Harvard Pilgrim Health Care

Benefit Handbook

THE HARVARD PILGRIM POS
MAINE

EFFECTIVE DATE: 01/01/2016
FORM #1157_04

INTRODUCTION

Welcome to the Harvard Pilgrim Point of Service (POS) Plan offered by Harvard Pilgrim Health Care (HPHC) and thank you for choosing us to help meet your health care needs.

When we use the words “we,” “us,” and “our” in this Handbook, we are referring to HPHC. When we use the words “you” or “your” we are referring to Members as defined in the Glossary.

The Harvard Pilgrim POS Plan has been designed to offer you the coordinated care and cost advantages of Health Maintenance Organization (HMO) health coverage as well as the choice of obtaining Covered Benefits outside the HMO provider network.

In-Network Benefits

Your "In-Network" benefits provide coverage at a lower out of pocket cost. With very limited exceptions, you must receive care from "Plan Providers" to obtain In-Network benefits. Plan Providers are medical providers under contract to care for HPHC members. They include Primary Care Providers (PCPs), specialists, hospitals and many other types of providers. You can locate Plan Providers by using the Plan's Provider Directory described in this Benefit Handbook. You may also call Member Services at **1–888–333–4742**.

In a Medical Emergency, you should promptly go to the nearest emergency room or call 911 or other local emergency number. You always receive In-Network coverage for care at a hospital emergency room. This also includes emergency transportation by ambulance.

Out-of-Network Benefits

If you choose to receive Covered Benefits from a provider or at a facility which is not a Plan Provider, your benefits will be covered at the Out-of-Network level. Your benefits will also be covered at the Out-of-Network level if you receive services from a Plan Provider in the Service Area without a Referral from your PCP, when a Referral is required.

Some benefits have limits on the amount of coverage provided in a Plan Year or Calendar Year. If a Covered Benefit has a benefit limit, your In-Network and Out-of-Network services are usually combined and count against each other to reach your benefit limit.

As a Member, you can take advantage of a wide range of helpful online tools and resources. For instance, **HPHConnect**offers you a secure place to help manage your health care. You are able to check your Schedule of Benefits and other plan documents, review your claim history, change PCPs, compare hospitals and much more! For details on how to register for an **HPHConnect** account, log on to **www.harvardpilgrim.org**.

You may also call the Member Services Department at **1–888–333–4742** if you have any questions. Member Services staff are available to help you with questions about the following:

- Selecting a PCP
- Your Benefit Handbook
- Your In-Network and Out-of-Network benefits
- Your enrollment

- Your claims
- Pharmacy management procedures
- Provider information
- Requesting a Provider Directory
- Requesting a Member Kit
- Requesting ID cards
- Registering a complaint

We can usually accommodate questions from non-English speaking Members, as we offer language interpretation services in more than 180 languages.

Deaf and hard-of-hearing Members who use a Teletypewriter (TTY) may communicate with the Member Services Department. For TTY service, please call **711.**

We value your input. We would appreciate hearing from you with any comments or suggestions that will help us further improve the quality of service we bring you.

Harvard Pilgrim Health Care
Member Services Department
1600 Crown Colony Drive
Quincy, MA 02169
1-888-333-4742
www.harvardpilgrim.org

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 applicable to a service or procedure for which coverage is requested. Clinical review criteria may be obtained by calling **1-888-888-4742 ext. 38723.**

[Spanish]

Los miembros que no dominan el inglés pueden llamar al Departamento de servicios para miembros de Harvard Pilgrim Health Care al 1-888-333-4742, donde se responderá a sus preguntas. El Plan ofrece un servicio de interpretación gratuito en más de 120 idiomas.

[Russian]

Те, кто не владеет английским языком, могут также получить ответы на свои вопросы, позвонив по телефону 1-888-333-4742 в отдел обслуживания медицинского центра Harvard Pilgrim. Данный план предоставляет бесплатные услуги по обеспечению устного перевода более, чем на 120 иностранных языков.

[Arabic]

كما يستطيع الأعضاء الغير الناطقين باللغة
الإنجليزية أن يتصلوا بقسم خدمات الأعضاء بهيئة
للعناية الصحية (Harvard Pilgrim)هارفارد بيلجريم
، وذلك للحصول على 1-888-333-4742على الرقم
إجابات لاستفساراتهم. ويقدم البرنامج خدمات
ترجمة مجانية بأكثر من 120 لغة.

[Portuguese]

Os membros que não falarem inglês também podem telefonar para o Departamento dos Serviços de Saúde Harvard Pilgrim para membros através do número 1 888 333 4742, de forma a obterem os esclarecimentos pretendidos. Este plano oferece serviços de interpretação gratuitos em mais de 120 idiomas.

[French]

Harvard Pilgrim Health Care propose des services d'interprétation gratuits dans plus de 120 langues pour répondre aux questions des membres qui ne parlent pas anglais. Pour utiliser ce service, appelez la section des services aux membres au 1-888-333-4742.

[Greek]

Τα Μέλη που δε μιλούν Αγγλικά μπορούν επίσης να τηλεφωνήσουν στο Τμήμα Εξυπηρέτησης Μελών του Harvard Pilgrim Health Care στον αριθμό 1-888-333-4742 για τυχόν ερωτήσεις. Το Πρόγραμμα παρέχει δωρεάν ξενόγλωσσες υπηρεσίες διερμηνείας για περισσότερες από 120 γλώσσες.

[Haitian Creole]

Manm yo ki pa pale Angle ka rele Depatman Sèvis Manm Harvard Pilgrim Health Care tou nan 1-888-333-4742 pou jwenn repons a keksyon yo. Plan an ofri sèvis entèpretasyon gratis nan plis ke 120 lang.

[Italian]

I Partecipanti che non parlano inglese possono anche rivolgere le proprie domande al Reparto Servizi Partecipanti dell'Harvard Pilgrim Health Care, chiamando il numero 1-888-333-4742. Il Piano offre servizi di interpretariato gratuiti in oltre 120 lingue.

[Traditional Chinese]

不說英語的會員亦可致電 1-888-333-4742，請 Harvard Pilgrim 醫療保健的 會員服務部門回答所提出的問題。該計劃免費提供120多種語言的翻譯服務。

[Lao]

ສະມາຊິກ ທັງ ໝົດ ທີ່ ປາກ ພາສາ ອັງກິດ ບໍ່ ເປັນກໍ ສາມາດ ຕິດ ຕໍ່ ຮັບ ພະແນກ ບໍລິການ ລູກ ຄ້າ ຂອງ ໂຄງ ການ ຮັກສາ ສຸຂະພາບ **Harvard Pilgrim** ໄດ້ ໂດຍ ໂທ ໄປ ທີ່ **1-888-333-4742** ເພື່ອ ຈະ ຊາບ ຄຳ ຕອບ ຂອງ ຄຳ ຖາມ ຕ່າງໆ ຂອງ ເຈົ້າ. ໂຄງ ການ ນີ້ ຈະ ສະໜອງ ບໍລິການ ແປ ພາສາ ໃນ ໝົດ ກວ່າ **120** ພາສາ ໂດຍ ບໍ່ ເສັຍ ຄ່າ ບໍລິການ ໃດ ທັງ ສິ້ນ.

[Cambodian]

សមាជិកដែលមិនចេះនិយាយភាសាអង់គ្លេស អាចទូរស័ព្ទទៅការិយាល័យផ្នែកសេវាបំរើសមាជិកនៃផែនការសុខភាព **Harvard Pilgrim Health Care** លេខ **1-888-333-4742** ដើម្បីឲ្យគេឆ្លើយតបនឹងសំណួរផ្សេងៗ ។ ផែនការសុខភាពនេះមានផ្តល់ជូនសេវាបកប្រែភាសាដោយឥតគិតថ្លៃ ច្រើនជាង 120 ភាសា ។

Non-English speaking Members may also call Harvard Pilgrim Health Care's Member Services Department at **1-888-333-4742** to have their questions answered. The Plan offers free language interpretation services in more than 120 languages.

TABLE OF CONTENTS

Benefit Handbook

I. How the Plan Works

This section describes how to use your Benefit Handbook and how your coverage works under the Harvard Pilgrim POS (the Plan).

A. HOW TO USE THIS BENEFIT HANDBOOK

1. Why This Benefit Handbook Is Important

This Benefit Handbook, the Schedule of Benefits, the Prescription Drug Brochure (if your Plan includes our outpatient pharmacy coverage) and any applicable riders and amendments (collectively referred to as the Evidence of Coverage) make up the legal agreement stating the terms of the Plan. This document also incorporates by reference an Employer Agreement issued to your Employer, which includes information on dependent eligibility. If you have any eligibility questions, we recommend that you see your Employer for information.

The Benefit Handbook describes how your membership works. It's also your guide to the most important things you need to know, including:

- Covered Benefits
- Exclusions
- The requirements for In-Network and Out-of-Network coverage

You can view your Benefit Handbook, Schedule of Benefits, Prescription Drug Brochure (if your Plan includes our outpatient pharmacy coverage) and any applicable ridersand amendments online by using **HPHConnect**at **www.harvardpilgrim.org**.

2. Words With Special Meaning

Some words in this Handbook have a special meaning. These words are capitalized and are defined in the *Glossary*.

3. How To Find What You Need To Know

This Handbook's Table of Contents will help you find the information you need. The following is a description of some of the important sections of the Handbook.

We put the most important information first. For example, this section explains important requirements for coverage. By understanding Plan rules, you can avoid denials of coverage.

Benefit details are described in section *III. Covered Benefits* and are in the same order as in your Schedule of Benefits. You must review section *III. Covered Benefits* and your Schedule of Benefits for a complete understanding of your benefits.

The Handbook provides detailed information on how to appeal a denial of coverage or file a complaint. This information is in section *VI. Appeals and Complaints*.

B. HOW TO USE YOUR PROVIDER DIRECTORY

To be eligible for In-Network coverage under the Plan, all services, except care in a Medical Emergency, must be received from Plan Providers. You can find Plan Providers by using the Provider Directory.

The Provider Directory lists the Plan's Providers you may use to obtain In-Network coverage. You may view the Provider Directory online at our web site, **www.harvardpilgrim.org**. Please select "POS" from the list of "standard plans". You can also get a paper copy of the Provider Directory, free of charge, by calling the Member Services Department at **1–888–333–4742.**

The online Provider Directory enables you to search for providers by name, gender, specialty, hospital affiliations, languages spoken and office locations. You can also obtain information about whether a provider is accepting new patients. Since it is frequently updated, the information in the online directory will be more current than the paper directory.

Please Note: Plan Providers participate through contractual arrangements that can be terminated either by a provider or by us. In addition, a provider may leave the network because of retirement, relocation or other reasons. This means that we cannot guarantee that the physician you choose will continue to participate in the network for the duration of your membership. If your PCP leaves the network for any reason, we will make every effort to notify you at least 60 days in advance, and will help you find a new Plan physician. Under certain circumstances you may be eligible for transition services if your provider leaves the network (please see section *I.G. SERVICES PROVIDED BY A DISENROLLED OR NON-PLAN PROVIDER* for details).

C. MEMBER OBLIGATIONS

1. Choose a Primary Care Provider (PCP)

If you live in the Plan's Service Area, you must select a PCP for yourself and each covered member of your family. You may choose a different PCP for each

family member. If you do not choose a PCP when you enroll, or if the PCP you select is not available, we will assign a PCP to you. The Plan Service Area is the states of Massachusetts, New Hampshire, Maine, Rhode Island, Connecticut and Vermont.

Even if you do not live in the Service Area, we strongly recommend that you choose a Primary Care Provider (PCP) for yourself and each covered person in your family.

A PCP may be a Provider of internal medicine, family practice, general practice, pediatrics, obstetrics and gynecology, or a certified nurse practitioner licensed by the Maine Board of Nursing, supervised by a doctor in one of those specialties. PCPs are listed in the Provider Directory. You can access our website at **www.harvardpilgrim.org** or call the Member Services Department to confirm that the PCP you select is available.

If you have not seen your PCP before, we suggest you call your PCP for an appointment. **Please do not wait until you are sick**. Your PCP can take better care of you when he or she is familiar with your health history.

You may change your PCP at any time. Just choose a new PCP from the Provider Directory. You can change your PCP online by using **HPHConnect** at **www.harvardpilgrim.org**or by calling the Member Services Department. The change is effective immediately. If you choose a new PCP, all Referrals from your prior PCP become invalid. You will need to get new Referrals from your new PCP.

2. Obtain Referrals to In-Network Specialists
In order to be eligible for In-Network coverage by the Plan, most care you receive in the Service Area must be provided or arranged by your PCP. For more information, please see section *I.D. HOW TO OBTAIN CARE*.

If you need to see a specialist in the Service Area, you must contact your PCP for a Referral prior to the appointment. In most cases, a Referral will be given to a Plan Provider who is affiliated with the same hospital as your PCP or who has a working relationship with your PCP. Referrals to Plan Providers must be given in writing.

You do not need a Referral from your PCP when you receive care outside of the Service Area. (The Service Area includes the states of Massachusetts, New Hampshire, Maine, Rhode Island or Vermont.) However, except in a Medical Emergency, you must obtain care from a Plan Provider to obtain In-Network coverage under this Handbook.

3. Show Your Identification Card
You should show your identification (ID) card every time you request health services. If you do not show your ID card, the Provider may not bill us for Covered Benefits, and you may be responsible for the cost of the service. You can order a new ID card online by using **HPHConnect** at **www.harvardpilgrim.org**or by calling the Member Services Department.

4. Share Costs
You are required to share the cost of Covered Benefits provided under the Plan. Your Member Cost Sharing may include one or more of the following:

- Copayments
- Coinsurance
- Deductibles

Your Plan may also have an Out-of-Pocket Maximum that limits the amount of Member Cost Sharing you may be required to pay. Your specific Member Cost Sharing responsibilities are listed in your Schedule of Benefits. See the *Glossary* for more information on Copayments, Coinsurance, Deductibles and Out-of-Pocket Maximums.

5. Obtain Prior Approval
You are required to notify HPHC or obtain Prior Approval before receiving certain Covered Benefits. For In-Network medical benefits, a Plan Provider will do this for you. Please see section *I.F. NOTIFICATION AND PRIOR APPROVAL* for more information on these requirements.

To provide notification or obtain Prior Approval for Out-of-Network medical services you should call: **1–800–708–4414**.

To provide notification or obtain Prior Approval for Out-of-Network mental health and drug and alcohol rehabilitation services, you should call the Behavioral Health Access Center at **1–888–777–4742.**

You do not need to provide advance notification or obtain Prior Approval if services are needed in a Medical Emergency.

6. Be Aware that your Plan Does Not Pay for All Health Services
There may be health products or services you need that are not covered by the Plan. Please review section *IV. Exclusions* for more information. In addition, some services that are covered by the Plan are limited. Such limitations are needed to maintain reasonable premium rates for all Members. Please see your

Schedule of Benefits for any specific limits that apply to your Plan.

D. HOW TO OBTAIN CARE

IMPORTANT POINTS TO REMEMBER

1) You and each enrolled Member of your family who lives in the Service Area must select a PCP.
2) The Service Area is the states of Massachusetts, New Hampshire, Maine, Rhode Island, Connecticut and Vermont.
3) You have two types of Covered Benefits, known as "In-Network" and "Out-of-Network."
4) In order to receive In-Network Covered Benefits in the Service Area, your care must be provided or arranged by your PCP through Plan Providers, except as noted below.
5) To receive In-Network Covered Benefits outside of the Service Area, you must use Plan Providers.
6) Out-of-Network Covered Benefits are available when received from Non-Plan Providers.
7) Some services require Prior Approval by the Plan.
8) In the event of a Medical Emergency, you should go to the nearest emergency facility or call 911 or other local emergency number. You do not need a Referral for services in a Medical Emergency.

In-Network and Out-of-Network Coverage

The Plan offers two different levels of coverage, referred to in this Handbook as "In-Network" and "Out-of-Network" benefits.

To receive In-Network coverage, you must use Plan Providers. Plan Providers have agreed to participate in the Plan and accept the Plan payment minus Member Cost sharing as payment in full. Since we pay Plan Providers directly, if you show your Member ID card, you should not have to file a claim when you use your In-Network coverage.

You receive Out-of-Network coverage when Covered Benefits are provided by Non-Plan Providers or Plan Providers without a PCP Referral when one is required. Although your Member Cost sharing is generally higher for Out-of-Network benefits, you may obtain Covered Benefits from the provider of your choice.

To find out if a provider is a Plan Provider, see the Provider Directory. The Provider Directory is available online at **www.harvardpilgrim.org** or by calling our Member Services Department at the telephone number listed on your ID card.

You coverage is described further below.

When obtaining Out-of Network benefits, some services require Prior Approval by the Plan. Please see the section titled *I.F. NOTIFICATION AND PRIOR APPROVAL* for information on the Prior Approval Program. To request Prior Approval, please call:

- **1-800-708-4414** for Medical Services
- **1-888-777-4742** for mental health care and drug and alcohol rehabilitation services.

Please see your Schedule of Benefits for the specific Member Cost Sharing that applies to the In-Network and Out-of-Network benefits purchased by your employer.

1. How Your In-Network Coverage Works

To obtain In-Network coverage in the Service Area, you must choose a Primary Care Provider (PCP) who is a Plan Provider and receive Covered Benefits in one of the following ways:

- The service must be provided by your PCP;
- The service must be provided by a Plan Provider upon Referral from your PCP;
- The service must be one of the special services that do not require a Referral listed in section *I.D.7. Services That Do Not Require a Referral*, and be received from a Plan Provider;
- In the case of mental health and drug and alcohol rehabilitation services, the service must be provided by a Plan Provider upon Referral from the Behavioral Health Access Center.
- The service must be provided in a Medical Emergency. In a Medical Emergency, including an emergency mental health condition, the Plan provides In-Network coverage for ambulance and hospital emergency room services. You do not need to use a Plan Provider and you do not need a Referral from your PCP.

To obtain In-Network coverage outside the Service Area, you must receive Covered Benefits through the Plan's national provider network. To find a Plan Provider, see the Provider Directory.

The Provider Directory is available online at **www.harvardpilgrim.org** or by calling our Member Services Department at **1–888–333–4742**.

All other Covered Benefits are covered at the Out-of-Network benefit level.

2. Your PCP Manages Your Health Care

When you need care in the Service Area, call your PCP. The Service Area includes the states of Massachusetts, New Hampshire, Maine, Rhode Island, Connecticut and Vermont.

In order to be eligible for In-Network coverage in the Service Area, most services must be provided by your PCP or arranged by your PCP and provided by a Plan Provider. The only exceptions are:

- Care in a Medical Emergency.
- Mental health care, which may be arranged by calling the Behavioral Health Access Center at **1–888–777–4742.** The telephone number for the Behavioral Health Access Center is also listed on your ID card. Please see section *III. Covered Benefits*, *Mental Health and Drug and Alcohol Rehabilitation Services* for information on this benefit.
- Special services that do not require a Referral that are listed in section *I.D.7. Services That Do Not Require a Referral*, below.

Either your PCP or a covering Plan Provider is available to direct your care 24 hours a day. Talk to your PCP and find out what arrangements are available for care after normal business hours. Some PCPs may have covering physicians after hours and others may have extended office or clinic hours.

You may change your PCP at any time. Just choose a new PCP from the Provider Directory. You can change your PCP online by using **HPHConnect** at **www.harvardpilgrim.org** or by calling the Member Services Department. The change is effective immediately. If you select a new PCP, all Referrals from your prior PCP become invalid. Your new PCP will need to assess your condition and provide new Referrals.

3. Referrals for Hospital and Specialty Care

When you need hospital or specialty care in the Service Area, you must first call your PCP. Your PCP will coordinate your care. Your PCP generally uses one hospital for inpatient care. This is where you will need to go for coverage, unless it is Medically Necessary for you to get care at a different hospital.

When you need specialty care, your PCP will refer you to a Plan Provider who is affiliated with the hospital your PCP uses. This helps your PCP coordinate and maintain the quality of your care. Please ask your PCP about the Referral networks that he or she uses.

If the services you need are not available through your PCP's Referral network, your PCP may refer you to any Plan Provider. If you or your PCP has difficulty finding a Plan Provider who can provide the services you need, we will assist you. For help finding a medical provider, please call **1–888–333–4742**. For help finding a mental health care provider, please call **1–888–777–4742**. If no Plan Provider has the expertise needed to meet your medical needs, we will assist you in finding an appropriate Non-Plan Provider.

Plan Providers with recognized expertise in specialty pediatrics are covered with a Referral from your PCP. Pediatric mental health care may be obtained by calling the Behavioral Health Access Center at **1–888–777–4742.**

Your PCP may authorize a standing Referral with a specialty care provider when:

1) The PCP determines that the Referral is appropriate;
2) The specialty care provider agrees to a treatment plan for the Member and provides the PCP with necessary clinical and administrative information on a regular basis; and
3) The services provided are Covered Benefits as described in this Handbook and your Schedule of Benefits.

Certain specialty services may be obtained without involving your PCP. For more information please see section*I.D.7. Services That Do Not Require a Referral*.

When you need hospital or specialty care outside the Service Area you may obtain Covered Benefits from the provider of your choice. You do not need a Referral for services received outside of the Service Area. However, you must receive Covered Benefits through a Plan Provider to receive In-Network coverage.

4. Using Plan Providers

Covered Benefits must be received from a Plan Provider to be eligible for In-Network coverage. However, there are specific exceptions to this requirement. Covered Benefits from a provider who is not a Plan Provider will only be covered at the In-Network benefit level if one of the following exceptions applies:

1. The service was received in a Medical Emergency from an emergency room or for ambulance transport. (Please see section *I.D.5. Medical Emergency Services* for information on your coverage in a Medical Emergency.)
2. No Plan Provider has the professional expertise needed to provide the required service. In this case, services by a Non-Plan Provider must be authorized in advance by us, unless one of the exceptions above applies.
3. Your physician is disenrolled as a Plan Provider or you are a new Member of the Plan, and one of the exceptions stated in section *I.G. SERVICES PROVIDED BY A DISENROLLED OR NON-PLAN PROVIDER* applies. Please refer to that section for the details of these exceptions.

To find out if a provider is in the Plan network, see the Provider Directory. The Provider Directory is available online at **www.harvardpilgrim.org** or by calling our Member Services Department at **1–888–333–4742**.

5. Medical Emergency Services

In a Medical Emergency, including a an emergency mental health condition, you should go to the nearest emergency facility or call 911 or other local emergency number. Your emergency room Member Cost Sharing is listed in your Schedule of Benefits. Please remember that if you are hospitalized, you must call the Plan at **1-888-333-4742** within 48 hours or as soon as you can. This telephone number can also be found on your ID card. If notice of hospitalization is given to the Plan or PCP by an attending emergency physician no further notice is required. If notification is not received when the Member's condition permits, the Member is responsible for the Penalty payment.

Follow up care outside the Plan's network will be covered at the Out-of-Network benefit level.

6. Coverage for Services When You Are Outside the Service Area

In-Network Coverage

In-Network Coverage is available outside of the Service Area by using Plan Providers enrolled in the Plan's national provider network. You can locate Plan Providers outside of the Service Area by using the Plan Provider Directory described earlier in this Handbook.

If you need mental health care and drug and alcohol rehabilitation services outside of the Service Area, simply contact the Plan's Behavioral Health Access Center at **1-888-777-4742**.

As is the case within the Service Area, you do not need to use a Plan Provider to obtain care in a Medical Emergency, including an emergency mental health condition. You also do not need to obtain a referral from your PCP. In a medical emergency, the Plan provides In-Network coverage for ambulance and hospital emergency room services.

Out-of-Network Coverage

When you are outside the Service Area, you may also obtain Out-of-Network coverage from Non-Plan Providers.

7. Services That Do Not Require a Referral

When you are inside the Service Area, you will need a Referral from your PCP to get In–Network coverage from any other Plan Provider. However, you do not need a Referral for the services listed below. You may obtain In-Network coverage for these services from any Plan Provider without a Referral from your PCP. Plan Providers are listed in the Provider Directory.

i. Family Planning Services:

- Contraceptive monitoring
- Family planning consultation, including pregnancy testing
- Tubal ligation if a covered benefit - Please see your Schedule of Benefits to determine if your Plan provides coverage for this benefit.
- Voluntary termination of pregnancy if a covered benefit - Please see your Schedule of Benefits to determine if your Plan provides coverage for this benefit.

ii. Outpatient Maternity Services

- Routine outpatient prenatal and postpartum care
- Consultation for expectant parents to select a PCP for the child

iii. Gynecological Services

- Annual gynecological exam, including routine pelvic and clinical breast exam
- Cervical cryosurgery
- Colposcopy with biopsy
- Excision of labial lesions
- Follow-up care provided by an obstetrician or gynecologist for obstetrical or gynecological conditions identified during maternity care or annual gynecological visit

- Laser cone vaporization of the cervix
- Loop electrosurgical excisions of the cervix (LEEP)
- Treatment of amenorrhea
- Treatment of condyloma

iv. Dental Services:

- Emergency Dental Care
- Extraction of teeth impacted in bone (if a covered benefit - Please see your Schedule of Benefits to determine if your Plan provides coverage for this benefit.)

v. Other Services:

- Acupuncture treatment for injury or illness (if a covered benefit - Please see your Schedule of Benefits to determine if your Plan provides coverage for this benefit.)
- Chiropractic care
- Routine eye examination (if a covered benefit - Please see your Schedule of Benefits to determine if your Plan provides coverage for this benefit.)
- Urgent eye care
- Urgent Care services

8. How Your Out-of-Network Benefits Work

You use your Out-of-Network coverage whenever you obtain Covered Benefits from Non-Plan Providers. This allows you to obtain services from any licensed health care professional. You do not need a Referral from your PCP and services are not limited to Plan Providers .

Services will also be covered as Out-of-Network services if you receive care from a Plan Provider without a PCP Referral when one is required.

The Plan pays only a percentage of the cost of Covered Benefits you receive from Non-Plan Providers. You are responsible for paying the balance. Your Member Cost Sharing is generally higher for Out-of-Network benefits. However, you have more flexibility in obtaining care and may go to the licensed health care professional of your choice.

When obtaining Out-of-Network benefits, some services require Prior Approval by the Plan. Please see section *I.F. NOTIFICATION AND PRIOR APPROVAL* for information on the Prior Approval Program.

To request Prior Approval, please call:

- **1-800-708-4414** for Medical Services
- **1-888-777-4742** for mental health and drug and alcohol rehabilitation services

Payments to Plan Providers are usually based on a contracted rate between us and the Plan Provider. Since we have no contract with Non-Plan Providers, there is no limit on what such providers can charge. You are responsible for any amount charged by a Non-Plan Provider in excess of the Allowed Amount for the service.

E. MEMBER COST SHARING

You are required to share the cost of Covered Benefits provided under the Plan. Your Member Cost Sharing may include Copayments, Coinsurance and Deductibles when using Plan Providers or Non-Plan Providers.

Your Plan may also have an Out-of-Pocket Maximum that limits the amount of Member Cost Sharing you may be required to pay. Your specific Member Cost Sharing responsibilities are listed in your Schedule of Benefits. See the *Glossary* for more information on Copayments, Coinsurance, Deductibles and Out-of-Pocket Maximums.

1. Out-of-Network Charges in Excess of the Allowed Amount

On occasion, a Non-Plan Provider may charge amounts in excess of the Allowed Amount. In those instances, you will be financially responsible for the difference between what the Provider charges and the Allowed Amount payable by the Plan. This means that you will be responsible for paying the full amount above the Allowed Amount. Amounts charged by a Non-Plan Provider in excess of the Allowed Amount do not count toward the Out-of-Pocket Maximum. You may contact the Member Services Department at **1–888–333–4742** or call **711** for TTY service if you have questions about the maximum Allowed Amount that may be permitted by HPHC for a service.

2. Penalty

A Member is responsible to pay a Penalty for certain Out-of-Network services when notification or Prior Approval has not been received before obtaining the services. The Penalty charge is in addition to any Member Cost Sharing amounts. Penalty charges do not count towards any Out-of-Pocket Maximum. Please see section *I.F. NOTIFICATION AND PRIOR APPROVAL* for a detailed explanation of the Prior Approval Program.

3. Combined Payment Levels

Under some circumstances you may receive services from both a Plan Provider and a Non-Plan Provider when obtaining care. When this occurs, your entitlement to In-Network or Out-of-Network coverage always depends upon the participation status of the individual service Provider and whether you chose to receive services from a Non-Plan Provider. For example, you may receive treatment in a Plan Provider's office but choose to receive associated blood work from a non-plan laboratory. In this example, the Plan Provider would be paid at the In-Network coverage level and the laboratory would be paid at the Out-of-Network coverage level because the laboratory is a Non-Plan Provider and you chose to receive those services from a Non-Plan Provider. However, if a Plan Provider directs you to a Non-Plan Provider and you did not choose that Non-Plan Provider to provide such services, you would be entitled to In-Network coverage for those services from the Non-Plan Provider.

The benefit payment level that is applied to a hospital admission depends on the participation status of both the admitting physician and the hospital. If a Plan Provider admits you to a participating hospital, both the hospital and physician are paid at the In-Network coverage level. If an Out-of-Network physician admits you to a participating hospital, the hospital's charges are paid at the In-Network coverage level but the physician's charges are paid at the Out-of-Network coverage level. Likewise, if a Plan Provider admits you to a non-plan hospital, the hospital's charges are paid at the Out-of-Network coverage level but the physician's charges are paid at the In-Network coverage level. All Out-of-Network payments are limited to the Allowed Amount.

F. NOTIFICATION AND PRIOR APPROVAL

Members are required to notify HPHC before the start of any planned inpatient admission to a Non-Plan Medical Facility. A "Non-Plan Medical Facility" is any inpatient medical Provider that is not under contract with us to provide care to Members. Members are also required to obtain Prior Approval from HPHC before receiving certain services. This section explains when notification and Prior Approval are required and the procedures to follow to meet those requirements.

Please note that your doctor or hospital can provide notification or seek Prior Approval on your behalf. Also, you do not need to provide advance notification or obtain Prior Approval if services are needed in a Medical Emergency.

1. Notification of Planned Inpatient Admissions

You must notify HPHC in advance of any planned inpatient admission to a Non-Plan Medical Facility. This requirement applies to admissions to all types of inpatient medical and mental health and drug and alcohol rehabilitation facilities, including hospitals, Skilled Nursing Facilities (SNFs) and rehabilitation hospitals.

To provide notification for medical services, you should contact HPHC at **1-800-708-4414** at least five (5) business days in advance of the admission. To provide notification for mental health and drug and alcohol rehabilitation services, you should contact the Behavioral Health Access Center at **1–888–777–4742**. You do not need to provide advance notification to HPHC or the Behavioral Health Access Center if you are hospitalized in a Medical Emergency. In the event of a Medical Emergency admission, you or your physician must notify HPHC or the Behavioral Health Access Center, as applicable, within 48 hours or as soon as possible.

If either the hospital or admitting physician is a Non-Plan Provider, you are responsible for notifying HPHC. As noted above, providers may notify HPHC on your behalf.

2. When Prior Approval is Required

Prior Approval must be obtained for any of the services listed below. If you will receive these services from a Non-Plan Provider, you must seek Prior Approval. If you will receive these services from a Plan Provider, he or she will obtain Prior Approval for you.

a) **For Mental Health and Drug and Alcohol Rehabilitation Services**

Prior Approval must be obtained before receiving certain mental health and drug and alcohol rehabilitation services from a Non-Plan Provider. To obtain Prior Approval for the mental health and drug and alcohol rehabilitation services listed below, you should call the Behavioral Health Access Center at **1-888-777-4742**. **Please refer to HPHC's Internet site at www.harvardpilgrim.org, or call Member Services for updates and revisions to the following list:**

1. **Intensive Outpatient Program Treatment** - Treatment programs at an outpatient clinic or other facility generally lasting three or more hours a day for two or more days a week.

2. **Partial Hospitalization and Day Treatment Programs**
3. **Extended Outpatient Treatment Visits –** Outpatient visits of more than 50 minutes duration with or without medication management or any treatment routinely involving more than one outpatient visit in a day.
4. **Outpatient Electro-Convulsive Treatment (ECT)**
5. **Psychological Testing**
6. **Applied Behavior Analysis (ABA) for the treatment of Autism**

Please Note: You may also contact the Behavioral Health Access Center at **1-888-777-4742**for assistance in obtaining covered mental health services (including substance abuse treatment), even if Prior Approval is not required for the service you require.

b) **For Medical Services.**

You must obtain Prior Approval in advance of receiving any of the medical services listed below from a Non-Plan Provider. To obtain Prior Approval for medical services you should call: **1-800-708-4414. Please refer to HPHC's Internet site at www.harvardpilgrim.org, for updates and revisions to the following list:**

- **Cosmetic, reconstructive and restorative procedures –** All Covered Benefits, including, but not limited to, blepharoplasty, breast reduction mammoplasty, gynocomastia surgery, panniculectomy, ptosis repair, rhinoplasty, and scar revision. (Please note that the Plan provides very limited coverage for Cosmetic Services. Please see "Reconstructive Surgery" in section *III. Covered Benefits* for details.)
- **Dental and Oral Surgery –** All Covered Benefits, including, but not limited to, surgical treatment of tempromandibular joint dysfunction (TMD). (Please note that the Plan provides very limited coverage for Dental Care. Please see "Dental Services" in section *III. Covered Benefits* for details.)
- **Durable Medical Equipment —** Continuous glucose monitoring systems only.
- **Formulas and enteral nutrition –** Outpatient services only.
- **Home health care** – Including, but not limited to, home infusion (including treatment of Lyme Disease) and home hospice care.
- **Immune Globulin (IVIg)**
- **Infertility Services –** All Covered Benefits for the treatment of infertility.
- **Non—Emergency Air Ambulance Transportation —** Emergency air ambulance transportation is immediate transportation by air ambulance that is arranged by police, fire or other emergency rescue officials during a Medical Emergency. Emergency air ambulance services do not require Prior Approval. You must obtain Prior Approval for coverage of any other air ambulance transportation.
- **Occupational therapy** – Outpatient services only.
- **Physical therapy** – Outpatient services only.
- **Pulmonary rehabilitation** – Outpatient services only
- **Radiology – High End Radiology**- Computerized axial tomography (CAT and CT and CTA scans); Magnetic resonance imaging (MRI and MRA scans); Nuclear cardiac studies; and Positron emission tomography (PET scans)
- **Speech and language therapy** – Outpatient services only
- **Surgery (both inpatient and outpatient)** – All Covered Benefits for surgical procedures, including but not limited to, bariatric Surgery (weight loss surgery), breast reduction and reconstructive surgery, including breast implant removal and gynecomastia; cholecystectomy; repair bladder defect (urinary incontinence); implantable neurostimulators; septoplasty; surgical treatment of obstructive sleep apnia, including uvulopalatopharyngoplasty (UPPP); sinus surgeries; total hysterectomy; total hip replacement; total knee arthroplasty; and treatment of varicose veins.

Please refer to HPHC's Internet site, www.harvardpilgrim.org, for a current list of

all services under these categories that are subject to Prior Approval.

3. How to Obtain Prior Approval

To seek Prior Approval for medical services received from a Non-Plan Provider, you should call: **1-800-708-4414.** To seek Prior Approval for mental health and drug and alcohol rehabilitation services received from a Non-Plan Provider you should call **1-888-777-4742**.

The following information must be given when seeking Prior Approval for medical services:

- The Member's name
- The Member's ID number
- The treating physician's name, address and telephone number
- The diagnosis for which care is ordered
- The treatment ordered and the date it is expected to be performed

For inpatient admission to a Non-Plan Provider the following additional information must be given:

- The name and address of the facility where care will be received
- The admitting physician's name, address and telephone number
- The admitting diagnoses and date of admission
- The name of any procedure to be performed and the date it is expected to be performed

4. The Effect of Notification and Prior Approval on Coverage

If you provide notification or obtain Prior Approval, the Plan will pay up to the full benefit limit stated in this Benefit Handbook and your Schedule of Benefits.

If you do not provide notification or obtain Prior Approval when required, you will receive coverage for services later determined to be Medically Necessary, but you will be responsible for paying the Penalty amount stated in the Schedule of Benefits in addition to any applicable Member Cost Sharing.

If HPHC determines at any point that a service is not Medically Necessary, no coverage will be provided for the services at issue, and you will be responsible for the entire cost of those services.

Neither notification nor Prior Approval entitle you to any benefits not otherwise payable under this Benefit Handbook or the Schedule of Benefits.

Please see section *X.L. UTILIZATION REVIEW PROCEDURES* for information on the time limits for Prior Approval decisions and reconsideration procedures for Providers if coverage is denied. Please see Section *VI. Appeals and Complaints* for a description of your appeal rights if coverage for a service is denied by HPHC.

5. What Notification and the Prior Approval Program Do

The notification and Prior Approval programs do different things depending upon the service in question. These may include:

- Assuring that the proposed service will be covered by the Plan and that benefits are being administered correctly.
- Consulting with Providers to provide information and promote the appropriate delivery of care.
- Evaluating whether a service is Medically Necessary, including whether it is, and continues to be, provided in an appropriate setting.

If the Prior Approval Program conducts a medical review of a service, you and your attending physician will be notified of the Plan's decision to approve or not to approve the care proposed. All decisions to deny a medical service will be reviewed by a physician (or, in the case of mental health and drug and alcohol rehabilitation services, a qualified clinician) in accordance with written clinical criteria. The relevant criteria will be made available to Providers and Members upon request.

If the Prior Approval Program denies a coverage request, it will send you a written notice that explains the decision, your Provider's right to obtain reconsideration of the decision, and your appeal rights.

G. SERVICES PROVIDED BY A DISENROLLED OR NON-PLAN PROVIDER

1. Disenrollment of Primary Care Provider (PCP)

If your PCP is disenrolled as a Plan Provider for reasons unrelated to fraud or quality of care, we will use our best efforts to provide you with written notice at least 60 days prior to the date of your PCP's disenrollment. That notice will also explain the process for selecting a new PCP. You may be eligible to continue to receive In-Network coverage for services provided by the disenrolled PCP, under the terms of this Handbook and your Schedule of Benefits, for at least 30 days after the disenrollment date. If you are undergoing an active course of treatment for an illness, injury or condition, we may authorize additional

coverage through the acute phase of illness, or for up to 90 days (whichever is shorter).

2. Pregnancy
If you are a female Member in your second or third trimester of pregnancy and the Plan Provider you are seeing in connection with your pregnancy is involuntarily disenrolled, for reasons other than fraud or quality of care, you may continue to receive In-Network coverage for services delivered by the disenrolled provider, under the terms of this Handbook and your Schedule of Benefits, for the period up to, and including, your first postpartum visit.

3. Terminal Illness
A Member with a terminal illness whose Plan Provider in connection with such illness is involuntarily disenrolled, for reasons other than fraud or quality of care, you may continue to receive In-Network coverage for services delivered by the disenrolled provider, under the terms of this Handbook and the Schedule of Benefits, until the Member's death.

H. 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 applicable to a service or procedure for which coverage is requested. Clinical review criteria may be obtained by calling **1-888-888-4742 ext. 38723.**

I. PROVIDER FEES FOR SPECIAL SERVICES (CONCIERGE SERVICES)

Certain physician practices charge extra fees for special services or amenities, in addition to the benefits covered by the Plan. Examples of such special physician services might include: telephone access to a physician 24-hours a day; waiting room amenities; assistance with transportation to medical appointments; guaranteed same day or next day appointments when not Medically Necessary; or providing a physician to accompany a patient to an appointment with a specialist. Such services are not covered by the Plan. The Plan does not cover fees for any service that is not included as a Covered Benefit under this Evidence of Coverage.

In considering arrangements with physicians for special services, you should understand exactly what services are to be provided and whether those services are worth the fee you must pay. For example, the Plan does not require Plan Providers to be available by telephone 24-hours a day. However, the Plan does require PCPs to provide both an answering service that can be contacted 24-hours a day and prompt appointments when Medically Necessary.

II. Glossary

This section lists words with special meaning within the Handbook.

Activities of Daily Living The basic functions of daily life include bathing, dressing, and mobility, including, but not limited to, transferring from bed to chair and back, walking, sleeping, eating, taking medications and using the toilet.

Adverse Benefit Determination Any of the following , including by not limited to (1) an Adverse Health Care Treatment decision or (2) a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a Covered Benefit, including an action based on a determination of a Member's ineligibility to participate in the plan.

Adverse Health Care Treatment Decision A health care treatment decision made by or on behalf of HPHC denying in whole or in part, payment for a provision of otherwise Covered Benefits requested by or on behalf of a Member. Adverse Health Care Treatment Decision includes a rescission determination and an initial coverage eligibility determination.

Allowed Amount The Allowed Amount is the maximum amount that we will pay for Covered Benefits minus any applicable Member Cost Sharing.

The Allowed Amount for In-Network benefits is the contracted rate the Plan has agreed to pay Plan Providers.

If services provided by a Non-Plan Provider are Covered Benefits under this Benefit Handbook, the Allowed Amount for such services depends upon where you receive the service, as explained below:

a. If you receive Out-of-Network services from a Provider located outside of the Service Area (the states of Massachusetts, New Hampshire, Maine, Rhode Island, Vermont and Connecticut) the Allowed Amount is defined as follows:

The Allowed Amount is the lower of the Provider's charge or a rate determined as described below:

The Allowed Amount is an amount that is consistent, in the judgement of the Plan, with the normal range of charges by health care Providers for the same, or similar, products or services provided to a Member. If the Plan has appropriate data for the area, the Plan will determine the normal range of charges in the geographic area where the product or services were provided to the Member. If the Plan does not have data to reasonably determine the normal range of charges where the products or services were provided, the Plan will utilize the normal range of charges in Boston, Massachusetts. Where services are provided by non-physicians but the data on provider charges available to the Plan is based on charges for services by physicians, the Plan will, in its discretion, make reasonable reductions in its determination of the allowable charge for such non-physician Providers.

b. If you receive Out-of-Network services from a Provider located outside of the Service Area (the states of Massachusetts, New Hampshire, Maine, Rhode Island, Vermont and Connecticut) the Allowed Amount is defined as follows:

The Allowed Amount is the lower of the Provider's charge or a rate determined as described below:

The Allowed Amount is determined based on 150% of the published rates allowed by the Centers for Medicare and Medicaid Services (CMS) for Medicare for the same or similar service within the geographic market.

When a rate is not published by CMS for the service, we use other industry standard methodologies to determine the Allowed Amount for the service as follows:

For services other than Pharmaceutical Products, we use a methodology called a relative value scale, which is based on the difficulty, time, work, risk and resources of the service. The relative value scale currently used is created by Optuminsight, Inc. If the Optuminsight, Inc. relative value scale becomes no longer available, a comparable scale will be used.

For Pharmaceutical Products, we use industry standard methodologies that are similar to the pricing methodology used by CMS and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by RJ Health Systems, Thomson Reuters (published in its Red Book), or UnitedHealthcare based on an internally developed pharmaceutical pricing resource.

When a rate is not published by CMS for the service and no industry standard methodology applies to the service, or the provider does not submit sufficient information on the claim to pay it under CMS published rates or an industry standard methodology, the Allowed Amount will be 50% of the provider's billed charge, except that the Allowed Amount for certain mental health services and substance use disorder services will be 80% of the billed charge.

Pricing of the Allowed Amount will be conducted by UnitedHealthcare, Inc. UnitedHealthcare, Inc., updates the CMS published rate data on a regular basis when updated data from CMS becomes available. These updates are typically implemented within 30 to 90 days after CMS updates its data.

Anniversary Date The date agreed to by HPHC and your Employer Group upon which the yearly Employer Group premium rate is adjusted and

benefit changes normally become effective. This Benefit Handbook, Schedule of Benefits, Prescription Drug Brochure and any applicable riders, and the Employer Group agreement will terminate unless renewed on the Anniversary Date.

> FOR EXAMPLE: If your Anniversary Date is January 1st, this is the date when the Plan goes into effect and begins to pay for Covered Benefits.

Behavioral Health Access Center The organization, designated by us, that is responsible for arranging for the provision of services for Members in need of mental health and drug and alcohol rehabilitation services. You may contact the Behavioral Health Access Center by calling **1-888-777-4742**. The Behavioral Health Access Center will assist you in finding an appropriate Plan Provider and arranging the services you require.

Benefit Handbook (or Handbook) This document that describes the terms and conditions of the Plan, including but not limited to, Covered Benefits and exclusions from coverage.

Benefit Limit The day, visit or dollar limit maximum that applies to certain Covered Benefits. Once the Benefit Limit has been reached, no more benefits will be paid for such services or supplies. If you exceed the Benefit Limit, you are responsible for all charges incurred. The Benefit Limits applicable to your Plan are listed in your Schedule of Benefits.

> FOR EXAMPLE: If your Plan offers 30 visits per Plan Year or Calendar Year for physical therapy services, once you reach your 30 visit limit for that Plan Year or Calendar Year, no additional benefits for that service will be covered by the Plan.

Calendar Year The one-year period beginning on January 1 for which benefits are purchased and administered. Benefits for which limited yearly coverage is provided renew at the beginning of the Calendar Year. Benefits for which limited coverage is provided every two years renew at the beginning of every second Calendar Year. Benefits under your Plan are administered on either a Plan Year or Calendar Year basis. Please see your Schedule of Benefits to determine which type of year your Plan utilizes.

Coinsurance A percentage of the Allowed Amount for certain Covered Benefits that must be paid by the Member. Coinsurance amounts are in addition to any Deductible. Coinsurance amounts applicable to your Plan are stated in your Schedule of Benefits.

> FOR EXAMPLE: If the Coinsurance for a service is 20%, you pay 20% of the Allowed Amount while we pay the remaining 80%. (In the case of Out-of-Network services, we only pay up to the Allowed Amount.)

Copayment A fixed dollar amount you must pay for certain Covered Benefits. The Copayment is usually due at the time of the visit or when you are billed by the provider. Copayment amounts applicable to your Plan are stated in your Schedule of Benefits.

> FOR EXAMPLE: If your Plan has a $20 Copayment for outpatient visits, you'll pay $20 at the time of the visit or when you are billed by the provider.

Cosmetic Services Cosmetic Services are surgery, procedures or treatments that are performed primarily to reshape or improve the individual's appearance.

Covered Benefit(s) The products and services that a Member is eligible to receive, or obtain payment for, under the Plan.

Custodial Care Services provided to a person for the primary purpose of meeting non-medical personal needs (e.g., bathing, dressing, preparing meals, including special diets, taking medication, assisting with mobility).

Deductible A specific dollar amount that is payable by a Member for Covered Benefits received each Plan Year or Calendar Year before any benefits subject to the Deductible are payable by the Plan. 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 Plan Year or Calendar Year. Deductible amounts are incurred on the date of service. If a Deductible applies to your plan, it will be stated in the Schedule of Benefits. The Deductible does not apply to non-Covered Benefits.

> FOR EXAMPLE: If your Plan has a $500 Deductible and you have a claim with the Allowed Amount of $1,000, you will be responsible for the first $500 to satisfy your Deductible requirement before the Plan begins to pay benefits.

Deductible Rollover A Deductible Rollover allows you to apply any Deductible amount incurred for Covered Benefits during the last three(3)months of a Plan Year or Calendar Year toward the Deductible for the next Plan Year or Calendar Year. To be eligible for a Deductible Rollover, a Member must have had continuous coverage with us through the same Employer Group at the time the prior Plan Year or Calendar Year charges were incurred. If your Plan has a Deductible Rollover it will be listed in your Schedule of Benefits.

Dental Care Any service provided by a licensed dentist involving the diagnosis or treatment of any disease, pain, injury, deformity or other condition of the human teeth, alveolar process, gums, jaw or associated structures of the mouth. However, surgery performed by an oral maxillofacial surgeon to correct positioning of the bones of the jaw (orthognathic surgery) is not considered Dental Care within the meaning of this definition.

Dependent A Member of the Subscriber's family who (1) meets the eligibility requirements for coverage through a Subscriber and (2) is enrolled in the Plan.

Employer Group or Employer An organization that has contracted with us to provide health care coverage for its employees under the Plan.

Evidence of Coverage The legal documents, including the Benefit

Handbook, Schedule of Benefits, Prescription Drug Brochure (if applicable), and any applicable riders and amendments which describe the services covered by the Plan, and other terms and conditions of coverage.

Experimental, Unproven, or Investigational Any products or services, including, but not limited to, drugs, devices, treatments, procedures, and diagnostic tests, will be deemed Experimental, Unproven, or Investigational by us under this Benefit Handbook for use in the diagnosis or treatment of a particular medical condition if any the following is true:
a. The product or service is not recognized in accordance with generally accepted medical standards as being safe and effective for the use in the evaluation or treatment of the condition in question. In determining whether a service has been recognized as safe or effective in accordance with generally accepted evidence-based medical standards, primary reliance will be placed upon data from published reports in authoritative medical or scientific publications that are subject to established peer review by qualified medical or scientific experts prior to publication. In the absence of any such reports, it will generally be determined that a service, procedure, device or drug is not safe and effective for the use in question.
b. In the case of a drug, the drug has not been approved by the United States Food and Drug Administration (FDA). (This does not include off-label uses of FDA approved drugs).

Family Coverage Coverage for a Member and one or more Dependents.

Habilitation Therapies Health care services that help a person keep, learn, or improve skills and functioning for daily living. These services may include physical and occupational therapies and speech-language services.

Harvard Pilgrim Health Care (HPHC) Harvard Pilgrim Health Care is a Massachusetts corporation that is licensed as a Health Maintenance Organization (HMO) in the state of Maine. HPHC provides or arranges for health care benefits to Members through a network of Primary Care Providers, specialists and other providers.

Individual Coverage Coverage for a Subscriber only. No coverage for Dependents is provided.

In-Network The level of benefits or coverage a Member receives when Covered Benefits are obtained through a Plan Provider.

Medical Drugs A prescription drug that is administered to you either (1) in a doctor's office or other outpatient medical facility, or (2) at home while you are receiving home health care services or receiving drugs administered by home infusion services. Medical Drugs cannot be self-administered. The words "cannot be self-administered" mean that the active participation of skilled medical personnel is always required to take the drug. When a Member is receiving drugs in the home, the words "cannot be self-administered" will also include circumstances in which a family member or friend is trained to administer the drug and ongoing supervision by skilled medical personnel is required.

Medical Emergency The onset of an illness or medical condition, sufficiently severe that the absence of immediate medical attention could reasonably be expected by the Member to result in: (a) placing the Member's physical and/or mental health in serious jeopardy (or with respect to pregnant woman, the health of the woman or her unborn child); (b) serious impairment to bodily functions; or (c) serious dysfunction of any bodily organ or part. Examples of Medical Emergencies are: heart attack or suspected heart attack, stroke, shock, major blood loss, choking, severe head trauma, loss of consciousness, seizures, and convulsions. A Medical Emergency includes a situation involving a pregnant woman who is having contractions where there is either inadequate time to safely transfer her to another hospital before delivery or any transfer may pose a threat to the safety of the woman or unborn child.

Please remember that if you are hospitalized, you must call the Plan within 48 hours or as soon as you can. If the notice of hospitalization is given to the Plan by an attending emergency physician, no further notice is required.

Medically Necessary or Medical Necessity Health care services or products provided to a Member for the purpose of preventing, diagnosing or treating an illness, injury or disease or the symptoms of an illness, injury or disease in a manner that is: (a) Consistent with generally accepted standards of medical practice; (b) Clinically appropriate in terms of type, frequency, extent, site and duration; (c) Demonstrated through scientific evidence to be effective in improving health outcomes; (d) Representative of best practices in the medical profession; and (e) Not primarily for the convenience of the enrollee or physician or the other health care practitioner.

Member Any Subscriber or Dependent covered under the Plan.

Member Cost Sharing The responsibility of Members to assume a share of the cost of the benefits provided under the Plan. Member Cost Sharing may include Copayments, Coinsurance and Deductibles. Please refer to your Schedule of Benefits for the specific Member Cost Sharing that applies to your Plan.

Non-Plan Provider A provider not under contract with HPHC or its affiliates to provide care to Members of your Plan.

Notification A process to (1) verify that certain Covered Benefits are and continue to be, Medically Necessary and provided in an appropriate and cost-effective manner or (2) arrange for the payment of benefits. Members are required to notify HPHC before the start of any planned inpatient admission to a Non-Plan medical facility. This requirement applies to admissions to all types of Non-Plan inpatient medical facilities, including

hospitals, Skilled Nursing Facilities (SNFs) and rehabilitation hospitals. Please see section *I.F. NOTIFICATION AND PRIOR APPROVAL* for a detailed explanation of the notification process.

Out-of-Network The level of benefits or coverage a Member receives when Covered Benefits are obtained through a Non-Plan Provider or from a Plan Provider in the Service Area without a Referral where one is required.

Out-of-Pocket Maximum An Out-of-Pocket Maximum is a limit on the amount of Member Cost Sharing (Copayments, Coinsurance and Deductibles) that you must pay for Covered Benefits in a Plan Year or Calendar Year. Some types of Member Cost Sharing may be excluded from your Out-of-Pocket Maximum. The Out-of-Pocket Maximum is specified in your Schedule of Benefits.

Please Note: Penalty payments and charges above the Allowed Amount never apply to the Out-of-Pocket Maximum.

✔ FOR EXAMPLE: If your plan has an individual Out-of-Pocket Maximum of $1,000, this is the most Member Cost Sharing you will pay for that Plan Year or Calendar Year. As an example, the Out-of-Pocket Maximum can be reached by the following: $500 in Deductible expenses, $400 in Coinsurance expenses and $100 in Copayment expenses.

Penalty The amount that a Member is responsible to pay for certain Out-of-Network services when notification or Prior Approval has not been received before receiving the services. The Penalty charge is in addition to any Member Cost Sharing amounts. Please see section *I.F. NOTIFICATION AND PRIOR APPROVAL* for a detailed explanation of the Prior Approval Program. A Penalty amount does not apply to an Out-of-Pocket Maximum, if any.

Physical Functional Impairment A condition in which the normal or proper action of a body part is damaged, and affects the ability to participate in Activities of Daily Living. Physical Functional Impairments include, but are not limited to, problems with ambulation, communication, respiration, swallowing, vision, or skin integrity.

A physical condition may impact an individual's emotional well-being or mental health. However such impact is not considered in determining whether or not a Physical Functional Impairment exists. Only the physical consequences of a condition are considered.

Plan This package of health care benefits offered by Harvard Pilgrim Health Care.

Plan Provider Providers who are under contract to provide In-Network services to Plan Members, and have agreed to charge Members only the applicable Copayments, Coinsurance and Deductible amounts for Covered Benefits. Plan Providers are listed in the Provider Directory.

Plan Year The one-year period for which benefits are purchased and administered. Benefits for which limited yearly coverage is provided renew at the beginning of the Plan Year. Benefits for which limited coverage is provided every two years renew at the beginning of every second Plan Year. Generally, the Plan Year begins on the Plan's Anniversary Date. Benefits under your Plan are administered on either a Plan Year or Calendar Year basis. Please see your Schedule of Benefits for your Plan Year information to determine which type of year your Plan utilizes.

✔ FOR EXAMPLE: A Plan Year could begin on April 1st and end on March 31st or begin on January 1st and end on December 31st.

Premium A payment made to us for health coverage under the Plan.

Primary Care Provider (PCP) A Plan Provider designated to help you maintain your health and to provide and authorize your medical care under the Plan. A PCP may be a physician specializing in internal medicine, family practice, general practice, pediatrics, obstetrics and gynecology, a certified nurse practitioner licensed by the Maine Board of Nursing, supervised by a doctor in one of those specialties. A PCP may designate other Plan Providers to provide or authorize a Member's care.

Prior Approval or Prior Approval Program A program to (1) verify that certain Covered Benefits are and continue to be, Medically Necessary and provided in an appropriate and cost-effective manner or (2) arrange for the payment of benefits. Prior Approval is required for certain Covered Benefits. Before you receive services requiring Prior Approval from a Non-Plan Provider, please refer to our Internet site, **www.harvardpilgrim.org,** or contact the Member Services Department at **1-888-333-4742** for the complete listing of Out-of-Network services that require Prior Approval. To seek Prior Approval for medical services you should call: **1-800-708-4414.** To seek Prior Approval for mental health and drug and alcohol rehabilitation services you should call **1-888-777-4742.** Please see section *I.F. NOTIFICATION AND PRIOR APPROVAL* for a detailed explanation of the Prior Approval Program.

Provider Providers include, but are not limited to a hospitals, Skilled Nursing Facilities, and medical professionals including: physicians, psychiatrists, nurse practitioners, physician assistants, certified nurse midwives, certified registered nurse anesthetists, registered first nurse assistants, dentists, independent practice dental hygienists, dental hygiene therapists, acupuncturists, chiropractors, essential health care providers (rural health clinics), and licensed mental health professionals, including psychologists, clinical social workers, marriage and family therapists, psychiatric/mental health advanced registered nurse practitioners, alcohol and drug counselors, clinical mental health counselors, and pastoral psychotherapists/counselors (except when providing services to a member of his or her church or congregation in the course of his or her duties as a

pastor, minister or staff person). Plan Providers are listed in the Provider Directory.

Provider Directory A directory that identifies Plan Providers. We may revise the Provider Directory from time to time without notice to Members. The most current listing of Plan Providers is available on **www.harvardpilgrim.org**.

Qualified Medical Child Support Order (QMCSO) A court order providing for coverage of a child under a group health plan that meets the requirements of the Employee Retirement Income Security Act (ERISA). A child Dependent enrolled under a QMCSO is subject to all the terms and conditions stated in this Handbook, the Schedule of Benefits, the Prescription Drug Brochure and any applicable riders.

Referral An instruction from your PCP that gives you the ability to see another Plan Provider for services that may be out of your PCP's scope of practice. You do not need a Referral from your PCP when you receive services from a Plan Provider outside of the Plan Service Area.

FOR EXAMPLE: If you need to visit a specialist, such as a dermatologist or cardiologist, you must contact your PCP first. Your PCP will refer you to a specialist who is a Plan Provider.

Rehabilitative Therapies Rehabilitative Therapies are treatments for disease or injury that restore or move an individual toward functional capabilities prior to disease or injury. For treatment of congenital anomalies with significant functional impairment, Rehabilitative Therapies improve functional capabilities to or toward normal function for age appropriate skills. Only the following are covered: cardiac rehabilitation therapy; occupational therapy; physical therapy; pulmonary rehabilitation therapy; speech therapy; or an organized program of these services when rendered by a health care professional licensed to perform these therapies.

Schedule of Benefits A summary of the benefits selected by your Employer and covered under your Plan are listed in the Schedule of Benefits. A more detailed description of the benefits is in this Benefit Handbook. In addition, the Schedule of Benefits contains any limitations and Copayments, Coinsurance or Deductible you must pay.

Service Area The Service Area includes the states of Massachusetts, New Hampshire, Maine, Rhode Island, Connecticut and Vermont.

Skilled Nursing Facility An inpatient extended care facility, or part of one, that is operating pursuant to law and provides skilled nursing services.

Subscriber The person who meets the Subscriber eligibility requirements described in this Benefit Handbook and is enrolled in the Plan.

Surgery - Outpatient A surgery or procedure in a day surgery department, ambulatory surgery department or outpatient surgery center that requires operating room, anesthesia and recovery room services.

Surrogacy Any procedure in which a person serves as the gestational carrier of a child with the goal or intention of transferring custody of the child after birth to an individual (or individuals) who is (are) unable or unwilling to serve as the gestational carrier. This includes both procedures in which the gestational carrier is, and is not, genetically related to the child.

Urgent Care Medically Necessary services for a condition that requires prompt medical attention but is not a Medical Emergency.

III. Covered Benefits

This section describes all of the benefits available under the Plan. Please see your Schedule of Benefits for your specific Covered Benefits. If your Plan includes our outpatient pharmacy coverage, that coverage is described in your Prescription Drug Brochure.

Some benefits have limits on the amount of coverage provided in a Plan Year or Calendar Year. If a Covered Benefit has a benefit limit, your In-Network or Out-of-Network benefits are combined and count toward your benefit limit. For example, if the Covered Benefit is limited to ten visits per Calendar Year and you receive nine visits In-Network and one visit Out-of-Network, then you have reached your benefit limit. That benefit will not be covered again until the next Plan Year or Calendar Year.

Member Cost Sharing information and any applicable benefit limitations that apply to your Plan are listed in your Schedule of Benefits. Benefits are administered on a Plan Year or Calendar Year basis. Please see your Schedule of Benefits to determine which type of year your Plan utilizes.

Basic Requirements for Coverage

To be covered, all services and supplies must meet each of the following requirements. They must be:

- Listed as a Covered Benefit in this section.
- Medically Necessary.
- Not excluded in Section *IV. Exclusions*.
- Received while an active Member of the Plan.
- Provided by or upon Referral from your PCP. This requirement does not apply to care needed in a Medical Emergency and care received outside of the Plan Service Area. Please see section *I.D.2. Your PCP Manages Your Health Care* for other exceptions that may apply.
- Some Out-of-Network services require Prior Approval by the Plan. Please see section *I.F. NOTIFICATION AND PRIOR APPROVAL* for information on the Prior Approval Program.

Important Notice: When you use your Out-of-Network benefits, some services require Prior Approval by the Plan. Before you receive services from a Non-Plan Provider, please refer to our Internet site, **www.harvardpilgrim.org,** or contact the Member Services Department at **1-888-333-4742** for the complete listing of Out-of-Network services that require Prior Approval. Please see section *I.F. NOTIFICATION AND PRIOR APPROVAL* for information on the Prior Approval Program.

Benefit	Description
1 . Acupuncture Treatment for Injury or Illness	
	The Plan may cover acupuncture treatment for illness or injury, including, electro-acupuncture, that is provided for the treatment of neuromusculoskeletal pain. **Please Note:** Not all Plans cover this benefit. Please see your Schedule of Benefits to determine if your Plan provides coverage for this benefit.
2 . Ambulance Transport	
	Emergency Ambulance Transport If you have a Medical Emergency, your Plan covers ambulance transport to the nearest hospital that can provide you with Medically Necessary care. **Non-Emergency Ambulance Transport** You're also covered for non-emergency ambulance transport between hospitals or other covered health care facilities or from a covered facility to your home when Medically Necessary. For In-Network coverage, services must be arranged by a Plan Provider.

Benefit	Description
3 . Autism Spectrum Disorders Treatment	
	The Plan covers the following services for the treatment of autism spectrum disorders to the extent required by Maine law: • Any assessment, evaluations or tests by a licensed physician or psychologist to diagnose whether a Member has an autism spectrum disorder. • Habilitative or rehabilitative services, including applied behavior analysis or other professional or counseling services necessary to develop, maintain and restore the functioning of an individual to the extent possible. To be covered by the Plan, applied behavior analysis must be provided by a person professionally certified by a national board of behavior analysts or performed under the supervision of a person professionally certified by a national board of behavior analysts. • Counseling services provided by a licensed psychiatrist, psychologist, clinical professional counselor or clinical social worker. • Therapy services provided by a licensed or certified speech therapist, occupational therapist or physical therapist. • Prescription drugs in the same manner as provided for the treatment of any other illness or condition if your Plan includes our outpatient prescription drug coverage. A licensed physician or licensed psychologist must determine that the service is Medically Necessary. Such determination must be renewed annually. For the purposes of this section the following terms are defined as follows: "Applied behavior analysis" means the design, implementation and evaluation of environmental modifications using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including the use of direct observation, measurement and functional analysis of the relations between environment and behavior. "Autism spectrum disorders" means any of the pervasive developmental disorders as defined by the Diagnostic and Statistical Manual of Mental Disorders, 4th edition, including autistic disorder, Asperger's disorder and pervasive developmental disorder not otherwise specified **Please Note:** The Plan may require a licensed physician or licensed psychologist to demonstrate ongoing Medical Necessity for coverage provided under this benefit, on an annual basis.
4 . Breast Cancer Treatment	
	The Plan covers breast cancer treatment, including prostheses and the following services: • Inpatient care for a mastectomy, a lumpectomy or a lymph node dissection is covered for a period of time determined to be medically appropriate by the attending physician, in consultation with the Member. • If the Member elects breast reconstruction following mastectomy surgery, the Plan covers reconstruction in the manner chosen by the Member and the physician. Coverage includes reconstruction of the breast on which the mastectomy was performed and surgery and reconstruction of the other breast to produce a symmetrical appearance.

Benefit	Description
Breast Cancer Treatment (Continued)	
	• Physical complications for all stages of mastectomy, including lymphademas are covered in a manner determined in consultation with the attending physician and the Member.
5 . Chemotherapy and Radiation Therapy	
	The Plan covers outpatient chemotherapy administration and radiation therapy at a hospital or other outpatient medical facility. Covered Benefits include the facility charge, the charge for related supplies and equipment, and physician services for anesthesiologists, pathologists and radiologists.
6 . Chiropractic Care/Treatment by Adjustment or Manipulation	
	The Plan covers Medically Necessary chiropractic services for musculoskeletal conditions up to the benefit limit stated in your Schedule of Benefits. The following services are covered: • Diagnostic x-ray • Care within the scope of standard chiropractic practice For In-Network coverage, you may consult with a Plan-contracted chiropractic provider for treatment of sudden or severe pain or accidental injury that affects your ability to engage in Activities of Daily Living. Plan contracted chiropractors are listed in the Provider Directory. If a visit limit is not stated on your Schedule of Benefits, coverage is as follows: • Treatment is covered for up to 3 weeks after the injury or onset of pain, or up to 12 visits, whichever comes first. If no improvement occurs after 3 weeks or 12 visits, treatment should be stopped and you should contact your PCP. • If your condition has improved and if recommended by the chiropractor, treatment is covered for up to 5 additional weeks or up to 12 additional visits, whichever comes first. • If pain recurs and subsequent treatment is necessary, no more than 36 visits will be covered for chiropractic care in a 12-month period without prior authorization from HPHC. For such extended chiropractic care, HPHC, at its option, may direct or redirect your care. If the chiropractor fails to send a report to the Member's PCP as required by Maine law, neither HPHC nor the Member are liable for payment of the provider's fees. For Out-of-Network coverage, you may obtain services from the Out-of-Network provider of your choice.
7 . Clinical Trials	
	The Plan covers services for Members enrolled in a qualified clinical trial for the treatment, prevention or detection of any form of cancer or other life-threatening disease under the terms and conditions provided for under Maine and federal law. All of the requirements for coverage under the Plan apply to coverage under this benefit. Coverage is provided under this benefit for services that are Medically Necessary for the treatment of your condition, consistent with the study protocol of the clinical trial, and for which coverage is otherwise available under the Plan.

Benefit	Description
8 . Dental Services	
	Important Notice: The Plan does not provide dental insurance. It covers only the limited Dental Care described below. No other Dental Care is covered. **Emergency Dental Care:** The Plan covers emergency Dental Care needed due to an injury to sound, natural teeth. All services, except for suture removal, must be received within three days of injury. Only the following services are covered: • Extraction of the teeth damaged in the injury when needed to avoid infection • Reimplantation and stabilization of dislodged teeth • Repositioning and stabilization of partly dislodged teeth • Suturing and suture removal • Medication received from the provider **Extraction of Teeth Impacted in Bone:** The Plan may cover extraction of teeth impacted in bone. If covered under your Plan, only the following services are covered: • Extraction of teeth impacted in bone Pre-operative and post-operative care, immediately following the procedure • Anesthesia • X-rays **Please Note:** Not all Plans cover this benefit. Please see your Schedule of Benefits to determine if your Plan provides coverage for this benefit. **General Anesthesia for Dentistry:** The Plan covers general anesthesia and associated facility charges for dental procedures rendered in a hospital for certain conditions. The following conditions are covered: • Members, including infants, with physical, intellectual or medically compromising conditions in which general anesthesia is Medically Necessary. • Members for which local anesthesia is ineffective due to acute infection, anatomic variation or allergy. • Extremely uncooperative, fearful, anxious, or uncommunicative children or adolescents with dental needs that can not be postponed and for whom lack of treatment may result in dental or oral pain or infection, loss of teeth or other increased oral or dental morbidty. • Members with extensive oral-facial or dental trauma for which local anesthesia would be ineffective or compromised. **Prior Approval or Notification Required:** Prior Approval is required for general anesthesia for dentistry. You must obtain Prior Approval for coverage under this benefit. If you use a Plan Provider, he/she will seek Prior Approval for you. The Prior Approval process is initiated by

Benefit	Description
Dental Services (Continued)	
	calling: **1-800-708-4414.** Please see section *I.F. NOTIFICATION AND PRIOR APPROVAL*for more information.
9 . Diabetes Services and Supplies	
	Diabetes Self-Management and Training/Diabetic Eye Examinations/Foot Care: The Plan covers outpatient self-management education and training programs provided by the ambulatory diabetes education facilities authorized by the Diabetes Control Project within the Maine Bureau of Health for the treatment of diabetes, including medical nutrition therapy services, used to diagnose or treat insulin-dependent diabetes, non-insulin dependent diabetes, or gestational diabetes. Services must be provided on an individual basis and for In-Network coverage, be provided by a Plan Provider. Benefits also include medical eye examinations (dilated retinal examinations) and preventive foot care. The following items are also covered: **Diabetes Equipment:** • Blood glucose monitors • Dosage gauges • Injectors • Insulin pumps (including supplies) and infusion devices • Lancet devices • Therapeutic molded shoes and inserts • Visual magnifying aids • Voice synthesizers **Pharmacy Supplies:** • Blood glucose strips • Insulin, insulin needles and syringes • Lancets • Oral agents for controlling blood sugar • Urine and ketone test strips For coverage of pharmacy items listed above, you must get a prescription from your Provider and present it at a participating pharmacy. You can find participating pharmacies online at **www.harvardpilgrim.org** *Click* Pharmacy Program or by calling the Member Services Department at **1-888-333-4742**.

Benefit	Description
10 . Dialysis	
	The Plan covers dialysis on an inpatient, outpatient or at home basis. When federal law permits Medicare to be the primary payer, you must apply for Medicare and also pay any Medicare premium. When Medicare is primary (or would be primary if the Member were timely enrolled), the Plan will cover only those costs that exceed what would be payable by Medicare. Coverage for dialysis in the home includes non-durable medical supplies, and drugs and equipment necessary for dialysis. For In-Network coverage, your PCP must direct you to a Plan Provider for dialysis care. **Prior Approval or Notification Required:** You must notify HPHC in advance of any planned inpatient admission to a Non-Plan Medical Facility. Also, Prior Approval is required for any services provided in the home. If you use a Plan Provider, he/she will notify HPHC of your inpatient admission or seek Prior Approval for you. The Prior Approval process is initiated by calling: **1-800-708-4414.** Please see section *I.F. NOTIFICATION AND PRIOR APPROVAL* for more information.
11 . Drug Coverage	
	You have limited coverage for drugs received during inpatient and outpatient treatment and also for certain medical supplies you purchase at a pharmacy under this Benefit Handbook. This coverage is described in Subsection 1, below. You may also have coverage for outpatient prescription drugs you purchase at a pharmacy under the plan's outpatient prescription drug coverage. Subsection 2, below, explains more about this coverage. **1. Your Coverage under this Benefit Handbook** This Benefit Handbook covers the following: a.) Drugs Received During Inpatient Care. The drug is administered to you while you are an inpatient at a hospital, Skilled Nursing Facility or other medical facility at which Covered Benefits are provided to you on an inpatient basis; b.) Drugs Received During Outpatient or Home Care. These drugs are known as "Medical Drugs." A Medical Drug is administered to you either (1) in a doctor's office or other outpatient medical facility, or (2) at home while you are receiving home care services or receiving drugs administered by home infusion services. Medical Drugs cannot be self-administered. The words "cannot be self-administered" mean that the active participation of skilled medical personnel is always required to take the drug. When a Member is receiving drugs in the home, the words "cannot be self-administered" will also include circumstances in which a family member or friend is trained to administer the drug and ongoing supervision by skilled medical personnel is required. An example of a drug that cannot be self-administered is a drug that must be administered intravenously. Examples of drugs that can be self-administered are drugs that can be taken in pill form and drugs that are typically self-injected by the patient. c.) Drugs and supplies required by law. Coverage is provided for: (1) certain diabetes supplies; and (2) certain orally administered medications for the treatment of cancer. There is no Member Cost Sharing for orally administered medications for the treatment of

Benefit	Description
Drug Coverage (Continued)	
	cancer. Please see the benefit for "Diabetes Services and Supplies" for the details of that coverage. No coverage is provided under this Benefit Handbook for: (1) drugs that have not been approved by the United States Food and Drug Administration; (2) drugs the Plan excludes or limits, including, but not limited to, drugs for cosmetic purposes or weight loss; and (3) any drug that is obtained at an outpatient pharmacy except covered diabetes supplies, as explained above. **2. Outpatient Prescription Drug Coverage** In addition to the coverage provided under this Benefit Handbook, you may also have the Plan's outpatient prescription drug rider. That rider provides coverage for most prescription drugs purchased at an outpatient pharmacy. If you have outpatient prescription coverage, your Member Cost Sharing for prescription drugs purchased at a pharmacy will be listed on your ID Card. Additional details on prescription drug coverage and limitations, including coverage of Nicotine Replacement Therapy, can be found in the Prescription Drug Brochure or on our website at **www.harvardpilgrim.org**.
12 . Durable Medical Equipment (DME)	
	The Plan covers DME when Medically Necessary and ordered by a Provider. We will rent or buy all equipment. The cost of the repair and maintenance of covered equipment is also covered. In order to be covered, all equipment must be: • Able to withstand repeated use; • Not generally useful in the absence of disease or injury; • Normally used in the treatment of an illness or injury or for the rehabilitation of an abnormal body part ; and • Suitable for home use. Coverage is only available for: • The least costly equipment adequate to allow you to perform Activities of Daily Living. Activities of Daily Living do not include special functions needed for occupational purposes or sports; and One item of each type of equipment that meets the Member's need. No back-up items or items that serve a duplicate purpose are covered. For example, the Plan covers a manual or an electric wheelchair, not both. Covered equipment and supplies include: • Canes • Certain types of braces • Crutches • Hospital beds • Oxygen and oxygen equipment • Respiratory equipment • Walkers • Wheelchairs

Benefit	Description
Durable Medical Equipment (DME) (Continued)	
	Member Cost Sharing amounts you are required to pay are based on the cost of equipment to the Plan.
13 . Early Intervention	
	The Plan covers early intervention services for children with an identified developmental disability or delay. Coverage is provided for children from birth until three years of age. The Plan covers early intervention services up to the Benefit Limit stated in your Schedule of Benefits. Coverage under this benefit is only available for services rendered by the following types of providers: • Occupational therapists • Physical therapists • Speech-language pathologists • Clinical social workers
14 . Emergency Room Care	
	If you have a Medical Emergency, you are covered for care in a hospital emergency room. Please remember the following: • If you are in the Service Area and need follow-up care after you are treated in an emergency room, you must call your PCP. For In-Network coverage, your PCP will provide or arrange for the care you need. • To obtain In-Network coverage outside of the Service Area, you must see Plan Providers for all follow up care. • If you are hospitalized, you must call the Plan at **1-888-333-4742** within 48 hours or as soon as you can. This telephone number can also be found on your ID card. If notice of hospitalization is given to the Plan or PCP by an attending emergency physician no further notice is required
15 . Family Planning Services	
	The Plan covers family planning services, including the following: • Contraceptive monitoring • Family planning consultation • Pregnancy testing • Genetic counseling • Professional services relating to the injection of birth control drugs and the insertion or removal of birth control implants or devices. **Please Note:** An exclusion may apply when coverage is provided by a religious employer group, as allowed by law. Please check with your employer to see if this exclusion applies to your plan.

Benefit	Description
16 . Gender Reassignment Surgery	
	The Plan may cover gender reassignment surgery as described below. If covered under your Plan, services are covered when your provider has determined that you are an appropriate candidate for gender reassignment surgery in accordance with HPHC clinical guidelines. Coverage includes surgery, related physician and behavioral health visits and outpatient prescription drugs, if you have outpatient prescription drug coverage under this Plan. Benefits for gender reassignment surgery are in addition to the other benefits provided under the Plan. HPHC does not consider gender reassignment surgery to be reconstructive surgery to correct a Physical Functional Impairment or Cosmetic Services. Coverage for reconstructive surgery or Cosmetic Services is limited to the services described under the Reconstructive Surgery benefit in this Handbook. If covered under your Plan, gender reassignment surgery is limited to the specific surgical procedures listed below. No other services are covered in connection with gender reassignment surgery: **Male-to-female:** • Vaginoplasty • Colovaginoplasty • Orchiectomy • Penectomy • Clitoroplasty • Labiaplasty • Initial augmentation mammoplasty • Facial feminization surgery limited to forehead contouring, mandible contouring, chondrolaryngoplasty (trachea shave), and rhinoplasty **Female-to-male:** • Bilateral mastectomy • Hysterectomy • Salpingo-oophorectomy • Colpectomy • Metoidioplasty • Urethroplasty • Phalloplasty • Rhinoplasty Once initial gender reassignment surgery has been completed, the Plan does not cover any further cosmetic changes. In addition, no coverage is provided for reversal of gender reassignment surgery whether or not originally covered by the Plan. Certain services covered under the benefit are provided by only a limited number of Providers in the country and may not currently be in the Plan's network. However, the Plan will work with you and your physician to identify one or more providers who are appropriate to provide services under this benefit.

Benefit	Description
Gender Reassignment Surgery (Continued)	
	For coverage of behavioral health services related to gender reassignment surgery, please see "Mental Health Care and Drug and Alcohol Rehabilitation Services" in section *III. Covered Benefits* for details. If your Plan includes our outpatient pharmacy coverage, please see the Prescription Drug Brochure for information on your outpatient prescription drug coverage. **Important Notice:** We use clinical guidelines to evaluate whether the gender reassignment surgery is Medically Necessary. If you are planning to receive gender reassignment surgery, we recommend that you review the current guidelines. To obtain a copy, please call **1-888-888-4742 ext. 38723**. **Prior Approval or Notification Required:** You must obtain prior approval for coverage under this benefit. If you use a Plan Provider, he/she will seek prior approval for you. The prior approval process is initiated by calling: **1-800-708-4414**. **Please Note:** Not all Plans cover this benefit. Please see your Schedule of Benefits to determine if your Plan provides coverage for this benefit.
17 . Hearing Aids	
	The Plan covers the purchase of hearing aids for each hearing impaired ear for Members through the age of 18, in accordance with the following conditions: • The Member's hearing loss must be documented by a physician or state-licensed audiologist. • The hearing aid must be purchased from a state licensed audiologist or hearing aid dealer. Coverage of hearing aids is provided up to the Benefit Limit stated in your Schedule of Benefits. If your Employer Group has selected additional hearing aid coverage for Members beyond age 18, that information will be described in your Schedule of Benefits. Please see your Schedule of Benefits for benefit details.
18 . Home Health Care	
	If you are homebound for medical reasons, you are covered for home health care services listed below for at least 90 days in a continuous 12 month period. To be eligible for home health care, your Provider must determine that skilled nursing care or physical therapy is an essential part of active treatment. There must also be a defined medical goal that your Provider expects you will meet in a reasonable period of time. When you qualify for home health care services as stated above, the Plan covers the following services: • Durable medical equipment and supplies (must be a component of the home health care being provided) • Medical social services • Nutritional counseling • Physical therapy • Occupational therapy • Services of a home health aide • Skilled nursing care • Speech therapy

Benefit	Description
Home Health Care (Continued)	
	Prior Approval or Notification Required: You must obtain Prior Approval for coverage under this benefit. If you use a Plan Provider, he/she will seek Prior Approval for you. The Prior Approval process is initiated by calling: **1-800-708-4414.** Please see section *I.F. NOTIFICATION AND PRIOR APPROVAL* for more information.
19 . Hospice Services	
	The Plan covers hospice services for terminally ill Members who need the skills of qualified technical or professional health personnel for palliative care. Care may be provided at home or on an inpatient basis. Inpatient respite care is covered for the purpose of relieving the primary caregiver. Inpatient care is also covered in an acute hospital or extended care facility when it is Medically Necessary to control pain and manage acute and severe clinical problems that cannot be managed in a home setting. Covered Benefits include: • Care to relieve pain • Counseling • Drugs that cannot be self-administered • Durable medical equipment appliances • Home health aide services • Medical supplies • Nursing care • Physician services • Occupational therapy • Physical therapy • Speech therapy • Respiratory therapy • Respite care • Social services • Volunteer services • Bereavement services **Prior Approval or Notification Required:** You must obtain Prior Approval for home hospice care. If you use a Plan Provider, he/she will seek Prior Approval for you. The Prior Approval process is initiated by calling: **1-800-708-4414.** Please see section*I.F. NOTIFICATION AND PRIOR APPROVAL* for more information.

Benefit	Description
20 . Hospital – Inpatient Services	
	The Plan covers acute hospital care including, but not limited to, the following inpatient services: • Semi-private room and board, or private room and board when Medically Necessary • Doctor visits, including consultation with specialists • Medications • Laboratory and x-ray services • Intensive care • Surgery, including related services • Anesthesia, including the services of a nurse-anesthetist • Radiation therapy • Physical therapy • Occupational therapy • Speech therapy • Medically Necessary breast reduction surgery and symptomatic varicose vein surgery, as required by Maine law. **Prior Approval or Notification Required:** You must notify HPHC in advance of any planned inpatient admission to a Non-Plan Medical Facility. This requirement applies to admissions to all types of inpatient medical facilities, including hospitals, Skilled Nursing Facilities (SNFs) and rehabilitation hospitals. Please see section *I.F. NOTIFICATION AND PRIOR APPROVAL* for more information.
21 . House Calls	
	The Plan covers house calls.
22 . Human Organ Transplant Services	
	The Plan covers Medically Necessary human organ transplants, including bone marrow transplants for a Member with metastasized breast cancer in accordance with the criteria of the National Cancer Institute. The Plan covers the following services when the recipient is a Member of the Plan: • Care for the recipient • Donor search costs through established organ donor registries • Donor costs that are not covered by the donor's health plan If a Member is a donor for a recipient who is not a Member, then the Plan will cover the donor costs for the Member, when they are not covered by the recipient's health plan.

Benefit	Description
23 . Infertility Services and Treatment	
	The Plan may cover the following diagnostic services for infertility: • Consultation • Evaluation • Laboratory tests **Please Note:** Not all Plans cover this benefit. Please see your Schedule of Benefits to determine if your Plan provides coverage for this benefit. The Plan may cover infertility treatment. If covered under your Plan, only the following infertility treatments are included: • Therapeutic donor insemination, including related sperm procurement and banking • Donor egg procedures, including related egg and inseminated egg procurement, processing and banking • Assisted hatching • Gamete intrafallopian transfer (GIFT) • Intra-cytoplasmic sperm injection (ICSI) • Intra-uterine insemination (IUI) • In-vitro fertilization (IVF) • Zygote intrafallopian transfer (ZIFT) • Preimplantation genetic diagnosis (PGD) • Miscrosurgical epididiymal sperm aspiration (MESA) • Testicular sperm extraction (TESE) Sperm collection, freezing and up to one year of storage is also covered for male Members in active infertility treatment under the following circumstances: (1) if the Member is also undergoing medical treatment, such as treatment for cancer, that is likely to cause permanent infertility; or (2) immediately following sperm collection using MESA or TESE. **Important Notice:** We use clinical guidelines to evaluate whether the use of infertility treatment is Medically Necessary. If you are planning to receive infertility treatment we recommend that you review the current guidelines. To obtain a copy, please call **1-888-888-4742 ext. 38723.** **Prior Approval or Notification Required:** You must obtain Prior Approval for all services for the treatment of infertility. If you use a Plan Provider, he/she will seek Prior Approval for you. The Prior Approval process is initiated by calling: **1-800-708-4414.** Please see section*I.F. NOTIFICATION AND PRIOR APPROVAL* for more information. **Please Note:** Not all Plans cover this benefit. Please see your Schedule of Benefits to determine if your Plan provides coverage for this benefit.

Benefit	Description
24 . Laboratory and Radiology Services	
	The Plan covers diagnostic laboratory and x-ray services, including High End Radiology, on an outpatient basis. The term "High End Radiology" means CT scans, PET Scans, MRI and MRA, and nuclear medicine services. Coverage includes: • The facility charge and the charge for supplies and equipment. • Charges of anesthesiologists, pathologists and radiologists. In addition, the Plan covers the following: • Diagnostic screening and tests, including blood tests and screenings mandated by state law. • Screening mammograms and non-routine mammograms. Screening mammograms are covered once every five years for women between the ages of 35 and 39, and once every year for women 40 years and over. A screening mammogram also includes an additional radiological procedure recommended by a Plan Provider when the initial radiologic procedure results are not definitive. Non-routine mammograms are covered when Medically Necessary. Services will be provided at your PCP's office or when directed to a Plan Provider. • Human leukocyte antigen testing necessary to establish bone marrow transplant donor suitability. The Plan provides coverage up to $150 (No Member Cost Sharing will be applied) toward the cost of human leukocyte antigen testing necessary to establish bone marrow transplant donor suitability. All charges above $150 will be the responsibility of the Member. In accordance with Maine law, the test must be performed in a nationally accredited laboratory. A member seeking coverage for bone marrow suitability testing under this benefit must, at the time of testing, sign a consent form that authorizes the results of the test to be used for participating in the National Marrow Donor Program, or its successor organization. The consent form must acknowledge the Member's willingness to be a bone marrow donor if a suitable match is found. Only one test is covered in a Member's lifetime. **Please Note:** Your Plan will cover certain preventive services and tests with no Member Cost Sharing. Please see your Schedule of Benefits for the coverage that applies to your Plan. **Prior Approval or Notification Required:** You must obtain Prior Approval for computerized axial tomography (CAT and CT and CTA scans); Magnetic resonance imaging (MRI and MRA scans); Nuclear cardiac studies; and Positron emission tomography (PET scans). If you use a Plan Provider, he/she will seek Prior Approval for you. The Prior Approval process is initiated by calling: **1-800-708-4414.** Please see section *I.F. NOTIFICATION AND PRIOR APPROVAL* for more information.
25 . Low Protein Foods	
	The Plan covers special modified low protein food products prescribed by a licensed physician for a person with an inborn error of metabolism as required by Maine law.

Benefit	Description
26 . Maternity Care	
	The Plan covers the following maternity services: • Routine outpatient prenatal care, including evaluation and progress screening, physical exams, recording of weight and blood pressure monitoring. • Prenatal genetic testing (For In-Network coverage, office visits require a Referral). • Delivery, including a minimum of 48 hours of inpatient care following a vaginal delivery and a minimum of 96 hours of inpatient care following a caesarean section. Any decision to shorten the inpatient stay for the mother and her newborn child will be made by the attending physician and the mother. • Routine newborn care, including hospital nursery care, physician services, vaccines and immunizations, and vitamins prior to discharge. • Routine outpatient postpartum care for the mother up to six weeks after delivery. **Important Notice:** You must notify HPHC in advance of any planned inpatient admission to a Non-Plan Medical Facility. This requirement applies to admissions to all types of inpatient medical facilities, including hospitals, Skilled Nursing Facilities (SNFs) and rehabilitation hospitals. Please see section *I.F. NOTIFICATION AND PRIOR APPROVAL* for more information.
27 . Medical Formulas	
	The Plan covers the following to the extent required by Maine law: 1) Metabolic formulas prescribed by a licensed physician for a person with an inborn error of metabolism 2) Amino acid-based elemental infant formula for children two years of age and under without regard to the method of delivery of the formula to the extent Medically Necessary as defined below. Coverage will be provided when a licensed physician has diagnosed, and through medical evaluation has documented, one of the following conditions: • Symptomatic allergic colotis or proctitis • Laboratory or biopsy-proven allergic or eosinophilic gastroenteritis • A history of anaphylaxis • Gastroesophageal reflux disease that is non-responsive to standard medical therapies • Severe vomiting or diarrhea resulting in clinically significant dehydration requiring medical treatment • Cystic fibrosis • Malabsorption of cow milk-based or soy milk-based infant formula In addition to meeting the conditions stated in the definition of Medically Necessary, amino acid-based elemental infant formula will be considered Medically Necessary when the following conditions are met: • The amino acid-based elemental infant formula is the predominant source of nutritional intake at a rate of 50% or greater; and • Other commercial infant formulas including cow milk-based and soy milk-based formulas have been tried and have failed or are contraindicated

Benefit	Description
Medical Formulas (Continued)	
	We may require that a licensed physician confirm and document at least annually that the formula remains Medically Necessary. **Prior Approval or Notification Required:** You must obtain Prior Approval for outpatient formulas and enteral nutrition. If you use a Plan Provider, he/she will seek Prior Approval for you. The Prior Approval process is initiated by calling: **1-800-708-4414.** Please see section *I.F. NOTIFICATION AND PRIOR APPROVAL* for more information.
28 . Mental Health and Drug and Alcohol Rehabilitation Services	
	The Plan covers Medically Necessary inpatient and outpatient mental health care and drug and alcohol rehabilitation services. Prior Approval is required for certain mental health care or drug or alcohol rehabilitation services. If you receive these services from a Non-Plan Provider, you must obtain Prior Approval from the Behavioral Health Access Center by calling **1-888-777-4742.** The mental health and drug and alcohol services for which Prior Approval is required are as follows: • **Intensive Outpatient Program Treatment** Treatment programs at an outpatient clinic or other facility generally lasting three or more hours a day for two or more days a week. • **Partial Hospitalization and Day Treatment Programs** • **Extended Outpatient Treatment Visits –** Outpatient visits of more than 50 minutes duration with or without medication management or any treatment routinely involving more than one outpatient visit in a day. • **Outpatient Electro-Convulsive Treatment (ECT)** • **Psychological Testing** • **Applied Behavior Analysis (ABA) for the treatment of Autism** Even when Prior Approval is not required, mental health and drug and alcohol rehabilitation services may be arranged through the Behavioral Health Access Center by calling **1–888–777–4742**. (The only exception applies to care required in a Medical Emergency.) The Behavioral Health Access Center phone line is staffed by licensed mental health clinicians. They will assist you in finding appropriate Plan Providers and arranging the services you require. In a Medical Emergency you should go to the nearest emergency facility or call 911 or your local emergency number. **Services for Biologically Based Mental Illness** Under Maine law, the Plan covers Medically Necessary treatment of Biologically Based Mental Illness at the same level as for any other medical condition. Biologically Based Mental Illnesses include the following diagnoses: psychotic disorders including paranoia and schizophrenia; dissociative disorders; mood disorders including bipolar disorder and major depressive disorder; anxiety disorders including panic disorder and obsessive compulsive disorder; personality disorders; paraphilias; attention deficit and disruptive behavior disorders; pervasive developmental disorders including autism; tic disorders; eating disorders including bulimia and anorexia; and substance abuse-related disorders. Coverage for mental health services includes: • Inpatient care

Benefit	Description
Mental Health and Drug and Alcohol Rehabilitation Services (Continued)	
	• Outpatient care • Outpatient home care • Psychological testing Coverage for drug and alcohol rehabilitation services includes: • Inpatient drug and alcohol rehabilitation, including partial hospitalization if you and your Provider agree that this treatment is best for you • Outpatient drug and alcohol rehabilitation, including evaluation, diagnosis, treatment and crisis intervention • Inpatient detoxification • Outpatient detoxification and medication management **Mental Health Care Services for non-Biologically Based Mental Illness** In addition to the coverage discussed above, the Plan will provide coverage for the care of all other conditions listed in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders. (The only exception is conditions for which only a "V Code" designation applies, which means that the condition is not attributable to a mental disorder.) Services for all other conditions not identified above will be covered to the extent Medically Necessary. Please refer to your Schedule of Benefits for the Member Cost Sharing that apply to the coverage of these services. 1. **Inpatient Mental Health Services** • Inpatient care is covered as described in your Schedule of Benefits • Coverage includes care in a partial hospitalization program. Partial hospitalization is an intensive outpatient program that provides coordinated services in a therapeutic setting. Partial hospitalization will only be covered if you and your Provider agree that this treatment is best for you. • Inpatient mental health care in a licensed general hospital is covered as long as it is Medically Necessary. 2. **Outpatient Mental Health** The Plan covers outpatient mental health care, including evaluation, diagnosis, treatment and crisis intervention and methadone maintenance. Coverage is provided as described in your Schedule of Benefits. 3. **Psychological Testing** The Plan covers psychological testing when Medically Necessary. For In-Network coverage, a Plan Provider must refer you for such testing and obtain HPHC approval for coverage in advance of obtaining services.
29 . Ostomy Supplies	
	The Plan covers ostomy supplies up to the Benefit Limit listed in the Schedule of Benefits. Only the following supplies are covered: • Irrigation sleeves, bags and catheters • Pouches, face plates and belts • Skin barriers

Benefit	Description
30 . Physician and Other Professional Office Visits	
	Physician services, including services of all covered medical professionals, can be obtained on an outpatient basis at a physician's office or a hospital. These services may include: • Routine physical examinations, including annual gynecological examination (screening Pap tests, routine pelvic and clinical breast examinations) and annual digital rectal test for the early detection of prostate cancer between ages 50 and 72 • Follow-up care provided by an obstetrician or gynecologist for obstetrical or gynecological conditions identified during maternity care or annual gynecological visit • Immunizations, including childhood immunizations as recommended by the United States Department of Health and Human Services, Centers for Disease Control and Prevention and the American Academy of Pediatrics • Second opinions • Well baby and well child care • Health education, including nutritional counseling and smoking cessation counseling • Sickness and injury care • Vision and Hearing screenings • Medication management • Chemotherapy • Radiation therapy **Please Note:** Your Plan will cover certain preventive services and tests with no Member Cost Sharing. If the primary purpose for an office visit is for the delivery of preventive health services, no Member Cost sharing will be applied. However, if the primary purpose for the office visit is for something other than the delivery of preventive health services, Member Cost Sharing will be applied. Please see your Schedule of Benefits for the coverage that applies to your Plan.
31 . Preventive and Well-Care Services	
	The Plan covers preventive and well-care services in accordance with Federal law. Please see your Schedule of Benefits for additional information.
32 . Prosthetic Devices	
	The Plan covers prosthetic devices when ordered by a Provider. The cost of the repair and maintenance of a covered device is also covered. In order to be covered, all devices must be able to withstand repeated use. Coverage is only available for: • The least costly prosthetic device (excluding prosthetic arms and legs) adequate to allow you to perform Activities of Daily Living. Activities of Daily Living do not include special functions needed for occupational purposes or sports; and • One item of each type of prosthetic device that meets a Member's medical need. No back-up items or items that serve a duplicate purpose are covered. Covered prostheses include:

Benefit	Description
Prosthetic Devices (Continued)	
	• Breast prostheses, including replacements and mastectomy bras • Prosthetic arms and legs which are the most appropriate model that meets the Member's medical needs (including myoelectric and bionic arms and legs that adequately allow you to perform Activities of Daily Living.) • Prosthetic eyes • Wigs and scalp hair prostheses, up to the benefit limit listed in the Schedule of Benefits if a Covered Benefit, when needed as a result of alopecia areata, alopecia totalis, alopecia medicamentosa resulting from the treatement from any form of cancer or leukemia or permanent loss of scalp hair due to injury. Member Cost Sharing amounts you are required to pay are based on the cost of equipment to the Plan.
33 . Reconstructive Surgery	
	The Plan covers reconstructive and restorative surgical procedures as follows: • Reconstructive surgery is covered when the surgery can reasonably be expected to improve or correct a Physical Functional Impairment resulting from an accidental injury, illness, congenital anomaly, birth injury or prior surgical procedure. If reconstructive surgery is performed to improve or correct a Physical Functional Impairment, as stated above, Cosmetic Services that are incidental to that surgery are also covered. After a Physical Functional Impairment is corrected, no further Cosmetic Services are covered by the Plan. • Restorative surgery is covered to repair or restore appearance damaged by an accidental injury. (For example, this benefit would cover repair of a facial deformity following an automobile accident.) Benefits are also provided for post mastectomy care, including coverage for: • Prostheses and physical complications for all stages of mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician and the patient; • Reconstruction of the breast on which the mastectomy was performed; and • Surgery and reconstruction of the other breast to produce a symmetrical appearance. Benefits include coverage for procedures that must be done in stages, as long as you are an active member. Membership must be effective on all dates on which services are provided. There is no coverage for Cosmetic Services or surgery except for (1) Cosmetic Services that are incidental to the correction of a Physical Functional Impairment, (2) restorative surgery to repair or restore appearance damaged by an accidental injury and (3) post-mastectomy care as described above. **Important Notice:** We use clinical guidelines to evaluate whether different types of reconstructive and restorative procedures are Medically Necessary. If you are planning to receive such treatment, you may review the current guidelines. To obtain a copy, please call **1-888-888-4742 ext. 38732.**

Benefit	Description
Reconstructive Surgery (Continued)	
	Prior Approval or Notification Required: You must obtain Prior Approval for coverage under this benefit. If you use a Plan Provider, he/she will seek Prior Approval for you. The Prior Approval process is initiated by calling: **1-800-708-4414.** Please see section *I.F. NOTIFICATION AND PRIOR APPROVAL* for more information.
34 . Rehabilitation Hospital Care	
	The Plan covers care in a facility licensed to provide rehabilitative care on an inpatient basis. Coverage is provided when you need daily Rehabilitative Therapies that must be provided in an inpatient setting. Rehabilitative Therapies include cardiac rehabilitation therapy, physical therapy, pulmonary rehabilitation therapy, occupational therapy and speech therapy. The Benefit Limit is listed in the Schedule of Benefits. **Important Notice:** You must notify HPHC in advance of any planned inpatient admission to a Non-Plan Medical Facility. This requirement applies to admissions to all types of inpatient medical facilities, including hospitals, Skilled Nursing Facilities (SNFs) and rehabilitation hospitals. Please see section *I.F. NOTIFICATION AND PRIOR APPROVAL* for more information.
35 . Rehabilitation Therapy – Outpatient	
	The Plan covers the following outpatient rehabilitation therapies: • Cardiac rehabilitation therapy • Occupational therapy • Physical therapy • Pulmonary rehabilitation therapy • Speech therapy Outpatient rehabilitation therapies are covered up to the Benefit Limit listed in the Schedule of Benefits. Services are covered only: • If, in the opinion of your Provider, there is likely to be significant improvement in your condition within the period of time benefits are covered; and • When needed to improve your ability to perform Activities of Daily Living. Activities of Daily Living do not include special functions needed for occupational purposes or sports. Rehabilitation Therapies are also covered under your inpatient hospital and home health benefits. When such therapies are part of an approved home care treatment plan they are available as described in the section *III. Covered Benefits, Home Health Care*. **Please Note:** Outpatient physical and occupational therapies for children under the age of 3 are covered to the extent Medically Necessary. The benefit limit stated in the Schedule of Benefits does not apply. **Prior Approval or Notification Required:** You must obtain Prior Approval for coverage of outpatient physical, occupational, pulmonary rehabilitation and speech therapy. If you use a Plan Provider, he/she will seek Prior Approval for you. The Prior Approval process is initiated by calling: **1-800-708-4414.** Please see section *I.F. NOTIFICATION AND PRIOR APPROVAL* for more information.

Benefit	Description
36 . Scopic Procedures – Outpatient Diagnostic	
	The Plan covers diagnostic scopic procedures and related services received on an outpatient basis. Diagnostic scopic procedures are those for visualization, biopsy and/or polyp removal. Scopic procedures are: • Colonoscopy • Endoscopy • Sigmoidoscopy In addition, the Plan covers any screening colonoscopy or sigmoidoscopy and any other colorectal cancer examination and laboratory test recommended by a Plan Provider in accordance with the most recently published colorectal cancer screening guidelines of a national cancer society. Coverage includes colorectal cancer screening for asymptomatic individuals who are 50 years of age or older, or less than 50 years of age and at high risk for colorectal cancer according to the most recently published colorectal cancer screening guidelines of a national cancer society.
37 . Skilled Nursing Facility Care	
	The Plan covers care in a health care facility licensed to provide skilled nursing care on an inpatient basis. Coverage is provided only when you need daily skilled nursing care that must be provided in an inpatient setting. The Benefit Limit is listed in the Schedule of Benefits. **Important Note:** You must notify HPHC in advance of any planned inpatient admission to a Non-Plan Medical Facility. This requirement applies to admissions to all types of inpatient medical facilities, including hospitals, Skilled Nursing Facilities (SNFs) and rehabilitation hospitals. Please see section *I.F. NOTIFICATION AND PRIOR APPROVAL* for more information.
38 . Surgery - Outpatient	
	The Plan covers outpatient surgery, including related services. Outpatient surgery is defined as any surgery or procedure in a day surgery department, ambulatory surgery department or outpatient surgery center. **Prior Approval or Notification Required:** You must obtain Prior Approval for coverage under this benefit. If you use a Plan Provider, he/she will seek Prior Approval for you. The Prior Approval process is initiated by calling: **1-800-708-4414.** Please see section *I.F. NOTIFICATION AND PRIOR APPROVAL* for more information.
39 . Telemedicine Services	
	The Plan covers Medically Necessary telemedicine services for the purpose of diagnosis, consultation or treatment in the same manner as an in-person consultation between you and your Provider. Telemedicine services are limited to the use of real-time interactive audio, video or other electronic media telecommunications as a substitute for in-person consultation with Providers. Cost Sharing for telemedicine services is the same as the Cost Sharing for the same type of service if it had been provided through an in-person consultation. Please refer to your Schedule of Benefits for specific information on Cost Sharing you may be required to pay.

Benefit	Description
40 . Temporomandibular Joint Dysfunction Services	
	The Plan covers medical treatment of Temporomandibular Joint Dysfunction (TMD). Only the following services are covered: • Initial consultation with a physician • Physical therapy (subject to the visit limit for outpatient physical therapy listed in the Schedule of Benefits) • Surgery • X-rays **Important Notice:** No Dental Care is covered for the treatment of Temporomandibular Joint Dysfunction (TMD). **Prior Approval or Notification Required:** You must obtain Prior Approval for coverage under this benefit. If you use a Plan Provider, he/she will seek Prior Approval for you. The Prior Approval process is initiated by calling: **1-800-708-4414.** Please see section *I.F. NOTIFICATION AND PRIOR APPROVAL* for more information.
41 . Urgent Care Services	
	The Plan may cover Urgent Care that you receive at (1) a convenience care clinic or (2) an urgent care clinic. Convenience care clinics provide treatment for minor illnesses and injuries. They are usually staffed by non-physician providers, such as nurse practitioners, and are located in stores, supermarkets, or pharmacies. To see a list of convenience care clinics covered by the Plan, please refer to your Provider Directory and search under "convenience care." Urgent care clinics provide treatment for illnesses and injuries that require urgent attention but are not life threatening. Urgent care clinics are independent clinics or certain hospital-owned clinics that provide urgent care services. Urgent care clinics are staffed by doctors, nurse practitioners, and physician assistants. To see a list of urgent care clinics covered by the Plan, please refer to your Provider Directory and search under "urgent care." Coverage is provided for services that are required to prevent deterioration to your health resulting from an unforeseen sickness or injury. Some hospitals provide urgent care services as part of the hospital's outpatient services. Because the services provided are considered outpatient hospital services, only the hospitals are listed in the Provider Directory. These services may require higher Member Cost Sharing than urgent care services received at independent urgent care clinics. Please refer to your Schedule of Benefits for your specific Member Cost Sharing requirements for urgent care services. Coverage for Urgent Care is provided for services that are required to prevent deterioration to your health resulting from an unforeseen sickness or injury. Covered services include, but are not limited to, the following: • Care for minor cuts, burns, rashes or abrasions, including suturing • Treatment for minor illnesses and infections, including ear aches • Treatment for minor sprains or strains You do not need to obtain a referral from your PCP to be covered for Urgent Care services at an urgent care or convenience care clinic. Whenever possible, you should contact your PCP prior to obtaining Urgent Care. Your PCP may be able to provide the services you require at a lower

Benefit	Description
Urgent Care Services (Continued)	
	out-of-pocket cost. In addition, your PCP is responsible for coordinating your health care services and should know about the services you receive. **Important Notice:** Urgent care is not emergency care. You should call 911 or go directly to a hospital emergency room if you suspect you are having an Medical Emergency. These include heart attack or suspected heart attack, shock, major blood loss, or loss of consciousness. Please see the section *I.D.5. Medical Emergency Services* for more information. **Please Note:** Not all Plans cover this benefit. Please see your Schedule of Benefits to determine if your Plan provides coverage for this benefit.
42 . Vision Services	
	Urgent Eye Care: The Plan covers urgent eye care services. You do not need a Referral for up to 2 visits, the initial visit and one follow-up visit, per urgent event. For In-Network coverage you must obtain care from a Plan Provider and a PCP Referral is required for any visits after the second urgent eye care visit. Urgent eye care services are services provided to treat conditions, illnesses or diseases of the eye that if not treated within 24 hours present a serious risk of harm. **Routine Eye Examinations:** The Plan may cover routine eye examinations. **Please Note:** Not all Plans cover this benefit. Please see your Schedule of Benefits to determine if your Plan provides coverage for this benefit. **Vision Hardware for Special Conditions:** The Plan may provide coverage for contact lenses or eyeglasses needed for the following conditions: • Keratonconus. One pair of contact lenses is covered per Plan Year or Calendar Year. The replacement of lenses, due to a change in the Member's condition, is limited to 3 per affected eye per Plan Year or Calendar Year. • Post cataract surgery with an intraocular lens implant (pseudophakes). Coverage is limited to $140 per surgery toward the purchase of eyeglass frames and lenses. The replacement of lenses due to a change in the Member's prescription of .50 diopters or more within 90 days of the surgery is also covered up to a limit of $140. • Post cataract surgery without lens implant (aphakes). One pair of eyeglass lenses or contact lenses is covered per Plan Year or Calendar Year. Coverage up to $50 per Plan Year or Calendar Year is also provided for the purchase of eyeglass frames. The replacement of lenses due to a change in the Member's condition is also covered. Replacement of lenses due to wear, damage, or loss, is limited to 3 per affected eye per Plan Year or Calendar Year. • Post retinal detachment surgery. For a Member who wore eyeglasses or contact lenses prior to retinal detachment surgery, the Plan covers the full cost of one lens per affected eye up to one Plan Year or Calendar Year after the date of surgery. For Members who have not previously

Benefit	Description
Vision Services (Continued)	
	worn eyeglasses or contact lenses, the Plan covers eyeglass lenses up to $50 toward the purchase of the frame or pair of contact lenses. **Please Note:** Not all Plans cover this benefit. Please see your Schedule of Benefits to determine if your Plan provides coverage for this benefit.
43 . Voluntary Sterilization	
	The Plan may cover voluntary sterilization, including tubal ligation and vasectomy. **Please Note:** Not all Plans cover male sterilization. Please see your Schedule of Benefits to determine if your Plan provides coverage for this benefit.
44 . Voluntary Termination of Pregnancy	
	The Plan may cover voluntary termination of pregnancy. **Please Note:** Not all Plans cover this benefit. Please see your Schedule of Benefits to determine if your Plan provides coverage for this benefit.

If you reside and work in New Hampshire, you may be eligible for New Hampshire mandated benefits. Please contact Member Services for more details.

IV. Exclusions

The exclusions headings in this section are intended to group together services, treatments, items, or supplies that fall into a similar category. Actual exclusions appear underneath the headings. A heading does not create, define, modify, limit or expand an exclusion.

The services listed in the table below are not covered by the Plan:

Exclusion	Description
1 . Alternative Treatments	
	1. Acupuncture care, except when specifically listed as a Covered Benefit. Please see your Schedule of Benefits to determine if your Plan provides coverage for this benefit. 2. Acupuncture services that are outside the scope of standard acupuncture care. 3. Alternative or holistic services and all procedures, laboratories and nutritional supplements associated with such treatments. 4. Aromatherapy, treatment with crystals and alternative medicine. 5. Health resorts, spas, recreational programs, camps, wilderness programs (therapeutic outdoor programs), outdoor skills programs, relaxation or lifestyle programs, including any services provided in conjunction with, or as part of such types of programs. 6. Massage therapy when performed by anyone other than a licensed physical therapist, physical therapy assistant, occupational therapist, or certified occupational therapy assistant. 7. Myotherapy.
2 . Clinical Trials	
	Coverage is not provided for the following: 1. The investigational item, device, or service itself; or 2. For services, tests or items that are provided solely to satisfy data collection and analysis for the clinical trial and that are not used for the direct clinical management of your condition.
3 . Dental Services	
	1. Dental Care, except the specific dental services listed in this Benefit Handbook and your Schedule of Benefits. 2. All services of a dentist for Temporomandibular Joint Dysfunction (TMD). 3. Extraction of teeth, except when specifically listed as a Covered Benefit. Please see your Schedule of Benefits to determine if your Plan provides coverage for this benefit.. 4. Pediatric dental care, except when specifically listed as a Covered Benefit. (Please see your Schedule of Benefits and any associated riders to determine if your Plan provides coverage for this benefit.)

Exclusion	Description
4 . Durable Medical Equipment and Prosthetic Devices	
	1. Any devices or special equipment needed for sports or occupational purposes. 2. Any home adaptations, including, but not limited to home improvements and home adaptation equipment. 3. Non-durable medical equipment, unless used as part of the treatment at a medical facility or as part of approved home health care services. 4. Repair or replacement of durable medical equipment or prosthetic devices as a result of loss, negligence, willful damage, or theft.
5 . Experimental, Unproven or Investigational Services	
	1. Any products or services, including, but not limited to, drugs, devices, treatments, procedures, and diagnostic tests that are Experimental, Unproven, or Investigational.
6 . Foot Care	
	1. Foot orthotics, except for the treatment of severe diabetic foot disease. 2. Routine foot care. Examples include nail trimming, cutting or debriding and the cutting or removal of corns and calluses. This exclusion does not apply to preventive foot care for Members with diabetes.
7 . Gender Reassignment Surgery	
	1. Face-lifting 2. Lip reduction/enhancement 3. Blepharoplasty 4. Laryngoplasty, or other voice modification surgery 5. Facial implants or injections 6. Silicone injections of the breast 7. Liposuction 8. Electrolysis, hair removal, or hair transplantation 9. Collagen injections 10. Removal of redundant skin
8 . Mental Health Care	
	1. Biofeedback. 2. Educational services or testing, except services covered under the benefit for Early Intervention Services. 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. 3. Sensory integrative praxis tests. 4. 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. 5. Services or supplies for the diagnosis or treatment of mental health and drug and alcohol rehabilitation services that, in the reasonable judgment of the Behavioral Health Access Center, are any of the following:

Exclusion	Description
Mental Health Care (Continued)	
	• Not consistent with prevailing national standards of clinical practice for the treatment of such conditions. • Not consistent with prevailing professional research demonstrating that the services or supplies will have a measurable and beneficial health outcome. • Typically do not result in outcomes demonstrably better than other available treatment alternatives that are less intensive or more cost effective.
9 . Physical Appearance	
	1. Cosmetic Services, including drugs, devices, treatments and procedures, except for (1) Cosmetic Services that are incidental to the correction of a Physical Functional Impairment, (2) reconstructive surgery to repair or restore appearance damaged by an accidental injury and (3) post-mastectomy care. 2. Hair removal or restoration, including, but not limited to, electrolysis, laser treatment, transplantation or drug therapy. 3. Liposuction or removal of fat deposits considered undesirable. 4. Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures). 5. Skin abrasion procedures performed as a treatment for acne. 6. Treatment for skin wrinkles or any treatment to improve the appearance of the skin. 7. Treatment for spider veins. 8. Wigs, except when specifically listed as a Covered Benefit. Please see your Schedule of Benefits to determine if your Plan provides coverage for this benefit.
10 . Procedures and Treatments	
	1. Care by a chiropractor 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. 2. Commercial diet plans, weight loss programs and any services in connection with such plans or programs. 3. Nutritional or cosmetic therapy using vitamins, minerals or elements, and other nutrition-based therapy. Examples include supplements, electrolytes, and foods of any kind (including high protein foods and low carbohydrate foods). 4. Physical examinations and testing for insurance, licensing or employment. 5. Services for Members who are donors for non-members, except as described under Human Organ Transplant Services. 6. Testing for central auditory processing. 7. Group diabetes educational programs or camps.

Exclusion	Description
11 . Providers	
	1. Charges for services which were provided after the date on which your membership ends, except as required by Maine law. 2. 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. 3. Charges for missed appointments. 4. Concierge service fees. (See section *I.I. PROVIDER FEES FOR SPECIAL SERVICES (CONCIERGE SERVICES)* for more information.) 5. No In-Network coverage for follow-up care after an emergency room visit, unless provided in the Service Area by a Plan Provider with a Referral where one is required. 6. Inpatient charges after your hospital discharge. 7. Provider's charge to file a claim or to transcribe or copy your medical records. 8. Services or supplies provided by: (1) anyone related to you by blood, marriage or adoption, or (2) anyone who ordinarily lives with you.
12 . Reproduction	
	1. Any form of Surrogacy or services for a gestational carrier. 2. Infertility drugs if a member is not in a Plan authorized cycle of infertility treatment. 3. Infertility drugs, if infertility services are not a Covered Benefit. 4. Infertility drugs that must be purchased at an outpatient pharmacy, unless your Plan includes outpatient pharmacy coverage. 5. Infertility treatment for Members who are not medically infertile. 6. Infertility treatment, except when specifically listed as a Covered Benefit. Please see your Schedule of Benefits to determine if your Plan provides coverage for this benefit. 7. Reversal of voluntary sterilization (including any services for infertility related to voluntary sterilization or its reversal). 8. Sperm collection, freezing and storage except when specifically listed as a Covered Benefit. Please see your Schedule of Benefits to determine if your Plan provides coverage for infertility treatments. 9. Sperm identification when not Medically Necessary (e.g., gender identification). 10. The following fees; wait list fees, non-medical costs, shipping and handling charges etc. 11. Voluntary sterilization, including tubal ligation and vasectomy, except when specifically listed as a Covered Benefit. Please see your Schedule of Benefits to determine if your Plan provides coverage for this benefit. 12. Voluntary termination of pregnancy, unless the life of the mother is in danger or unless it is specifically listed as a Covered Benefit. Please see your Schedule of Benefits to determine if your Plan provides coverage for this benefit.

Exclusion	Description
13 . Services Provided Under Another Plan	
	1. Costs for any services for which you are entitled to treatment at government expense, including military service connected disabilities. 2. 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.
14 . Telemedicine	
	1. 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. Specific Telemedicine benefits are covered. Please see the benefit for Telemedicine in Section *III. Covered Benefits* earlier in this Handbook.
15 . Types of Care	
	1. Custodial Care. 2. Rest or domiciliary care. 3. All institutional charges over the semi-private room rate, except when a private room is Medically Necessary. 4. Pain management programs or clinics. 5. Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, and diversion or general motivation. 6. Private duty nursing. 7. Sports medicine clinics. 8. Vocational rehabilitation, or vocational evaluations on job adaptability, job placement, or therapy to restore function for a specific occupation.
16 . Vision and Hearing	
	1. Eyeglasses, contact lenses and fittings, except as listed in this Benefit Handbook and any associated Riders. 2. Refractive eye surgery, including, but not limited to, lasik surgery, orthokeratology and lens implantation for the correction of myopia, hyperopia and astigmatism. 3. Routine eye examinations, except when specifically listed as a Covered Benefit. Please see your Schedule of Benefits to determine if your Plan provides coverage for this benefit.

Exclusion	Description
17 . All Other Exclusions	
	1. Any service provided by a Non-Plan Provider except where: (a) your care is provided in a Medical Emergency; or (b) your PCP or Physician has been disenrolled as a Plan Provider or you are a new Member of the Plan and one of the exceptions stated in Section *I.G. SERVICES PROVIDED BY A DISENROLLED OR NON-PLAN PROVIDER* applies. 2. Any service or supply furnished in connection with a non-Covered Benefit. 3. Beauty or barber service. 4. Any drug or other product obtained at an outpatient pharmacy, except for pharmacy supplies covered under the benefit for diabetes services, unless your Plan includes outpatient pharmacy coverage. 5. Food or nutritional supplements, including, but not limited to, FDA-approved medical foods obtained by prescription, except as required by law. 6. Guest services. 7. Services for non-Members. 8. Services for which no charge would be made in the absence of insurance. 9. Services for which no coverage is provided in this Benefit Handbook, Schedule of Benefits or Prescription Drug Brochure. 10. Services that are not Medically Necessary. 11. Taxes or governmental assessments on services or supplies. 12. Transportation other than by ambulance. 13. The following products and services: • Air conditioners, air purifiers and filters, dehumidifiers and humidifiers. • Car seats. • Chairs, bath chairs, feeding chairs, toddler chairs, chair lifts, recliners. • Electric scooters. • Exercise equipment. • Home modifications including but not limited to elevators, handrails and ramps. • Hot tubs, jacuzzis, saunas or whirlpools. • Mattresses. • Medical alert systems. • Motorized beds. • Pillows. • Power-operated vehicles. • Stair lifts and stair glides. • Strollers. • Safety equipment. • Vehicle modifications including but not limited to van lifts. • Telephone. • Television.

V. Reimbursement and Claims Procedures

The information in this section applies when you wish to file a claim or seek reimbursement following receipt of Covered Benefits from a Non-Plan Provider. In most cases, you should not receive bills from a Plan Provider.

A. BILLING BY PROVIDERS

You may receive bills from a Non-Plan Provider or a Plan Provider when you do not have a Referral. If you get a bill for a Covered Benefit you may ask the provider to:

1) Bill us on a standard health care claim form (such as the CMS 1500 or the UB-04 form); and
2) Send it to the address listed on the back of your Plan ID card.

B. REIMBURSEMENT FOR BILLS YOU PAY

If you pay a provider who is not a Plan Provider for a Covered Benefit, we will reimburse you less your applicable Member Cost Sharing.

Claims for Mental Health Care:

Behavioral Health Access Center
P.O. Box 31053
Laguna Hills, CA 92654-1053

Pharmacy Claims:

MedImpact
DMR Department
10680 Treena Street, 5th Floor
San Diego, CA 92131

All Other Claims:

HPHC Claims
P.O. Box 699183
Quincy, MA 02269–9183

To obtain reimbursement for a bill you have paid, other than for pharmacy items, you must provide us with all of the following information:

- The Member's full name and address
- The Member's date of birth
- The Member's Plan ID number (on the front of the Member's Plan ID card)
- The name and address of the person or facility providing the services for which a claim is made and their tax identification number
- The Member's diagnosis or ICD 9 code
- The date the service was rendered
- The CPT code (or a brief description of the illness or injury) for which payment is sought
- The amount of the provider's charge
- Proof that you have paid the bill

Important Notice: We may need more information for some claims. If you have any questions about claims, please call our Member Services Department at **1–888–333–4742**.

1. International Claims

If you are requesting reimbursement for services received while outside of the United States, you must submit an International Claim Form. The form can be obtained online at **www.harvardpilgrim.org**or by calling the Member Services Department. In addition to the International Claim Form, you will need to submit an itemized bill and proof of payment. We may also require you to provide additional documentation, including, but not limited to: (1) records from financial institutions clearly demonstrating that you have paid for the services that are the subject of the claim; and (2) the source of funds used for payment.

2. Pharmacy Claims

To obtain reimbursement for pharmacy bills you have paid, you must submit a Prescription Claim Form. The form can be obtained online at **www.harvardpilgrim.org**or by calling the Member Services Department.

In addition to the Prescription Claim Form, you must send a drug store receipt showing the items for which reimbursement is requested.

The following information must be on the Prescription Claim Form:

- The Member's name and Plan ID number
- The name of the drug or medical supply
- The quantity
- The number of days supply of the medication provided
- The date the prescription was filled
- The prescribing Provider's name
- The pharmacy name and address
- The amount you paid

Important Notice: Reimbursement for prescription drugs will only be made if your plan includes our optional outpatient pharmacy coverage. Please see your Prescription Drug Brochure (if applicable) for more information.

Members can contact the **MedImpact** help desk at **1-800-788-2949** regarding pharmacy claims.

C. TIME LIMITS ON FILING CLAIMS

To be eligible for payment, we must receive claims within one year of the date care was received, unless the Member can show that due to physical or mental incapacity it was impossible for them or their designee to send the claim in that time.

Claims will be paid by us consistent with applicable Maine law.

D. PAYMENT LIMITS

We limit the amount we will pay for services that are not rendered by Plan Providers. The maximum amount we will pay for services by Non-Plan Providers is the Allowed Amount. If a service is provided by a Non-Plan Provider, you are responsible for any amount in excess of the Allowed Amount.

The percentage of payment of any claim by HPHC (i.e. the amount payable minus the applicable Deductible, Copayment and Coinsurance amounts, if any) will be based upon the Allowed Amount. The Member is responsible for any expenses incurred that exceed the Allowed Amount for the service received.

FOR EXAMPLE: If the Allowed Amount is $1,000 and the applicable Member Cost Sharing for the service is 20% Coinsurance, the maximum amount we will pay is $800.

Please contact the Member Services Department at **1–888–333–4742** or call **711** for TTY service if you have questions about the Allowed Amount that may be permitted by HPHC for a service provided by a Non-Plan Provider.

VI. Appeals and Complaints

This section explains our procedures for processing appeals and complaints and the options available if an appeal is denied.

A. BEFORE YOU FILE AN APPEAL

On occasion, claim denials result from a misunderstanding with a provider or a claim processing error. Since these problems can be easy to resolve, we recommend that Members contact a Member Service Representative before filing an appeal. A Member Service Representative can be reached toll-free at **1–888–333-4742** or call **711** for TTY service. The Member Service Representative will investigate the claim and either resolve the problem or explain why the claim is being denied. If you are dissatisfied with the response of the Member Service Representative, you may file an appeal using the procedures outlined below.

B. OUR MEMBER APPEAL PROCEDURES

If you receive an Adverse Benefit Determination, you may appeal. We have established the following steps to ensure that you receive a timely and fair review of your appeal.

1. Initiating Your Appeal

To initiate your appeal, please mail or fax a letter to us or call us about the coverage you are requesting and why you feel it should be granted. Please be as specific as possible. We need all the important details in order to make a fair decision, including pertinent medical records and itemized bills. We must get this information within one year (365 days) of the denial of coverage, except in cases of extenuating circumstances.

Please send your appeal to the following address:

HPHC Member Appeals
HPHC Member Services Department
1600 Crown Colony Drive
Quincy, MA 02169
Telephone: 1-888-333-4742
Fax: 1–617–509-3085

If you are deaf or hard of hearing or visually impaired, you may request appeal procedure materials in an appropriately accessible format by calling Member Services toll free at **1-888-333-4742** or call **711** for TTY service.

Appeals concerning mental health and drug and alcohol rehabilitation services should be submitted to:

HPHC Behavioral Health Access Center
c/o United Behavioral Health
Appeals Department
100 East Penn Square, Suite 400
Philadelphia, PA 19107
Telephone: 1–888–777-4742
Fax: 1–888–881–7453

When we receive your appeal, we will assign an Appeals Coordinator to manage your appeal throughout the entire appeal process, including the second-level appeal process described below. We will send you a letter identifying your Appeals Coordinator within three business days of receiving your appeal. That letter will include detailed information on the first and the second level appeal processes described below, as well as your right to independent external review and your right to contact the Maine Bureau of Insurance. Your Appeals Coordinator is available to answer any questions you may have about your appeal and the review process.

In addition to the appeals process, we utilize mediation to resolve some coverage disputes. Both the Plan and you must agree to mediation. Your Appeal Coordinator will inform you if we feel that your appeal is appropriate for mediation.

2. First-Level Appeal Process

Standard Review Procedure: Your Appeal Coordinator will investigate your appeal, determine if additional information is required and request any needed information from you. Such information may include statements from your doctors, medical records and bills and receipts for services you have received. If your appeal involves a medical determination, an appropriate clinical peer will review it.

After we receive all the information needed to make a decision, your Appeals Coordinator will inform you in writing of whether we have approved or denied your appeal. Most appeals can be resolved within 30 days. If we cannot reasonably meet the 30 day time frame due to an inability to obtain necessary information from Non-Plan Providers, we will inform you in writing of the reason for the delay and that we need more time to make a decision.

Expedited Review Procedure: If your appeal involves services which, if delayed, could seriously jeopardize your health or your ability to regain maximum function, please inform us and we will provide an expedited review. We will grant an expedited review

to any appeal for services concerning (1) an inpatient admission, (2) availability of care, or (3) continued health care or services for a Member who has received emergency services and has not been discharged from the hospital where emergency care was provided. You, your representative or your doctor may request an expedited review.

We will investigate and decide expedited appeals as quickly as possible, but in all cases we will respond within 72 hours of the receipt of your appeal. Your help in promptly providing all necessary information is essential for us to provide you with an expedited review. For expedited appeals involving (1) continued emergency services to screen or stabilize a Member, or (2) continued care under an authorized admission or course of treatment, coverage will be continued without liability to the Member until the Member has been notified of the expedited appeal decision. To ensure a timely response, we may inform you of our decision on your expedited appeal by telephone. Following telephone notice, we also will provide you with a written decision within two working days after this phone call.

Adverse Determination of Appeal: If we deny your first-level appeal (standard or expedited) in whole or in part, we will provide you with a written decision that includes: (1) the names, titles and credentials of the reviewers who decided your appeal; (2) a statement of the reviewers' understanding of the issues and all the relevant facts; (3) reference to the specific Plan provisions and evidence or documents upon which the decision is based, including the clinical review criteria used to make the determination: (4) the reviewers' decision and the basis for that decision, including the clinical rationale, if any; (5) a reference to the evidence or documentation used as the basis for the decision; (6) notice of your right to contact the Maine Bureau of Insurance by telephone at **1–800–300-5000 (within Maine) or 1–207–624-8475** (outside Maine) or by mail at 34 State House Station, Augusta, ME 04333 as required by Maine law; (7) a description of the process to obtain a second-level review; and (8) notice of your right to contact the ombudsman, Consumers for Affordable Health Care by telephone at **1–800–965–7476** or by mail at P.O. Box 2490, Augusta, ME 04338–2490.

3. Second-Level Appeal Process

If you are dissatisfied with the decision of the first level appeal process, you may ask that your appeal be reviewed by our review committee. You have a right to attend the meeting to discuss your case with the review committee. Just let your Appeals Coordinator know if you wish to attend. You may also participate in the meeting by telephone if you wish. We will hold a review meeting within 45 days after receiving your request for a second-level appeal. You will be notified in writing at least 15 days in advance of the review meeting. You may submit supporting materials before and at the review meeting. You also may be represented by someone at the review meeting. You may also obtain your medical file and information relevant to the appeal free of charge upon request. The decision of the review committee will be sent to you in writing within 5 working days of the meeting. The decision of the review committee is the final decision.

If you elect not to attend the review committee meeting in person or participate by telephone, you will be provided with a written response to your appeal within 30 calendar days of your request for a second-level appeal.

If we deny your second-level appeal in whole or in part, we will provide you with a written decision that includes: (1) the names, titles credentials of the reviewers who decided your appeal; (2) a statement of the reviewers' understanding of the issues and all the relevant facts; (3) reference to the specific Plan provisions and evidence or documents upon which the decision is based, including the clinical review criteria used to make the determination; (4) the reviewers' decision and the basis for that decision, including the clinical rationale, if any; (5) a reference to the evidence or documentation used as the basis for the decision; (6) notice of your right to contact the Maine Bureau of Insurance by telephone at **1–800–300-5000** (within Maine) or **1–207–624-8475** (outside Maine) or by mail 34 State House Station, Augusta, ME 04333 as required by Maine law; (7) a description of the process to obtain a second-level review and (8) notice of your right to contact the ombudsman, Consumer for Affordable Health Care by telephone at **1–800–965–7476** or by mail at P.O. Box 2490, Augusta, ME 04338–2490.

You may waive your right to a second level appeal. You have the right to instead request an external review after the first level appeal decision.

C. INDEPENDENT EXTERNAL REVIEW OF APPEALS

Appeal decisions involving an Adverse Health Care Treatment Decision by the Plan are eligible for review by an independent review organization designated by the Maine Bureau of Insurance. In most cases you are required to complete our first and second-level appeals process to be eligible for external review. However, this

requirement does not apply if (1) Harvard Pilgrim has failed to make a decision on your first or second level appeal in the time frames noted above; (2) you and the Plan mutually agree to bypass the member appeals process; (3) your life or health is in jeopardy; (4) the Member for whom external review is requested has died; or (5) Adverse Health Care Treatment Decision to be reviewed concerns an admission, availability of care, a continued stay or health care services when the Member has received emergency services but has not been discharged from the facility that provided the emergency services.

Requests for external review must be in writing to the Maine Bureau of Insurance at 34 State House Station, Augusta, ME 04333 and must be made within 12 months of our final denial of Covered Benefits prior to the initiation of the appeals process. You also may name someone you trust to file an appeal for you. However, you must give that person written permission to do so.

The review organization designated by the Maine Bureau of Insurance will consider all relevant clinical information submitted by you and us. In addition, the review organization will consider any concerns you express about your health status. You have the right to attend the external review meeting at which time you may ask questions of our representative present at the meeting. You also are entitled to obtain information relating to the adverse decision under review. You may use outside assistance for the external review process. This assistance is your own financial responsibility.

The external review decision will be made as quickly as required by the medical condition at issue. If the appeal relates to a serious medical condition and delay would jeopardize the Member's life health or ability to regain maximum function, the external review decision will be made within 72 hours of receipt of completed request. All other decisions will be made within at least 30 days of a completed request for external review. You will receive a written decision from the review organization. We will pay the fees of the independent review organization for conducting the review. If the independent review organization decides in your favor, we will cover the services approved.

D. MEMBER COMPLAINTS

If you have any complaints about your care under the Plan or about our service, we want to know about it. We are here to help. For all complaints, except mental health and drug and alcohol rehabilitation complaints, please call or write to us at:

HPHC Member Appeals
HPHC Member Services Department
1600 Crown Colony Drive
Quincy, MA 02169
Telephone: 1-888-333-4742
Fax: 1–617–509-3085
www.harvardpilgrim.org

Appeals concerning mental health and drug and alcohol rehabilitation services should be submitted to:

HPHC Behavioral Health Access Center
c/o United Behavioral Health
Appeals Department
100 East Penn Square, Suite 400
Philadelphia, PA 19107
Telephone: 1–888–777-4742
Fax: 1–888–881–7453

We will respond to you as quickly as we can. Most complaints can be investigated and responded to within thirty (30) days.

You may also contact the Maine Bureau of Insurance Superintendent's office at:

Maine Bureau of Insurance
34 State House Station
Augusta, ME 04333
Telephone: 1–800–300-5000 (within Maine) or 1–207–624–8475 (outside Maine)
Fax: 1–207–624-8599

TTY: 1–888–577–6690

E. INCONTESTABILITY

Any statement made by the Employer Group or a Member in applying for insurance under this Plan, other than a fraudulent misstatement, will be considered a representation and not a warranty. No such statement will be used to contest a claim for benefits under this Plan unless the statement is in writing and a copy is or has been furnished to the Member.

No such statement will be used in contesting the validity of a Member's coverage under this Plan once such coverage has been in effect for two years during the Member's lifetime.

VII. Eligibility

Important Notice: Your membership in the Plan is effective on the date of enrollment by your Employer Group. Because your employer may notify Harvard Pilgrim of enrollment changes retroactively, we may not have current information concerning membership status. Only your Employer Group can confirm membership status.

This section describes requirements concerning eligibility under the Plan. It is important to understand that eligibility of Dependents and effective dates of coverage are determined by the Employer Group.

Eligible Subscribers and Dependents can enroll in a plan, or change their existing plan, during their annual open enrollment period. Please contact your Employer Group to determine the dates of your open enrollment.

A. ELIGIBILITY

1. Subscriber Eligibility

To be a Subscriber under this Plan, you must:

1) Be an employee of an Employer Group, in accordance with employee eligibility guidelines agreed to by the Employer Group and us; and
2) Be enrolled through an Employer Group that is up-to-date in the payment of the applicable premium for coverage.

The Plan has the right to examine an Employer Group's records, including payroll records, to verify eligibility and premium payments.

2. Dependent Eligibility

Unless an employer has elected different types of coverage for Dependents, a Dependent must meet one of the requirements for coverage listed below to be eligible for coverage under the Plan. Please note that employers may elect different coverage for Dependents and different ages for the termination of Dependents to the extent allowed by law. Please consult your Employer Group's Benefits Office to determine the specific Dependent eligibility requirements that apply to your Plan.

To be eligible as a Dependent, an individual must be one of the following:

1) The legal spouse of the Subscriber, including a domestic partner.
2) A child (including an adopted child or stepchild) of the Subscriber or spouse of the Subscriber until the end of the month in which the child turns 26.
3) A child (including an adopted child or stepchild) of the Subscriber or spouse of the Subscriber, age 26 years or older who meets each of the following requirements: (a) is currently Disabled; (b) was Disabled on his or her 26th birthday; and (c) lives either with the Subscriber or spouse or in a licensed institution. The term "Disabled" means unable to engage in any substantial gainful activity by reason of a specific medically determinable physical or mental impairment which can be expected to last, or has lasted, for at least 12 months or result in death.
4) A child under the age of 19* years for whom the Subscriber or Subscriber's spouse is the court appointed legal guardian. Proof of guardianship must be submitted to HPHC prior to enrollment.
5) The child of an eligible Dependent of the Subscriber until such time as the parent is no longer a Dependent.

Reasonable evidence of eligibility may be required from time to time.

* Age requirements shown are minimum, option will only be offered to adjust upward.

B. EFFECTIVE DATE - NEW DEPENDENTS AND EXISTING DEPENDENTS

Please see your Employer Group's Benefit Administrator for information on enrollment and effective dates of coverage. Please also see section *VII.F. SPECIAL ENROLLMENT RIGHTS*.

C. EFFECTIVE DATE - ADOPTIVE DEPENDENTS

An adoptive child who has been living with you, and for whom you have been receiving foster care payments, may be covered from the date the child is placed for adoption with you or your spouse. "Placed for adoption" means the assumption and retention of a legal obligation for the total or partial support of a child in anticipation of adoption of the child. If the legal obligation ceases to exist, the child is no longer considered placed for adoption.

D. CHANGE IN STATUS

It is your responsibility to inform your Employer Group and HPHC of all changes that affect Member eligibility. These changes include: address changes; marriage of a Dependent; and death of a Member.

Please Note: We must have your current address on file in order to correctly process claims for Out-of-Network care.

E. ADDING A DEPENDENT

To add a new dependent to your Plan, please contact your Employer's human resources or benefits department. If you already have family coverage, you may also call our Member Services Department at **1-888-333-4742** to add a newborn or newly adopted child.

Dependents of eligible employees who meet the eligibility guidelines described in this Handbook and the Employer Agreement will be enrolled in the Plan using HPHC enrollment forms or in a manner otherwise agreed to in writing by the Plan and the Member's Employer Group. HPHC must receive proper notice from the Employer Group of any Member enrollment in, or termination from, the Plan no more than 60 days after such change is to be effective unless otherwise required by law. Please see your Employer Group for information on Dependent eligibility and effective dates of coverage.

F. 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.

G. NEWBORN COVERAGE

Coverage for a newborn child is effective from the moment of birth for up to 31 days. Coverage includes the Covered Benefits in this Handbook, including Medical Emergency services. No coverage is provided after the 31-day period, unless the Subscriber obtains Family Coverage within 60 days of the date of birth.

Please Note: Generally, newborn coverage is bundled with the mother's maternity coverage. When the mother is not an HPHC member, HPHC needs to be put on notice of delivery in order to manage the newborn's care. HPHC recognizes that coverage under the terms of this Handbook must be provided for the first 31 days of life regardless of whether the newborn is enrolled.

H. HOW YOU'RE COVERED IF MEMBERSHIP BEGINS WHILE YOU'RE HOSPITALIZED

If your membership happens to begin while you are hospitalized, coverage starts on the day membership is effective. To obtain In-Network coverage, you must be in a hospital that is a Plan Provider and, if you are in the Service Area you must call the Plan and allow us to manage your care. Please see your Employer Group's benefits administrator for information on enrollment and effective date of coverage. All other terms and conditions of coverage under this Handbook will apply.

If you are hospitalized at an Out-of-Network hospital, you must notify HPHC by calling **1-800-708-4414** for medical services. Your benefits at the out-of-network hospital will be covered at the out of network level. For all mental health and drug and alcohol rehabilitation services please call **1-888-777-4742**. Please see section *I.F. NOTIFICATION AND PRIOR APPROVAL*for more information.

Please see your Employer Group's benefits administrator for information on enrollment and effective date of coverage. All other terms and conditions of coverage under this Handbook will apply

VIII. Termination and Transfer to Other Coverage

Important Notice: We may not have current information concerning membership status. Employer Groups may notify us of enrollment changes retroactively. As a result, the information we have may not be current. Only your Employer Group can confirm membership status.

A. TERMINATION BY THE SUBSCRIBER

You may end your membership under this Plan with your Employer Group's approval. We must receive a completed Enrollment/Change form from the Employer Group within sixty (60) days of the date you want your membership to end.

B. TERMINATION FOR LOSS OF ELIGIBILITY

The Member's coverage may end under this Plan for failing to meet any of the specified eligibility requirements.

You will be notified in writing if coverage ends for loss of eligibility.

You may be eligible for continued enrollment under federal or state law, if your membership is terminated. See "Continuation of Employer Group Coverage" in this Section for more information.

Please Note: HPHC may not have current information concerning membership status. Employer Groups have up to 60 days to notify us of enrollment changes. As a result, the information we have may not be current. Only your Employer Group can confirm membership status.

C. TERMINATION FOR NON-PAYMENT BY THE EMPLOYER GROUP

A Member's coverage will end under this Plan if the Employer Group contract through which the Member receives coverage is terminated for non-payment. A 30-day grace period exists under the Employer Group contract during which time your coverage continues in force. We will notify you in writing if your coverage is terminated due to your Employer Group failing to pay its premium.

You may be eligible for continued enrollment under federal or state law, if your membership is terminated. See "Continuation of Employer Group Coverage" in this Section for more information.

D. TERMINATION FOR CAUSE

HPHC may end a Member's coverage for any of the following causes:

- Misrepresentation of a material fact on an application for membership;
- Committing or attempting to commit fraud to obtain benefits for which the Member is not eligible under this Handbook; or
- Obtaining or attempting to obtain benefits under this Handbook for a person who is not a Member.

Termination of membership for misrepresentation or fraud to the Plan may go back to the Member's effective date or the date of the misrepresentation or fraud as determined by the Plan. It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Termination of membership for the other causes will be effective thirty (30) days after notice. Premium paid for periods after the effective date of termination will be refunded.

E. TERMINATIONS FOR OTHER REASONS

HPHC may also end a Member's coverage under the Plan for any of the following other reasons:

- If HPHC elects to discontinue this Plan or type of coverage in one or more markets in Maine, on ninety (90) days notice, in accordance with the requirements of Maine law.
- If HPHC elects to discontinue all coverage, including under this Plan, for one or more markets in Maine, on one hundred eighty (180) days notice, in accordance with the requirements of Maine law.
- The termination or non-renewal of the Employer Agreement under which the Member is enrolled in the Plan.

F. CONTINUATION OF EMPLOYER GROUP COVERAGE REQUIRED BY LAW

1. Maine Law

Continuation of coverage under state law may be available if you lose eligibility for membership. You should contact your Employer Group for more information if membership ends due to:

- Layoff
- Loss of employment because of an injury or disease for which you claim Workers' Compensation.

2. Federal Law
If you lose Employer Group eligibility, you may be eligible for continuation of group coverage under the federal law known as the Consolidated Omnibus Budget Reconciliation Act (COBRA). You should contact your Employer Group for more information if health coverage ends due to 1) separation from employment; 2) reduction of work hours; or 3) loss of dependency status. Continuation of coverage may not be extended beyond the applicable time allowed under federal law.

You may select either your continuation of coverage rights under state or federal law.

G. INDIVIDUAL COVERAGE

We offer individual health plans for Maine, New Hampshire and Massachusetts residents. Coverage purchased on an individual basis may differ from the coverage under your previous Plan. Individuals may enroll only in a plan offered in the state of their residence and must satisfy all eligibility guidelines. Your state of residence will have specific rules about eligibility and coverage.

1. Maine Residents:
For individual coverage questions please call us at **1-888-333-4742**.

2. Massachusetts residents:
For individual coverage questions please call us at **1-800-208-1221**.

3. New Hampshire Residents:
For individual coverage questions please call us at **1-844-213-1591**.

Please call our Member Services Department at **1-888-333-4742**or call **711** for TTY service for current information on the availability, eligibility requirements, and benefits of nongroup plans offered by HPHC.

H. EXTENSION OF BENEFITS UPON DISCONTINUATION OF EMPLOYER GROUP COVERAGE

If your Employer Group discontinues your Plan coverage and you are totally disabled on the date the discontinuation takes place your benefits will be extended for the condition relating to your disability, unless you are covered under replacement coverage from your Employer Group.

Your benefits will be extended as follows:

Benefits under this Evidence of Coverage will be continued for the treatment of the impairment causing the disability until:

a) treatment is no longer Medically Necessary; or

b) the expiration of six months, whichever comes first.

For purposes of this section the term "totally disabled" means for a Member who was gainfully employed prior to disability, the inability to engage in any gainful occupation for which he or she is suited by training, education and experience, or for a Member who was not gainfully employed prior to disability, the inability to engage in most normal activities of a person of like age in good health.

For the purposes of this extension of benefits, all of the terms, conditions and limitation of coverage under this Handbook shall apply except that no premium shall be charged. In the event you are covered under replacement coverage, your new coverage will be the primary payer and your replaced coverage will be the secondary payer.

After discontinuation of the group policy, HPHC is liable for: (1) accrued liabilities and (2) extensions of benefits for persons who are totally disabled upon discontinuation of the Plan. If your employer group obtained replacement coverage, such replacement coverage will pay as primary coverage and HPHC will pay as secondary coverage for the Covered Benefits relating to the total disability.

I. REINSTATEMENT

A Member's coverage will not be reinstated automatically if it is terminated. Reapplication is necessary. Notwithstanding the foregoing, you have the right to (1) designate a third party to receive notice of cancellation; (2) change the designation; and (3) be reinstated if you suffer from cognitive impairment or functional incapacity and the ground for cancellation was for nonpayment of premium or other lapse or default on your part pursuant to Maine law. If you suffer from cognitive impairment or functional incapacity, you may designate someone to receive notice of cancellation with a "Third Party Notice Request Form." This form will be sent to you within 10 days of your request. Notice will be provided to you or the designee 10 days prior to cancellation.

IX. When You Have Other Coverage

This section explains how benefits under the Plan will be paid when another company or individual is also responsible for payment for health services a Member has received. This can happen when there is other insurance available to pay for health services, in addition to that provided by the Plan. It can also happen when a third party is legally responsible for an injury or illness suffered by a Member.

Nothing in this section should be interpreted as providing coverage for any service or supply that is not expressly covered under the Handbook, Schedule of Benefits and Prescription Drug Brochure (if applicable) or to increase the level of coverage provided.

A. BENEFITS IN THE EVENT OF OTHER INSURANCE

Benefits under this Handbook, Schedule of Benefits, and Prescription Drug Brochure will be coordinated to the extent permitted by law with other plans covering health benefits, including: motor vehicle insurance, medical payment policies, homeowners' insurance, governmental benefits (including Medicare), and all Health Benefit Plans. The term "Health Benefit Plan" means all group HMO and other group prepaid health plans, medical or hospital service corporation plans, commercial health insurance and self-insured health plans. There is no coordination of benefits with Medicaid plans or with hospital indemnity benefits.

Coordination of benefits will be based upon the Allowed Amount for any service that is covered at least in part by any of the plans involved. If benefits are provided in the form of services, or if a provider of services is paid under a capitation arrangement, the reasonable value of these services will be used as the basis for coordination. No duplication in coverage of services will occur among plans.

When a Member is covered by two or more Health Benefit Plans, one will be “primary” and the other plan (or plans) will be secondary. The benefits of the primary plan are determined before those of secondary plan(s) and without considering the benefits of secondary plan(s). The benefits of secondary plan(s) are determined after those of the primary plan and may be reduced because of the primary plan's benefits.

In the case of Health Benefit Plans that contain provisions for the coordination of benefits, the following rules will determine which health benefit plans are primary or secondary:

1. Dependent/Non-Dependent
The benefits of the plan that covers the person as an employee or Subscriber are determined before those of the plan that covers the person as a Dependent.

2. A Dependent Child Whose Parents Are Not Separated or Divorced
The order of benefits is determined as follows:

1) The benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in that year; but,
2) If both parents have the same birthday, the benefits of the plan that covered the parent longer are determined before those of the plan that covered the other parent for a shorter period of time;
3) However, if the other plan does not have the rule described in (1) above, but instead has a rule based upon the gender of the parent, and if, as a result, the plans do not agree on the order of benefits, the other plan will determine the order of benefits.

3. Dependent Child/Separated or Divorced Parents
Unless a court order, of which HPHC has knowledge of, specifies one of the parents as responsible for the health care benefits of the child, the order of benefits is determined as follows:

1) First the plan of the parent with custody of the child;
2) Then, the plan of the spouse of the parent with custody of the child;
3) Finally, the plan of the parent not having custody of the child.

4. Active/Inactive Employee
The benefits of the plan that covers the person as an active employee are determined before those of the plan that covers the person as a laid-off or retired employee.

5. Longer/Shorter Length of Coverage
If none of the above rules determines the order of benefits, the benefits of the plan that covered the employee, Member or Subscriber longer are determined before those of the plan that covered that person for the shorter time.

If you are covered by a health benefit plan that does not have provisions governing the coordination of benefits between plans, that plan will be the primary plan.

B. PAYMENT WHEN HPHC COVERAGE IS PRIMARY OR SECONDARY

When HPHC is primary, HPHC is responsible for processing and paying claims for Covered Benefits first. Coverage will be provided to the full extent of benefits available under this Handbook, Schedule of Benefits and Prescription Drug Brochure.

When HPHC is secondary, HPHC is responsible for processing claims for Covered Benefits after the primary plan has been issued a benefit determination. HPHC will first review the primary plan's benefit determination. HPHC will then pay or provide Covered Benefits as the secondary payor. HPHC's benefits will be reduced so that the total amount paid by all plans for a Covered Benefit will not exceed the amount payable under this Handbook. HPHC may recover any payments made for services in excess of HPHC's liability as the secondary plan, either before or after payment by the primary plan.

When a member is covered under more than one expense-incurred health plan, payments made by the primary plan, payments made by the member and payments made from a health savings account or similar fund for benefits covered under the secondary plan will be credited toward the deductible of the secondary plan, except where the secondary plan is designed to supplement the primary plan.

C. WORKER'S COMPENSATION/GOVERNMENT PROGRAMS

If HPHC has information indicating that services provided to you are covered under Worker's Compensation, employer's liability or other program of similar purpose, or by a federal, state or other government agency, HPHC may suspend payment for such services until a determination is made whether payment will be made by such program, 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. If HPHC provides or pays for services for an illness or injury covered under Worker's Compensation, Employer's liability or other program of similar purpose, or by a federal, state or other government agency, HPHC will be entitled to recovery of its expenses from the provider of services or the party or parties legally obligated to pay for such services.

D. SUBROGATION AND REIMBURSEMENT

Subrogation is a means by which HPHC and other health plans recover expenses of services where a third party is legally responsible for a Member's injury or illness.

If another person or entity is, or may be, liable to pay for services related to a Member's illness or injury, which have been paid for or provided by HPHC, HPHC will be subrogated and succeed to all rights of the Member to recover against such person or entity 100% of the value of the services paid for or provided by the Plan, subject to the provisions of the following paragraph. HPHC will have the right to seek such recovery from, among others, the person or entity that caused the injury or illness, his/her liability carrier or the Member's own auto insurance carrier, in cases of uninsured or underinsured motorist coverage. HPHC's right to recovery shall apply even if a recovery the Member receives for the illness or injury is designated or described as being for injuries other than health care expenses. HPHC's recovery will be made from any recovery the Member receives from an insurance company or any third party, subject to the provisions of the following paragraph. HPHC will also be entitled to recover from a Member 100% of the value of services provided or paid for by HPHC when a Member has been, or could be, reimbursed for the cost of care by another party, subject to the provisions of the following paragraph. The subrogation and recovery provisions in this section apply whether or not the Member recovering money is a minor.

All subrogation payments made under this Section shall be made on a just and equitable basis. A just and equitable basis means that any factors that diminish the potential value of the enrollee's claim may likewise reduce the share in the claim for those claiming payment for services or reimbursement. Such factors include, but are not limited to:

1. Legal defenses. Questions of liability and comparative negligence or other legal defenses;
2. Exigencies of trial. Exigencies of trial that reduce a settlement or award in order to resolve the claim; and
3. Limits of coverage. Limits on the amount of applicable insurance coverage that reduce the claim to an amount recoverable by the insured.

In the event of a dispute as to the application of any such provision or the amount available for

payment to those claiming payment for services or reimbursement, that dispute must be determined, if the action is pending, before the court in which it is pending; or if no action is pending, by filing an action in any court for determination of the dispute.

To enforce its subrogation rights under this Handbook, HPHC will have the right to take legal action, with or without the Member's consent, against any party to secure recovery of the value of services provided or paid for by HPHC for which such party is, or may be, liable. By signing your enrollment form requesting coverage under the Plan, you have authorized HPHC's right of subrogation.

E. MEDICAL PAYMENT POLICIES

For Members who are entitled to benefits under the medical payment benefit of a motor vehicle, motorcycle, boat, homeowners, hotel, restaurant or other insurance policy, HPHC has the right to coordinate with other insurance carriers under its subrogation rights. The benefits under this Handbook shall not duplicate any benefits to which the Member is entitled under any medical payment policy or benefit. All sums payable for services provided under this Handbook to Members that are covered under any medical payment policy or benefit are payable to HPHC.

F. MEMBER COOPERATION

You agree to cooperate with HPHC in exercising its rights of subrogation and coordination of benefits under this Handbook. Such cooperation will include, but not be limited to, a) the provision of all information and documents requested by HPHC, b) the execution of any instruments deemed necessary by HPHC to protect its rights, c) the prompt assignment to HPHC of any monies received for services provided or paid for by HPHC, and d) the prompt notification to HPHC of any instances that may give rise to HPHC's rights. You further agree to do nothing to prejudice or interfere with HPHC's rights to subrogation or coordination of benefits.

If you fail to perform the obligations stated in this Subsection, you shall be rendered liable to HPHC for any expenses HPHC may incur, including reasonable attorneys fees, in enforcing its rights under this Handbook.

G. HPHC'S RIGHTS

Nothing in this Handbook shall be construed to limit HPHC's right to utilize any remedy provided by law to enforce its rights to subrogation or coordination of benefits under this agreement.

H. MEMBERS ENROLLED IN MEDICARE

When a Member is enrolled in Medicare and receives Covered Benefits that are eligible for coverage by Medicare as the primary payor, the claim must be submitted to Medicare before payment by HPHC. HPHC will be liable for any amount eligible for coverage that is not paid by Medicare. The Member shall take such action as is required to assure payment by Medicare, including presenting his or her Medicare card at the time of service.

For a Member who is eligible for Medicare by reason of End Stage Renal Disease, HPHC will be the primary payor for Covered Benefits during the "coordination period" specified by federal regulations at 42 CFR Section 411.162. Thereafter, Medicare will be the primary payor. When Medicare is primary, HPHC will pay for services only to the extent payments would exceed what would be payable by Medicare.

X. Plan Provisions and Responsibilities

A. IF YOU DISAGREE WITH RECOMMENDED TREATMENT

You enroll in HPHC with the understanding that Plan Providers are responsible for determining treatment appropriate to your care. You may disagree with the treatment recommended by Plan Providers for personal or religious reasons. You may demand treatment or seek conditions of treatment that Plan Providers judge to be incompatible with proper medical care. In the event of such a disagreement, you have the right to refuse the recommendations of Plan Providers. In such a case, HPHC shall have no further obligation to provide coverage for the care in question. If you obtain care from Non-Plan Providers because of such disagreement you do so with the understanding that HPHC has no obligation for the cost or outcome of such care. You have the right to appeal benefit denials.

B. LIMITATION ON LEGAL ACTIONS

Any legal action against HPHC for failing to provide Covered Benefits must be brought within two years of the denial of any benefit.

C. ACCESS TO INFORMATION

You agree that, except where restricted by law, we may have access to (1) all health records and medical data from health care providers providing services covered under this Handbook and (2) information concerning health coverage or claims from all providers of motor vehicle insurance, medical payment policies, homeowners' insurance and all types of health benefit plans. We will comply with all laws restricting access to special types of medical information including, but not limited to, HIV test data, and drug and alcohol abuse rehabilitation and mental health care records.

You can obtain a copy of the Notice of Privacy Practices through the Harvard Pilgrim Web site, **www.harvardpilgrim.org** or by calling the Member Services Department at **1-888-333-4742**.

D. SAFEGUARDING CONFIDENTIALITY

We are committed to ensuring and safeguarding the confidentiality of our Members' information in all settings, including personal and medical information. Our staff access, use and disclose Member information only in connection with providing services and benefits and in accordance with our confidentiality policies. We permit only designated employees, who are trained in the proper handling of Member information, to have access to and use of your information. We sometimes contract with other organizations or entities to assist with the delivery of care or administration of benefits. Any such entity must agree to adhere to our confidentiality and privacy standards.

When you enrolled with us, you agreed to certain uses and disclosures of information which are necessary for us to provide and administer services and benefits, such as: coordination of care, including Referrals and authorizations; conducting quality activities, including member satisfaction surveys and disease management programs; verifying eligibility; fraud detection and certain oversight reviews, such as accreditation and regulatory audits. When we disclose Member information, we do so using the minimum amount of information necessary to accomplish the specific activity.

We disclose our Members' personal information only: (1) in connection with the delivery of care or administration of benefits, such as utilization review, quality assurance activities and third-party reimbursement by other payers, including self-insured employer groups; (2) when you specifically authorize the disclosure; (3) in connection with certain activities allowed under law, such as research and fraud detection; (4) when required by law; or (5) as otherwise allowed under the terms of your Benefit Handbook. Whenever possible, we disclose Member information without Member identifiers and in all cases only disclose the amount of information necessary to achieve the purpose for which it was disclosed. We will not disclose to other third parties, such as employers, member-specific information (i.e. information from which you are personally identifiable) without your specific consent unless permitted by law or as necessary to accomplish the types of activities described above.

In accordance with applicable law, we, and all of our contacted health care providers, agree to provide Members access to, and a copy of, their medical records upon a Member's request. In addition, your medical records cannot be released to a third party without your consent or unless permitted by law.

You can obtain a copy of the Notice of Privacy Practices through the Harvard Pilgrim Web site,

www.harvardpilgrim.org or by calling the Member Services Department at **1-888-333-4742**.

E. NOTICE

Any notice to a Member may be sent to the last address of the Member on file with HPHC. Notice to HPHC, other than a request for Member appeal, should be sent to:

HPHC Member Services Department
1600 Crown Colony Drive
Quincy, MA 02169

For the addresses and telephone numbers for filing appeals, please see section *VI. Appeals and Complaints*.

Premium rate information is available from your Employer Group. We will give written notice to your Employer of any rate increase sixty (60) days prior to your Employer's Anniversary Date or the effective date of any increase.

F. MODIFICATION OF THIS HANDBOOK

This Benefit Handbook, Schedule of Benefits, Prescription Drug Brochure and applicable riders, may be amended by us upon sixty (60) days written notice to your Employer Group. Amendments do not require the consent of Members.

This Benefit Handbook, the Schedule of Benefits, Prescription Drug Brochure, applicable riders and amendments comprise the entire contract between you and the Plan. The responsibilities of HPHC to the Member are only as stated in those documents. They can only be modified in writing by an authorized officer of the Plan. No other action by us, including the deliberate non-enforcement of any benefit limit shall be deemed to waive or alter any part of these documents.

G. OUR RELATIONSHIP WITH PLAN PROVIDERS

Our relationship with Plan Providers is governed by separate agreements. They are independent contractors. Such Providers may not modify this Handbook or Schedule of Benefits, Prescription Drug Brochure, and any applicable riders, or create any obligation for HPHC. We are not liable for statements about this Handbook by them, their employees or agents. We may change our arrangements with service Providers, including the addition or removal of Providers, without notice to Members.

H. IN THE EVENT OF A MAJOR DISASTER

We will try to provide or arrange for services in the case of a major disaster. This might include war, riot, epidemic, public emergency, or natural disaster. Other causes include the partial or complete destruction of our facility(ies) or the disability of service providers. If we cannot provide or arrange services due to a major disaster, we are not responsible for the costs or outcome of this inability.

I. EVALUATION OF NEW TECHNOLOGY

We have a dedicated team of staff that evaluates new diagnostics, testing, interventional treatment, therapeutics, medical/behavioral therapies, surgical procedures, medical devices and drugs as well as ones with new applications. The team manages the evidence-based evaluation process from initial inquiry to final policy recommendation in order to determine whether it is an accepted standard of care or if the status is Experimental, Unproven or Investigational. The team researches the safety and effectiveness of these new technologies by reviewing published peer reviewed medical reports and literature, consulting with expert practitioners, and benchmarking. The team presents its recommendations to internal policy committees responsible for making decisions regarding coverage of the new technology under the Plan. The evaluation process includes:

- Determination of the FDA approval status of the device/product/drug in question,
- Review of relevant clinical literature, and
- Consultation with actively practicing specialty care providers to determine current standards of practice.

The team presents its recommendations to internal policy committees responsible for making decisions regarding coverage of the new technology under the Plan.

J. GOVERNING LAW

This Evidence of Coverage is governed by Maine law.

K. UTILIZATION REVIEW PROCEDURES

We use the following utilization review procedures to evaluate the medical necessity of selected health care services using clinical criteria, and to facilitate clinically appropriate, cost-effective management of your care. This process applies to guidelines for both physical and mental health services.

- **Prospective Utilization Review (Prior Approval).** We review selected products, admissions, procedures and services prior to the provision of such to determine whether they meet clinical criteria for coverage. Please see section *I.F. NOTIFICATION AND PRIOR APPROVAL* for further information on HPHC's Prior Approval requirements, including procedures for which Prior Approval is required. Prior Approval review determinations will be made within two working days after obtaining all necessary information. In the case of a determination to approve an admission, procedure or service, we will give notice to the requesting provider by telephone within 24 hours of the decision and will send a written or electronic confirmation of the telephone notification to you and the provider within two working days. In the case of a determination to deny or reduce benefits ("an adverse determination"), we will notify the provider rendering the service by telephone within 24 hours of the decision and will send a written or electronic confirmation of the telephone notification to you and the provider within one working day thereafter. In the case of an urgent care determination not involving concurrent review, we will notify you of a decision within 48 hours after receiving all necessary information.
- **Concurrent Utilization Review.** We review selected ongoing admissions to inpatient hospitals, rehabilitation hospitals, skilled nursing facilities and skilled home health services to assure that services being provided meet clinical criteria for coverage. Concurrent review decisions will be made within one working day of obtaining all necessary information. In the case of either a determination to approve additional services or an adverse determination, we will notify the provider rendering the service by telephone within 24 hours of the decision. We will send a written or electronic confirmation of the telephone notification to you and the provider within one working day. In the case of ongoing services, coverage will be continued without liability to you until you have been notified of an adverse determination.

  Active case management and discharge planning is incorporated as part of the concurrent review process and may also be provided upon the request of your Provider.
- **Retrospective Utilization Review.** Retrospective Utilization Review may be used in situations where services were provided before authorization was obtained. Retrospective utilization review decisions will be made within 30 days after obtaining all information. In the case of an adverse determination involving clinical review, you will receive written notification that cites the specific rationale upon which the decision was made and includes information about the appeals process and the right to request in writing copies of any clinical utilization review criteria applied in a denial of coverage decision.

If you wish to determine the status or outcome of a clinical review decision you may call the Member Services Department toll free at **1-888-333-4742**. For information about decisions concerning mental health and drug and alcohol rehabilitation services, you may call the Behavioral Health Access Center at **1-888-777-4742**.

In the event of an Adverse Health Care Treatment Decision involving clinical review, your treating provider may discuss your case with a physician reviewer or may seek reconsideration from us. The reconsideration will take place within one working day of your provider's request. If the adverse determination is not reversed on reconsideration you may appeal. Your appeal rights are described in the *VI. Appeals and Complaints* section Your right to appeal does not depend on whether or not your provider sought reconsideration.

L. QUALITY ASSURANCE PROGRAMS

The goal of our quality program is to ensure the provision of consistently excellent health care, health information and service to our Members, enabling them to maintain and improve their physical and behavioral health and well-being. Some components of the quality program are directed to all Members and others address specific medical issues and providers.

Examples of quality activities in place for all Members include a systematic review and re-review of the credentials of Plan Providers and contracted facilities, as well as the development and dissemination of clinical standards and guidelines in areas such as preventive care, medical records, appointment access, confidentiality, and the appropriate use of drug therapies and new medical technologies.

Activities affecting specific medical issues and providers include disease management programs for those with chronic diseases like asthma, diabetes and congestive heart failure, and the investigation and

resolution of quality-of-care complaints registered by individual Members.

M. PROCEDURES USED TO EVALUATE EXPERIMENTAL/INVESTIGATIONAL DRUGS, DEVICES, OR TREATMENTS

We use a standardized process to evaluate inquiries and requests for coverage received from internal and/or external sources, and/or identified through authorization or payment inquiries. The evaluation process includes:

- Determination of the FDA approval status of the device/product/drug in question,
- Review of relevant clinical literature, and
- Consultation with actively practicing specialty care providers to determine current standards of practice.

Decisions are formulated into recommendations for changes in policy, and forwarded to our management for review and final implementation decisions.

N. PROCESS TO DEVELOP CLINICAL GUIDELINES AND UTILIZATION REVIEW CRITERIA

We use clinical review criteria and guidelines to make fair and consistent utilization management decisions. Criteria and guidelines are developed in accordance with standards established by The National Committee for Quality Assurance (NCQA), and reviewed (and revised, if needed) at least biennially, or more often if needed to accommodate current standards of practice. This process applies to guidelines for both physical and mental health services.

We use the nationally recognized InterQual criteria to review elective surgical day procedures, and services provided in acute care hospitals. InterQual criteria are developed through the evaluation of current national standards of medical practice with input from physicians and clinicians in medical academia and all areas of active clinical practice. InterQual criteria are reviewed and revised annually.

Criteria and guidelines used to review other services are also developed with input from physicians and other clinicians with expertise in the relevant clinical area. The development process includes review of relevant clinical literature and local standards of practice.

Our Clinician Advisory Committees, comprised of actively practicing physicians from throughout the network, serve as the forum for the discussion of specialty-specific clinical programs and initiatives, and provide guidance on strategies and initiatives to evaluate or improve care and service.

XI. MEMBER RIGHTS & RESPONSIBILITIES

Members have a right to receive information about HPHC, its services, its practitioners and providers, and Members' rights and responsibilities.

Members have a right to be treated with respect and recognition of their dignity and right to privacy.

Members have a right to participate with practitioners in decision-making regarding their health care.

Members have a right to a candid discussion of appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage.

Members have a right to voice complaints or appeals about HPHC or the care provided.

Members have a right to make recommendations regarding the organization's members' rights and responsibilities policies.

Members have a responsibility to provide, to the extent possible, information that HPHC and its practitioners and providers need in order to care for them.

Members have a responsibility to follow the plans and instructions for care that they have agreed on with their practitioners.

Members have a responsibility to understand their health problems and participate in developing mutually agreed upon treatment goals to the degree possible.

Harvard Pilgrim Health Care, Inc.

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