HPHC Insurance Company

Benefit Handbook

PPO ACCESS HSA FOR INDIVIDUAL MEMBERS

MAINE

This certificate does not provide pediatric dental benefits. You must purchase an exchange certified stand-alone pediatric dental plan through the carrier of your choice.

This certificate is also available as a child only certificate.

Important Notice: This Plan includes the PPO provider network. Plan Providers may be found in the states of Maine, Massachusetts, New Hampshire, Vermont, and Rhode Island. This Plan also includes the Plan's national network of Plan Providers. Please consult the Provider Directory or visit the provider search tool at **www.harvardpilgrim.org** to determine if a provider is in the network.

EFFECTIVE DATE: 01/01/2025
FORM #2856_02

INTRODUCTION

Welcome to the PPO Access HSA for Individual Members offered by HPHC Insurance Company (HPHC) and thank you for choosing us to help meet your health care needs.

The Plan is designed to meet Internal Revenue Service rules for a "High Deductible Health Plan." You may be eligible for a Health Savings Account (HSA) with this High Deductible Health Plan. An HSA may be used to pay for:

- Member Cost Sharing for Covered Benefits; and
- Some health care services that are not covered by the Plan.

An HSA may also provide tax advantages. Please consult a qualified tax advisor. He or she can advise if you are eligible for an HSA and how it works.

The words "we," "us," and "our" used in this Handbook, refer to HPHC. The words "you" or "your" used in this handbook refer to Members as defined in the Glossary.

Renewing Your Coverage

When renewing your premium, your coverage renews. Your coverage is renewable unless:

1. you are no longer eligible for the Plan,
2. you can be terminated for cause, or
3. HPHC discontinues the Plan.

Premiums may change. We will notify you of any premium changes and the date the changes will occur. Please see *IX. Termination and Transfer to Other Coverage* for more information.

10 Day Policy Review

You may return the policy within 10 days of delivery if you are not satisfied for any reason. You will be refunded any premium paid.

To use the Plan effectively, you must review this Handbook and the Schedule of Benefits together. They describe your In-Network, and Out-of-Network benefits. This Plan is designed to allow you to obtain Covered Benefits through the Plan's network of Plan Providers or the Non-Plan Provider of your choice. Benefits are covered both In-Network and Out-of-Network. Your In-Network benefits provide you with a higher level of coverage at a lower out-of-pocket cost.

All In-Network care must be provided by Plan Providers, except in a Medical Emergency.

Covered Benefits received from a Non-Plan Provider are covered at the Out-of-Network level.

Some benefits have limits on the amount of coverage provided in a Calendar Year. When a benefit has a limit, In-Network and Out-of-Network services will usually be combined and count together against the limit. Please see your Schedule of Benefits for detailed information regarding benefit limits on your coverage.

Your covered health care services are described in this Handbook, the Schedule of Benefits, the Prescription Drug Brochure and any riders or amendments to those documents.

We provide helpful online tools and resources at **www.harvardpilgrim.org**. **Your secure online account** offers a safe way to help manage your health care. You can check your Schedule of Benefits and Benefit Handbook. You can look up:

- benefits,
- cost sharing,
- claim histories, and
- compare Hospitals.

For details on how to register **your secure online account**, log on to **www.harvardpilgrim.org**.

Call Member Services at **1–877–907–4742** if you have any questions. Member Services staff can help you with questions about the following:

- Selecting Plan Providers
- 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 help with questions from non-English speaking Members. We offer language interpretation services in more than 180 languages.

Deaf and hard-of-hearing Members may call **711** for TTY service.

We value your input. We appreciate any comments or ideas that will help us improve the quality of our services.

HPHC Insurance Company, Inc.
Member Services Department
1 Wellness Way
Canton, MA 02021
1–877–907–4742
www.harvardpilgrim.org

Medical Necessity Guidelines

We use evidence based clinical review criteria to evaluate whether certain services or procedures are Medically Necessary for your care. To get Medical Necessity Guidelines, you or your Provider may call Member Services at **1-877-907-4742** or go to **www.harvardpilgrim.org**.

Exclusions or Limitations for Preexisting Conditions

The Plan has no pre-existing condition restrictions, limitations or exclusions.

This is not a Medicare Supplement policy. If you are eligible for Medicare, review the Medicare Supplement Buyer's Guide available from the company. If you have a Medicare Supplement policy or major medical policy, this coverage may be more than you need. For information call the Bureau of Insurance at **1-800-300-5000**.

Your health insurance policy will not fully cover your medical claims once you become eligible for Medicare Part B. To maintain the most coverage available, you must sign up for Medicare Part B before your 65th birthday. Otherwise, you will be responsible for paying your doctors and other providers what Medicare would have paid.

If you have questions, contact your local Area Agency on Aging at **1-877-353-3711**, or Consumers for Affordable Health Care at **1-800-965-7476**, or by email at consumerhealth@mainecahc.org.

For help, you can also contact the Maine Bureau of Insurance at (800) 300-5000 or by email at Insurance.PFR@maine.gov.

Language Assistance Services

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

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

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

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

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

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

العربية (Arabic)
إنتباه: إذا أنت تتكلم اللُّغة **العربية** ، خدمات المساعدة اللُّغوية متوفرة لك مجانا. **إتصل على 1 888-333-4742**
(TTY: 711)

ខ្មែរ (Cambodian) ប្រសិនជាអ្នកនិយាយភាសាខ្មែរ, សេវាកម្មបកប្រែ ជូនលោកអ្នកដោយ គិតថ្លៃ។ ចូរ ទូរស័ព្ទ 1-888-333-4742 (TTY: 711)។

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

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

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

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

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

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

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

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

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

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

(Continued)

General Notice About Nondiscrimination and Accessibility Requirements

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

HPHC:

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

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

If you believe that HPHC has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex (including pregnancy, sexual orientation, and gender identity), you can file a grievance with: Civil Rights Compliance Officer, 1 Wellness Way, Canton, MA 02021-1166, (866) 750-2074, TTY service: 711, Fax: (617) 509-3085, Email: civil_rights@point32health.org. You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, the Civil Rights Compliance Officer is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

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

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

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

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Benefit Handbook

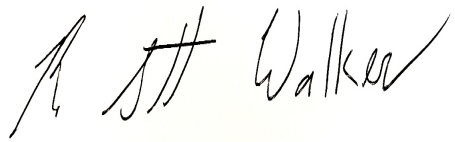
PPO Access HSA for Individual Members
MAINE

This Benefit Handbook (Handbook), including the Schedule of Benefits, Prescription Drug Brochure , any applicable riders and all appendices, is the legal document which defines the relationship between Members and HPHC Insurance Company, Inc. It describes benefits, limitations, conditions, exclusions, requirements and other important information relevant to Members enrolled in PPO Access HSA for Individual Members (the Plan).

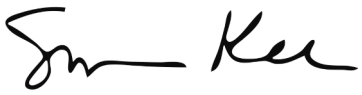
In exchange for premiums paid in advance by the Member, HPHC Insurance Company agrees to pay for Member's health care services, subject to all the terms of this Handbook, for the period the premium covers.

By signing or electronically submitting the enrollment application, the Member applies for coverage under the Plan and agrees to all of its terms.

Please read this document carefully and keep it for future reference.



R. Scott Walker
President
HPHC Insurance Company, Inc.



Susan Kee
Clerk
HPHC Insurance Company, Inc.

TABLE OF CONTENTS

Benefit Handbook

I. How the Plan Works

This section describes:

- how to use your Benefit Handbook.
- how your coverage works.

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 and applicable riders and amendments make up the Evidence of Coverage (EOC). The EOC is the legal agreement stating the terms of the Plan. The EOC also incorporates by reference an Employer Agreement. The Employer Agreement includes information on Dependent eligibility. Please contact your Employer for more information on eligibility.

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

- How to obtain benefits with the lowest out-of-pocket cost
- Covered Benefits
- Exclusions
- The requirements for In-Network and Out-of-Network coverage

You can view your EOC documents online by using **your secure online account** 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 describes some important sections of the Handbook.

We put the most important information first. For example, section explains important requirements for coverage.

Benefit details are described in section *III. Covered Benefits* and in your Schedule of Benefits. Please review these together for a complete understanding of your benefits.

Section *VI. Appeals and Complaints* provides detailed information on how to appeal a denial of coverage or file a complaint.

B. HOW TO USE YOUR PROVIDER DIRECTORY

The Provider Directory lists the Plan Providers you must use for In-Network Benefits. You may view the Provider Directory online at **www.harvardpilgrim.org**. You can also get a paper copy, free of charge. Call Member Services at **1-877-907-4742** to get a copy.

The online Provider Directory enables you to search for providers by:

- name,
- gender,
- specialty,
- Hospital affiliations,
- languages spoken, and
- office locations.

You can get information about which Providers are accepting new patients. The online directory complies with state and Federal laws. It is more current than the paper directory.

Please Note: Plan Providers are contracted to be part of our network. Contracts can be terminated either by a provider or by us. A provider may also leave the network to retire, relocate or for other reasons. This means that we cannot guarantee your Provider will be in the network for the duration of your membership. You may be eligible for transition services if your provider leaves the network. See section *I.G. SERVICES PROVIDED BY A DISENROLLED OR NON-PLAN PROVIDER* for details.

C. MEMBER OBLIGATIONS

1. Show Your Identification Card

Please 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. You may be responsible for the cost of the service. You can order a new ID card online. Log in to **your secure online account** or call Member Services.

2. Share Costs
You must 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 has an Out-of-Pocket Maximum. This limits the amount of Member Cost Sharing you will be required to pay. Your specific Member Cost Sharing is listed in your Schedule of Benefits. See section *I.E. MEMBER COST SHARING* for more information.

3. Obtain Prior Approval
You must obtain Prior Approval before receiving certain Covered Benefits. Please see section *I.F. PRIOR APPROVAL* for more information.

4. 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. Also, some Covered Benefits are limited by the Plan. These limits are needed to maintain reasonable premium rates for all Members. See your Schedule of Benefits for the limits that apply to your Plan.

D. HOW TO OBTAIN CARE

IMPORTANT POINTS TO REMEMBER

1) The Plan has two levels of benefit coverage known as In-Network benefits and Out-of-Network benefits.
2) In-Network benefits are used when you receive Covered Benefits from Plan Providers.
3) Plan Providers are under contract with HPHC to provide services to Members.
4) Out-of-Network benefits are used when you receive Covered Benefits received from Non-Plan Providers.
5) Some services require Prior Approval by the Plan.
6) In the event of a Medical Emergency, go to the nearest emergency facility or call 911 or other local emergency number.

1. How Your In-Network Benefits Work
In-Network benefits apply when you receive Covered Benefits from a Plan Provider. Your Member Cost Sharing is generally lower for In-Network benefits.

In-Network coverage applies to Plan Providers in Massachusetts, Maine, New Hampshire, Rhode Island and Vermont. In-Network benefits also apply to large number of Providers in HPHC's affiliated national network around the country. We pay Plan Providers directly. You do not have to file a claim when you use your In-Network benefits.

Plan Providers are under contract to provide Covered Benefits to Members. They are listed in the Plan Provider Directory. Every effort is made to keep the Provider Directory up-to-date. However, changes may occur for a number of reasons. Members can call Member Services at **1-877-907-4742** to confirm a Provider's status. Members should present their ID card to a Provider before receiving services.

Some services require Prior Approval by the Plan. See section *I.F. PRIOR APPROVAL* for more information.

Please Note: In Massachusetts, Maine, New Hampshire and Rhode Island, some specialized services must be received from a "Center of Excellence" to receive In-Network coverage. Please see section *I.D.4. Centers of Excellence* for more information.

2. How Your Out-of-Network Benefits Work
Out-of-Network Benefits are available when you receive Covered Benefits from Non-Plan Providers. The Plan pays only a percentage of the cost of Covered Benefits received from Non-Plan Providers. You must pay the balance. Your Member Cost Sharing is generally higher for Out-of-Network benefits. However, you may go to the licensed health care professional of your choice.

Some services require Prior Approval by the Plan. Please see section *I.F. PRIOR APPROVAL* for more information.

Payments to Plan Providers are based on a contracted rate between us and the Plan Provider. As Non-Plan Providers are not contracted, there is no limit on the amount they can charge. The Plan will pay up to the Allowed Amount for a Covered Benefit. You must pay any charges above the Allowed Amount for the service, unless it is a Surprise Bill. See section *V. Reimbursement and Claims Procedures* for more information.

3. Selecting a Plan Provider
To use In-Network benefits you must receive services from a Plan Provider. You may use the Provider Directory to find Plan Providers. The Provider Directory identifies the Plan's participating specialists, Hospitals and other providers.

If you have difficulty finding a Plan Provider who can provide the services you need, we will help you. For help finding a medical, mental health or substance use disorder treatment Provider, call Member Services at **1-877-907-4742**. If no Plan Provider has the expertise needed to meet your medical needs, we will help you find an appropriate Non-Plan Provider.

4. Centers of Excellence

Plan Providers with special training, experience, facilities or protocols for certain specialized services are designated as "Centers of Excellence."

We choose Centers of Excellence based on the findings of recognized specialty organizations or government agencies such as Medicare. Centers of Excellence are located in Massachusetts, Maine, New Hampshire and Rhode Island. You must get the following care at a designated Center of Excellence:

- Weight loss surgery (bariatric surgery)

A list of Centers of Excellence may be found in the Provider Directory. See your Provider Directory online at **www.harvardpilgrim.org** or call Member Services at **1-877-907-4742.**

Services or procedures may be added to or removed from the list with 30 days' notice to Members. We may:

- add services to the list if significant improvements in the quality of care may be obtained through the use of selected Providers.
- remove services from the list if we determine the care advantages through the use of a specialized panel of Providers no longer exists.

To receive In-Network benefits for the service listed above in Massachusetts, Maine, Rhode Island or New Hampshire, you must obtain care at a Plan Provider that has been designated as a Center of Excellence.

Important Notice: If you choose to receive care in MA, ME, NH or RI, for the above services at a facility other than a contracted Center of Excellence, coverage will be at the Out-of-Network benefit level.

To receive In-Network benefits for the services listed above outside of MA, ME, NH or RI, you must obtain care at a hospital that is listed as a Plan Provider. See your Provider Directory for a list of participating hospitals.

If you choose to receive care for the above service at a facility other than a Plan Provider, coverage will be at the Out-of-Network benefit level.

5. Covered Benefits from Our Affiliated National Network of Providers

HPHC offers a comprehensive network of Plan Providers located in Massachusetts, New Hampshire, Rhode Island, Vermont and Maine. In addition, HPHC's national provider network allows Members to use In-Network benefits outside of those states. As of the date on this Handbook, the national network includes nearly 1.1 million Plan Providers and over 4,500 Hospitals. To locate one of these Providers, go to **www.harvardpilgrim.org** or call Member Services at **1–877–907–4742**.

6. How to get Care After Hours

Either your doctor or a covering provider is available to direct your care 24-hours a day. Talk to your doctor to find out what to do for care needed after normal business hours. Some doctors may have covering Physicians after hours. Others may have extended office/clinic hours. In a Medical Emergency, go to the nearest emergency facility or call 911 or other local emergency number.

7. Medical Emergency Services

In a Medical Emergency, including a mental health condition, go to the nearest emergency facility or call 911 (or other local emergency number). See your Schedule of Benefits for your Member Cost Sharing. If you are admitted to the hospital, you must call the Plan at **1-877-907-4742** within 48 hours or as soon as you can. This phone number is also on your ID card. If an attending emergency Physician contacts us or your PCP, then no further notice is needed. See the *Glossary* for additional information on Medical Emergency Services.

E. MEMBER COST SHARING

In-Network and Out-of-Network Member Cost Sharing may include Copayments, Coinsurance and/or Deductible amounts. There may be two types of office visit cost sharing that apply to your Plan:

- a lower cost sharing known as "Level 1" and
- a higher cost sharing known as "Level 2."

See your Schedule of benefits for the Member Cost Sharing See your Schedule of benefits for the .

When using Plan Providers, you are only responsible for your Member Cost Sharing. Plan Providers are not allowed to balance bill you. When using Non-Plan Providers, you are responsible for your Member Cost Sharing and any amount charged by a Non-Plan Provider in excess of the Allowed Amount, unless it is a Surprise Bill.

1. Copayment

A Copayment is a fixed dollar amount that you must pay for certain Covered Benefits. Copayments are due at the time of service or when billed by the Provider.

Your Plan may have other Copayment amounts. See your Schedule of Benefits for more information on your specific Copayments.

2. Deductible

A Deductible is a specific dollar amount that is paid by the Member for Covered Benefits received each Calendar Year. A Deductible is applied:

- before any benefits subject to the Deductible are paid by the Plan.
- on the date the benefit is received.

Your Plan will have one of the following types of Deductibles:

Individual Deductible. An individual Deductible will apply when you have Individual Coverage. Once you have met the individual Deductible, you will have no additional Deductible costs for the rest of the Calendar Year. **Note:** An individual Deductible may also apply if you have Family Coverage. See Family Deductible with an embedded individual Deductible below.

Family Deductible. A family Deductible applies when you have Family Coverage. This Deductible may be met by all family Members combined. For example, a family of four would meets a $4,000 family Deductible as follows:

- one covered family Member incurs $3,000 in covered medical expenses, and
- another covered family Member incurs $1,000 in covered medical expenses.

In this example, the family Deductible is met for the entire family for the rest of that Calendar Year.

Family Deductible with an embedded individual Deductible. A family Deductible with an embedded individual Deductible applies when you have Family Coverage. This Deductible can be met in one of two ways:

a. A Member of a covered family meets an individual Deductible. In this instance, that Member has no additional Deductible costs for the rest of the Calendar Year.

b. Any number of Members in a covered family collectively meet the family Deductible. In this instance, all Members of a covered family have no additional Deductible costs for the rest of the Calendar Year. No one family member may contribute more than the individual Deductible amount to the family Deductible.

An embedded individual Deductible may not be less than the applicable minimum family Deductible required for a High Deductible Health Plan.

Please see your Schedule of Benefits to determine which Deductibles apply to your Plan.

Once a Deductible is met, coverage by the Plan is subject to any other Member Cost Sharing that may apply.

A Member may change from Family Coverage to Individual Coverage or from Individual Coverage to Family Coverage within a Calendar Year. In either case, costs the Member paid toward the Deductible under the prior coverage will apply toward the Deductible limit under their new coverage. If the previously paid Deductible amount is more than the new Deductible limit, the Member or family will only need to pay the Copayment or Coinsurance amounts listed in on their new Schedule of Benefits.

3. Coinsurance

After your Deductible is met, you may have to pay Coinsurance. Coinsurance is a percentage of the Allowed Amount or the Recognized Amount, if applicable. For Plan Providers, the Allowed Amount is based on the contracted rate between HPHC and the Provider. For Non-Plan Providers, the Allowed Amount is based on the Provider's charge for the service up to the Allowed Amount for the service. In most cases higher Coinsurance amounts will apply to Out-of-Network services. Coinsurance amounts are listed on your Schedule of Benefits.

4. Out-of-Pocket Maximum

Your Plan has an Out-of-Pocket Maximum. This is the total amount of Member Cost Sharing you must pay in a Calendar Year. Member Cost Sharing includes any Copayments, Deductible and Coinsurance payments.

Once the Out-of-Pocket Maximum is reached, there is no additional Member Cost Sharing for the rest of the year. HPHC will pay 100% of the Allowed Amount for the remainder of the Calendar Year.

Certain costs do not apply to the Out-of-Pocket Maximum. Penalty amounts and charges above the Allowed Amount never apply to the Out-of-Pocket Maximum.

Individual Out-of-Pocket Maximum. An individual Out-of-Pocket Maximum applies when you have Individual Coverage. Once you meet the individual

Out-of-Pocket Maximum, you will have no additional Member Cost Sharing for the rest of the year. Note: An individual Out-of-Pocket Maximum may also apply if you have Family Coverage. See Family Out-of-Pocket Maximum with an embedded individual Out-of-Pocket Maximum below.

Family Out-of Pocket Maximum. A family Out-of-Pocket Maximum applies when you have Family Coverage. A family Out-of-Pocket Maximum can be met by all Members of the family combined. For example, a family of four meets a $10,000 family Out-of-Pocket Maximum as follows:

- one covered family Member pays $5,000 in Member Cost Sharing; and
- another family Member pays $3,000 in Member Cost Sharing; and
- another covered family Member pays $2,000 in Member Cost sharing.

In this example, the $10,000 family Out-of-Pocket Maximum is met for the entire family for the rest of the year.

Family Out-of-Pocket Maximum with an embedded individual Out-of-Pocket Maximum. This family Out-of-Pocket Maximum may apply when you have Family Coverage. It can be met in one of two ways:

a. A Member of a covered family meets an individual Out-of-Pocket Maximum. In this case, the Member has no additional Member Cost Sharing for the rest of the year.

b. Any number of Members in a covered family collectively meet the family Out-of-Pocket Maximum. In this case, all Members of the covered family have no additional Member Cost Sharing for the rest of the year. Note: No one family member may contribute more than the individual Out-of-Pocket Maximum amount toward the family Out-of-Pocket Maximum.

Please see your Schedule of Benefits to determine which Out-of-Pocket Maximum applies to your Plan.

A Member may change from Family Coverage to Individual Coverage or from Individual Coverage to Family Coverage within a Calendar Year. In either case, costs the Member paid under the prior coverage will apply toward the Out-of-Pocket Maximum limit under their new coverage. If the Out-of-Pocket Maximum amount paid is greater than the new Out-of-Pocket Maximum limit, the Member will have no additional Member Cost Sharing for that Calendar Year.

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

On occasion, a Non-Plan Provider may charge more than the Allowed Amount covered by the Plan. You must pay the difference between what the Provider charges and the amount the Plan paid, unless it is a Surprise Bill. Amounts charged by a Non-Plan Provider above the Allowed Amount do not count toward the Out-of-Pocket Maximum. Call Member Services at **1-877-907-4742** or at **711** for TTY service. They can answer questions about the maximum Allowed Amount that may be paid by HPHC for a service. See section *V. Reimbursement and Claims Procedures* for more information.

6. Penalty

The amount you must pay for certain Out-of-Network services when Prior Approval was not obtained before receiving 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. See your Schedule of Benefits for your Out–of–Network Penalty Payment amount. See section *I.F. PRIOR APPROVAL* for a detailed explanation of the Prior Approval Program.

7. Combined Payment Levels

Under some circumstances you may receive services from both a Plan Provider and a Non-Plan Provider. Use of 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 can receive treatment in a Plan Provider's office, then choose to receive associated blood work from a non-plan laboratory. In this example, you chose to receive services from a Non-Plan Provider. The Plan Provider would be paid at the In-Network level and the laboratory would be paid at the Out-of-Network level. However, if a Plan Provider directs you to a Non-Plan Provider and you did not choose that Non-Plan Provider, you would be entitled to In-Network coverage for those services from the Non-Plan Provider.

The benefit payment level applied to a Hospital admission depends on the participation of both the admitting doctor and the Hospital. If a Plan Provider admits you to a participating Hospital, both the Hospital and Plan Provider are paid at the In-Network level. If an Out-of-Network doctor admits you to a participating Hospital, the Hospital is paid at the In-Network level but the doctor's charges are paid at the Out-of-Network level. Likewise, if a Plan Provider admits you to a non-plan Hospital, the Hospital's

charges are paid at the Out-of-Network level but the Plan Provider's charges are paid at the In-Network level. All Out-of-Network payments by the Plan are limited to the Allowed Amount.

F. PRIOR APPROVAL

Prior Approval must be obtained before receiving certain medical services, Medical Drugs or mental health and substance use disorder treatment.

If you use a Plan Provider located within the Service Area, he/she will seek Prior Approval for you. If you use a Non-Plan Provider or Plan Provider outside the Service Area, you must seek Prior Approval. This section explains when Prior Approval is required and how to meet those requirements.

For a detailed list of services that require Prior Approval or for updates and revisions to the Prior Approval list, please visit our website at www.harvardpilgrim.org. If you have questions regarding services that require Prior Approval, call Member Services at **1–877–907–4742**.

Please Note: Your doctor or Hospital can seek Prior Approval on your behalf. You do not need to obtain Prior Approval if services are needed in a Medical Emergency.

1. When Prior Approval is Required

Prior Approval must be obtained for the services listed below.

1) **For the following Mental Health and Substance Use Disorder Treatment obtained from a Non-Plan Provider:**
   - **Psychological testing and Neuropsychological testing**
   - **Applied Behavior Analysis (ABA) services for the treatment of Autism**
   - **Repetitive Transcranial Magnetic Stimulation (rTMS)**
2) **For the following Medical Services or Medical Drugs obtained from a Non-Plan Provider or Plan Provider Outside the Service Area:**
   - **Inpatient services**
   - **Outpatient services and treatments** including, but not limited to: fertility; genetic testing; home health care, advanced radiology; and pain management.
   - **Outpatient surgery**
   - **Medical Drugs**
   - **Medical formulas**
   - **Diabetic equipment**
   - **Positive airway pressure devices, including CPAP and BIPAP devices**
   - **Power wheelchairs**
   - **Non-emergency medical transportation**

     Please note, Prior Approval is not required for transportation provided by wheelchair van.
   - **Prosthetic arms and legs**
   - **Dental services**

     Please note, the Plan provides very limited coverage for Dental Care. (Please see "Dental Services" in section III. Covered Benefits and your Schedule of Benefits for details.)

Please Note: Not all plans cover every service listed on the Prior Approval List. See your Schedule of Benefits to determine if your Plan provides coverage for a specific benefit or call Member Services at **1–877–907–4742**.

2. How to Obtain Prior Approval

To seek Prior Approval for services received from a Non-Plan Provider or a Plan Provider outside the Service Area, call:

- **1-800-708-4414** for medical services
- **1–877–907–4742** for Medical Drugs
- **1-800-708-4414** for mental health and substance use disorder treatment

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

- The Member's name
- The Member's ID number
- The treating Physician's name, address and phone 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 or a Plan Provider outside the Service Area, 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 phone 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

3. The Effect of Prior Approval on Coverage

If you obtain Prior Approval when required, the Plan covers up to the full benefit limit stated in this Benefit Handbook and your Schedule of Benefits.

If you do not obtain Prior Approval when required, the Plan covers only the services later determined to be Medically Necessary. You will be responsible for any applicable Member Cost Sharing. For services received from a Non-Plan Provider, you must also pay the Penalty amount stated in the Schedule of Benefits.

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 must pay the entire cost of those services.

Prior Approval does not entitle you to any benefits not otherwise payable under this Benefit Handbook or the Schedule of Benefits.

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

4. What Prior Approval Does

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

- Assuring that the proposed service will be covered by the Plan.
- Assuring 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:
  - the level of care,
  - place of service, and
  - 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 Physician will be notified of the Plan's decision to approve or not to approve the care proposed. If part of the review is related to level of care, place of service or setting, then providing services in a higher level of care will not be considered Medically Necessary when those same services can be safely provided to you in a lower level of care, place of service or setting.

All decisions to deny a medical service will be reviewed by a Physician or a qualified clinician in accordance with written Medical Necessity Guidelines. Medically Necessary Guidelines are based on many sources. These sources include medical policy and clinical guidelines. The relevant Medically Necessary Guidelines are 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,
- our 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 a Plan Provider

If your Provider is disenrolled as a Plan Provider, we do our best to notify you in writing at least 60 days prior to the date of disenrollment. That notice will explain how to select a new Plan Provider. If disenrollment was not related to fraud or quality of care, you may be able to continue to receive In-Network benefits from the disenrolled Plan Provider under the terms of this Handbook and your Schedule of Benefits, for at least 60 days after the disenrollment date.

You may also be eligible to continue to receive coverage for the following services from the disenrollment date or the date of the disenrollment member notice (whichever is later):

i. Active Course of Treatment

When you are undergoing an active course of treatment for an illness, injury or condition, we may approve additional coverage through the active course of treatment or up to 90 days (whichever is shorter). An active course of treatment is when you:

- have a "serious and complex condition."
- are undergoing a course of institutional or inpatient care.
- have scheduled nonelective surgery including any related postoperative care.

The term "serious and complex condition" is an acute illness that requires specialized medical treatment to avoid the reasonable possibility of death or permanent harm; or is a chronic illness that is (a) life-threatening, degenerative, potentially disabling, or congenital; and (b) requires specialized medical care over a prolonged period of time.

ii. Pregnancy

When you are pregnant, you may continue to receive In-Network benefits from your disenrolled provider. Coverage will be through delivery and up to 12 months of postpartum visits immediately following childbirth.

iii. Terminal Illness

When you have a terminal illness, you may continue to receive In-Network benefits from the disenrolled provider until death.

2. New Membership

If you are a new Member, we will provide coverage from a physician who is not a Plan Provider. The terms of this Handbook and your Schedule of Benefits apply. Coverage will be provided for up to 60 days from your effective date of coverage if the physician is providing you with an ongoing course of treatment. We will provide you with written notice explaining the process for obtaining an alternate Plan Provider.

For a Member in her second or third trimester of pregnancy, this provision shall apply to services rendered through the first postpartum visit. For a Member with a Terminal Illness, this provision shall apply to services rendered until death.

3. Conditions for Coverage of Services by a Disenrolled or Non-Plan Provider

Services received from a disenrolled or Non-Plan Provider as described above, are only covered when the physician agrees to:

- accept reimbursement from us at the rates applicable prior to the start of the transitional period as payment in full.
- not to impose Member Cost Sharing in an amount that would exceed the amount that could have been imposed if the he/she had not been disenrolled.
- adhere to our policies and procedures, including Referrals, obtaining Prior Approval and providing Covered Benefits pursuant to a treatment plan, if any, approved by us.

H. MEDICAL NECESSITY GUIDELINES

We use evidence based clinical review criteria to evaluate whether certain services or procedures are Medically Necessary for your care. You or your Provider may obtain a copy of the Medical Necessity Guidelines applicable to a service or procedure for which coverage is requested. Medical Necessity Guidelines may be obtained by calling Member Services at **1-877-907-4742** or going to **www.harvardpilgrim.org**.

I. PROVIDER FEES FOR SPECIAL SERVICES (CONCIERGE SERVICES)

Certain Physician practices charge extra fees for special services or amenities. Examples of such special Physician services might include:

- phone 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.
- providing a physician to accompany a patient to an appointment with a specialist. Such services are not covered by the Plan.

Such services are not covered by the Plan. The Plan does not cover fees for any service not included as a Covered Benefit under your Plan.

In considering arrangements with Physicians for special services, you should understand exactly what services are to be provided. You will need to decide if these services are worth the fee you must pay. For example, the Plan does not require Plan Providers to be available by phone 24-hours a day. However, the Plan does require Plan Primary Care Providers (PCPs) to provide both an answering service that can be contacted 24-hours a day and prompt appointments when Medically Necessary.

J. BUNDLED PAYMENT ARRANGEMENTS

The Plan may participate in bundled payment arrangements with certain Providers. Under these arrangements, a specific service or treatment is paid for based on a fixed sum for all services you receive. Member Cost Sharing for Covered Benefits under a bundled payment arrangement may be less

than if the Covered Benefits were received without the bundled payment arrangement. Please refer to **www.harvardpilgrim.org** or call Member Services at **1-877-907-4742** for a list of Providers with bundled payment arrangements and their corresponding services. We may revise the services or Providers who have bundled payment arrangements upon 30 days notice to Members.

K. CARE MANAGEMENT PROGRAMS

The Plan provides care management programs for Members with certain illnesses and injuries. These programs are designed to encourage the use of the most appropriate and cost-effective treatment and to provide support for the Member's care.

Care management may include programs for medical and behavioral health care including, but not limited to:

- cancer;
- heart, lung and kidney diseases;
- severe traumatic injuries;
- behavioral health disorders;
- substance use disorders;
- high risk pregnancies and newborn care.

The Plan may work with certain providers to establish care management programs. The Plan or providers affiliated with the care management program may contact Members that may be candidates for its programs. The Plan or providers may also contact Members to:

- assist with enrollment.
- develop treatment plans.
- establish goals.
- determine alternatives to a member's current treatment plan.

Member Cost Sharing may apply to Covered Benefits provided through a care management program.

II. Glossary

This section lists words with special meaning within the Handbook.

Glossary Term	Definition
1 . Accident or Accidental Injury	
	Accidental bodily injury sustained by the insured person that is the direct cause of the condition for which benefits are provided and that occurs while the insurance is in force.
2 . 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.
3 . Adverse Benefit Determination	
	Any of the following, including but 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.
4 . 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.
5 . 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 in the states of Massachusetts, New Hampshire, Vermont, Rhode Island or Maine, 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: An amount that is consistent, in the judgment 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 states of Massachusetts, New Hampshire, Vermont, Rhode Island or Maine, 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:

Glossary Term	Definition
Allowed Amount (Continued)	
	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 and substance use disorder treatment will be 80% of the billed charge. Pricing of the Allowed Amount will be conducted by UnitedHealthcare, Inc. UnitedHealthcare, 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.
6 . Anniversary Date	
	The date upon which your yearly premium rate is adjusted and benefit changes become effective. The EOC 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.
7 . Authorized Representative	
	A person to whom you have given express written consent to represent you in an external review; a person authorized by law to provide consent to request an external review on your behalf; a family member or treating health care provider if you are unable to provide consent to request an external review; or a provider from which you are receiving active treatment.
8 . 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.
9 . 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 Calendar Year for physical therapy services, once you reach your 30 visit limit for that Calendar Year, no additional benefits for that service will be covered by the Plan.

Glossary Term	Definition
10 . 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.
11 . Centers of Excellence	
	Plan Providers with special training, experience, facilities or protocols for certain services, selected by us based on the findings of recognized specialty organizations or government agencies such as Medicare. Certain specialized services are only covered as In-Network services in Massachusetts, Maine, Rhode Island or New Hampshire when received from designated Centers of Excellence.
12 . Clinical Peer	
	A Physician or other licensed health care practitioner who holds a non-restricted license in a state in the U.S., is board certified in the same or similar specialty as typically manages the medical condition, procedure, or treatment under review, and whose compensation does not depend, directly or indirectly, upon the quantity, type, or cost of the medical condition, procedure, or treatment that the practitioner approves or denies on behalf of the Plan.
13 . Coinsurance	
	A percentage of the Allowable Amount, or Recognized Amount, if applicable, for certain Covered Benefits that must be paid by the Member. Coinsurance amounts are in addition to any Deductible and any applicable Copayment. 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, unless it is a Surprise Bill.)
14 . Copayment	
	A fixed dollar amount you must pay for certain Covered Benefits. The Copayment is usually due at the time services are rendered or when billed by the provider. Your specific Copayment amounts, and the services to which they apply, are listed in your Schedule of Benefits. Occasionally the Copayment may exceed the contract rate payable by the Plan for a service. If the Copayment is greater than the contract rate, you are responsible for the full Copayment, and the provider keeps the entire Copayment. **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.
15 . Cosmetic Services	
	Cosmetic Services are surgery, procedures or treatments that are performed primarily to reshape or improve the individual's appearance.
16 . Covered Benefit(s)	
	The products and services that a Member is eligible to receive, or obtain payment for, under the Plan.
17 . 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).

Glossary Term	Definition
18 . Deductible	
	A specific dollar amount that is payable by a Member for Covered Benefits received each Calendar Year before any benefits subject to the Deductible are payable by the Plan. There may be an individual Deductible and a family Deductible, and you may have different Deductibles that apply to different Covered Benefits under your Plan. 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.
19 . 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.
20 . 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.
21 . Direct Primary Care Provider	
	An individual who is a licensed physician or osteopathic physician or other advanced health care practitioner who is a non-Plan Provider, who is authorized to engage in independent medical practice in Maine, who is qualified to provide primary care services and who chooses to practice direct primary care by entering into a direct primary care service agreement with patients. The term includes, but is not limited to, an individual primary care provider or a group of primary care providers. **Please Note:** A referral can be made by a Direct Primary Care Provider who is not included in the Plan's provider network, subject to confirmation of the Direct Primary Care Provider's relationship with the Member.
22 . Evidence of Coverage (EOC)	
	The legal documents, including the Benefit Handbook, Schedule of Benefits, Prescription Drug Brochure, and any applicable riders and amendments which describe the services covered by the Plan, and other terms and conditions of coverage.
23 . 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) or if approved

Glossary Term	Definition
Experimental, Unproven, or Investigational (Continued)	
	for lawful marketing by the FDA and reliable scientific evidence does not support that the treatment is effective in improving health outcomes or that appropriate patient selection has not been determined. c. For purposes of the fertility treatment only, the service, procedure, drug or device has not been recognized as a "non-experimental infertility procedure" under the Maine Fertility Care statute or its implementing regulations 24-A MRSA §4320-U.
24 . Family Coverage	
	Coverage for a Member and one or more Dependents.
25 . Health Savings Account or HSA	
	A tax-exempt trust or custodial account, similar to an individual retirement account (IRA), but established to pay qualified medical expenses. In order to establish a Health Savings Account an individual must: (1) be covered under a High Deductible Health Plan during the months in which contributions are made to the account; (2) not be covered by any other health plan that is not a High Deductible Health Plan (with certain limited exceptions established by law); (3) not be entitled to Medicare benefits; and (4) not be claimed as a dependent on another person's tax return. Members should consult a qualified tax advisor before establishing a Health Savings Account.
26 . High Deductible Health Plan	
	A health care plan that meets the requirements of Section 223 of the Internal Revenue Code with respect to Deductibles and Out-of-Pocket Maximums. A person who is enrolled in a High Deductible Health Plan and meets other requirements stated in that law may establish a Health Savings Account (or HSA) for the purpose of paying qualified medical expenses.
27 . Habilitation Services	
	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.
28 . HPHC Insurance Company, Inc. (HPHC)	
	HPHC Insurance Company, Inc. is an insurance company that underwrites the health care benefits described in this Handbook.
29 . Hospital	
	An inpatient facility that is licensed to operate pursuant to law and that is primarily and continuously engaged in providing or operating (either on its premises or in facilities available to the Hospital on a prearranged basis and under the supervision of a staff of licensed Physicians) medical, diagnostic, and major surgical facilities for the medical care and treatment of sick or injured persons on an inpatient basis for which a charge is made.
30 . Individual Coverage	
	Coverage for a Subscriber only. No coverage for Dependents is provided.
31 . In-Network	
	The level of benefits or coverage a Member receives when Covered Benefits are obtained through a Plan Provider.

Glossary Term	Definition
32 . 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.
33 . Medical Emergency	
	The sudden and, at the time, unexpected onset of a physical or behavioral health condition, including severe pain, manifesting itself by symptoms of sufficient severity, regardless of the final diagnosis that is given, that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that the absence of immediate medical attention for the Member could reasonably be expected 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.
34 . Medical Emergency Services	
	Services provided during a Medical Emergency, including: • A medical screening examination (as required under section 1867 of the Social Security Act or as would be required under such section if such section applied to an independent freestanding emergency department) that is within the capability of the emergency department of a Hospital, or an independent freestanding emergency department, as applicable, including ancillary services routinely available to the emergency department to evaluate such Medical Emergency, and • Further medical examination and treatment, within the capabilities of the staff and facilities available at the Hospital or independent freestanding emergency department, as applicable, as are required under section 1867 of the Social Security Act, or as would be required under such section if such section applied to an independent freestanding emergency department, to stabilize the patient (regardless of the department of the Hospital in which such further exam or treatment is provided). • Items and services, otherwise covered under the Plan, that are provided by a Non-Plan Provider or facility (regardless of the department of the Hospital in which the items and services are provided) after the Member is stabilized and as part of an inpatient stay or outpatient services that are connected to the original Medical Emergency, unless each of the following conditions are met: a. The Provider or facility, as described above, determines the Member is able to travel using non-medical transportation or non-emergency medical transportation.

Glossary Term	Definition
Medical Emergency Services (Continued)	
	b. The Provider furnishing the additional items and services satisfies notice and consent criteria in accordance with applicable law. c. The patient is in such a condition to receive information as stated in b) above and to provide informed consent in accordance with applicable law. d. Any other conditions as specified by the Secretary.
35 . 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: • Consistent with generally accepted standards of medical practice; • Clinically appropriate in terms of type, frequency, extent, site and duration; • Demonstrated through scientific evidence to be effective in improving health outcomes; • Representative of best practices in the medical profession; and • Not primarily for the convenience of the enrollee or Physician or the other health care practitioner. **Please Note:** To determine coverage of Medically Necessary services, we use Medical Necessity Guidelines (MNG) created using 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 the Medical Necessity Guideline(s) applicable to a service or procedure for which coverage is requested by going online or calling **1–877–907–4742**.
36 . Medicare	
	The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as then constituted or later amended.
37 . Member	
	Any Subscriber or Dependent covered under the Plan.
38 . 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. There may be two types of office visit cost sharing that apply to your Plan: a lower cost sharing known as "Level 1" and a higher cost sharing known as "Level 2."
39 . Non-Plan Provider	
	A Provider who does not have a special agreement or contract with HPHC or its affiliates. The payment schedule for services received from Non-Plan Providers is based on the Allowed Amount or Out-of-Network Rate, if applicable. When care is received from a Non-Plan Provider, Members are responsible for the applicable Deductible and Coinsurance plus any amounts in excess of the Allowed Amount, unless it is a Surprise Bill. These financial responsibilities are described in your Schedule of Benefits.
40 . Nurse	
	A person duly licensed as a Nurse, including a registered Nurse, licensed practical Nurse, and a licensed Nurse who is certified by the American Nurses' Association as a clinical specialist in adult psychiatric and mental health nursing or as a clinical specialist in child and adolescent psychiatric and mental health nursing that provides services within the scope of an applicable statute or administrative rules of the licensing or registry board of the applicable state.

Glossary Term	Definition
41 . Out-of-Network	
	The level of benefits or coverage a Member receives when Covered Benefits are obtained through a Non-Plan Provider.
42 . Out-of-Network Rate	
	With respect to a Surprise Bill, the total amount paid by the Plan to a Non-Plan Provider for Covered Benefits under section 2799A-1 and 2799A-2 of the Public Service Act and their implementing regulations for: (1) Emergency Medical Services, (2) non-emergency ancillary services, (3) non-emergency, non-ancillary services, and (4) air ambulance services. The amount is based on: (1) Applicable state law, (2) an All Payer Model Agreement if adopted, (3) the initial payment made by us or the amount subsequently agreed to by the Non-Plan Provider and us, or (4) the amount determined by Independent Dispute Resolution between us and the Non-Plan Provider.
43 . Out-of-Pocket Maximum	
	An Out-of-Pocket Maximum is a limit on the amount of Deductibles, Copayments, and Coinsurance that a Member must pay for certain Covered Benefits in a Calendar Year. The Out-of-Pocket Maximum is stated 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 out-of-pocket costs for that 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.
44 . Penalty	
	The amount that a Member is responsible to pay for certain Out-of-Network services when 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. 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.
45 . 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.
46 . Physician	
	A person duly licensed as a Doctor of Medicine or Doctor of Osteopathy that provides services within the scope of an applicable license and training and in accordance with applicable laws.
47 . Plan	
	This package of health care benefits offered by HPHC Insurance Company, Inc.
48 . 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.

Glossary Term	Definition
49 . Premium	
	A payment made to us for health coverage under the Plan.
50 . Prior Approval or Prior Approval Program (also known as Prior Authorization)	
	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. Please see section *I.F. PRIOR APPROVAL* for a detailed explanation of the Prior Approval Program.
51 . Provider	
	Providers include, but are not limited to Hospitals; Skilled Nursing Facilities; and medical professionals including: Physicians, psychiatrists, Nurse practitioners, advanced practice registered Nurses, Physician assistants, certified midwives, certified Nurse midwives, certified registered Nurse anesthetists, registered first Nurse assistants, dentists, independent practice dental hygienists, dental hygiene therapists, naturopaths, 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, optometrists, and pastoral psychotherapists/counselors. Services must be within the lawful scope of the licensing required for such Provider in Maine. Plan Providers are listed in the Provider Directory.
52 . 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**
53 . Recognized Amount	
	With respect to a Surprise Bill, the amount on which a Copayment, Coinsurance or Deductible is based for Medical Emergency Services and certain non-emergency Covered Benefits when provided by Non-Plan Providers. The amount under sections 2799A-1 and 2799A-2 of the Public Service Act and their implementing regulations is based on: (1) Applicable state law, (2) an All Payer Model Agreement if adopted, or (3) the lesser of the amount billed by the Provider or the qualifying payment amount as determined under applicable law. **Please Note:** Member Cost Sharing based on the Recognized Amount may be higher or lower than Member Cost Sharing based on the Allowed Amount.
54 . Rehabilitation Services	
	Rehabilitation Services 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, Rehabilitation Services 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.
55 . Schedule of Benefits	
	A summary of the benefits 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.

Glossary Term	Definition
56 . Service Area	
	The Service Area includes the states of Massachusetts, Maine, New Hampshire, Rhode Island and Vermont.
57 . Sickness	
	An illness or disease of an insured person.
58 . Skilled Nursing Facility	
	An inpatient extended care facility, or part of one, that is operating pursuant to law and provides skilled nursing services.
59 . Subscriber	
	The person who meets the Subscriber eligibility requirements described in this Benefit Handbook and is enrolled in the Plan.
60 . 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.
61 . Surprise Bill	
	An unexpected bill you may receive if: (1) you obtain services from a Non-Plan Provider in an emergency, (2) you obtain services from a Non-Plan Provider while you were receiving a service from a Plan Provider or facility, and you did not knowingly select the Non-Plan Provider, or (3) you obtain services from a Non-Plan Provider during a service previously approved or authorized by HPHC where you did not knowingly select a Non-Plan Provider.
62 . 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.
63 . 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. Your outpatient pharmacy coverage is described in your Prescription Drug Brochure.

Some benefits have limits on the amount of coverage provided in a 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 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 Calendar Year basis.

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.
- In-Network services must be provided by a Plan Provider. The only exception is care needed in a Medical Emergency.
- Some services require Prior Approval by the Plan. Please see section *I.F. PRIOR APPROVAL* for information on the Prior Approval Program.
- In Massachusetts, Maine, Rhode Island and New Hampshire, there are certain specialized services that must be received from designated Plan Providers, referred to as "Centers of Excellence," to receive In-Network coverage. Please see section *I.D.4. Centers of Excellence* for a list of these services.

Covered Benefits	Benefit
64 . Acupuncture Treatment	
	The Plan covers acupuncture treatment, including electro-acupuncture, that is provided for the treatment of neuromusculoskeletal pain.
65 . Ambulance and Medical 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 Medical Transport** You're also covered for non-emergency medical transport, including but not limited to ambulance and wheelchair vans, between Hospitals or other covered health care facilities or from a covered facility to your home when Medically Necessary. Services must be arranged by a Provider. **Prior Approval Required:** You must obtain Prior Approval for non-emergency medical transportation. Please note Prior Approval is not required for transportation provided by a wheelchair van. If you use a Plan Provider located within the Service Area, 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. PRIOR APPROVAL* for more information.

Covered Benefits	Benefit
66 . 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 assessments, evaluations or tests by a licensed Physician or psychologist to diagnose whether a Member has an autism spectrum disorder. • Rehabilitation and Habilitation 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. For purposes of this section the following terms have 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.
67 . Bariatric Surgery	
	The Plan covers the surgical treatment of obesity and morbid obesity (bariatric surgery). Services are covered in accordance with the patient qualification and treatment standards set forth by the American Society for Metabolic and Bariatric Surgery or the American College of Surgeons. Coverage may be limited or excluded under your Plan unless services are performed at a designated Center of Excellence. Please see section *I.D.4. Centers of Excellence* for important information concerning your coverage for this service. **Important Notice:** We use clinical guidelines to evaluate whether bariatric surgery is Medically Necessary. If you are planning to receive bariatric surgery services, we recommend that you review the current Medical Necessity Guidelines. To obtain a copy, please call **1–877–907–4742.**

Covered Benefits	Benefit
68 . 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. • Physical complications for all stages of mastectomy, including lymphademas are covered in a manner determined in consultation with the attending Physician and the Member.
69 . 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. **Prior Approval Required:** You must obtain Prior Approval for radiation oncology. If you use a Plan Provider located within the Service Area, 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. PRIOR APPROVAL* for more information.
70 . 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. Therapeutic adjustive and manipulative services are covered when performed by an allopathic, osteopathic or chiropractic doctor. The following services are covered: • Diagnostic x-ray • Care within the scope of standard chiropractic practice
71 . 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.

Covered Benefits	Benefit
72 . COVID-19 Services	
	The Plan covers the following services for COVID-19 in accordance with federal and state law: • COVID-19 screening and testing for COVID-19, except when such screening and testing is part of a surveillance testing program. This coverage is provided at no cost to the Member after the Deductible has been met. • COVID-19 immunization is covered for any COVID-19 vaccine licensed or authorized under an emergency use authorization by the United States Food and Drug Administration that is recommended by the United States Centers for Disease Control and Prevention Advisory Committee on Immunization Practices, or successor organization, for administration to a Member. This coverage is provided at no cost to the Member.
73 . Dental Services	
	Important Notice: The Plan does not provide dental insurance. It covers only the limited Dental Care described below. **Emergency Dental Care:** The Plan covers emergency Dental Care needed due to an injury to sound, natural teeth, or to dental prostheses. All services, except for suture removal, must be received within six months of injury, or within six months of the effective date of coverage, whichever is later. Only the following services are covered: • Extraction of the teeth or dental prostheses damaged in the injury when needed to avoid infection • Reimplantation and stabilization of dislodged teeth or dental prostheses • Repositioning and stabilization of partly dislodged teeth or dental prostheses • Suturing and suture removal • Medication received from the provider **Extraction of Teeth Impacted in Bone:** The Plan covers extraction of teeth impacted in bone. Only the following services are covered: • Extraction of teeth impacted in bone Pre-operative and post-operative care, immediately following the procedure • Anesthesia • Bitewing x-rays **Dental Services for Cancer Patients** The plan covers Medically Necessary dental procedures in accordance with state law for Members who have been diagnosed with cancer. Covered services include the following: • Fluoride treatment

Covered Benefits	Benefit
Dental Services (Continued)	
	• Laboratory assessments, medications and treatments • Medically Necessary dental procedures to reduce the risk of infection, eliminate infection, or to treat tooth loss or decay prior to beginning cancer treatment • Medically Necessary dental procedures to reduce the risk of infection, eliminate infection, or to treat tooth loss or decay that are a direct or indirect result of cancer treatment **Prior Approval Required:** You must obtain Prior Approval for the extraction of teeth impacted in bone. If you use a Plan Provider located within the Service Area, 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. PRIOR APPROVAL* for more information. **Please Note:** Your plan may provide coverage for pediatric dental services. Please see your Schedule of Benefits and any associated Riders to determine if you have this coverage. **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. **Other Dental Services:** The Plan also provides benefits for: • Setting a jaw fracture • Removing a tumor (but not a root cyst) **Prior Approval 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 located within the Service Area, 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. PRIOR APPROVAL* for more information.

Covered Benefits	Benefit
74 . 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. Benefits also include medical eye exams (dilated retinal exams) and preventive foot care. Diabetes equipment and supplies are also covered. Some equipment and supplies listed below may be furnished by a Durable Medical Equipment (DME) provider or a pharmacy. Your Member Cost Sharing is based on who furnishes the equipment and/or supplies. The following items are covered: **Diabetes Equipment (covered under your DME benefit):** • Blood glucose monitors • Continuous glucose monitors • Dosage gauges • Injectors • Insulin pumps (including supplies) and infusion devices • Lancet devices • Therapeutic molded shoes and inserts • Visual magnifying aids • Voice synthesizers Please see the "Durable Medical Equipment (DME)" benefit for more information. **Pharmacy Supplies (covered at a pharmacy):** • Blood glucose strips • Certain blood glucose monitors • Certain insulin pumps (including supplies) and infusion devices • Flash glucose monitors (including supplies) • 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. Member Cost Sharing for up to a 30 day supply of insulin will not exceed $35 in accordance with state law. You can find participating pharmacies by logging into **your secure online account** at **www.harvardpilgrim.org** or by calling Member Services at **1–877–907–4742**. Please see the "Drug Coverage" benefit for more information.

Covered Benefits	Benefit
Diabetes Services and Supplies (Continued)	
	Prior Approval Required: You must obtain Prior Approval for certain diabetic equipment and supplies. If you use a Plan Provider located within the Service Area, 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. PRIOR APPROVAL* for more information.
75 . Dialysis	
	The Plan covers dialysis on an inpatient, outpatient or at home basis and dialysis training. 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. **Prior Approval Required:** You must obtain Prior Approval for any planned inpatient admission or for any service provided in the home. If you use a Plan Provider located in the Service Area, he/she will notify seek Prior Approval for you. The Prior Approval process is initiated by calling: **1-800-708-4414**. Please see section *I.F. PRIOR APPROVAL* for more information.
76 . Drug Coverage	
	1. Drug Coverage under this Benefit Handbook a Medical Drugs Received During Outpatient Home Care. 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 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. See your Schedule of Benefits for your Medical Drug Member Cost Sharing. b Drugs and supplies required by law. Some drugs or supplies required by law may only be available through a pharmacy. Coverage is provided for: • certain diabetes supplies (See the "Diabetes Services and Supplies" benefit for details.); and • certain prescribed self-administered anti-cancer medications used to kill or slow the growth of cancerous cells are covered with no Member Cost Sharing after the Deductible has been met. 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

Covered Benefits	Benefit
Drug Coverage (Continued)	
	limited to, drugs for cosmetic purposes; and (3) any drug that is obtained at an outpatient pharmacy except as explained above. **Prior Approval Required:** You must obtain Prior Approval for select Medical Drugs. If you use a Plan Provider located within the Service Area, he/she will seek Prior Approval for you. The Prior Approval process is initiated by calling: 1-877-907-4742. Please see section *I.F. PRIOR APPROVAL* for more information. **2. Outpatient Prescription Drug Coverage** In addition to the coverage provided under this Benefit Handbook, you also have HPHC's outpatient prescription drug rider. That rider covers most prescription drugs purchased at an outpatient pharmacy. See the Prescription Drug Brochure for more information. See your ID card for your Member Cost Sharing.
77 . 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 diabetes supplies and equipment (See the "Diabetes Services and Supplies" benefit for details.) • Certain types of braces • Crutches • Hospital beds • Oxygen and oxygen equipment • Respiratory equipment • Walkers • Wheelchairs • Medically Necessary orthotic devices for the treatment of: (a) diabetes mellitus; (b) impaired circulation/sensation of the foot; (c) chronic neuromuscular disease; or (d) rheumatoid arthritis and variants

Covered Benefits	Benefit
Durable Medical Equipment (DME) (Continued)	
	Member Cost Sharing amounts you are required to pay are based on the cost of equipment to the Plan. **Prior Approval Required:** You must obtain Prior Approval for positive airway pressure devices, including CPAP and BIPAP devices and power wheelchairs. If you use a Plan Provider located within the Service Area, 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. PRIOR APPROVAL* for more information.
78 . Early Intervention Services	
	The Plan covers early intervention services for children with an identified developmental disability or delay. Coverage is provided for children from birth up to 3 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
79 . 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 need follow-up care after you are treated in an emergency room, you must get your care from a Plan Provider for coverage to be at the In-Network benefit payment level. • If you are hospitalized, you must call the Plan at **1–877–907–4742** within 48 hours or as soon as you can. This phone number can also be found on your ID card. If notice of hospitalization is given to the Plan by an attending emergency Physician no further notice is required.
80 . 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.

Covered Benefits	Benefit
81 . Fertility Treatment	
	This fertility treatment benefit applies to members who meet the definition of a fertility patient under Maine Fertility Care statute or its implementing regulations 24-A MRSA §4320-U. A fertility patient is defined as an individual or couple with infertility, an individual or couple who is at increased risk of transmitting a serious inheritable genetic or chromosomal abnormality to a child or an individual unable to conceive as an individual or with a partner because the individual or couple does not have the necessary gametes for conception. The Plan covers the following diagnostic services for fertility: • Consultation • Evaluation • Laboratory tests • Preimplantation genetic testing (PGT) When a Member meets Medical Necessity Guidelines, the Plan will cover the following fertility treatment. Only the following services are included: • Therapeutic donor insemination, including related sperm procurement and storage. • Donor egg procedures, and related egg and inseminated egg procurement, processing and storage • Donor oocyte (DO/IVF) • Donor embryo/frozen embryo transfer (DO/FET) • Frozen embryo transfer (FET) • Assisted hatching • Gamete intrafallopian transfer (GIFT) • Intra-cytoplasmic sperm injection (ICSI) • Intra-uterine insemination (IUI) up to three cycles per lifetime • In-vitro fertilization (IVF) including in vitro fertilization where the embryo is transferred to a gestational carrier or surrogate who is a Member of the Plan • Zygote intrafallopian transfer (ZIFT) • Miscrosurgical epididiymal sperm aspiration (MESA) • Testicular sperm extraction (TESE) • Sperm collection, freezing and storage is also covered for male Members in active fertility treatment. • Cryopreservation of eggs, sperm, and embryos when the Member is in active fertility treatment. **Please Note:** Storage of gametes, embryos and reproductive material is covered from the time of cryopreservation for a period of 5 years. Benefits for any combination of in vitro fertilization (IVF), gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), or fresh or frozen embryo transfer (FET) are limited to two cycles per lifetime. **Important Notice:** We use evidence based clinical criteria to evaluate whether the use of fertility treatment is Medically Necessary. Fertility treatments evolve and new treatments may be developed. If you are planning to receive fertility treatment we recommend that you review the

Covered Benefits	Benefit
Fertility Treatment (Continued)	
	current Medical Necessity Guidelines online at **www.harvardpilgrim.org**. To obtain a copy, call Member Services at **1-877-907-4742.** **Prior Approval Required:** You must obtain Prior Approval for all fertility treatment services. If you use a Plan Provider located within the Service Area, 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. PRIOR APPROVAL* for more information.
82 . Gender Affirming Services	
	The Plan covers gender affirming services to the extent Medically Necessary and in accordance with Medical Necessity Guidelines. Coverage includes surgery, related physician and behavioral health visits, and outpatient prescription drugs. If you are planning to receive gender affirming services, you should review the current Medical Necessity Guidelines that identify covered services under this benefit. To receive a copy of HPHC guidelines please call **1–877–907–4742** or go to our website at **www.harvardpilgrim.org**. Benefits for gender affirming services are in addition to other benefits provided under the Plan. HPHC does not consider gender affirming services 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 Benefit Handbook. **Prior Approval Required:** You must obtain Prior Approval for coverage under this benefit. If you use a Plan Provider located within the Service Area, 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. PRIOR APPROVAL* for more information.
83 . Hearing Aids	
	The Plan covers the purchase of hearing aids for each hearing impaired ear 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. **Prior Approval Required:** You must obtain Prior Approval for cochlear implants. If you use a Plan Provider located within the Service Area, 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. PRIOR APPROVAL* for more information.

Covered Benefits	Benefit
84 . Home Health Care	
	If you are homebound for medical reasons, you are covered for home health care services listed below. 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. 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) • Laboratory services • Medical and surgical supplies • Medical social services • Nutritional counseling • Palliative care • Physical therapy • Professional office visits • Occupational therapy • Services of a home health aide • Skilled nursing care • Speech therapy • Home infusion therapy • Enteral and parenteral therapy • X-rays **Prior Approval Required:** You must obtain Prior Approval for coverage under this benefit. If you use a Plan Provider located within the Service Area, 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. PRIOR APPROVAL* for more information.
85 . 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

Covered Benefits	Benefit
Hospice Services (Continued)	
	• Physical therapy • Speech therapy • Respiratory therapy • Respite care • Social services • Volunteer services • Bereavement services **Prior Approval Required:** You must obtain Prior Approval for hospice care. If you use a Plan Provider located within the Service Area, 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. PRIOR APPROVAL* for more information.
86 . 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 • Palliative care • Medications • Laboratory, radiology, and other diagnostic servicess • Intensive care • Blood transfusions • Infusion therapy • Inhalation therapy • 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. • Weight loss surgery (bariatric surgery) **Please Note:** In Massachusetts, Maine, Rhode Island and New Hampshire, there are certain specialized services that must be received from designated Plan Providers, referred to as "Centers of Excellence" to receive In-Network coverage. Please see section *I.D.4. Centers of Excellence* for further information. **Prior Approval Required:** You must obtain Prior Approval for any planned inpatient admission. If you use a Plan Provider located within the Service Area, 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. PRIOR APPROVAL* for more information.

Covered Benefits	Benefit
87 . House Calls	
	The Plan covers house calls.
88 . Human Organ and Tissue 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. **Prior Approval Required:** You must obtain Prior Approval for any planned inpatient admission. If you use a Plan Provider located within the Service Area, 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. PRIOR APPROVAL* for more information.
89 . Laboratory, Radiology and Other Diagnostic Services (including Independent Laboratories and Freestanding Imaging Centers)	
	The Plan covers laboratory and radiology services (including Advanced Radiology), and other diagnostic services on an outpatient basis. The term "Advanced 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: • Human leukocyte antigen testing necessary to establish bone marrow transplant donor suitability. The Plan provides coverage up to $150 toward the cost of human leukocyte antigen testing necessary to establish bone marrow transplant donor suitability. Services are subject to the In-Network Deductible. 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 participation 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. • Diagnostic screening and tests, including allergy testing and blood tests and screenings mandated by state law. • Screening mammograms at least once a year for women 40 years of age and over, and non-routine mammograms. A screening mammogram also includes an additional radiological procedure recommended by a Provider when the initial radiologic procedure results are not definitive. Non-routine mammograms are covered when Medically Necessary. • Comprehensive ultrasound screening of the entire breast.

Covered Benefits	Benefit
Laboratory, Radiology and Other Diagnostic Services (including Independent Laboratories and Freestanding Imaging Centers) (Continued)	
	• Magnetic resonance imaging of an entire breast or breasts in accordance with guidelines established by the American Cancer Society. **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 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 located within the Service Area, 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. PRIOR APPROVAL* for more information.
90 . 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.
91 . 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. • 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 twelve months after delivery. **Prior Approval Required:** You must obtain Prior Approval for any planned inpatient admission or when a newborn is admitted to a neonatal intensive care unit. If you use a Plan Provider located within the Service Area, 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. PRIOR APPROVAL* for more information. **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.

Covered Benefits	Benefit
92 . Medical Formulas and Donor Breast Milk	
	The Plan covers medical formulas and donor breast milk 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 We may require that a licensed Physician confirm and document at least annually that the formula remains Medically Necessary. 3) Donor breast milk **Please Note:** Prior approval is not required for donor breast milk **Prior Approval Required:** You must obtain Prior Approval for outpatient formulas and enteral nutrition. If you use a Plan Provider within the Service Area, 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. PRIOR APPROVAL* for more information.

Covered Benefits	Benefit
93 . Mental Health and Substance Use Disorder Treatment	
	The Plan covers Medically Necessary inpatient and outpatient mental health and substance use disorder (including alcoholism) treatment. Prior Approval is required for certain mental health and substance use disorder treatment. If you receive these services from a Non-Plan Provider, you should obtain Prior Approval by calling **1-800-708-4414**. The mental health and substance use disorder treatment for which Prior Approval is required are as follows: • **Psychological testing and Neuropsychological testing** • **Applied Behavior Analysis (ABA) services for the treatment of Autism** • **Repetitive Transcranial Magnetic Stimulation (rTMS)** 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 use-related disorders. Coverage for mental health services includes: • Inpatient care • Outpatient care (including online counseling through secure digital messaging) • Outpatient home care • Psychological and neuropsychological testing Coverage for substance use disorder treatment includes: • Inpatient substance use disorder treatment, including partial hospitalization • Outpatient substance use disorder treatment, including evaluation, diagnosis, treatment and crisis intervention (including online counseling through secure digital messaging) • 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. Services for all other conditions not identified above will be covered to the extent Medically Necessary.

Covered Benefits	Benefit
Mental Health and Substance Use Disorder Treatment (Continued)	
	Please refer to your Schedule of Benefits for the Member Cost Sharing that apply to the coverage of these services. 1. **Inpatient Services** • Mental Health Services • Substance use disorder treatment • Detoxification services 2. **Intermediate Care** • Acute residential treatment (including detoxification) • Partial hospitalization programs (PHP) • Intensive outpatient programs (IOP) 3. **Outpatient Services** • Care by a licensed mental health professional (including online counseling through secure digital messaging • Crisis intervention services (Crisis care stabilization) • In-home family stabilization • Substance use disorder treatment • Detoxification services • Medication management • Methadone maintenance • Psychological and neuropsychological testing
94 . Observation Services	
	The Plan covers observation services including short term treatment, assessment and reassessment for up to 48 hours in an acute care facility (i.e. Hospital). Observation services determine if a Member needs to be admitted for additional treatment or if the Member is able to be discharged from the Hospital.
95 . 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
96 . Palliative Care	
	The Plan covers palliative care in conjunction with inpatient, home health care, hospice and physician services. Member Cost Sharing for palliative care is included in the cost sharing associated with these services. Palliative care is a medical specialty that supports improved quality of life for Members with chronic or serious illness. Care is focused on providing relief from symptoms and the stress of illness. Palliative care can be provided at any stage of illness, along with treatment for your condition while remaining under the care of your regular provider. This care is offered alongside curative or other treatments you may be receiving. Palliative care may include physician services, nursing care, home health care, pain and symptom management, medication management, rehabilitation therapies (occupational, physical, speech and pulmonary), behavioral health services and durable medical equipment.

Covered Benefits	Benefit
97 . 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 and 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 • Non-routine foot care • Well baby and well child care • Health education, including nutritional counseling, and smoking cessation counseling • Palliative care • Sickness and injury care • Vision and Hearing screenings • Medication management • Chemotherapy • Radiation therapy • Inhalation therapy • Infusion therapy • Allergy injections **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 if preventive health services, Member Cost Sharing will be applied. Please see your Schedule of Benefits for the coverage that applies to your Plan.
98 . Preventive and Well-Care Services	
	The Plan covers preventive and well-care services in accordance with Federal law. In addition, certain other preventive services and tests are covered, including prostate-specific antigen (PSA) screenings. Please see your Schedule of Benefits for additional information.

Covered Benefits	Benefit
99 . 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: • 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.) **Please Note:** One additional prosthetic device determined to be the most appropriate model to meet the Member's needs for sports or recreational purposes is covered for Members under the age of 18. • Prosthetic eyes Member Cost Sharing amounts you are required to pay are based on the cost of equipment to the Plan. **Prior Approval Required:** You must obtain Prior Approval for upper and lower prosthetic arms and legs. If you use a Plan Provider located within the Service Area, he or she will seek Prior Approval for you. The Prior Approval process is initiated by calling: **1-800-708-4414**. Please see section *I.F. PRIOR APPROVAL* for more information.
100 . 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;

Covered Benefits	Benefit
Reconstructive Surgery (Continued)	
	• 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, (3) post-mastectomy care as described above, and (4) gender affirming procedures and related services. **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 Medical Necessity Guidelines. To obtain a copy, please call **1–877–907–4742** **Prior Approval Required:** You must obtain Prior Approval for coverage under this benefit. If you use a Plan Provider located within the Service Area, 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. PRIOR APPROVAL* for more information.
101 . 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 Rehabilitation Services that must be provided in an inpatient setting. Rehabilitation Services include cardiac rehabilitation therapy, physical therapy, pulmonary rehabilitation therapy, occupational therapy and speech therapy. The Benefit Limit is listed in the Schedule of Benefits. **Prior Approval Required:** You must obtain Prior Approval for rehabilitation hospital care. If you use a Plan Provider located within the Service Area, 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. PRIOR APPROVAL* for more information.
102 . Rehabilitation and Habilitation Services – Outpatient	
	The Plan covers the following outpatient Rehabilitation and Habilitation Services (including treatment for head injuries): • Cardiac rehabilitation therapy • Occupational therapy • Physical therapy • Pulmonary rehabilitation therapy • Speech therapy • Massage therapy when performed by a licensed physical therapist, physical therapy assistant, occupational therapist, or certified occupational therapy assistant Outpatient Rehabilitation and Habilitation Services are covered up to the Benefit Limit listed in the Schedule of Benefits. Services are covered only:

Covered Benefits	Benefit
Rehabilitation and Habilitation Services – Outpatient (Continued)	
	• 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 and Habilitation Services 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 section *III. Covered Benefits, Home Health Care*. **Prior Approval Required:** You must obtain Prior Approval for coverage of outpatient pulmonary rehabilitation therapy. If you use a Plan Provider located within the Service Area, 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. PRIOR APPROVAL* for more information. **Please Note:** Outpatient physical and occupational therapies for children up to the age of 3 are covered to the extent Medically Necessary. The benefit limit stated in the Schedule of Benefits does not apply.
103 . 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 individuals at average risk for colorectal cancer according to the most recently published colorectal cancer screening guidelines of a national cancer society or individuals at high risk for colorectal cancer. **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.
104 . 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. **Prior Approval Required:** You must obtain Prior Approval for Skilled Nursing Facility care. If you use a Plan Provider located within the Service Area, 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. PRIOR APPROVAL* for more information.

Covered Benefits	Benefit
105 . 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. **Please Note:** In Massachusetts, Maine, Rhode Island and New Hampshire, there are certain specialized services that must be received from designated Plan Providers, referred to as "Centers of Excellence" to receive In-Network coverage. Please see section *I.D.4. Centers of Excellence* for further information. **Prior Approval Required:** You must obtain Prior Approval for coverage under this benefit. If you use a Plan Provider located within the Service Area, 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. PRIOR APPROVAL* for more information.
106 . Telemedicine Virtual Visit Services	
	The Plan covers Medically Necessary telemedicine virtual visit services for the purpose of diagnosis, consultation or treatment that would have been a covered service if performed at an in-person visit. Telemedicine virtual visit services include the use of real-time interactive audio, video or other electronic media telecommunications, telemonitoring, and telemedicine services involving stored images forwarded for future consultations, i.e. "store and forward" telecommunication as a substitute for in-person consultation with Providers. Telephonic services involving audio-only telephone, are only covered where telemedicine is technologically unavailable at a scheduled time and is medically appropriate for the corresponding covered health services. Member Cost Sharing for telemedicine virtual visit services is the same as the Member 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 Member Cost Sharing you may be required to pay.
107 . Vision Services	
	Urgent Eye Care: The Plan covers urgent eye care services. 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 covers routine eye examinations. Please see your Schedule of Benefits for additional information. **Pediatric Vision Care:** The Plan also provides coverage for pediatric vision care. Please see your Schedule of Benefits for additional information. **Vision Hardware for Special Conditions:** The Plan provides coverage for contact lenses or eyeglasses needed for the following conditions:

Covered Benefits	Benefit
Vision Services (Continued)	
	• Keratoconus. One pair of contact lenses is covered per Calendar Year. The replacement of lenses, due to a change in the Member's condition, is limited to 3 per affected eye per 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 Calendar Year. Coverage up to $50 per 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 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 Calendar Year after the date of surgery. For Members who have not previously worn eyeglasses or contact lenses, the Plan covers either (1) a pair of eyeglass lenses and up to $50 toward the purchase of the frames, or (2) a pair of contact lenses. **Early Refills for Prescription Eye Drops:** The plan covers one early refill of prescription eye drops if the following criteria are met and to the extent required by Maine law: • At least 70% of the authorized days of use must have elapsed; • The original prescription must indicate that a specific number of refills are authorized; and • The refill request must not exceed the number of refills on the original prescription. **Please Note:** Your Member Cost Sharing for prescription drugs purchased at a pharmacy will be listed on your ID Card or Summary of benefits and Coverage (SBC). Additional details on prescription drug coverage and limitations can be found in the Prescription Drug Brochure or on our website at **www.harvardpilgrim.org**.
108 . Voluntary Sterilization	
	The Plan covers voluntary sterilization, including tubal ligation and vasectomy.
109 . Voluntary Termination of Pregnancy	
	The Plan covers voluntary termination of pregnancy.

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 services that are outside the scope of standard acupuncture care. 2. Alternative or holistic services and all procedures, laboratories and nutritional supplements associated with such treatments. 3. Aromatherapy, treatment with crystals and alternative medicine. 4. Any of the following types of programs: Health resorts, spas, recreational programs, camps, wilderness programs (therapeutic outdoor programs), outdoor skills programs, life skills programs, therapeutic or educational boarding schools, and relaxation or lifestyle programs. 5. Massage therapy when performed by anyone other than a licensed physical therapist, physical therapy assistant, occupational therapist, or certified occupational therapy assistant. 6. Myotherapy. 7. Services by a naturopath that are not covered by other Providers under the Plan.
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, your Schedule of Benefits, and any associated Riders. 2. Office visits, consultations, and all related services for Temporomandibular Joint Dysfunction (TMD). 3. 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.
4 . Durable Medical Equipment and Prosthetic Devices	
	1. Any devices or special equipment needed for sports or occupational purposes.with the exception of prosthetics arms and legs for Members under the age of 18. 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.

Exclusion	Description
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 systemic circulatory diseases or 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 or systemic circulatory diseases.
7 . Maternity Services	
	1. Planned home births. 2. Services provided by a doula.
8 . Mental Health Care	
	1. 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 or (2) to resolve problems of school performance. 2. Sensory integrative praxis tests. 3. Mental health care that is (1) provided to Members who are confined or committed to a jail, house of correction, prison, or custodial facility of the Department of Youth Services; or (2) provided by the Department of Mental Health. 4. Services or supplies for the diagnosis or treatment of mental health and substance use disorders that, in the reasonable judgment of the Plan, are any of the following: • 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, (3) post-mastectomy care, and (4) gender affirming procedures and related services. 2. Electrolysis or laser hair removal, except for what is Medically Necessary as part of gender affirming services. 3. Hair removal or restoration, including, but not limited to, transplantation or drug therapy. 4. Liposuction, except for what is Medically Necessary as part of gender affirming services, or removal of fat deposits considered undesirable.

Exclusion	Description
Physical Appearance (Continued)	
	5. Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures). 6. Skin abrasion procedures performed as a treatment for acne. 7. Treatments and procedures related to appearance including but not limited to, abdominoplasty; chemical peels; collagen injections; dermabrasion; implantations (e.g. cheek, calf, pectoral, gluteal); lip reduction/enhancement; panniculectomy; removal of redundant skin; and silicone injections (e.g. for breast enlargement), except for what is Medically Necessary as part of gender affirming services or another Covered Benefit. 8. Treatment for skin wrinkles and skin tags or any treatment to improve the appearance of the skin. 9. Treatment for spider veins. 10. Wigs.
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 other than the initial x-ray. 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. If a service received in Massachusetts, Maine, Rhode Island or New Hampshire is listed as requiring that it be provided at a Center of Excellence, no In-Network coverage will be provided under this Handbook if that service is received in Massachusetts, Maine, Rhode Island or New Hampshire from a Provider that has not been designated as a Center of Excellence. Please see the Benefit Handbook section *"Centers of Excellence"* for more information. 5. Physical examinations and testing for insurance, licensing or employment. 6. Services for Members who are donors for non-members, except as described under Human Organ Transplant Services. 7. Testing for central auditory processing. 8. 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. Inpatient charges after your Hospital discharge. 6. Provider's charge to file a claim or to transcribe or copy your medical records. 7. 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. Services for a surrogate or gestational carrier who is not a Member of the Plan. 2. Reversal of voluntary sterilization (including any services for infertility related to voluntary sterilization or its reversal). 3. Sperm identification when not Medically Necessary (e.g., gender identification). 4. The following fees: wait list fees, non-medical costs, shipping and handling charges etc.
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. Telemedicine services involving e-mail, or fax. 2. Telemedicine services involving audio-only telephone, except where telemedicine is technologically unavailable at a scheduled time and is medically appropriate for the corresponding covered health services. 3. Provider fees for technical costs for the provision of telemedicine services.

Exclusion	Description
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. Over the counter hearing aids. 3. Refractive eye surgery, including, but not limited to, lasik surgery, orthokeratology and lens implantation for the correction of naturally occurring myopia, hyperopia and astigmatism.
17 . All Other Exclusions	
	1. 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. 2. Any service or supply furnished in connection with a non-Covered Benefit. 3. Any service, supply or medication when there is a less intensive Covered Benefit or most cost-effective alternative that can be safely and effectively provided, in accordance with applicable Medical Necessity Guidelines. 4. Any service, supply or medication that is required by a third party that is not otherwise Medically Necessary (examples of a third party are an employer, an insurance company, a school or court). 5. Any service or supply (with the exception of contact lenses) purchased from the internet. 6. Beauty or barber service. 7. Diabetes equipment replacements when solely due to manufacturer warranty expiration. 8. Externally powered exoskeleton assistive devices and orthoses. 9. Food or nutritional supplements, including, but not limited to, FDA-approved medical foods obtained by prescription, except as required by law and prescribed for Members who meet HPHC policies for enteral tube feedings. 10. Guest services. 11. Medical equipment, devices or supplies except as listed in this Benefit Handbook.

Exclusion	Description
All Other Exclusions (Continued)	
	12. Medical services that are provided to Members who are confined or committed to jail, house of correction, prison, or custodial facility of the Department of Youth Services. 13. Reimbursement for travel expenses. 14. Services for non-Members. 15. Services for which no charge would be made in the absence of insurance. 16. Services for which no coverage is provided in this Benefit Handbook, Schedule of Benefits or Prescription Drug Brochure. 17. Services provided under an individualized education program (IEP), including any services provided under an IEP that are delivered by school personnel or any services provided under an IEP purchased from a contractor or vendor. 18. Services that are not Medically Necessary. 19. Taxes or governmental assessments on services or supplies. 20. Transportation, except for emergency ambulance transport, and non-emergency medical transport needed for transfer between Hospitals or other covered health care facilities or from a covered facility to your home when Medically Necessary. 21. Voice modification surgery, except when Medically Necessary for gender affirming services. 22. 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. In most cases, you should not receive bills from Plan Providers.

If you receive a Surprise Bill, you are only responsible for the applicable Member Cost Sharing based on the Recognized Amount. HPHC will reimburse Non-Plan Providers at the Out-of-Network Rate unless otherwise agreed to by the Provider and HPHC. You will not be billed for any charges other than the applicable Member Cost Sharing based on the Recognized Amount. You are not responsible, and a Non-Plan Provider cannot bill you for:

- Amounts in excess of your Member Cost Sharing, based on the Recognized Amount, for non-emergency ancillary Covered Benefits received at certain In-network facilities by a Non-Plan Provider.
- Amounts in excess of your Member Cost Sharing, based on the Recognized Amount, for non-emergency, non-ancillary Covered Benefits received at certain In-network facilities from a Non-Plan Provider who has not satisfied the notice and consent criteria of section 2799B-2(d) of the Public Service Act.
- Amounts in excess of your Member Cost Sharing, based on the Recognized Amount, for Covered Benefits that are Medically Emergency Services provided by a Non-Plan Provider.
- Amounts in excess of your applicable Member Cost Sharing, based on the rates that would apply if the service was provided by a Plan Provider, for Covered Benefits that are air ambulance services provided by a Non-Plan Provider.

You can obtain information about your Member Cost Sharing online at **www.harvardpilgrim.org** or by calling Member Services at **1–877–907–4742**.

A. HOW TO FILE A CLAIM (PROOF OF LOSS)

Proof of loss is administered under this Handbook by filing a claim on a health care reimbursement claim form. These forms may be obtained by calling Member Services at **1–877–907–4742**.

Standard health care industry claim forms, known as the CMS 1500 and the UB-04 will also be accepted. These forms are available at most Hospitals and Physician's offices. In order to be paid by HPHC, all claims must be filed in writing or electronically. (Providers should contact HPHC for instructions concerning electronic filing.) Claims for services must be submitted to the following addresses:

Pharmacy Claims:

OptumRx
Manual Claims
P.O. Box 650334
Dallas, TX 75265-0334

All Other Claims:

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

If you request a health care reimbursement claim form from Member Services, one will be provided to you within 15 days.

Please note: Prior Approval is required to receive full coverage for certain services. See section *I.F. PRIOR APPROVAL* for more details. For services that require Prior Approval from HPHC, have your Provider call **1-800-708-4414**.

B. REIMBURSEMENT FOR BILLS YOU PAY

To obtain reimbursement for a bill you have paid, other than for pharmacy items, you must submit a health care reimbursement claim form with the provider or facility information. A legible claim form from the provider or facility that provided your care may also be included but is not required. The form must include 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 Member's signature
- The name and address of the person or facility providing the services for which a claim is made and their Tax Identification Number (TIN) or National Provider Identification (NPI) number
- The Member's diagnosis description, diagnosis code, or ICD 10 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 (if reimbursement is sought)
- Other insurance information

Important Notice: We may need more information for some claims. If you have any questions about claims, please call Member Services.

A health care reimbursement claim form can be obtained online at **www.harvardpilgrim.org** or by calling Member Services at **1–877–907–4742**.

1. International Claims

If you are requesting reimbursement for services received while outside of the United States, you must submit a health care reimbursement claim form along with 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 (2) the source of funds used for payment; and (3) an English translated description of the services received.

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 Member Services.

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

If you have a question regarding your reimbursement, call Member Services at **1–877–907–4742**.

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.

In accordance with Maine law, we will send you reimbursement within 30 days of receipt of all information needed to process your claims.

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 will be based on the Allowed Amount, unless it is a Surprise Bill. If a service is provided by a Non-Plan Provider, you are responsible for any amount in excess of the Allowed Amount, unless it is a Surprise Bill.

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, unless it is a Surprise Bill.

✔ 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.

Call Member Services at **1–877–907–4742** or **711** for TTY service if you have questions about the Allowed Amount for a service provided by a Non-Plan Provider.

E. NOTICE OF CLAIM

The Member is not required to give notice to HPHC prior to the filing of a claim, except for the Prior Approval requirements applicable to certain services. Please see section *I.F. PRIOR APPROVAL* for more information.

F. MISCELLANEOUS CLAIMS PROVISIONS

Generally, benefits will be paid to the Member who received the services for which a claim is made or directly to the health care provider whose charge is the basis for the claim.

HPHC will have the right to require that a Member for whom a claim is made be examined by a Physician as often as may be reasonably necessary to determine HPHC's liability for the payment of benefits under this Handbook. HPHC will also have a right, where not prohibited by law, to have an autopsy performed. Any such examination or autopsy will be conducted by a licensed Physician chosen by HPHC and at its expense.

Any payment by HPHC in accordance with the terms of this Handbook will discharge HPHC from all further liability to the extent of such payment.

VI. Appeals and Complaints

This section explains how we process appeals and complaints. It explains your options if an appeal is denied.

A. BEFORE YOU FILE AN APPEAL

If a claim is denied as a result of a claims processing error, or a misunderstanding with a provider, please call Member Services at **1–877–907–4742** (**711** for TTY service). Member Services will investigate the claim and either (i) resolve the problem, or (ii) explain why the claim was denied. If you are not satisfied with the response from Member Services, you may file an appeal. See section for more information.

B. MEMBER APPEAL PROCEDURES

If you receive an Adverse Benefit Determination, you may appeal.

- the denial of a health service you requested; or
- the denial of payment for a health service you already received.

Follow the steps below to ensure a timely and fair review of your appeal.

1. Initiating Your Appeal

To begin, you may file your appeal:

- in person,
- by mail,
- by fax,
- by phone, or
- electronically via the secure online member portal.

You should explain what coverage you are requesting and why you feel it should be granted. Please be as specific as possible. We need all the details in order to make a fair decision, including pertinent medical records and itemized bills. You must submit your request within 180 days of the denial of coverage.

An "authorized representative" may also submit an appeal on your behalf. A provider for which you are receiving active treatment, and who is acting as your authorized representative, must notify you in writing at least 14 days prior to filing an appeal on your behalf, and within 7 days after filing or withdrawing an appeal on your behalf.

You have the right to object to a provider filing an appeal on your behalf at any time. Additionally, you may notify the Plan that you intend take the place of the provider as a party to the appeal.

Please send your appeal to the following address:

HPHC Appeals and Grievances Department
1 Wellness Way
Canton, MA 02021
Phone: 1–877–907–4742
Fax: 1–617–509-3085

If you are deaf, hard of hearing or visually impaired, you may request appeal materials in an accessible format by calling Member Services at **1–877–907–4742**. You may also call **711** for TTY service.

After an appeal is filed, we assign an Appeals and Grievance Analyst. This analyst will manage your appeal throughout the entire process, including the second-level appeal process described below. We will send you a letter within three business day of receipt of your appeal. This letter will:

- identify your Appeals and Grievances Analyst,
- include detailed information on the first and the second level appeal processes described below, and
- include information on your right to independent external review and your right to contact the Maine Bureau of Insurance.

Your Appeals and Grievances Analyst can answer any questions you may have about your appeal and the review process.

We also utilize mediation to resolve some coverage disputes. Both the Plan and you must agree to mediation. You will be informed if we feel your appeal is appropriate for mediation.

2. First-Level Appeal Process

Standard Review Procedure: Your Appeals and Grievances Analyst will research your appeal, determine if additional information is needed and may request more information from you. This information may include:

- medical records,
- statements from doctors, and
- bills and receipts for services you have received.

If your appeal involves a medical determination, an appropriate Clinical Peer will review it. This review will be conducted by Clinical Peers not involved in the previous decision.

After we receive all information needed to make a decision, your appeal will be reviewed. We will send you a written decision within 30 days of receiving your appeal. We may not meet the 30 day time frame if we are not able to obtain necessary information from Non-Plan providers. If this happens, we will inform you in writing of the reason for the delay and the need for more time to make a decision.

Expedited Review Procedure: We will provide an expedited review if your appeal involves services which, if delayed, could seriously jeopardize your health or your ability to regain maximum function. We will grant an expedited review to any appeal for services concerning:

- an inpatient admission,
- availability of care, or
- 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, or your Authorized Representative may request an expedited review.

We will investigate and decide expedited appeals as quickly as possible. In all cases we will respond within 72 hours of the receipt of your appeal. You must promptly provider all necessary information for us to provide an expedited review. Coverage will be continued without liability if the expedited appeal involves:

- continued emergency services to screen or stabilize a Member, or
- continued care under an authorized admission or course of treatment.

Coverage will continue until the Member has been notified of the expedited appeal decision. To ensure a quick response, we may inform you of our decision on your expedited appeal by phone. We will also provide a written decision within two working days of 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:

- the names, titles and credentials of the reviewers who decided your appeal;
- a statement of the reviewers' understanding of the issues and all the relevant facts;
- the reviewers' decision and the basis for that decision, including the clinical rationale, if any;
- a reference to any Plan provisions used to make the decision;
- a reference to evidence or documentation used as the basis for the decision, including Medical Necessity Guidelines;
- notice of your right to contact the Maine Bureau of Insurance by phone at **1–800–300-5000 1–207–624-8475**, or by mail at 34 State House Station, Augusta, ME 04333 as required by Maine law;
- a description of the process to obtain a second-level review; and
- notice of your right to contact the ombudsman, Consumers for Affordable Health Care by phone at **1–800–965–7476** or by mail at P.O. Box 2490, Augusta, ME 04338–2490

3. Second-Level Appeal Process

If you disagree with the decision of the first level appeal process, you may ask for your appeal to be reviewed by our review committee. You have a right to attend the meeting to discuss your case with the review committee. Let your Appeals and Grievances Analyst know if you wish to attend. Please be advised that an attorney representative from the health plan will be present. You have the right to obtain your own legal representation. You may also take part in the meeting by phone. A review meeting will be held within 45 days of you asking 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. Your Authorized Representative may attend the review meeting on your behalf. Upon request, you may get your medical file and information relevant to the appeal free of charge. The review committee's decision will be sent to you in writing within 5 working days of the meeting. The decision of the review committee is final, subject to any right to external review as discussed below.

If you do not want to attend the review committee meeting in person or by phone, you will be given a written response to your appeal. The written response will be sent 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:

- the names, titles credentials of the reviewers who decided your appeal;
- a statement of the reviewers' understanding of the issues and all the relevant facts;

- reference to the specific Plan provisions and evidence or documents upon which the decision is based, including the Medical Necessity Guidelines used to make the determination;
- the reviewers' decision and the basis for that decision, including the clinical rationale, if any;
- a reference to the evidence or documentation used as the basis for the decision;
- notice of your right to contact the Maine Bureau of Insurance by phone at **1–800–300–5000** or **1–207–624–8475**, or by mail at 34 State House Station, Augusta, ME 04333 as required by Maine law;
- a description of the process to request an external review of your appeal as discussed below; and
- notice of your right to contact the ombudsman, Consumer for Affordable Health Care by phone 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. Instead, you have the right to 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 (IRO). IRO's are designated by the Maine Bureau of Insurance. You must complete the first level appeals process to be eligible for external review. You may be eligible for an independent external review if:

- HPHC has failed to make a decision on your first or second level appeal in the time frames noted above;
- you and the Plan mutually agree to bypass the member appeals process;
- your life or health is in jeopardy;
- the Member the external review is for has died; or
- the decision to be reviewed concerns one of the following:
  - an admission;
  - the availability of care;
  - a continued stay; or
  - health care services when you have emergency services but are not discharged from the facility that provided the emergency services.

External review of Adverse Health Care Treatment Decisions for Experimental, Unproven or Investigational treatments or services that have at least all of the protections are available for external reviews based on:

- Medical Necessity,
- appropriateness,
- health care setting,
- level of care, or
- effectiveness of a Covered Benefit.

Requests for external review must be in writing. Send your request to:

Maine Bureau of Insurance
34 State House Station
Augusta, ME 04333

Requests for external review must be made within 12 months of our final denial of Covered Benefits prior to the initiation of the appeals process. Your Authorized Representative may file an appeal for you. However, you must give that person written permission to do so.

The IRO designated by the Maine Bureau of Insurance will consider all relevant clinical information submitted by you and us. In addition, the IRO will consider any concerns you express about your health status. You have the right to attend the external review meeting. At the meeting, you may ask questions of our attending representative. You can also get information related 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 IRO. We will pay the fees of the IRO for conducting the review. If the IRO decides in your favor, we will cover the services approved.

Note: Payment disputes are not eligible for external review, except when the appeal is filed to determine if Surprise Bill protections are applicable.

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, please call or write to us at:

HPHC Member Appeals and Grievances Department
1 Wellness Way
Canton, MA 02021
Phone: 1–877–907–4742
Fax: 1–617–509-3085
www.harvardpilgrim.org

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
Phone: 1–800–300-5000 or 1–207–624–8475
Fax: 1–207–624-8599

TTY: 1–888–577–6690

E. INCONTESTABILITY

Any statement made by 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 three years during the Member's lifetime.

VII. Eligibility

This section describes eligibility rules under this Plan.

Eligible Subscribers and Dependents can enroll in a plan, or change their existing plan, during their annual open enrollment period.

A. MEMBER ELIGIBILITY

1. General Eligibility Requirements

To be eligible for coverage under this Plan, you must:

1) be a resident of Maine, and
2) meet the following requirements:
   - Agree to pay the monthly premium for coverage under the Plan;
   - Not be entitled to or enrolled under Medicaid, or Medicare Parts A, B or D.

HPHC reserves the right to request proof of residency at any time.

2. Dependent Eligibility

A Dependent must meet one of the requirements for coverage listed below to be eligible for coverage under the Plan. The eligibility requirements are as follows.

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

1) The Subscriber's legal spouse, including a domestic partner.
2) A child (including an adopted child or stepchild) of the Subscriber or spouse of the Subscriber. Coverage is provided 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. The child must meet each of the following requirements: (a) is currently Disabled;
   - is currently Disabled;
   - was Disabled on his or her 26th birthday; and
   - 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) An unmarried child up to the age of 19 years for whom the Subscriber or Subscriber's spouse is the court appointed legal guardian. You must submit proof of guardianship to HPHC prior to enrollment.
5) The unmarried child of an eligible Dependent of the Subscriber until such time as the parent is no longer a Dependent.

We may require evidence of eligibility.

B. EFFECTIVE DATE - NEW DEPENDENTS AND EXISTING DEPENDENTS

New Dependents may be added, and coverage will be effective as of the date of:

1) Marriage;
2) Birth;
3) Adoption;
4) Legal guardianship; or
5) The Subscriber becoming legally responsible for a Dependent's health care coverage.

   Please see section *VII.E. SPECIAL ENROLLMENT RIGHTS* for more information.

We must receive notice of the new Dependent within 60 days of the effective date of the qualifying event. If we are not notified within 60 days of the effective date of the qualifying event, Dependents may be added only on the Anniversary Date.

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 and the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities. 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 the 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. To add a new Dependent, please contact HPHC.

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 HPHC of all changes that affect Member eligibility. These changes include:

- address changes;
- marriage of a Dependent;
- death of a Member; and
- loss of Dependent eligibility as described above.

If you purchased coverage through CoverME.gov, please see section *VII.H. MARKETPLACE MEMBERSHIP* below for information applicable to your plan. .

E. SPECIAL ENROLLMENT RIGHTS

A special enrollment period is a period during which an eligible individual or enrollee, or Dependent where applicable, experiences certain qualifying events or changes in eligibility that permit enrollment, or a change in enrollment, outside of the annual open enrollment period. Unless specifically stated otherwise, an eligible individual or enrollee, or Dependent where applicable, must select a plan within sixty (60) days of the following triggering events:

- Loss of minimum essential coverage or other qualifying health coverage*
- Change in primary place of living*
- Gains access to an individual coverage Health Reimbursement Account (ICHRA) or a Qualified Small Employer Health Reimbursement Arrangement (QSEHRA)*
- Change in eligibility for CoverME*
- Change in eligibility for the Premium Tax Credit or other cost sharing reductions*
- Gains a new Dependent or becomes a Dependent through marriage, birth, adoption or placement for adoption
- If you purchased coverage through CoverME, you may have additional special enrollment rights as determined by CoverME, including but not limited to:
  - Change in eligibility for Medicaid or the Children's Health Insurance Program (CHIP)
  - Gaining or maintaining status as a member of a federally recognized tribe or a shareholder in an Alaska Native Corporation
  - Gains status as a U.S. citizen, national, or lawfully present individual
  - Meets eligibiltiy guidelines for Exceptional Circumstances as determined by CoverME

*An eligible individual or enrollee, or a Dependent where applicable, may have sixty (60) days before or after the triggering event to select a plan.

These special enrollment rights comply with the Affordable Care Act (45 CFR 155.420) and Maine state law (24-A MRSA Sec. 2736-C).

If you need more information or have questions about special enrollment rights or special enrollment periods, please call Member Services at **1–877–907–4742**.

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

Coverage starts on the day membership is effective, even if you are in the hospital. All other terms and conditions of coverage under this Handbook will apply.

For In-Network coverage, you must be inpatient in an In-Network Hospital.

If you are inpatient at an Out-of-Network Hospital, you must notify HPHC by calling **1-800-708-4414**. See section *I.F. PRIOR APPROVAL* for more information.

G. PARENTAL NOTIFICATION

If the Member is a parent of a Dependent child, the Member may request that we provide:

1. An explanation of the payment or denial of any claim filed on behalf of the Dependent child, except to the extent that the Dependent child has the right to withhold consent and does not affirmatively consent to notifying the parent;
2. An explanation of any proposed change in the terms of the Plan; and
3. Reasonable notice that the Plan may lapse, but only if the Member has provided us with the address where notice should be delivered. The

Member may also provide us with information about a claim relating to the Member's Dependent child so that we may process the claim.

H. MARKETPLACE MEMBERSHIP

Individuals purchasing coverage through CoverME must submit their application and enroll directly through CoverME. Administrative changes concerning coverage under this plan, including changes in address, effective dates of coverage or termination of coverage must be made through CoverME.

VIII. Premiums

A. PREMIUM AMOUNT

You are responsible for paying the premium for this Policy. Your first premium payment for January 1st coverage under this policy is due by January 10th. If you purchase coverage through a Special Enrollment Period (SEP) through CoverME, your first premium payment is due 30 days from the day we receive your enrollment application from CoverME or the effective date of the coverage period, whichever is later. Premium payments are due by the date stated on your invoice which is generally the 1st day of the month.

We may change your premium retroactive back to the effective date if:

- there is a misrepresentation on your application, or
- there is an omission on your application.

The rates provided are guaranteed for the twelve (12) month period following the 1st day of your effective date or renewal date, except that the premium will change when:

- you add or remove a Member from the Plan; or
- when you change your coverage.

B. GRACE PERIOD

If you are a Subscriber who does not receive Advance Premium Tax Credit (APTC) assistance, this Policy has a 31 day grace period to pay your premium. This means that if any premium is not paid by the due date, it may be paid during the next 31 days. During the grace period, this Policy will remain in force. If the premium is not paid before the grace period ends, this Policy will lapse and will end as of the paid through date.

If you are a Subscriber who receives APTC assistance and at least one month's premium has been paid, HPHC will provide a grace period of at least three consecutive months (90 days). During the grace period HPHC must apply any payment received to the first billing cycle in which payment was delinquent and continue to collect the APTC from the federal government. If full premium is not received during the 90-day grace period, the policy will be terminated retroactively back to the last day of the first month of the 3 consecutive month grace period. HPHC must pay claims during the first month of the grace period but may pend claims in the second and third months subject to our right to cancel the Policy as described in this Policy. You will be liable for the premium payment due including those for the grace period and for any claims payments made for services incurred after the date through with which the premium is paid.

IX. Termination and Transfer to Other Coverage

A. TERMINATION BY THE SUBSCRIBER

You may end your membership under this Handbook at any time. You must notify us in writing within 15 days of the date you want your membership to end. HPHC will refund you any premiums paid for coverage past the termination date. If you have coverage through CoverME, you must contact them to cancel your policy. Termination may be processed for the same day that you notify CoverME or a later date of your choosing.

B. TERMINATION FOR LOSS OF ELIGIBILITY

HPHC may end a Member's coverage under this Handbook for failing to meet any of the specified eligibility requirements. You will be notified if individual coverage is ending for loss of eligibility. We will inform you in writing.

C. TERMINATION FOR CAUSE

We may end your coverage for any of the following causes:

- Misrepresentation of a material fact on an application for membership;
- Failure to meet any of the specified eligibility requirements. This includes relocating outside the state of Maine;
- Obtaining or attempting to obtain benefits under the EOC for a person who is not a Member.
- Termination for nonpayment of premium by the Subscriber.

Termination 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 for the other causes will be effective thirty (30) days after notice. Premium paid for periods after the date of termination will be refunded. Termination for nonpayment of premium by the Subscriber will be effective retroactive back to the point of nonpayment. A 30 day grace period exists during which time your coverage continues in force.

CoverME Members Receiving Advance Premium Tax Credits (APTCs): CoverME Members who receive premium assistance are entitled to a three-month grace period during which time coverage is continued. We are required to pay all claims during the first month of the grace period.

Termination for nonpayment of premium by the Subscriber will be effective retroactive back to the last day of the first month of the grace period. All claims previously paid during the second and third months of the grace period will be reprocessed and the member will be responsible for paying for services provided during this time period.

D. TERMINATION DUE TO PRODUCT DISCONTINUANCE

We may terminate this coverage by giving you written notice at least 90 days prior to the date we will stop offering the Plan in Maine. In the event of termination due to the product discontinuance, you may purchase another individual health plan we offer in Maine.

E. TERMINATIONS FOR OTHER REASONS

We may also end your coverage under the Plan for any of the following 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.

F. REINSTATEMENT

If you're purchasing coverage through CoverME there is no reinstatement of this policy unless the coverage was terminated due to an error on the part of HPHC or CoverME.

If your premium is not paid before the applicable grace period ends (90 days for Members with APTC assistance and 31 days for all other Members), this Policy will lapse. Later acceptance of premium, along with a required reinstatement fee of up to $50, by HPHC or by an agent duly authorized by HPHC to accept such premium, without requiring an application for reinstatement, shall reinstate this Policy. If HPHC requires an application for reinstatement, it must be submitted to HPHC along with the required premium payment. Reinstatement of the Policy is subject to

approval by HPHC. If the application is disapproved, this Policy will not be reinstated. If the application and the applicable premium payment are received by HPHC and the application is not disapproved in writing, this Policy will be reinstated upon the date of the receipt of the application. A reinstated Policy will provide coverage for services you incurred after the date of reinstatement. In all other respects your rights and the rights of HPHC will remain the same, subject to any provisions noted on or attached to the reinstated Policy 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 so long as such request for reinstatement is made within 90 days of cancellation.

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.

If you suffer from a cognitive impairment or functional incapacity, and you do not have a third party designated prior to your policy's cancellation due to nonpayment of premium, you or your authorized representative have 90 days request reinstatement after such cancellation. Harvard Pilgrim may require a medical demonstration that you suffered from cognitive impairment or functional incapacity at the time of cancellation.

If a request for reinstatement of coverage because of cognitive impairment or functional incapability is denied, notice of denial shall be provided to the insured and to the person making the request, if different. The notice of denial shall include notification of the 30 day period following receipt of the notice during which a hearing before the Superintendent may be requested.

X. When You Have Other Coverage

This section explains how Plan benefits will be paid when another company or individual must also pay for health services a Member has received. This can happen when:

- other insurance, in addition to this Plan, is available to pay for health services.
- a third party is legally responsible for a Member's injury or illness.

Nothing in this section should be interpreted as:

- providing coverage for any service or supply that is not expressly covered under the EOC; or
- increasing the level of coverage provided.

A. BENEFITS IN THE EVENT OF OTHER INSURANCE

Benefits under this EOC 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, or Recognized Amount. This applies 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, the reasonable value of these services will be used as the basis for coordination. This also applies if a provider of services is paid under a capitation arrangement.

No duplication in coverage of services will occur among plans.

For prescription drug claims, we will coordinate benefits pursuant to our secondary payer allowed amount in all cases.

A Member may be 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.

Health Benefit Plans may contain provisions for the coordination of benefits. The rules below will determine which health benefit plans are primary or secondary:

1. Employee/Dependent

The benefits of the plan that covers the person as an employee or Subscriber are determined first. The benefits of the plan that covers the person as a Dependent are determined second.

2. Dependent Children

i. 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 first. The benefits of the plan of the parent whose birthday falls later in the year are determined second.
2) Both parents may have the same birthday. The benefits of the plan that covered the parent longer are determined first. The benefits of the plan that covered the other parent for a shorter period of time are determined second.
3) The other plan may not have the rule described in (1) above. Instead, it may have a rule based upon the gender of the parent. As a result, the plans may not agree on the order of benefits. In this case, the other plan will determine the order of benefits.

ii. Dependent Child/Separated or Divorced Parents

A court order may specify one of the parents as responsible for the health care benefits of the child.

Unless HPHC is aware of such court order, 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.

3. Active Employee or Retired or Laid-Off Employee

1) The benefits of a plan that covers the person as an active employee or as a dependent of an active employee are determined first.
2) The benefits of the plan that covers the person as an individual who is retired or laid off or as a dependent of that person are determined second.

4. COBRA or State Continuation

1) The benefits of a plan that covers the person as an employee, member, subscriber or retiree, or as a dependent thereof, are determined first.
2) The benefits of the plan that covers the person as an individual under COBRA or other right to continuation of coverage under state or federal law are determined second.

5. Longer/Shorter Length of Coverage

None of the above rules may determine the order of benefits. In this case,

1) The benefits of the plan that covered the employee, Member or Subscriber longer are determined first.
2) The benefits of the plan that covered that person for the shorter time are determined second.

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.

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

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 the EOC.

When HPHC is secondary: HPHC

- HPHC is responsible for processing claims for Covered Benefits after the primary plan has 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 the EOC.
- 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

HPHC may have information that shows the services provided to you are covered under:

- Workers' Compensation,
- Employer's liability or other program of similar purpose, or
- by a federal, state or other government agency.

In this case, HPHC may hold payment. Services will not be paid until it is determined if one of these programs is responsible for payment. Payment will be held 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 another program of similar purpose, or by a federal, state or other government agency, HPHC will be entitled to recovery of its expenses. Recovery will be from the provider of services or the party or parties legally obligated to pay for such services.

D. SUBROGATION AND REIMBURSEMENT

If you have an injury or illness legally caused by a third party, we have a right to be reimbursed by the third party for claims we pay for Covered Services you need. This is called subrogation.

Specifically:

- HPHC will be subrogated and succeed to all rights of the Member to recover against such third party (person or entity) 100% of the value of the services paid for or provided by the Plan.
- 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, excluding casualty insurance; or
  - the Member's own auto insurance carrier; in cases of uninsured or underinsured motorist coverage.
- HPHC's recovery will be made from any recovery the Member receives from an insurance company or any third party.
- 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

A Member may be 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:

1) the provision of all information and documents requested by HPHC;
2) the execution of any instruments deemed necessary by HPHC to protect its rights;
3) the prompt assignment to HPHC of any monies received for services provided or paid for by HPHC; and
4) the prompt notification to HPHC of any instances that may give rise to HPHC's rights.

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 Subscriber or an enrolled Dependent reaches age 65, that person may become entitled to Medicare based on is or her age group. That person may also become entitled to Medicare under age 65 due to disability or end stage renal disease.

HPHC will pay benefits **before** Medicare:

- for you or your enrolled spouse, if you or your spouse is age 65 or older, if you are actively working and if your employer has 20 or more employees;
- for you or your enrolled Dependent, for the first 30 months you or your Dependent is eligible for Medicare due to end stage renal disease; or
- for you or your enrolled Dependent,
  - if you are actively working,
  - you or your Dependent are eligible for Medicare under age 65 due to disability, and
  - your Employer has 100 or more employees.

HPHC may pay benefits **after** Medicare (including if you are eligible but not enrolled):

- if you are age 65 or older and are not actively working;
- if you are age 65 or older and your employer has fewer than 20 employees;
- after the first 30 months you are eligible for Medicare due to disability but are not actively working or are actively working for an employer with fewer than 100 employees.

Note: When Medicare is primary due to End Stage Renal Disease (or would be primary if the Member were timely enrolled), the Plan will pay for Medicare Part B services only to the extent payments would exceed what would be payable by Medicare. The Plan will estimate the amount that would be payable by Medicare and pay secondary benefits accordingly. The Plan may apply the same terms when Medicare is primary due to age or disability (or would be primary if the Member were timely enrolled).

XI. Plan Provisions and Responsibilities

A. LIMITATION ON LEGAL ACTIONS

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

B. ACCESS TO INFORMATION

You agree that we may have access to the following (except where restricted by law):

- all health records and medical data from Providers of Covered Benefits.
- information concerning health coverage or claims from all providers of:
  - motor vehicle insurance.
  - medical payment policies.
  - home-owners' insurance.
  - all types of health benefit plans.

We will comply with all laws that restrict access to special types of medical information. This includes, but is not limited to data and records for:

- HIV test data,
- substance use disorder treatment, and
- mental health care records.

C. SAFEGUARDING CONFIDENTIALITY

HPHC values your privacy rights. HPHC is committed to safeguarding protected health information (PHI) and personal information (PI). Our Privacy and Security policies include:

- how HPHC administers privacy and security programs;
- staff training; and
- how PHI and PI can be used and disclosed.

We may collect, use, and disclose financial and medical information about you when doing business with you or others. We follow our privacy policies and state and federal laws. Our business partners administer your health care coverage on our behalf. We require our partners to protect your information according to state and federal law.

For a copy of our Notice of Privacy Practices go to **www.harvardpilgrim.org** call Member Services at **1-877-907-4742**.

D. NOTICE

Member mailings are sent to your last address that we have on file. Mailings may include:

- notices;
- plan documents;
- invoices; and
- Activity Statements.

Be sure to let us know of an address change. This ensures mailings go to the right address. We are not responsible for mail you don't receive, if you have not sent an address change.

Notice to HPHC should be sent to:

HPHC Member Services Department
1 Wellness Way
Canton, MA 02021
1–877–907–4742
www.harvardpilgrim.org

See section *VI. Appeals and Complaints* for the address and phone numbers to file an appeal.

We will give written notice to Members of any rate increase sixty (60) days prior to the Anniversary Date or the effective date of any increase.

E. MODIFICATION OF THIS HANDBOOK

We may amend the EOC. We will provide sixty (60) days written notice to the Subscriber. Amendments do not require the consent of Members.

The EOC is the entire contract between you and the Plan. HPHC's responsibilities to you are only as stated in the EOC documents. The EOC can only be modified in writing by an authorized Plan officer. No other action by us will waive or alter any part of the EOC. This includes non-enforcement of any benefit.

F. OUR RELATIONSHIP WITH PLAN PROVIDERS

Separate agreements govern our relationship with Plan Providers. Plan Providers:

- are independent contractors.
- may not modify the EOC.
- may not create any obligation for HPHC.

We are not liable for their statements about the EOC. This includes their employees or agents.

Without notice to Members, we may:

- change our arrangements with service Providers; or
- add or remove Providers from the Plan.

G. WELLNESS INCENTIVES

A Member may be able to receive incentives for taking part in health and wellness programs. Incentives may include reimbursement for certain fees you pay for taking part in:

- fitness programs;
- weight loss programs; or
- other wellness programs.

Receiving an incentive does not depend upon the outcome of the program. Go to **www.harvardpilgrim.org** for more information. See your EOC for any incentive amounts included with your Plan. For tax information, please consult with your employer or tax advisor.

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).
- the disability of service providers.

We may not be able to provide or arrange services in 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; and
- new applications of the above.

The team manages an evidence-based evaluation process. This process recommends a status of (i) an accepted standard of care; or (ii) 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 makes recommendations to internal policy committees. These committees make final policy decisions for new technology coverage. The policy evaluation process includes:

- determining the FDA approval status of the device/product/drug in question;
- reviewing relevant clinical literature; and
- consulting actively practicing specialists about current practice standards.

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 certain services. We use clinical criteria to assure your care is clinically appropriate and cost-effective. This applies to both physical and behavioral health services.

- **Prospective Utilization Review (Prior Approval).** We review certain services before they are provided. This Prior Approval review determines eligibility and whether the proposed services meet Medical Necessity Guidelines. Services include but are not limited to:
  - elective inpatient admissions;
  - surgical day care;
  - outpatient treatment /ambulatory procedures; and
  - Medical Drugs.

  If we require additional information, we will notify you and your requesting provider. After receiving all necessary information, Prior Approval decisions and notice, except for urgent requests, are made within 72 hours or two working days, whichever is less.

  If a decision and notification of the non-urgent request is not made within the lesser of 72 hours or two working days, the request for Prior Approval is granted.

  Special rules apply to any Prior Approval request for a drug in urgent or exigent circumstances. An exigent circumstance exists when:

a. A Member is suffering from a health condition that could seriously jeopardize the life or health of the Member or the ability of the Member to regain maximum function; or

b. A Member is undergoing a current course of treatment with a non-formulary drug.

In the event of an urgent Prior Approval request, we will make a decision and notify you and the requesting provider of the decision as soon as possible, but not later than 24 hours of receiving the request.

- **Concurrent Utilization Review.** We review ongoing admissions or treatment for certain services. These reviews are used to verify Member eligibility and to ensure that the services provided meet Medical Necessity Guidelines. These services may be at:
  - hospitals, including acute care hospitals;
  - rehabilitation hospitals;
  - skilled nursing facilities; and
  - skilled home health providers.

  Concurrent review decisions are made and communicated within one working day of receiving all necessary information.

  For a decision to approve an extended stay or additional services , we will notify you and your provider in writing or by electronic notification within one working day.

  For a decision to deny an extended stay or additional services we will notify you and your provider in writing or by electronic notification within one working day. You will be covered without liability until you are notified of the determination.

  Concurrent review includes active case management and discharge planning. Your Provider may also request these services.

  The same rules apply to concurrent review of urgent or exigent circumstances as described above under "Prospective Utilization Review (Prior Approval)."

- **Retrospective Utilization Review**. We may review services after they have occurred, or that were provided before Prior Approval was obtained. This may include review of emergency medical admissions for appropriate level of care. Retrospective utilization review decisions are made within 30 days after obtaining all necessary information. In the case of an adverse decision (denial) involving clinical review, you will receive written notification within 5 working days of the decision. The written notice will include the specific rationale upon which the decision was made, and will also include information about the appeals process and the right to request in writing copies of any Medical Necessity Guidelines applied in a denial of coverage decision. If a decision and notification of the retrospective request are not made within the timeframes outlined above, the retrospective request is granted.

To find the status of a clinical review decision call Member Services at **1-877-907-4742**.

For an adverse decision involving clinical review, your Provider may discuss your case with a physician reviewer. Your Provider may also ask us to reconsider our decision. We will reconsider a decision within one working day of your Provider's request. If the adverse decision is not reversed, you may appeal. Your appeal rights are described in section *VI. Appeals and Complaints*. Your right to appeal does not depend on making a request to reconsider our decision.

L. QUALITY ASSURANCE PROGRAMS

HPHC has quality controls in place guided by the National Committee for Quality Assurance (NCQA). Our Quality Assurance programs are designed to ensure consistently excellent health plan services. Key Quality Assurance programs include:

- **Verifying Provider Credentials** - HPHC obtains, verifies, and assesses Plan Provider qualifications to provide care or services. This involves gathering evidence of licensure, education, training and other experience and/or qualifications.
- **Verifying Facility Credentials** - HPHC reviews and confirms licensures and certifications based on facility type.
- **Quality of Care Complaints** – HPHC follows a process to investigate, resolve and monitor Member complaints about care provided by a Plan Provider.
- **Evidence Based Practice** – HPHC compiles Medical Necessity Guidelines. These guidelines are based on the most current evidence-based standards. They provide an analytical framework for clinicians to evaluate and treat of common health conditions.
- **Performance monitoring** – HPHC collects data to measure outcomes. This data is related to the

Health Care Effectiveness Data and Information Set (HEDIS). It is used to monitor health care quality across various domains of evidence-based care and practice.

- **Quality program evaluation**- Annually HPHC develops, plans and implements initiatives to improve clinical service and quality. The Quality Program is documented, tracked and evaluated against milestones and objectives. See and review the full program description at **https://www.harvardpilgrim.org/public/about-us/quality**.

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

We use a standard process to assess coverage questions and requests. These may come to us from internal or external sources. The process includes:

- Determining FDA approval status of the device, product, or drug question;
- Reviewing relevant clinical literature; and
- Consulting with actively practicing specialists about current practice standards.

Decisions are developed into policy change recommendations. These are then sent to our management for review and final approval.

N. PROCESS TO DEVELOP MEDICAL NECESSITY GUIDELINES AND UTILIZATION REVIEW CRITERIA

We use Medical Necessity Guidelines to make fair and consistent utilization management decisions. Medical Necessity Guidelines are developed according to NCQA standards. Guidelines are reviewed (revised, if needed) at least annually. Review may occur more often to include updates in practice standards. This process applies to criteria for both physical and mental health services.

For example, we use the nationally recognized InterQual criteria to review (i) elective surgical day procedures; and (ii) services provided in acute care hospitals. InterQual criteria are developed from current national standards of medical practice. Physicians and clinicians in academic medicine and all areas of active clinical practice provide input. InterQual criteria are reviewed and revised annually.

Medical Necessity Guidelines are also used to review other services. Physicians and other clinicians with relevant clinical expertise provide input. The process includes review of relevant clinical literature and local practice standards.

O. NEW TO MARKET DRUGS

New to market prescription drugs are reviewed by the Plan prior to coverage. This ensures that the drug is safe and effective. New to market drugs are reviewed by HPHC's:

- Medical Policy Department;
- New Technology Assessment Committee or Pharmacy Services Department; and
- the Pharmacy and Therapeutics Committee.

The review will take place within the first 180 days of their introduction to the market. Coverage for a new to market drug may apply Prior Approval and coverage limitations.

P. PAYMENT RECOVERY

We may determine that a mistake was made paying Plan benefits. We reserve the right to:

- recover such payments from the Provider or Member.
- offset later benefit payments to a Provider (regardless of payment source) or Member by any such overpayment amount.

XII. MEMBER RIGHTS & RESPONSIBILITIES

You have a right to receive information about:

- HPHC's services.
- Plan practitioners and Providers.
- Your rights and responsibilities.

You have a right:

- to privacy.
- to be treated with dignity and respect.
- to participate in decision-making regarding your health care.
- to a candid discussion of appropriate treatment options for your condition, regardless of cost or benefit coverage.
- to voice a complaint or appeal about HPHC or the care provided.
- to suggest changes to HPHC's members' rights and responsibilities policies.
- to assign benefits for your care to your provider. This assignment does not affect or limit the payment of benefits otherwise payable under the Plan.

You have a responsibility to:

- provide, to the extent possible, information that the Plan and Plan Providers need to manage your care.
- to follow your Provider's plans and instructions for care.
- to understand your health problems.
- to participate in developing mutually agreed upon treatment goals to manage your health.

HPHC Insurance Company, Inc.

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