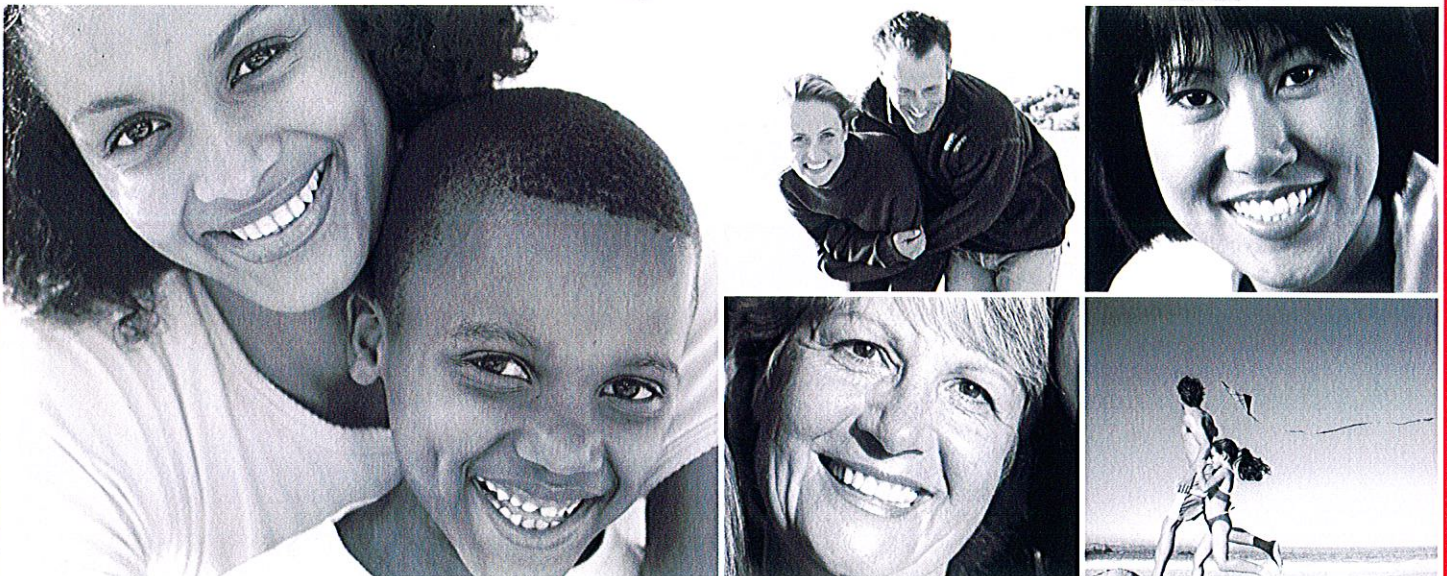


# Schedule of Benefits





## SECTION A. Summary of Benefits

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This Summary is part of your Benefit Handbook. It states the Cost Sharing amounts that you must pay for Covered Benefits and some important limitations on your coverage. It also identifies any supplemental medical benefits included in your Plan.

**For complete information on Covered Benefits, including limitations on your coverage, you must refer to Section C of the Benefit Handbook, and if applicable, Section D for Supplemental Benefits and Section P for Prescription Drug Coverage. For information on how the Best Buy HSA PPO Plan works, please see Section B of the Benefit Handbook.**

Please note when using Non-Participating Providers, you are financially responsible for the difference between the Usual, Customary and Reasonable Charge (UCR) amount allowed by the Plan and the amount charged by the Provider. Please refer to Section B.3.g for additional information about Usual, Customary and Reasonable Charges.

General Cost Sharing Features	In-Network	Out-of-Network
Coinsurance	None	See Covered Benefits below
Copayment	None	None
Deductible Your Plan has a family Deductible with an embedded individual Deductible	\$2,500 per Member \$5,000 per family	\$5,000 per Member \$10,000 per family
Out-of-Pocket Maximum	\$2,500 per Member \$5,000 per family	\$10,000 per Member \$20,000 per family
Penalty Payment	None	\$500

SECTION A. Summary of Benefits

Covered Benefits	Your Cost Sharing In-Network	Your Cost Sharing Out-of-Network
<b>Outpatient Professional Services</b>		
<ul style="list-style-type: none"> <li>Ambulance Transport, Non-Emergency</li> </ul>	Deductible, then no charge	20% Coinsurance after Deductible up to the UCR
<ul style="list-style-type: none"> <li>Autism Spectrum Disorders Treatment for Members up to the age of 6</li> </ul>		
<ul style="list-style-type: none"> <li>Applied behavioral analysis - limited to \$36,000 per calendar year</li> </ul>	Deductible, then no charge	20% Coinsurance after Deductible up to the UCR
<p>All other benefits are covered as stated in this Summary of Benefits</p> <p>No benefit limit applies to physical therapy, occupational therapy or speech therapy for the treatment of autism spectrum disorders</p>	<p>Your Member Cost Sharing depends upon the type of service provided, as listed in this Summary of Benefits. For example: for services provided by a physician see "Physician Services." For services provided by a physical therapist, speech therapist and occupational therapist see "Physical, Speech and Occupational Therapies."</p>	<p>Your Member Cost Sharing depends upon the type of service provided, as listed in this Summary of Benefits. For example: for services provided by a physician see "Physician Services." For services provided by a physical therapist, speech therapist and occupational therapist see "Physical, Speech and Occupational Therapies."</p>
<ul style="list-style-type: none"> <li>Cardiac Rehabilitation</li> </ul>	Deductible, then no charge	20% Coinsurance after Deductible up to the UCR
<ul style="list-style-type: none"> <li>Chiropractic Care - limit of 20 visits per calendar year</li> </ul>	Deductible, then no charge	20% Coinsurance after Deductible up to the UCR
<ul style="list-style-type: none"> <li>Diagnostic Laboratory and X-rays</li> </ul>	Deductible, then no charge	20% Coinsurance after Deductible up to the UCR
<ul style="list-style-type: none"> <li>Dialysis</li> </ul>	Deductible, then no charge	20% Coinsurance after Deductible up to the UCR
<ul style="list-style-type: none"> <li>Early Intervention Services – limited to \$3,200 per calendar year up to a maximum of \$9,600</li> </ul>	<p>Your Member Cost Sharing depends upon the type of service provided, as listed in this Summary of Benefits. For example: for services provided by a physician see "Physician Services." For services provided by a physical therapist, speech therapist and occupational therapist see "Physical, Speech and Occupational Therapies."</p>	<p>Your Member Cost Sharing depends upon the type of service provided, as listed in this Summary of Benefits. For example: for services provided by a physician see "Physician Services." For services provided by a physical therapist, speech therapist and occupational therapist see "Physical, Speech and Occupational Therapies."</p>

SECTION A. Summary of Benefits

Covered Benefits	Your Cost Sharing In-Network	Your Cost Sharing Out-of-Network
<b>Outpatient Professional Services (Continued)</b>		
▪ Formulas and Low Protein Foods	Deductible, then no charge	20% Coinsurance after Deductible up to the UCR
▪ 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	Deductible, then no charge	20% Coinsurance after Deductible up to the UCR
▪ Home Health Care and Hospice	Deductible, then no charge	20% Coinsurance after Deductible up to the UCR
▪ Physical, Speech and Occupational Therapies - combined up to 40 visits per calendar year	Deductible, then no charge	20% Coinsurance after Deductible up to the UCR
▪ Physician Services, except for the Preventive Care Services listed below	Deductible, then no charge	20% Coinsurance after Deductible up to the UCR
Preventive Care Services – the In-Network Deductible and Out-of-Network Deductible do not apply to the following services		
Preventive Care by a Physician	Nothing	20% Coinsurance
Preventive Maternity Care	Nothing	20% Coinsurance
Preventive Tests and Procedures	Nothing	20% Coinsurance
▪ Surgical Day Care	Deductible, then no charge	20% Coinsurance after Deductible up to the UCR
▪ Vision Hardware for Special Conditions	Deductible, then no charge	20% Coinsurance after Deductible up to the UCR
<b>Emergency Services</b>		
▪ Ambulance Transport, Emergency	Deductible, then no charge	Same as In-Network
▪ Emergency Dental Care - in a professional office within 72 hours of injury	Deductible, then no charge	20% Coinsurance after Deductible up to the UCR
▪ Emergency Room Care	Deductible, then no charge	Same as In-Network
<b>Inpatient Services</b>		
▪ Acute Hospital Care		
▪ Maternity Care	Deductible, then no charge	20% Coinsurance after Deductible up to the UCR
▪ Rehabilitation Hospital and Skilled Nursing Facility Care - combined limit of 100 days per calendar year		

SECTION A. Summary of Benefits

Covered Benefits	Your Cost Sharing In-Network	Your Cost Sharing Out-of-Network
<b>Mental Health and Drug and Alcohol Rehabilitation Services</b>		
▪ Services for Biologically Based Mental Illness		
Inpatient Care, including drug and alcohol rehabilitation and detoxification care	Deductible, then no charge	20% Coinsurance after Deductible up to the UCR
Outpatient Care and Outpatient Home Care, including drug and alcohol rehabilitation and detoxification care, and psychological testing	Deductible, then no charge	20% Coinsurance after Deductible up to the UCR
▪ Mental Health Services for non-Biologically Based Mental Illness		
Inpatient Care	Deductible, then no charge	20% Coinsurance after Deductible up to the UCR
Outpatient Care and Outpatient Home Care	Deductible, then no charge	20% Coinsurance after Deductible up to the UCR
Psychological Testing	Deductible, then no charge	20% Coinsurance after Deductible up to the UCR
<b>Durable Medical Equipment and Prosthetic Devices</b>		
▪ Covered to the extent Medically Necessary, including the items listed below	Deductible, then no charge  Please note: On July 1, 2011, a Member Cost Sharing of 20% Coinsurance will be applied to this benefit, including the items listed below.	20% Coinsurance after Deductible up to the UCR
Blood Glucose Monitors, Insulin Pumps and Infusion Devices	Deductible, then no charge	20% Coinsurance after Deductible up to the UCR
Breast Prostheses, including Replacements and Mastectomy Bras	Deductible, then no charge	20% Coinsurance after Deductible up to the UCR
Medical Equipment and Supplies for Diabetes Treatment	Deductible, then no charge	20% Coinsurance after Deductible up to the UCR
Oxygen and Respiratory Equipment	Deductible, then no charge	20% Coinsurance after Deductible up to the UCR

SECTION A. Summary of Benefits

Covered Benefits	Your Cost Sharing In-Network	Your Cost Sharing Out-of-Network
<b>Durable Medical Equipment and Prosthetic Devices (Continued)</b>		
Prosthetic Arms and Legs	Deductible, then no charge	20% Coinsurance after Deductible up to the UCR
Wigs - 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	Deductible, then no charge	20% Coinsurance after Deductible up to the UCR
<b>Telemedicine Services</b>		
<ul style="list-style-type: none"> <li>Outpatient and Inpatient Telemedicine Services</li> </ul>	Your Member Cost Sharing will depend upon the types of services provided, as listed in this Summary of Benefits. For example, for services provided by a physician, see "Physician Services." For inpatient hospital care, see "Acute Hospital Care."	Your Member Cost Sharing will depend upon the types of services provided, as listed in this Summary of Benefits. For example, for services provided by a physician, see "Physician Services." For inpatient hospital care, see "Acute Hospital Care."
<b>Supplemental Medical Benefits</b>		
<ul style="list-style-type: none"> <li>Annual Eye Examination</li> </ul>	Nothing	20% Coinsurance
<ul style="list-style-type: none"> <li>Extraction of Impacted Teeth</li> </ul>	Deductible, then no charge	20% Coinsurance after Deductible up to the UCR
<ul style="list-style-type: none"> <li>Infertility Treatment - (Limited to Consultation, Evaluation and Laboratory Tests)</li> </ul>	Deductible, then no charge	20% Coinsurance after Deductible up to the UCR
<ul style="list-style-type: none"> <li>Voluntary Termination of Pregnancy</li> </ul>	Deductible, then no charge	20% Coinsurance after Deductible up to the UCR

## Exclusions

### The Plan does not cover the following:

- Cosmetic procedures, except as described in this Handbook.
- Commercial diet plans, weight loss programs and any services in connection with such plans or programs.
- Gender reassignment 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, but not limited to, laser surgery, orthokeratology and lens implantation for the correction of myopia, hyperopia and astigmatism.
- Transportation other than by ambulance.
- Costs for any services for which you are legally 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 and 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 and testing 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, television charges and exercise equipment.
- 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.
- 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 Benefit under this 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 this Handbook, your Summary of Benefits or Prescription Drug Brochure (if your Plan includes coverage for prescription drugs).
- 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.
- Birth control drugs, implants, injections and devices, if your Plan does not include coverage for prescription drugs.
- 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 Benefit.
- Taxes or assessments on services or supplies.
- Home health care services that extend beyond a short-term intermittent basis, as described in the home health care benefit section.
- Private duty nursing.
- Any Dental Care, except the specific dental services listed in this Handbook.
- Wigs, except as described in Section C.6., if listed as a Covered Benefit in your Summary of Benefits (Section A).
- Eyeglasses, contact lenses and fittings, except as listed in this Handbook.
- Unless otherwise specified in this Benefit Handbook or the Summary 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
- 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.

**The following are also excluded under your Plan unless specifically listed as a Supplemental Benefit in the Summary of Benefits (Section A):**

- Annual eye examinations.
- Extraction of impacted teeth.
- Foot orthotics, except when Medically Necessary for the treatment of certain medical conditions.
- Infertility treatment, including consultation, evaluation and related laboratory testing.
- Infertility treatment using 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.
- Infertility treatment using therapeutic donor insemination, including related sperm procurement and banking.
- Medical treatment of temporomandibular joint dysfunction (TMD).

- Voluntary sterilization.
- Voluntary termination of pregnancy, unless the life of the mother is in danger.