### Mental Health and Drug and Alcohol Rehabilitation Services

<table>
<thead>
<tr>
<th>Service</th>
<th>Copayment Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient mental health services</td>
<td>$250 Copayment per day up to a maximum of $1,250 per calendar year, up to 30 days per calendar year.</td>
</tr>
<tr>
<td>Inpatient drug and alcohol rehabilitation services, including detoxification</td>
<td>$250 Copayment per day up to a maximum of $1,250 per calendar year, up to 30 days per calendar year. Inpatient lifetime maximum of 60 days for drug and alcohol rehabilitation services.</td>
</tr>
<tr>
<td>Outpatient mental health services</td>
<td>$10 Copayment per visit up to a maximum of $1,000 per calendar year.</td>
</tr>
<tr>
<td>Outpatient drug and alcohol rehabilitation services, including detoxification</td>
<td>$10 Copayment per visit up to a maximum of $1,000 per calendar year.</td>
</tr>
<tr>
<td>Outpatient mental health services in the home - home visits count toward the visit limit for outpatient mental health services</td>
<td>Covered in full up to a maximum of $1,000 per calendar year.</td>
</tr>
</tbody>
</table>

### Diabetes Equipment and Supplies

<table>
<thead>
<tr>
<th>Item</th>
<th>Coverage Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Therapeutic molded shoes and inserts, dosage gauges, injectors, lancet devices, voice synthesizers and visual magnifying aids</td>
<td>Covered in full.</td>
</tr>
<tr>
<td>Blood glucose monitors, insulin pumps and supplies and infusion devices</td>
<td>Covered in full.</td>
</tr>
<tr>
<td>Insulin, insulin syringes, insulin pens with insulin, lancets, oral agents for controlling blood sugar, blood test strips, and glucose, ketone and urine test strips</td>
<td>Subject to the applicable prescription drug Copayment listed on your ID card.</td>
</tr>
</tbody>
</table>

1 Additional mental health coverage for certain biologically based conditions may be purchased separately. Under this separate Rider, coverage for these conditions will be at the same level of physical conditions. Please call the HPHC number listed on your enrollment kit for further information.

2 Partial hospitalization services are available up to a maximum of 60 days per calendar year in place of inpatient mental health services and up to a maximum of 60 days per calendar year in place of inpatient drug and alcohol rehabilitation services. Partial hospitalization services are subject to a $125 Copayment per course of treatment.
### 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
- 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

| Covered in full. |

### Prosthetic Arms and Legs

- Prosthetic arms and legs

| Covered in full. |

### Autism Spectrum Disorders Treatment

Autism spectrum disorders treatment for Members up to age 6 is covered as follows:

- Applied behavioral analysis - up to a limit of $36,000 per calendar year
- 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

| $10 Copayment per visit. |

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 - up to a limit of $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**

<table>
<thead>
<tr>
<th>Service</th>
<th>Cost Sharing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulance services</td>
<td>$50 Copayment per transport.</td>
</tr>
<tr>
<td>Day surgery</td>
<td>$250 Copayment per visit.</td>
</tr>
<tr>
<td>Chiropractic care</td>
<td>$250 Copayment per visit.</td>
</tr>
<tr>
<td>Cardiac rehabilitation</td>
<td>$10 Copayment per visit.</td>
</tr>
<tr>
<td>Dialysis</td>
<td>$10 Copayment per visit.</td>
</tr>
<tr>
<td>Physical, speech, and occupational therapies</td>
<td></td>
</tr>
<tr>
<td>Hospice care</td>
<td></td>
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<tr>
<td>Low protein foods ($3,000 per calendar year)</td>
<td>Covered in full.</td>
</tr>
<tr>
<td>State mandated formulas</td>
<td></td>
</tr>
<tr>
<td>Hearing aids for Members up to the age of 19</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>

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.”
Routine Physical Examination Schedule

A routine physical examination should be an important part of each member’s own personal health maintenance program. The Plan encourages its Members to have a physical examination at regular intervals. Coverage for these exams shall not exceed the following schedule:

**Children**
- Birth to one year: six visits, to include routine immunizations
- Age 1 through 2: two visits, to include routine immunizations
- Age 3 through 17: one visit each year, to include routine immunizations

**Adults**
- Age 18 and over: one exam per calendar year
- Women are entitled to one visit each year to include a breast and pelvic exam, PAP smear, and a family planning consultation (no referral required)
- Women are entitled to screening mammograms once every five years between ages of 35 and 39, and every year for ages 40 and over
- Men are entitled to one annual prostate screening for ages 50-72, if recommended by a physician

**Maternity Services**
HPHC covers the following outpatient prenatal and postpartum care visits:
- One office visit per month during the first two trimesters of pregnancy
- Two office visits per month during the seventh and eighth month of pregnancy
- One office visit per week during the ninth and until term
- Postpartum care
Membership Requirements

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

- Members must live in the state of Maine for at least six months of the year.
- 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.

Out-of-Pocket Expenses

As a Member of the Plan, you are responsible for a portion of the cost of certain benefits through Copayments. These Copayments are payable to the provider at the time of service. Your identification card indicates the Copayment amounts for the Plan’s most frequently used services. This Schedule of Benefits provides further detail on all Copayment requirements.
Exclusions

- A Member's Pre-Existing Condition for the first 12 months following the membership effective date, except to the extent that benefits would have been payable under a Member's health benefit coverage in effect within 90 days of eligibility for coverage under your Benefit Handbook. Please see Section I.J.5. (Limits for Pre-existing Conditions) for further information.
- Cosmetic surgery, except as specified in Section I.B.8.f in your Benefit Handbook
- Sex change surgery
- Dental services or supplies except the specific dental services listed in your Benefit Handbook
- Treatment for temporomandibular joint dysfunction (TMD)
- Any products or services, including, but not limited to, drugs, devices, treatments, procedures, and diagnostic tests, which are Experimental, Unproven, or Investigational
- Eyeglasses, contact lenses, radial keratotomy, and eye refraction or any examination or fitting related to these devices
- Routine foot care services
- Custodial Care
- Services for which no charge would be made in the absence of insurance
- Services and supplies not administered or ordered by a physician or other covered professional
- Diagnosis or treatment for infertility when infertility is the only diagnosis
- Work-related injuries or illness, 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
- Services or supplies furnished by any institution owned or operated by any federal, state, county or municipal government
- Expenses that are or could be recovered through any federal, state, county, or municipal law, other than Medicaid
- Services that are provided by immediate family members
- Losses which are due to war or any act of war, whether declared or undeclared
- Services related to intentionally self-inflicted injury or illness
- 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 provided to a Member with autism spectrum disorders under an individualized education plan or an individualized family service plan.