Schedule of Benefits

Harvard Pilgrim Health Care, Inc.

MAINE DIFFERENCE DEDUCTIBLE HMO
MAINE

This Schedule of Benefits states any Benefit Limits and Member Cost Sharing amounts you must pay for Covered Benefits. However, it is only a summary of your benefits. Please see your Benefit Handbook for details. Your Member Cost Sharing may include a Deductible, Coinsurance, and Copayments. Please see the tables below for details.

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

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 on our website at **www.harvardpilgrim.org** or by calling **1–888–888–4742 ext. 38723**.

Copayment Levels

There are two types of office visit Copayments that apply to your Plan: a lower Copayment, known as "Level 1," and a higher Copayment known as "Level 2."

Level 1 applies to covered outpatient professional services from the following types of providers: all Primary Care Providers (PCPs); obstetricians and gynecologists; licensed mental health professionals; certified Nurse midwives; and Nurse practitioners who bill independently.

Level 2 applies to most outpatient specialty care.

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

Your Plan may have other Copayment amounts. Please see the benefit table below for specific Copayment requirements.

Covered Benefits

Your Covered Benefits are administered on a Calendar Year basis. Your Member Cost Sharing will depend upon the type of service provided and the location the service is provided in, as listed in this Schedule of Benefits. For example, for services provided in a doctor's office, see "Physician and Other Professional Office Visits." For services provided in a Hospital emergency room, see "Emergency Room Care," and for outpatient surgical procedures, please see "Surgery - Outpatient."

General Cost Sharing Features:	Member Cost Sharing:
Coinsurance and Copayments	
	See the benefits table below

General Cost Sharing Features:	Member Cost Sharing:
Deductible	
	$1,500 per Member per Calendar Year $3,000 per family per Calendar Year
Important Notice: If a family Deductible applies, it can be met in one of two ways: a. If a Member of a covered family meets an individual Deductible, then that Member has no additional Deductible Member Cost Sharing responsibilities for Covered Benefits for the remainder of the Calendar Year. b. If any number of Members in a covered family collectively meets a family Deductible, then all Members in that covered family have no additional Deductible Member Cost Sharing responsibilities for Covered Benefits for the remainder of the Calendar Year.	
Deductible Rollover	
Your Plan has a Deductible Rollover that applies to any Deductible amount that is incurred for services during the last 3 months of the Calendar Year and is applied toward the Deductible requirement for the next Calendar Year.	
Out-of-Pocket Maximum	
Includes all Member Cost Sharing except Member Cost Sharing for prescription drugs, which has a separate Out-of-Pocket Maximum	$3,000 per Member per Calendar Year $6,000 per family per Calendar Year

Benefit	Your Cost Sharing
Acupuncture Treatment for Injury or Illness	
– Limited to 20 visits per Calendar Year	Level 1: $30 Copayment per visit
Ambulance Transport	
Emergency ambulance transport	No charge
Non-emergency ambulance transport	No charge
Autism Spectrum Disorders Treatment	
Applied behavior analysis	Level 1: $30 Copayment per visit
Chemotherapy and Radiation Therapy	
	Deductible, then 20% Coinsurance
Chiropractic Care	
	Level 1: $30 Copayment per visit
Dental Services	
Important Notice: Coverage of Dental Care is very limited. Please see your Benefit Handbook for the details of your coverage.	
Extraction of teeth impacted in bone (performed in a Physician's office)	Deductible, then 20% Coinsurance
Dialysis	
	Level 1: $30 Copayment per visit Level 2: $50 Copayment per visit
Durable Medical Equipment	
Durable medical equipment	Deductible, then 20% Coinsurance
Blood glucose monitors, infusion devices, and insulin pumps (including supplies)	No charge
Oxygen and respiratory equipment	No charge

Benefit	Your Cost Sharing
Early Intervention Services (for Members up to the age of 3)	
– Limited to $3,200 per Member per Calendar Year, up to a maximum of $9,600	Level 1: $30 Copayment per visit
Emergency Room Care	
	$200 Copayment per visit
This Copayment is waived if admitted to the Hospital directly from the emergency room.	
Hearing Aids	
– Limited to $1,400 per hearing aid every 36 months, for each hearing impaired ear	Deductible, then 20% Coinsurance
Home Health Care	
	Deductible, then 20% Coinsurance
If services include the administration of drugs, please see the benefit for "Medical Drugs" for Member Cost Sharing details.	
Hospice – Outpatient	
	Deductible, then 20% Coinsurance
Hospital – Inpatient Services	
Acute Hospital care	Deductible, then 20% Coinsurance
Inpatient maternity care	Deductible, then 20% Coinsurance
Inpatient routine nursery care	No charge
Inpatient rehabilitation – limited to 100 days per Calendar Year Day limits combined with skilled nursing facility care	Deductible, then 20% Coinsurance
Skilled nursing facility – limited to 100 days per Calendar Year Day limits combined with inpatient rehabilitation	Deductible, then 20% Coinsurance
Infertility Services and Treatments (see the Benefit Handbook for details)	
Diagnostic services including only the following: consultation, evaluation and laboratory tests	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."
Infertility treatment – limited to 3 cycles per lifetime.	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."
Laboratory and Radiology Services	
Laboratory and x-rays	Deductible, then 20% Coinsurance
Advanced radiology, including CT scans, PET scans, MRI, MRA and nuclear medicine services	Deductible, then 20% Coinsurance
Low Protein Foods	
– Limited to $3,000 per Calendar Year	No charge

Benefit	Your Cost Sharing
Maternity Care – Outpatient	
Routine outpatient prenatal and postpartum care	No charge
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, Member Cost Sharing for services provided by a specialist is listed under "Physician and Other Professional Office Visits" and Member Cost Sharing for an ultrasound billed as a specialized or non-routine service is listed under "Laboratory and Radiology Services."	
Medical Drugs (drugs that cannot be self-administered)	
Medical drugs received in a doctor's office or other outpatient facility	20% Coinsurance up to a maximum Coinsurance of $250 per treatment
Medical drugs received in the home	20% Coinsurance up to a maximum Coinsurance of $250 per treatment
Some medical drugs received in a Physician's office or outpatient facility may be provided by the Specialty Pharmacy Program under your outpatient prescription drug benefit. If you have outpatient prescription drug coverage, your Member Cost Sharing is listed on your ID Card. Please see the Prescription Drug Brochure, for a detailed explanation of your benefits.	
Medical Formulas	
State mandated formulas	No charge
Mental Health and Drug and Alcohol Rehabilitation Services	
Inpatient Services	Deductible, then 20% Coinsurance
Partial hospitalization services	Deductible, then 20% Coinsurance
Outpatient group therapy	$10 Copayment per visit
Mental health services in the home	Level 1: $30 Copayment per visit
Outpatient treatment, including individual therapy, detoxification, and medication management	Level 1: $30 Copayment per visit
Outpatient methadone maintenance	Level 1: $30 Copayment per week
Outpatient psychological testing and neuropsychological assessment	Level 1: $30 Copayment per visit
Ostomy Supplies	
	Deductible, then 20% Coinsurance
Physician and Other Professional Office Visits (This includes all covered Plan Providers unless otherwise listed in this Schedule of Benefits.)	
Routine examinations for preventive care, including immunizations	No charge
Not all services you receive during your routine exam are covered at no charge. Only preventive services designated under the Patient Protection and Affordable Care Act (PPACA) are covered at no charge. Other services not included under PPACA may be subject to additional cost sharing. For the current list of preventive services covered at no charge under PPACA, please see the Preventive Services notice on our website at **www.harvardpilgrim.org**. Please see "Laboratory and Radiology Services," for the Member Cost Sharing that applies to diagnostic services not included on this list.	
Consultations, evaluations, Sickness and injury care	Level 1: $30 Copayment per visit Level 2: $50 Copayment per visit

Benefit	Your Cost Sharing
Physician and Other Professional Office Visits (This includes all covered Plan Providers unless otherwise listed in this Schedule of Benefits.) (Continued)	
Office based treatments and procedures, including but not limited to administration of injections, casting, suturing, and the application of dressings, non-routine foot care, and surgical procedures	No charge
Administration of allergy injections	Level 1: $30 Copayment per visit
Preventive Services and Tests	
	No charge
Under Federal law, many preventive services and tests are covered with no Member Cost Sharing, including preventive colonoscopies certain labs and x-rays, voluntary sterilization for women and all FDA approved contraceptive devices. For a complete list of covered preventive services, please see the Preventive Services notice on our website at **www.harvardpilgrim.org**. You may also get a copy of the Preventive Services notice by calling the Member Services Department at **1–888–333–4742**. Harvard Pilgrim will add or delete services from this benefit for preventive services and tests in accordance with Federal guidance.	
The following additional preventive services and tests: alpha-fetoprotein (AFP), fetal ultrasound, hepatitis C testing, lead level testing, prostate-specific antigen (PSA) screening, routine hemoglobin tests, group B streptococcus (GBS), and routine urinalysis	No charge
Prosthetic Devices	
Prosthetic devices (other than arms and legs)	Deductible, then 20% Coinsurance
Prosthetic arms and legs	20% Coinsurance
Rehabilitation and Habilitation Services – Outpatient	
Cardiac rehabilitation Pulmonary rehabilitation therapy	Level 1: $30 Copayment per visit Level 2: $50 Copayment per visit
Physical, speech and occupational therapies combined – limited to 60 visits per Calendar Year	Level 1: $30 Copayment per visit
Outpatient physical, occupational and speech therapies are covered to the extent Medically Necessary for: (1) children under the age of three and (2) the treatment of Autism Spectrum Disorders.	
Scopic Procedures – Outpatient Diagnostic and Therapeutic	
Colonoscopy, endoscopy and sigmoidoscopy	Deductible, then 20% Coinsurance
Surgery – Outpatient	
	Deductible, then 20% Coinsurance
Telemedicine	
Outpatient and Inpatient Telemedicine 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."

Benefit	Your Cost Sharing
Urgent Care Services	
Convenience care clinic	Level 1: $30 Copayment per visit
Urgent care clinic	$50 Copayment per visit
Hospital urgent care clinic	$50 Copayment per visit
Additional Member Cost Sharing may apply. Please refer to the specific benefit in this Schedule of Benefits. For example, if you have an x-ray or have blood drawn, please refer to "Laboratory and Radiology Services."	
Vision Services	
Urgent eye care	Level 1: $30 Copayment per visit Level 2: $50 Copayment per visit
Routine adult eye examinations – limited to 1 exam per Calendar Year	Level 1: $30 Copayment per visit
Routine pediatric eye examinations – limited to 1 exam per Calendar Year	Level 1: $30 Copayment per visit
Vision hardware for special conditions	Deductible, then 20% Coinsurance
Voluntary Sterilization – in a Physician's Office	
	No charge
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 "Office based treatments and procedures." For inpatient Hospital care, see "Hospital – Inpatient Services."
Wigs and Scalp Hair Prostheses	
– Limited to $350 per Calendar Year (see the Benefit Handbook for details)	Deductible, then 20% Coinsurance

Language Assistance Services

Español (Spanish) ATENCIÓN: Si usted habla español, servicios de asistencia lingüística, de forma gratuita, están a su disposición. Llame al 1-888-333-4742 (TTY: 711).

Português (Portuguese) ATENÇÃO: Se você fala português, encontram-se disponíveis serviços linguísticos gratuitos. Ligue para 1-888-333-4742 (TTY: 711).

Kreyòl Ayisyen (French Creole) ATANSYON: Si nou palé Kreyòl Ayisyen, gen asistans pou sèvis ki disponib nan lang nou pou gratis. Rele 1-888-333-4742 (TTY: 711).

繁體中文 (Traditional Chinese) 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-888-333-4742（TTY：711）。

Tiếng Việt (Vietnamese) CHÚ Ý: Nếu quí vị nói Tiếng Việt, dịch vụ thông dịch của chúng tôi sẵn sàng phục vụ quí vị miễn phí. Gọi số 1-888-333-4742 (TTY: 711).

Русский (Russian) ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-888-333-4742 (телетайп: 711).

العربية (Arabic)

إنتباه: إذا أنت تتكلم اللغة **العربية**، خدمات المساعدة اللغوية متوفرة لك مجانا. **إتصل على 1 888-333-4742**

(TTY: 711)

ខ្មែរ (Cambodian) [ប្រសូជូនដំណឹង៖ បើអ្នកនិយាយភាសាខ្មែរ, សេវាកម្មបកប្រែ ជូនលោកអ្នកដោយ ឥតគិតថ្លៃ។ ចូរ ទូរស័ព្ទ 1-888-333-4742 (TTY: 711)។

Français (French) ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-888-333-4742 (ATS: 711).

Italiano (Italian) ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-888-333-4742 (TTY: 711).

한국어 (Korean) '알림': 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-888-333-4742 (TTY: 711) 번으로 전화해 주십시오.

ελληνικά (Greek) ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, υπάρχουν στη διάθεσή σας δωρεάν υπηρεσίες γλωσσικής υποστήριξης. Καλέστε 1-888-333-4742 (TTY: 711).

Polski (Polish) UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-888-333-4742 (TTY: 711).

हिंदी (Hindi) ध्यान दीजिए: अगर आप हिंदी बोलते हैं तो आपके लिये भाषाकी सहायता मुफ्त में उपलब्ध है. जानकारी के लिये फोन करे. 1-888-333-4742 (TTY: 711)

ગુજરાતી (Gujarati) ધ્યાન આપો : જો તમે ગુજરાતી બોલતા હો તો આપને માટે ભાષાકીય સહાય તદ્દન મફત ઉપલબ્ધ છે. વિશેષ માહિતી માટે ફોન કરો. 1-888-333-4742 (TTY: 711)

ພາສາລາວ (Lao) ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-888-333-4742 (TTY: 711).

ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call 1-888-333-4742 (TTY: 711).

Harvard Pilgrim Health Care includes Harvard Pilgrim Health Care, Harvard Pilgrim Health Care of Connecticut, Harvard Pilgrim Health Care of New England and HPHC Insurance Company.

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General Notice About Nondiscrimination and Accessibility Requirements

Harvard Pilgrim Health Care and its affiliates as noted below ("HPHC") comply with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. HPHC does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

HPHC:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, audio, other formats)
- Provides free language services to people whose primary language is not English, such as qualified interpreters.

If you need these services, contact our Civil Rights Compliance Officer.

If you believe that HPHC has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with: Civil Rights Compliance Officer, 93 Worcester St, Wellesley, MA 02481, (866) 750-2074, TTY service: 711, Fax: (617) 509-3085, Email: civil_rights@harvardpilgrim.org. You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, the Civil Rights Compliance Officer is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
(800) 368-1019, (800) 537-7697 (TTY)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

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